CancerCare Manitoba
ActionCancerManitoba
BreastCheck CervixCheck ColonCheck

CervixCheck Colposcopist Registration

FIRST & LAST NAME _____ BILLING NO. _____

SITE NAME _____

SITE ADDRESS _____

CITY/TOWN _____ **POSTAL CODE** _____

SITE PHONE _____ **SITE FAX** _____

The information collected above will be included in the CervixCheck registry.

Would you like us to include your **COLPOSCOPY CLINIC** information on our website colposcopist listing?

☐ Yes ☐ No

Only **bolded** fields above will be published on our website.

The information collected below is not shared. CervixCheck uses this information to notify you of program changes.

PHYSICIAN EMAIL _____

PHYSICIAN PHONE _____

ADMIN CONTACT NAME _____

ADMIN EMAIL _____

Provide a brief description of the training you have received in the area of colposcopy:

In submitting this form to CervixCheck, I understand as per the Public Health Act, Cervical Cancer Screening Registry Regulation (31/2009), colposcopy reports are to be submitted to CervixCheck within 30 days of the result of the colposcopy being known.

Fax this completed form to:

CervixCheck, CancerCare Manitoba
Attention: CervixCheck Senior Administration Clerk
Fax: 204-779-5748
Ph: 1-855-95-CHECK (24325)

INTERNAL OFFICE USE

_____ _____

MEET & GREET DATE BY (NAME)