Royal College of Surgeons
FACULTY OF DENTAL SURGERY

DIPLOMA IN SPECIAL CARE DENTISTRY

PART A
APPLICATION FORM

Contact details

Last name in full			Other names	
Title			GDC no. (if applicable)	
Date of birth			Telephone Number:	
Email address				
Home Address:				
Work Address:				

Academic Record

Primary Dental Qualification		Date
Qualifying University		
Dental School at which degree obtained		Country:

Work Experience

**Please provide a short CV detailing your Special Care Dentistry Experience

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IMPORTANT NOTICE

If your name does not appear on the current dentists register (including those with temporary registration) you must submit either certified copies or originals of the following documents

A) ☐ Primary dental qualification and date of acquirement

B) ☐ Proof that the qualification you hold is acceptable for registration with the General Dental Council (GDC)

Permission to release correspondence details

The 'Guidance to Candidates' Document encourages candidates to 'establish a network with other candidates and to provide support groups'. To be able to do this the Directorate of Dental and Surgical Examinations needs your permission to release your correspondence details to other candidates. If you do not sign this section, we will not do so. Your details will only be released to other candidates who have applied for this examination and who request this information.

I give permission for my correspondence details to be sent to other candidates if requested

Signature:…… **Date:……..**

Declaration			
I declare that to the best of my knowledge, all the information given in this form is a true statement of fact. I have read and understood the regulations.			
Signature:		Date:	

All personal information held by the department will be held in accordance with the Data Protection Act 1998. Data collected will not be released outside the four UK Surgical Colleges without your permission.

PRIVACY STATEMENT

The information you have given on this form will be held by the Examinations Department of the Royal College of Surgeons of England on a compartmented secure server in accordance with the General Data Protection Regulation (GDPR), and will be used only in connection with the purposes that you originally contacted us for. The information is kept by The Royal College of Surgeons of England and will be available to all members of staff within the same department, and will not be shared throughout the wider organisation unless instructed otherwise. Your information will be held in line with the relevant College retention schedule.

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Payment Method

Payment must be made in full by cheque or credit card.

By Cheque:
Please attach a cheque (made payable to The Royal College of Surgeons of England) to this form
Please print candidate name on the back of the cheque

Credit card:

☐	MasterCard	☐	Visa	☐	Switch	☐	Delta
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐							
Expiry Date		Issue No.		Security Code [3 digits]		Signature	
Cardholders Name							

This information will be securely disposed of by the Examinations Department
If you are paying by credit card, then this form must accompany your application form which must reach the College by the closing date for submissions.

Please submit application to address below:

Diploma in Special Care Dentistry
Surgical and Dental Examinations Directorate, Royal College of Surgeons of England
35-43 Lincoln's Inn Fields, London, WC2A 3PE