Trainee Supervision Agreement Form

Please note this registration form will only be accepted in digital format & returned via email to stu@cervicalcheck.ie

Part A to be completed by Trainee

Trainee Name: Click or tap here to enter text.

MCRN/NMBI: Click or tap here to enter text.

GP☐ GP Trainee ☐

Registered General Nurse ☐ Registered Midwife ☐ (please note that nurses registered on these divisions are only eligible)

Practice Address & Eircode:

Practice Tel No: Click or tap here to enter text.

Mobile: Click or tap here to enter text.

Email: Click or tap here to enter text.

Can you be contacted via text message? Yes ☐ No ☐

Do you have a specific learning disability that may affect your studies? Yes ☐ No☐ if yes please provide further details

_____

I confirm that I wish to register for the following course. Yes ☐ No☐

Course Details:

Title: Choose an item.

Date: Click or tap to enter a date.

Mandatory Requirements:

I have completed the " **CervicalCheck in Practice"** online elearning module on the following date: **Click or tap to enter a date.**

The registered doctor or nurse (trainee) acknowledges and agrees that programme cervical screening tests will be carried out under the clinical responsibility of the general practitioner (GP) pursuant to the contract with registered medical practitioners for the provision of a primary care based cervical screening service. The Contracted GP shall receive payment for all such tests carried out.

Signature of Trainee: _____

Date:

Part B to be completed by CRD

- I am aware that a CervicalCheck appointed trainer will visit the trainee in my practice. ☐
- In modelling best practice, I understand that the CervicalCheck appointed trainer may take a cervical screening test in my practice. ☐
- I agree to supervise the trainee and support the policies and protocols of CervicalCheck – The National Screening Programme. ☐
- The Clinically Responsible Doctor/CRD i.e. the contract holder with CervicalCheck must sign the below section: ☐

Name of Clinically Responsible GP/Doctor:
Click or tap here to enter text.

Medical Council Number:
Click or tap here to enter text.

Signature of Clinical Responsible Doctor:

_____

Date of Signature: Click or tap to enter a date.

The doctor or nurse and/or the General Practitioner will be notified when the registration process has been completed.

Please Note: CervicalCheck appointed clinical trainers are covered by clinical indemnity

Privacy Notice: *Your personal details that you provided will be kept on file within the screening training unit (STU) to enable us to facilitate the Cervical Screening Education Programme.*