

# PART A APPLICATION FORM

Other names

Country:

#### Contact details

Last name in full

Title		GDC no. (if applicable)									
Date of birth		Telephone Number:									
Email address											
Home Address:											
Work Address:											
Academic Record											
Primary Dental Qualification			Date								
Qualifying University			,								

## Work Experience

Dental School at which degree obtained

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



#### IMPORTANT NOTICE

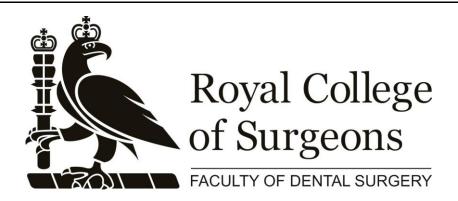
registration) you must submit either certified copies or originals of the following documents									
A) Primary dental qualification and date of acquirement									
B) Proof that the qualification you hold is acceptable for registration with the General Dental Council (GDC)									
Permission to 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  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.

Diploma in Special Care Dentistry
Surgical and Dental Examinations Department, Royal College of Surgeons of England
35-43 Lincoln's Inn Fields, London, WC2A 3PE
Tel: 0207 869 6281 Fax: 0207 869 6290 Email: dentalexams@rcseng.ac.uk



# **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.	Secur [3 dig	ity Code its]		Signa	ture		
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