**Performers List Validation by Experience**

**(PLVE)**

Application Form

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**Please ensure that you:**

* **Complete all Sections and Sign the Declarations in** [**Section 2**](#Sig2) **and** [**Section 3**](#Sig1) **before submitting your assessment request**
* **Enclose 2 x Clinical References (these should be your two most recent employers and written in English)**
* **Please refer to the “*Initial Application Flow Chart”* to ensure you have enclosed all items prior to submission**

**This form must be completed electronically and then hand signed.**

**Please return the completed form and attachments by email to:**

HEIW.DPSU@Wales.nhs.uk

**Please be aware that incomplete documentation and information will not be considered by the panel. Please ensure, prior to submission you have all relevant information included and that you adhere to the submission deadlines. Failure to do so will result in the application being rejected and not being considered at a PLVE Panel meeting.**

**Section 1 – Structured CV**

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| Part 1 | Personal Details | | | | | | | | | |
| Surname: | |  | | | | | | | | *As registered with the GDC* | | |
| First name: | |  | | | | | | | |
| Preferred title: | | Mr |  | Mrs |  | Miss |  | Ms |  | Other (please specify) | |  |
| Nationality: | |  | | | | | | | | | | |
| Contact address (including postcode) | |  | | | | | | | | | | |
| Mobile phone number | |  | | | | | | | | | | |
| Daytime phone number (if different) | |  | | | | | | | | | | |
| Email address: | |  | | | | | | | | | | |

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| Part 2 | Registration and Qualifications | |
| GDC registration number |  | |
| Date of UK registration as a dentist |  | (dd/mm/yy)  Click or tap to enter a date. |
| List the qualifications that entitle you to be a dentist (in chronological order, with the most recent first) | | |
| **Qualification** | **Country where qualification was gained** | **Year gained** |
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| Part 3 | | Employment History | | | | | | | | | | |
| Please provide a profile of your previous working posts since qualifying (in chronological order, with the most recent first) | | | | | | | | | | | | |
| **Employer name** | | **Address of clinic/surgery**  **/practice** | | | **Your role/job title** | | **Average hours per week treating patients** | | | **Dates**  (from and to) | | |
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| Please give details of any gaps or overlaps in your employment history: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Total time you have worked as a dentist in General Dental Practice (if applicable) | | | | | | | | | | | |
| Months: |  | | Years: |  | |  | |  | | | |
| Was this: | Full time? | | Yes  No | Part-time? | | Yes  No | | | Number of days per week (if part-time): | |  |

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| Part 4 | NHS Practice Information | | | | | |
| Completion of this part of the form confirms that you have applied to join the dental performers list in Wales | | | | | | |
| I have applied on: | | |  | | Date – dd/mm/yy | |
| to be included on the Dental List of | | |  | | Health Board | |
| Address of proposed practice (including postcode) | | |  | | | |
| Practice phone number (including area code) | | |  | | | |
| The proposed Mentor for the duration of the Performers List Validation by Experience is: | | | | | | |
| Name: | |  | | GDC Number: | |  |
| Proposed Mentor’s email address (if known) | | | |  | | |

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| Part 5 | Enclosures and Declaration | | |
| You will need to provide all the following documents to support your assessment request and should supply as many as possible now. Most are required before starting NHS practice. Please indicate which of the following are enclosed with this assessment request. | | | |
|  | | | **Enclosed** |
| Clinical Experience Checklist (see next section for document to be completed) | | |  |
| Continuing Professional Development (CPD) record for past 2 years | | |  |
| Certificates of attendance at courses for: | | **Date attended course** | **Enclosed** |
| IR(ME)R / Radiology (within 5 years) | |  |  |
| Cross Infection Control (within 5 years) | |  |  |
| CPR (within last 12 months) | |  |  |
| Ethics and Medico-Legal Topics (within 5 years) | |  |  |
| Safeguarding children and vulnerable adults level 2 (within 3 years) | |  |  |

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| **Signed:** |  | **Date:** |  | | |
|  |  |  |  | | |
| **I declare that, to the best of my knowledge, the above information is correct.** | | | | |
|  |  |  |  | | |
| **You must also complete Sections 2 and 3 and sign both Declarations** | | | |

**Section 2 – Record of Clinical Experience**

This document will form part of the assessment of your previous clinical experience:

* Please provide as much information as possible to assist the assessors
* Do **not** include experience obtained as a student
* Please base all figures on your **last 12 months** of clinical practice
* Please complete electronically

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| **Confidence:** | Indicate how confident you now feel on a scale of 1 to 6 (where 6 is ‘very confident’) | | | | | |
| **Number:** | Approximate numbers of procedures you have carried out in the last 12 months of employment as a dentist | | | | | |
| **Period** | State below which 12 month period you are using for your response | | | | | |
|  | From: |  | *(mm/yyyy)* | To: |  | *(mm/yyyy)* |
|  | Average number of hours per week spent treating patients in this period: | | | | |  |
| **Description:** | Please add detail in the space available, using the guidance questions. | | | | | |

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| Extractions and Oral Surgery |
| Have you undertaken the following procedures? | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Simple extractions | Yes  No |  |  |  |
| Extractions including root division | Yes  No |  |  |  |
| Complex extractions with flap and bone removal | Yes  No |  |  |  |
| Removal of a party erupted third molar (wisdom) tooth | Yes  No |  |  |  |
| Removal of buried tooth or roots | Yes  No |  |  |  |
| Re-implantation (and splinting) of avulsed teeth | Yes  No |  |  |  |
| Have you used luxators and elevators | Yes  No |  |  |  |
| Have you treated a dry or infected socket? | Yes  No |  |  |  |
| If yes, describe how you manage a dry socket and the materials you use |  | | | | |

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| Children’s (Paediatric) Dentistry |
| Have you carried out the following procedures on deciduous teeth? | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Fillings: | | | | |
| Anterior teeth | Yes  No |  |  |  |
| Posterior teeth | Yes  No |  |  |  |
| Comment on the materials you normally use |  | | | |
| Vital pulpotomy | Yes  No |  |  |  |
| Comment on the materials you normally use |  | | | |
| Stainless steel crown on a molar tooth | Yes  No |  |  |  |
| Have you applied topical fluoride as a preventative measure? | Yes  No |  |  |  |
| If yes, please give a brief description of the process you used |  | | | |
| Have you undertaken the provision of sealant restorations? | Yes  No |  |  |  |
| If yes, please give a brief description of the processes you used |  | | | |
| What is your understanding of “Delivering Better Oral Health” |  | | | |

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| Dental Trauma |
|  | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| How many traumatised incisors have you treated? |  |  |  |
| Please indicate in which scenarios you would treat traumatised teeth by: |  |  |  |
| Indirect pulp capping |  |  |  |
| Direct pulp capping |  |  |  |
| Please indicate how you would manage the traumatised open apex of an anterior tooth |  |  |  |

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| Preventative Dentistry |
| Do you routinely provide the following advice to patients: | **Please provide any additional information which may be helpful to the assessors** | |
| Brushing and flossing | Yes  No |  |
| Diet | Yes  No |  |
| Smoking Cessation | Yes  No |  |
| Alcohol use | Yes  No |  |

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| Orthodontics |
|  | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Have you ever carried out treatment with removable orthodontic appliances? | Yes  No |  |  |  |
| Have you ever carried out treatment with fixed or bonded orthodontic appliances? | Yes  No |  |  |  |
| Have you used the IOTN assessment system? | Yes  No |  |  |  |
| Have you used the PAR index? | Yes  No |  |  |  |
| Have you ever taken impressions for orthodontic study models? | Yes  No |  |  |  |
| If yes, briefly describe the process you used |  | | | |
| Under what circumstances would you refer a patient to an orthodontic specialist? |  | | | |

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| Prosthetics / Prosthodontics |
| Have you ever undertaken the following: | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Design and provision of full upper and lower dentures? | Yes  No |  |  |  |
| Design and provision of immediate dentures? | Yes  No |  |  |  |
| Adding a tooth to a denture? | Yes  No |  |  |  |
| Relining an old denture? | Yes  No |  |  |  |
| Adding a soft lining to an old denture? | Yes  No |  |  |  |
| Design and provision of acrylic partial dentures? | Yes  No |  |  |  |
| Design and provision of cast chrome-cobalt partial dentures? | Yes  No |  |  |  |
| Repair of a fractured denture? | Yes  No |  |  |  |
| Design and provision of overdentures? | Yes  No |  |  |  |
| Design and provision of implant retained dentures? | Yes  No |  |  |  |

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| Restorative Dentistry |
| Have you carried out the following treatments: | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Fillings using silver amalgam? | Yes  No |  |  |  |
| Fillings using composite resin? | Yes  No |  |  |  |
| Fillings using glass ionomer cement? | Yes  No |  |  |  |
| Porcelain crowns? | Yes  No |  |  |  |
| Porcelain fused to metal crowns? | Yes  No |  |  |  |
| Porcelain veneers? | Yes  No |  |  |  |
| Direct composite resin veneers? | Yes  No |  |  |  |
| Metal crowns? | Yes  No |  |  |  |
| Resin Bonded bridges? | Yes  No |  |  |  |
| Fixed conventional bridges? | Yes  No |  |  |  |
| Cantilever conventional bridges? | Yes  No |  |  |  |
| Post crowns with cast metal posts? | Yes  No |  |  |  |
| Post crowns with pre-fabricated posts? | Yes  No |  |  |  |
| Inlays and onlays? | Yes  No |  |  |  |
| When carrying out a filling on a premolar or molar tooth please indicate the proportion of cases in which you would choose: | **% of cases** | **Please provide any additional information which may be helpful to the assessors** | | |
| Silver amalgam |  |  | | |
| Composite resin |  |  | | |
| Glass ionomer cement |  |  | | |
| Other (please name) |  |  | | |

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| Restorative Dentistry *(continued)* |
|  | **Please provide any additional information which may be helpful to the assessors** | |
| What do you understand by the term close support (4 handed) dentistry? |  | |
| Have you previously worked this way? | Yes  No |  |

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| Endodontics |
| How many root fillings have you carried out on: | **Number of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Anterior teeth |  |  |
| Premolar teeth |  |  |
| Molar teeth |  |  |
| What materials do you usually use for filling the canals? |  | |
| Have you been trained in the use of nickel titanium rotary technique | Yes  No | |
| If yes, please give details of the technique |  | |
| What technique do you use to file / clean the canals? | **% of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Hand files |  |  |
| Nickel titanium rotary technique |  |  |
| Other (please name) |  |  |
| Experience of use of Rubber Dam |  |  |

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| Periodontology | | | |
| Please interpret this BPE chart, indicating how you would manage the patient: | | | | **Please provide any additional information which may be helpful to the assessors** | | |
|  | 4 | 1 | 3 |  | | |
| 2 | 2 | 2 |
|  | | | | | **Number of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Have you used ultrasonic scaling techniques? | | | | Yes  No |  |  |
| Have you used hand scaling techniques? | | | | Yes  No |  |  |
| Have you performed root debridement or root planning (under local anaesthetic)? | | | | Yes  No |  |  |
| Have you performed gingival surgery? | | | | Yes  No |  |  |
| How do you treat acute gingival infections? | | | |  | | |
| How do you treat acute periodontal infections | | | |  | | |
| How do you treat chronic periodontal disease? | | | |  | | |
| Have you previously worked with a dental hygienist? | | | | Yes  No |  | |
| If yes, please give an example of a prescription to a hygienist for a typical patient | | | |  | | |

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| Conscious Sedation / Anaesthesia |
| If you have never treated a patient under any form of conscious sedation (either administered by yourself by yourself or someone else) please put a cross here. | | | |
|  | | **Number of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Have you treated patients under general anaesthesia? | Yes  No |  |  |
| Have you treated patients under inhalational sedation? | Yes  No |  |  |
| Have you treated patients under intravenous conscious sedation?  If yes, which drugs do you / the Seditionist routinely use? | Yes  No |  |  |
|  | | |
| What preoperative assessments would you carry out? | Yes  No |  |  |
| Have you given intra-venous sedation as well as treating the patient?  If yes which drug(s) did you use? | Yes  No |  |  |
|  | | |
| Have you received any specific training in conscious sedation?  If yes, please give brief details | Yes  No |  |  |
|  | | |

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| Local Anaesthetic / Pain Control | | |
|  | | | | **Please provide any additional information which may be helpful to the assessors** |
| What local anaesthetic do you usually administer? | | |  | |
| What local anaesthetic do you administer for patients with latex allergy? | | |  | |
| Have you used Articaine?  If yes, when would you use it? | | | Yes  No |  |
|  | |
| Do you give a local anaesthetic for a simple filling? | | |  | |
| Always | Never |  |  | |
|  | |
|  | | | Number | **Please provide any additional information which may be helpful to the assessors** |
| Approximately how many inferior dental blocks (IDBs) have you given?  Which anaesthetic agent would you use for IDB? | | |  |  |
|  |  |
| Do you routinely use an aspirating syringe? | | | Yes  No |  |
| Do you routinely use a sheathing device? | | | Yes  No |  |
| Have you given local anaesthetic by the intra-ligamentous route? | | | Yes  No |  |

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| Medical Emergencies and Cardio-Pulmonary Resuscitation (CPR) |
|  | | **Please provide any additional information which may be helpful to the assessors** |
| Have you taken part in recent CPR training?  Please give the date of the last training? | Yes  No |  |
| Have you received training in medical emergencies (other than CPR) | Yes  No |  |
| If yes, please give details of this training and the date(s) it was given |  | |
| Have you had to manage a medical emergency? | Yes  No |  |
| If so what problem occurred and how did you deal with it? |  |  |
| Please outline your understanding of the basic principles given in the Resuscitation Council’s guidelines on Basic Life Support |  | |
| What drugs would you expect to find in a dental practice emergency drugs box, please outline what you would use each one for? |  | |

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| Radiology |
| Would you normally take your own radiographs? | Yes  No |  |
| If no, please give details of who takes them |  | |
| How often would you take (or prescribe) bitewing radiographs for patients in the following caries risk categories? | Frequency  (in month) | **Please provide any additional information which may be helpful to the assessors** |
| High |  |  |
| Low |  |  |
| Medium |  |  |
| Which periapical radiographs would you normally take for a tooth requiring endodontic treatment, before and during the treatment? |  | |
| Would you normally take a periapical radiograph before carrying out the following? | **Please state the reasons for your decision** | |
| A routine extraction | Yes  No |  |
| A root filling | Yes  No |  |
| A crown | Yes  No |  |
| A bonded bridge | Yes  No |  |
| Recementing a post crown | Yes  No |  |

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| Radiology *(continued)* | Please provide any additional information which may be helpful to the assessors | |
| Please state the date of your last IRMER training |  | |
| Do you prescribe Panoral (OPT) radiographs? | Yes  No |  |
| If yes, how often would this be carried out? |  | |
| Have you used digital radiographic equipment? | Yes  No |  |
| Do you use a long cone technique for intra-oral radiographs? | Yes  No |  |
| Do you use aiming devices for intra-oral radiographs? | Yes  No |  |
| Do you regularly carry out an audit of your radiographs? | Yes  No |  |
| If yes, please give details |  | |
| What are the essential requirements of IRR99 and IR(ME)R 2000 Regulations in the UK regarding dental X-rays |  | |

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| Patient Management |
| Have you carried treatments on the following groups of patients: | **Yes / No** | **Number of cases** | **Confidence**  *Scale of 1 to 6 (where 6 is ‘very confident’**)* | **Please provide any additional information which may be helpful to the assessors** |
| Anxious children? | Yes  No |  |  |  |
| Children in pain? | Yes  No |  |  |  |
| Anxious adults? | Yes  No |  |  |  |
| Adults in pain? | Yes  No |  |  |  |
| Aggressive patients? | Yes  No |  |  |  |
| Metal crowns? | Yes  No |  |  |  |
| Resin Bonded Bridges? | Yes  No |  |  |  |

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| Clinical Photography |
| Have you carried out: | **Yes / No** | **Number of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Intra oral photograph (including use of intraoral mirror)? | Yes  No |  |  |
| Extra oral photography? | Yes  No |  |  |

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| Miscellaneous |
| Have you carried out: |  | **Number of cases** | **Please provide any additional information which may be helpful to the assessors** |
| Have you fitted an upper or lower occlusal splint? | Yes  No |  |  |
| If yes, what materials have you used? |  | | |
| Have you been trained in child protection? | Yes  No |  | |
| Have you been trained in safeguarding vulnerable adults? | Yes  No |  | |
| What is your understanding of the charting notation used in the UK? |  | | |
| Please describe and show the charting for the following teeth? |  | | |
| 1. An upper left first molar |  |  | |
| 1. A lower right second premolar |  |  | |
| 1. An upper left deciduous second incisor |  |  | |

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| Miscellaneous *(continued)* | Please provide any additional information which may be helpful to the assessors | |
| Have you ever placed a dental implant? | Yes  No |  |
| If yes, which system did you use? |  | |
| Outline your understanding of the provision of implants within the NHS |  | |
| When would you suggest an implant to a patient and what information would you provide? |  | |
| How would you normally test the vitality of a tooth? |  | |
| How do you treat dental hypersensitivity? |  | |
| Have you worked as part of an extended dental team i.e. with therapists / hygienists |  | |

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| DECLARATION: | | | |
| I confirm that this is a true and accurate record of my clinical experience as a qualified dental surgeon | | | |
| Signed: |  | Date: |  |

**IMPORTANT – Please also complete the Data Protection Declaration on the following page**

**Section 3 – Data Protection Declaration**

**DATA PROTECTION ACT**

HEIW is registered with the Data Protection Registrar under the Terms and Conditions of the Data Protection Act 1998. HEIW is committed to upholding the Eight Protection Principles of good information handling practices.

Where appropriate, information is shared with those who have a responsibility for the organisation, management and delivery of the PLVE process, to help them execute their function I the planning, monitoring and delivery PLVE programmes for dentists.

**I understand that the information provided in the application form will be processed in accordance with the Data Protection Act and agree for my information to be shared as set out above.**

|  |  |
| --- | --- |
| **SIGNE****D** |  |
| **NAME**  *(IN CAPITALS):* |  |

*HEIW is a data controller in respect of the personal data it holds concerning Vocational Training (VT) numbers issued, Performers List Validation by Experience (PLVE) and Dental Professional Support (DPSU) Dentists applications in Wales. For further information please refer to the Privacy Notice:* [Dental professional support - HEIW (nhs.wales)](https://heiw.nhs.wales/education-and-training/dental/about-us/dental-professional-support/)

**APPENDIX – Guidance on CPD Record Keeping**

The GDC specifies that dentists have a duty to keep their knowledge and skills up to date in order to give patients the best possible treatment and care. CPD is compulsory and dentists must complete and keep records of at least 250 hours of CPD over five years. A minimum of 75 of these hours must be verifiable CPD. To count as verifiable CPD, an activity must have:

* Concise educational aims and objectives;
* Clear anticipated outcomes;
* Quality controls (participants should be given the opportunity to provide feedback)

A certificate from the provider or organiser, detailing number of hours spent, will be evidence of participation in the activity. Examples of verifiable CPD include:

* Courses and lectures
* Educational elements of professional and specialist society meetings
* Conference attendance
* Peer Review and Clinical Audit
* Distance learning

General CPD activities are those which contribute to professional development but that don’t meet the criteria above for verifiable CPD. Examples of general CPD include:

* Staff training
* Background research (using the internet, for example)
* Private study
* Journal reading

For the CPD to count towards the required hours, it must be recorded whether it is verifiable or general CPD.

**In addition to the CPD record, where available you should also enclose:**

1. A copy of certificates of attendance at **GDC highly recommended** verifiable CPD courses on Medical Emergencies; Disinfection and Decontamination; Radiography and Radiation Protection. Also, attendance at **GDC recommended** verifiable CPD courses which include Legal and ethical issues; Complaints handling; Oral Cancer – Early detection; Safeguarding children and young people; Safeguarding vulnerable adults.
2. A certificate of attendance at an ‘Introduction to the NHS / NHS induction Course.
3. Evidence of completion of a Clinical Audit, including an outline of the project undertaken.