

## FORM FOR MAINTENANCE ON THE REGISTER OF COLPOSCOPISTS

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

Have you attended a postgraduate meeting relating to colposcopy in the last two years?  
Yes / No \*

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

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

***I (print name) \_\_\_\_\_  
 certify that I am currently in active colposcopic practice and have performed at  
 least 30 colposcopies over the last 2 years.***

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

***\* Delete as appropriate***

*Please return this form by fax or mail to:*

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