DENTAL POSTGRADUATE SECTION

WELSH DENTAL THERAPIST FOUNDATION TRAINING PROGRAMME - SEPTEMBER 2020

Application form to be completed for the post of Welsh Dental Therapist Foundation Educational Supervisor

Applications to be returned to: Mrs Kath Liddington WDTFT Officer Dental Section HEIW 1st Floor Ty Dysgu Cefn Coed Nantgarw CF15 7QQ	PLEASE NOTE If we do not receive your practice advert with this application form, the only details to be included on your advert will be your practice name and address. CLOSING DATE FOR APPLICATIONS: **26th JUNE 2020**

PERSONAL DETAILS

Title:	**Full Name:**
Dental School:	
Degrees:	**Graduation Date:**
Practice Address: **Postcode:** **Telephone No:** **Fax No:**	**Home Address:** **Postcode:** **Telephone No:** **Fax No:**
Email Address (*essential – please print clearly*):	

LHB Area:	**GDC No:**
Provider/Performer No:	**Registration Date:**
Have you received a full HIW inspection in the last 3 years? **If yes please send a copy of your HIW inspection report**	

Qualifications – Degrees or Diploma (with dates)

Membership of Professional Organisations (e.g. BDA, GDPA etc)

Membership of Interest Groups, National or Local, and Committees

Experience in General Dental Practice (giving appointments and years)

Have you or the practice ever taken part in Dental Foundation Training?

If yes, in which years? .

PRACTICE AND ADMINISTRATION

Describe the practice and facilities in which you are working

Give details of the personnel associated with your practice

Please indicate the name of the designated experienced nurse who will be working with the Therapist, and their GDC Registration number **Name:** **GDC No:**
Describe the range of professional work undertaken in the practice and how you would ensure a Therapist would integrate with this

Describe the range of NHS treatment a Therapist would have opportunity to carry out in your practice

How are communication and teaching undertaken within the practice?

Describe the patient mix, patient selection and arrangements for new patients within the practice

Describe the systems used for recording patient activity

Would the surgery be suitable for a left handed practitioner?

Please indicate in the table below the sessions when you are in the practice

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM					
PM					

Please indicate in the table below when other experienced dentists are working on the same premises

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM					
PM					

Name of second dentist:

Qualifications (with date):

Have you, in the last 5 years, or are you currently, under on-going investigations by the NHS DS, the GDC, the LHB or the Police?

If yes, give details below (attach additional sheet if necessary)

Have you had any withholdings or judgements made against you by any of the above authorities?

If yes, give details below (attach additional sheet if necessary)

CHECKLIST

Please use this checklist to ensure copies of the following forms are sent with this application form:

Record of Audit
(Copy of most recent Audit certificate)
Record of CPD
(Postgraduate Department record plus any other CPD carried out but not recorded on Postgraduate database)
HIW Inspection Report
(If applicable)
Practice Advertisement
(If not received, only details to be included will be practice name and address)

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING THIS FORM

I understand, if I am approved as an Educational Supervisor, I will be required to employ my Therapist under the approved Contract. I will ensure the Therapist is provided with appropriate numbers of all categories of NHS Patients. I accept that the decision of the Director of Dental Postgraduate Education shall be final and not subject to appeal.

Signed: **Date:**

Print Name: