

**TRI-COLLEGIATE DIPLOMA OF MEMBERSHIP IN SPECIAL CARE DENTISTRY**

**DECLARATION FORM - CLINICAL CASE PRESENTATION**

*This form should be completed and placed in an envelope with all the other forms relating to the clinical case presentation.*

*The envelope should then be handed to the Examination Section which receives the clinical case presentation.*

Date of examination .....

Candidate name .....

Candidate date of birth .....

Patient's initials and age .....

**I certify that the treatment for the named patient was carried out by the Candidate during the period of their training.**

Supervisor name .....

Supervisor signature .....

Date .....

Stamp of training institution or hospital (if available):

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**I confirm that I have not plagiarised from any source.**

Candidate name .....

Candidate signature .....

Date .....