



# CERVICAL SCREENING PROGRAMME

**Withdrawal Form**  
for Women, Service Providers  
& Lab Professionals

(Please fill in this form in BLOCK letters)

## Personal Particulars

Name*: <small>(As on HKID/passport)</small>	<i>Surname</i>   <i>Given names</i>	Chinese name*: <small>(If any, as on HKID/passport)</small>	
#HKID / Passport no.*:		Date of birth: _____ / _____ / _____ <small>Day Month Year</small>	
User type*:	<input type="checkbox"/> Woman	<input type="checkbox"/> Service provider	<input type="checkbox"/> Laboratory professional

## Declaration

<p>1. I confirm that I want to withdraw from the Cervical Screening Programme.</p> <p>2. I understand that I will no longer enjoy the privileges offered by the Cervical Screening Programme.</p> <p>Signature: _____ Date: _____</p>
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Thank you for your support in the past

# Delete as appropriate  
\* indicates a mandatory field and must be provided

Please send this completed form to Cervical Screening Programme by fax (2833 5445) or by mail to:



**Cervical Screening Programme**  
**Department of Health,**  
**18/F, Wu Chung House, 213 Queen's Road East, Wanchai, Hong Kong**

*Photocopy of the blank form is allowed.*