



MAINTENANCE ON THE REGISTER OF COLPOSCOPISTS

Family Name _____ Given Name _____

Contact Address _____

_____ Post Code _____

Telephone Number _____ (office/clinic) _____ (mobile)

Fax Number _____ Email Address _____

Place of Practice _____

Address _____ Postal Code _____

Current Position _____ MCR No. _____

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, Secretariat, SCCPS
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