****

|  |
| --- |
| **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**

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

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

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

|  |
| --- |
| 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.