Last Name: ................................................. First Name: ……………………… Title.............………..

Contact Address: ................................................................................................... Post Code......................…

Telephone Contact Number: .....…………….......……….……. E-mail address: …………………….………………

Hospital/Institution: …………………………………............................................................................……………...…

Address: ……………………………………………………………………………… Post Code: ………………….…

Current Post: ................................................. Qualifications: .......................................................

I (*name of trainee*)........................................................................................ (*print name*) certify that I have completed colposcopy training as defined by the BSCCP and submitted my Electronic Trainee Logbook to the BSCCP.

**Signature of trainee:** .................................................................................. **Date**...............................................

**The following Declarations to be completed by Trainer:**

(1) “I (*name of trainer*)......................................................................................(*print name*)

certify that I have supervised the training of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*name of trainee)* and am satisfied that the above trainee is capable of independent colposcopic practice.

(2) “I hereby declare that the above trainee has carried out the requisite number of OSATS, Mini Cex and CbD’s and that their competence reflects standard practice in this Unit”.

(3) “I hereby declare that the above trainee has attended at least 50% (a minimum of 6) Multidisciplinary Team Meetings during their period of training”.

**Signature of trainer:**................................................................................... **Date**.....................................................

**Institution**:..................................................................................................... **Certificate No:** …………….................

**Completed form to be returned to: Elaine Radford, BSCCP, Birmingham Women’s Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2TG**