

## FORM FOR REGISTRATION FOR COLPOSCOPY UNDER THE GRANDFATHER CLAUSE

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 \*

How many colposcopies do you do in a year? 0-25      26-50      51-100      >100

Would you be willing to be a trainer for new colposcopists? Yes / No \*

***I (print name)*** \_\_\_\_\_

***certify that I have attained the basic training standards as recommended by the SCCPS for colposcopy training and have maintained the knowledge and skills consistent with those recommendations. I confirm that I am currently in active colposcopic practice.***

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

**\* Delete as appropriate**

*Please return this form by fax, or mail to SCCPS together with a cheque of \$50 made payable to "COLPOSCOPY REGISTRATION COMMITTEE". Registration fee for SCCPS members is waived.*

Ms Michelle Choy  
c/o 17 Jalan Mesin, #04-01  
Lee Hwa Industrial Building  
Singapore 368816  
Tel. 6339 8687  
Fax. 6339 9536 / 3731  
Email. crc@sccps.org