Registration Form

Cervical Screening Audit

Please complete all sections below. Please note: Supplying your RACGP/ACRRM/RANZCOG/ACN number and email address is vital for us to accurately allocate your education points.

DOCTOR INFORMATION

Title: _________ First Name: ______________________________________ Last Name: ____

QML Dr. Code (if known): _____________________ Provider No.: ____

Name of College: ______________________________ College Registration No.: ______________________________ Mandatory

Practitioner Type

☐ General Practitioner ☐ General Practitioner specialising in Women's Health

☐ Sexual Health Clinic ☐ Obstetrician and Gynaecologist ☐ Nurse Practitioner

PRACTICE DETAILS

Practice Name (Primary Location): ____

Practice Address (Primary Location): ____

Suburb: _____________________________________ State: _________________________ Postcode: ___________________________

Phone: ______________________________________ Fax: __________________________ Mobile: _____________________________

Email Address: ____ Required

Other practice locations to be included in this audit: ____

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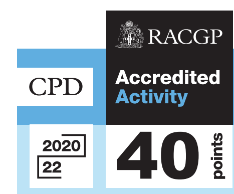
I, Dr ____ *(print name)* confirm that I wish to receive a 'Cervical Screening Audit Report' of my pathology cases and I will contact QML Pathology if my contact details change or if I no longer want to receive the 'Cervical Screening Audit Report'.

Doctor's Signature ____ Date: ______________________________

Please Note: It is recommended that specimens be submitted on **lavender** Cervical Screening Test Request forms which are available via your Medical Liaison Officer, your stores network or your nearest laboratory.

Complete, scan and email or fax this registration form to **education@qml.com.au** / **(07) 3121 4478**



Specialist Diagnostic Services Pty Ltd (ABN 84 007 190 043) t/a QML Pathology PUB/MR/1050_V6_Apr20