



NATIONAL CERVICAL SCREENING REGISTER

USER ACCESS REQUEST FORM

Only one form will be processed for each facility.

If more than one form is submitted there will be delays while the correct form is confirmed.

[All fields are mandatory]

FAX: 04 816 4484

FIRST NAME _____			
FAMILY NAME _____			
HEALTH FACILITY NAME e.g. Aotea Pathology, Medlab Hamilton _____			
ORGANISATION TYPE (Circle one) SERVICES	LABORATORY	COLPOSCOPIST	REGIONAL
HEALTH FACILITY ADDRESS _____			
SUBURB _____			
CITY / TOWN _____			
HEALTH FACILITY PHONE _____			
EMAIL ADDRESS [To confirm activation] _____			
START DATE (DD/MM/YYYY) _____			
[Date from which the user account will have access to the register]			

All Users of NCSP-R are to comply with **Part 4A and Section 22c of the Health Act 1956 (Amendment No. 2)**, the **Health Information Privacy Code 1994**, as well as their parent organisation's policies and protocols on privacy / confidentiality and other codes of conduct or conditions of employment. Access to information in relation to individuals must be for clinical purposes only. By signing this document you, and any staff member in your organisation delegated to use the NCSP-R, agree to abide by these terms and conditions.

Manager Name: _____

Signature: _____

Signature: _____