



## REGISTERING AS A TRAINEE IN COLPOSCOPY

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

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

Contact Address \_\_\_\_\_  
 \_\_\_\_\_ Post Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ (office/clinic) \_\_\_\_\_ (mobile)

Fax 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 \_\_\_\_\_ of \_\_\_\_\_  
 (print name) (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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*Please return this form by fax or mail together with a cheque of \$10.00 made payable to "COLPOSCOPY REGISTRATION COMMITTEE" to*

Ms Michelle Choy , SCCPS Secretariat  
 c/o CityState Conference & Exhibition Pte Ltd  
 115 Amoy Street, #03-00, Singapore 069935  
 Tel: (65) 6410 9695 Fax: (65) 6372 1793  
 Email: secretariat@sccps.org