

**Professional Certificate Advanced Imaging in Fertility**

**Ultrasound (X989)**

**Declaration of Clinical Placement**

 ***Applicant’s Name:***

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***Hospital/Clinic Name & Address:***

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***Name, Current Position and Academic Qualifications of Clinical Supervisor:***

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 I confirm that the above applicant is guaranteed to obtain a minimum of 70 hours

 clinical experience whilst undertaking the UCDProfessional Certificate in Advanced Imaging in Fertility Ultrasound. These hours incorporate SIS & HyCosy procedures and 3D ultrasound

**Applicant’s Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_

**Clinical Supervisor Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_