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Please give this form to the referee(s) who will verify your clinical experience.

You may need to give a copy to more than one referee in order to demonstrate that you have fulfilled the 1600 hour requirement.

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| CLINICAL EXPERIENCE REQUIREMENT  |
| **DETAILS OF CLINICAL EXPERIENCE REFEREE** |
| *This section is to be completed in the referee’s own handwriting in black ink**Please refer to the document ‘Application Form Guidance ’ when completing this form* |
| Title | *(Mr/Mrs/Ms/Miss/Dr/Other)* |  |
| Family name or surname |  |
| Given or first name(s) |  |
| GDC Registration number (if applicable) |  |
| Position held |  |
| Organisation/University |  |
| Department/Unit |  |
| Address |  |
|  |
| Town/City |  |
| County/State |  | Postcode |  |
| Country |  |
| Work telephone number (including STD Code) |  |
| Email address |  |
| Name of Applicant |  |

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| **Where did the applicant gain the required clinical experience? (Please choose A, B or C from the options below)** |
| **A**[ ] **UNDERGRADUATE CLINICAL EXPERIENCE**(please check the box) |
| Place where clinical experience was gained |  |
| Number of clinical hours completed |  |
| Date started |  | Date completed |  |

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| **B** [ ] **POST – QUALIFICATION EXPERIENCE**(please check the box) |
| Place where clinical experience was gained |  |
| Number of clinical hours completed |  |
| Date started |  | Date completed |  |
| Job title/Positionof the applicant |  |
| Did you supervise the work of the applicant directly? |  |

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| **C**[ ] **TEMPORARY REGISTRATION EXPERIENCE**(please check the box) |
| Please provide the applicant’s TR number |  |
| Place where clinical experience was gained |  |
| Number of clinical hours completed |  |
| Date started |  | Date completed |  |

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| **Please describe the clinical experience undertaken by the applicant including the number of hours that the applicant has personally treated patients in the dental chair.** *Please note that the number of hours of this clinical experience must be hours the applicant has spent undertaking appropriate investigations and administering dental treatment. It must not include time observing other dentists or assisting other dentists/dental students in undertaking diagnosis/treatment planning or provision of treatment.* |
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| *If necessary, please continue on a separate sheet of paper and attach it to this application form indicating that you are referring to the clinical experience requirement.* |
| **The information that I have provided is complete, true and correct. I understand the Royal College of Surgeons of England will contact me to verify this reference, and that the candidate will not be allowed to sit the LDS Part 2 until I have responded to confirm the validity of the reference.** |
| Name |  | Signed |  |
| Date |  |