

Application Form



Applicant Information

Name:

Address:
(Including
Eircode)

DOB:

Phone:

Email:

Preferred method of communication:

E-mail

Telephone

Post

No preference

Do you require an interpreter for meetings?

Yes

No

If yes, please advise the language required:

Eligibility

These meetings are only available to those who are eligible. Eligibility is set out in the CervicalCheck Tribunal Act 2019 and is as follows:

- a) women who were part of the Review of Cervical Screening and whose review findings were discordant;
- b) women whose slides were sought to be part of the Review of Cervical Screening process but whose slides could not be re-examined due to circumstances beyond the control of the woman concerned;
- c) women who were part of the retrospective CervicalCheck cytology clinical audit and whose cytology review findings were discordant with those of the original cytology;
- d) the dependants of a woman who has passed away but would have been eligible to apply under one of the above categories.

I confirm I am eligible to apply under one of the above categories:

Yes

No



Applications under Category D

If you are eligible under category d, please provide details of the person you are the dependant* of:

Name

Address

DOB

PPSN

Relationship to applicant

** Please note, as per the Civil Liability Act 1961, a dependant is defined as a spouse, co-habitant, civil partner (within the meaning of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010), parent, grandparent, step-parent, child, grandchild, step-child, brother, sister, half-brother or half-sister of the deceased.*

Type of Meeting

Please select the type of meeting you may like:

Telling your story and talking about your experiences

Documenting your experiences

Requesting information from other parties

Sharing your experiences with other parties

Meeting with other parties to discuss your experiences

Other

I'm not sure - I would like to discuss with the Moderator first.

If you would like to meet with a particular person please provide their contact details below, if known

Name

Address

Phone

E-mail



Any other relevant information you wish to bring to the attention of the RTM Team

Signature and Consent

If you consent, please place a mark in the box.

I consent to be contacted in relation to my application for a Restoration of Trust Meeting and that my personal data collected as part of this application process may be processed for the purposes of Restoration of Trust Meetings.

I consent to my eligibility for a Restoration of Trust Meeting being confirmed with the National Screening Service. (Note: If you do not consent to your eligibility being confirmed with the National Screening Service, please contact us directly at info@rtm.ie)

Signature

Date

[Facilitator - Office Use Only]

Case Reference:

Date eligibility confirmed:

Moderator nominated:

Date appointed: