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| **TRI-COLLEGIATE DIPLOMA OF SPECIALTY MEMBERSHIP**  APPLICATION FOR APPOINTMENT TO THE PANEL OF EXAMINERS FOR THE  MEMBERSHIP IN ORAL SURGERY, PAEDIATRIC DENTISTRY AND SPECIAL CARE DENTISTRY EXAMINATIONS |

APPOINTMENT OF EXAMINERS – REFEREES FORM

**PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE**

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| APPLICANTS DETAILS | |
| **Surname:**  **First names:**  **Title:**  **Email address:** | **Contact address:**  **Post code:** |

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| PERSONAL DETAILS OF REFEREE | |
| **Surname:**  **First names:**  **Title:**  **Telephone:**  **Email address:** | **Contact address:**  **Post code:** |

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| **In what capacity do you know the applicant:** |

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| Comments on suitability of candidate to join Faculty of Examiners |
| **Teaching experience / Skills** |
| **Examining / Assessing experience / skills** |
| **Other relevant experience / skills** |

I confirm that I support the above applicant’s application to join the Panel of Examiners for the Tri-Collegiate Specialty Membership in Oral Surgery / Paediatric Dentistry / Special Care Dentistry (delete as applicable).

**PLEASE ENSURE THAT SIGNATURES ARE INK. ANY FORM WITHOUT A SIGNATURE OR WITH A TYPED SIGNATURE WILL NOT BE ACCEPTED.**

**Signed:……………………………………………………………….Date:……………………………………………**

Please return your completed and signed referee form to the applicant’s address provided at the top of the document.