

**FORM FOR REGISTERING AS A TRAINEE IN COLPOSCOPY**

Family Name \_\_\_\_\_ Title \_\_\_\_\_

Given Name \_\_\_\_\_

Contact Address \_\_\_\_\_

\_\_\_\_\_ Post Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Email address \_\_\_\_\_

Place of Practice \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Current Position \_\_\_\_\_

Degrees held \_\_\_\_\_

Are you a SCCPS Member? Yes / No \*

Have you attended a basic colposcopy course? Yes / No \*

If Yes, which meeting and when? \_\_\_\_\_  
**(please append Certificate of Attendance)**

Have you identified a trainer for the clinical components of training? Yes / No \*

If Yes, please indicate the institution and obtain the signature of your proposed trainer in the section below.

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**To be completed by trainer**

**I (print name)** \_\_\_\_\_ **of**  
\_\_\_\_\_ **(Institution address)**

**hereby certify that I am a SCCPS Certified Colposcopist and am prepared to supervise the training of the above named trainee.**

Signed \_\_\_\_\_ Dated \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\* Delete as appropriate**

*Please return this form by fax or mail to the SCCPS together with a cheque of \$10 made payable to "COLPOSCOPY REGISTRATION COMMITTEE".*

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