

**Trainee Supervision Agreement Form**

**Please note this registration form will only be accepted in digital format**

Part A to be completed by Trainee	Part B to be completed by CRD
<p><b>Trainee Name:</b> Click or tap here to enter text.</p> <p><b>MCRN/NMBI:</b> Click or tap here to enter text.</p> <p>GP <input type="checkbox"/> GP Trainee <input type="checkbox"/></p> <p>Registered General Nurse <input type="checkbox"/> Registered Midwife <input type="checkbox"/> (please note that nurses registered on these divisions are only eligible)</p> <p><b>Practice Address &amp; Eircode:</b></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p><b>Practice Tel No:</b> Click or tap here to enter text.</p> <p><b>Mobile:</b> Click or tap here to enter text.</p> <p><b>Email:</b> Click or tap here to enter text.</p> <p>Can you be contacted via text message? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you have a specific learning disability that may affect your studies? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes please provide further details</p> <hr/> <p>I confirm that I wish to register for the following course. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Course Details:</b></p> <p><b>Title:</b> Choose an item.</p> <p><b>Date:</b> Click or tap to enter a date.</p>	<ul style="list-style-type: none"> <li>I am aware that a CervicalCheck appointed trainer will visit the trainee in my practice. <input type="checkbox"/></li> <li>In modelling best practice, I understand that the CervicalCheck appointed trainer may take a cervical screening test in my practice. <input type="checkbox"/></li> <li>I agree to supervise the trainee and support the policies and protocols of CervicalCheck – The National Screening Programme. <input type="checkbox"/></li> <li>The Clinically Responsible Doctor/CRD i.e. the contract holder with CervicalCheck must sign the below section: <input type="checkbox"/></li> </ul> <hr/> <p><b>Name of Clinically Responsible GP/Doctor:</b> Click or tap here to enter text.</p> <p><b>Medical Council Number:</b> Click or tap here to enter text.</p> <p><b>Signature of Clinical Responsible Doctor:</b></p> <hr/> <p><b>Date of Signature:</b> Click or tap to enter a date.</p> <hr/> <p><i>The doctor or nurse and/or the General Practitioner will be notified when the registration process has been completed.</i></p> <p><i>Please Note: CervicalCheck appointed clinical trainers are covered by clinical indemnity</i></p>
<p><b>Mandatory Requirements:</b></p> <p>I have completed the “ <b>CervicalCheck in Practice</b>” online elearning module on the following date: <b>Click or tap to enter a date.</b></p> <p>The registered doctor or nurse (trainee) acknowledges and agrees that programme cervical screening tests will be carried out under the clinical responsibility of the general practitioner (GP) pursuant to the contract with registered medical practitioners for the provision of a primary care based cervical screening service. The Contracted GP shall receive payment for all such tests carried out.</p> <p><b>Signature of Trainee:</b> _____</p> <p><b>Date:</b> _____</p>	<p><b>Privacy Notice:</b> <i>Your personal details that you provided will be kept on file within the screening training unit (STU) to enable us to facilitate the Cervical Screening Education Programme.</i></p>