DENTAL NURSE Training
From Pinhoe Dental Centre

COURSE APPLICATION

APPLICANT INFORMATION

Full Name	GDC Number	NEBDN number
D.O.B.	Company Name	
Home Address	Company Address	
Contact Email	Home Tel	
Work Tel	Mobile	
Next of Kin	Contact number	

Are you a UK citizen? Yes ☐ No ☐ How did you hear about us?

COURSE APPLIED FOR

Diploma in Dental Nursing ☐	Diploma in Dental Nursing **Online** ☐
Certificate in Oral Health Education ☐	Certificate in Oral Health Education **Online** ☐
Topical Fluoride Application **Online** ☐	

MENTOR DETAILS

Please provide the details of the Mentor

Full Name	GDC Number
Contact Email	

Is the practice paying for the course? Yes ☐ No ☐

Supervising clinician declaration: I take overall responsibility to supervise the above named student throughout their studies and to guide them through all aspects of their training, other GDC registrants in our setting may also supervise the student but I understand that I have overall responsibility.

Signed ..... Date .....

(Mentor)

WHERE DO YOU CURRENTLY WORK?

General Practice ☐ Orthodontic/Specialist ☐ Hospital ☐ Community ☐

ARE YOU PLANNING TO OR CURRENTLY TAKING ANY OTHER STUDIES DURING THE COURSE?

Yes ☐ No ☐ If yes, Please list .....

HOW LONG HAS IT BEEN SINCE YOU HAVE UNDERTAKEN ANY FURTHER EDUCATION?

< 1 Year ☐ < 2 Years ☐ >3 Years ☐ >5 Years ☐

HOW DO YOU FEEL ABOUT WORKING DIRECTLY WITH PATIENTS (OHE COURSE ONLY)

Confident ☐ Not Confident ☐

Comments .....

THIS COURSE REQUIRES THE USE OF A COMPUTER. (FULL USE FOR ONLINE COURSES). YOU WILL NEED TO BE ABLE TO UPLOAD/DOWNLOAD FILES/DOCUMENTS, CREATE PRESENTATIONS. DO YOU FEEL CONFIDENT TO DO THIS?

Yes ☐ No ☐ Comments .....

ARE YOU ABLE TO SET ADEQUATE TIME ASIDE AT HOME TO STUDY ON A REGULAR BASIS FOLLOWING A TIMETABLE?

Yes ☐ No ☐ Comments .....

DO YOU FEEL YOU ARE COMPETENT TO COMPLETE THIS COURSE?

Yes ☐ No ☐ Comments .....

DO YOU HAVE ANY MEDICAL CONDITIONS/MEDICATIONS THAT WE NEED TO BE AWARE OF INCASE AN EMERGENCY ARISES DURING YOUR TRAINING?

Yes ☐ No ☐ If yes, Please list .....

DO YOU NEED EXTRA TIME IN LECTURES/EXAMINATIONS DUE TO SPECIFIC LEARNING NEEDS?

Yes ☐ No ☐ If yes, Please enclose a report for us to send to the NEBDN to apply for extra Examination time

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COURSE APPLICANTS SIGNATURE

Signed ..... Date .....

(Applicant)

TO BE COMPLETED BY PERSON AUTHORISING PAYMENT

I agree to pay £100 deposit at the time of application and I understand this is **non-refundable** as it secures a place on the course applied for. This will be deducted from the total course fee.

☐ I agree to the above terms

☐ I have enclosed a cheque for £100 made payable to Pinhoe Dental Centre LTD

☐ I have made a BACS transfer for £100 to Account: 10174395 Sort code: 16 19 25

Full Name ..... Position .....

Signed ..... Date .....

(Person Authorising Payment)

Please return application forms to: **info@dentalnurse.training** or post to Erica Clatworthy, Course Administrator, Pinhoe Dental Centre, 402 Pinhoe Road, Exeter, EX4 8EH

Please ring the course administrator if you have any queries 01392 466113