

TRI-COLLEGIATE DIPLOMA OF SPECIALTY MEMBERSHIP
Examination Application form

Last name of candidate:
(BLOCK LETTERS)

Other names in full:
(BLOCK LETTERS)

Title:

Date of birth (dd/mm/yyyy): Male/Female:.....

Full postal address:
.....
.....

Daytime telephone no: E-mail:

Mobile No:
(Including full international dialling code for overseas trainees)

I wish to enter the Tri-Collegiate Specialty Membership Examination in

Oral Surgery / Special Care Dentistry / Paediatric Dentistry
Please delete as appropriate

Date of examination.....and enclose the required fee of £.....



RESIT CANDIDATES ONLY

I am applying to re-sit the following examination section(s):

Please give details of your qualifications:

<u>Qualification</u>	<u>Awarding body</u>	<u>Date</u>
.....
.....
.....

GDC registration number: (if applicable)

(Candidates whose names do not appear in the current UK Dentists Register must submit evidence of their qualifications and the date of acquisition)

TO BE COMPLETED BY ALL CANDIDATES

Eligibility to take the examination (please indicate by ticking the appropriate box)

I have completed a minimum of 30 months of a full-time (or equivalent part-time) 3 year training appointment

I am registered as a Specialist in Oral Surgery / SCD / Paed Dent

I have completed at least 30 months full-time (or part-time equivalent) of specialty training overseas or in the European Economic Area in a programme of specialty training which the Colleges consider to be equivalent

I have had my training assessed and had confirmation that I am eligible as per paragraph 4.3 (b) or (c) of the Regulations

Please note that satisfactory evidence must be provided to support your eligibility to take the examination

PLEASE PROVIDE CONFIRMATION OF THE TRAINING YOU ARE OFFERING FOR ENTRY TO THE EXAMINATION

Title of post/course:

NTN/VTN/FTN. (if applicable):

Dates (dd/mm/yyyy): From To

Signature of Specialist in charge of training:

PRINT NAME:

Position held:

Date of signing (**must be completed**):

AND

I certify that the above named has occupied a training post as specified above and that all in-service assessments have been satisfactory:

Signature of Head of Hospital:

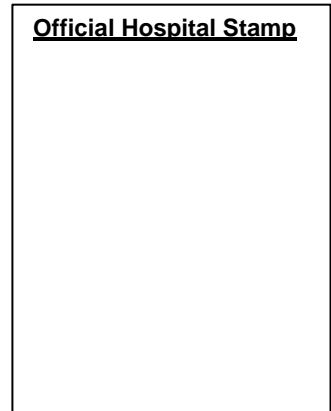
PRINT NAME:

Date of signing (**must be completed**):

Official Hospital Stamp



Official Hospital Stamp



Candidates who are unable to have the above sections signed must produce certified confirmation of the posts they have held and attach to this form.

Candidates who wish to offer more than one period of training should print additional copies of this page and attach to their application form.

CANDIDATE CHECKLIST

Is your application form complete?

Failure to provide the documentation listed below may result in your application form being returned

Have you included the following:	YES	NO
1. Complete and up-to-date contact information	<input type="checkbox"/>	<input type="checkbox"/>
2. Two recent passport sized photographs	<input type="checkbox"/>	<input type="checkbox"/>
3. Certified copy of your primary dental qualification certificate	<input type="checkbox"/>	<input type="checkbox"/>
4. Evidence of 30 months full time (or part-time equivalent) training	<input type="checkbox"/>	<input type="checkbox"/>

If your name appears on the current UK Dentists Register a certified copy of your certificate is not required.

If you are unable to obtain the signature and stamp of your Trainer or Consultant on your application form then you must submit letters or certificates confirming your posts.

Candidates who apply for entry with less than 36 months full time (or part-time equivalent) training will be required to provide evidence of completion of training before they can be awarded their diploma (upon success in the examination).

Copies of letters and certificates will only be accepted if they have been verified as a true copy by your Trainer or authorised hospital official and stamped with the official hospital stamp. (The signature and stamp must be original.) Please also note that if the official hospital stamp is not in English applicants will be required to obtain an official English translation from a translation agency.

5. Full examination fee	<input type="checkbox"/>	<input type="checkbox"/>
6. Signed and dated the declaration confirming that you have read and understood the regulations	<input type="checkbox"/>	<input type="checkbox"/>
7. Confirmed which College you wish to affiliate to	<input type="checkbox"/>	<input type="checkbox"/>

If paying by cheque, ensure that the cheque has been signed, dated and has the amount written in words and numbers. Cheques and bank / demand drafts must be drawn on a UK bank. Ensure that your name is written on the back of the cheque or draft.

CANDIDATE DECLARATION

I declare that I have read and understood the Regulations and Guidance to Candidates relating to the Examination for which I wish to apply and I now confirm that to the best of my knowledge all the information given on this form is a true statement of fact. I understand that success in this Examination will not automatically confer entry onto the United Kingdom's General Dental Council Specialist List. (This is dealt with by the GDC not the Colleges).

Candidate Signature: Date:

AFFILIATION

In accordance with the Regulations, candidates who are successful in these examinations will receive their Diploma from the College of their choice.

On completion of the Tri-Collegiate Specialty Membership Examination I wish to affiliate to *(please tick as appropriate)

*RCS Edinburgh

*RCS England

*RCPS Glasgow

** You may apply to affiliate to more than one College. If you indicate this by ticking more than one box, you will be liable for the affiliation fee required by each College*

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.

EQUAL OPPORTUNITIES MONITORING

The Royal Colleges of Surgeons of Great Britain and Ireland aim to ensure fair treatment in relation to admission and assessment of examination candidates. Completing this form will allow us to monitor our statistics and ensure that we are delivering a fair examination to all candidates.

In line with UK and Irish legislation and good practice guidelines, we are asking all applicants to complete this section. You are not obliged to provide any of the information in this section, but if you do so, it will enable us to monitor our business processes and ensure that we provide equality of opportunity to all.

Gender

- Female
- Male
- Transgender
- Prefer not to say

Ethnicity

Choose one selection from the list below to indicate your ethnic group or background.

a) White

- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background (write in)

b) Mixed / Multiple Ethnic Groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background (write in)

c) Asian or Asian British

- Bangladeshi
- Chinese
- Indian
- Pakistani
- Any other Asian background (write in)

d) Black / African / Caribbean / Black British

- African
- Caribbean
- Any other Black / African / Caribbean / Black British (write in)

e) Other Ethnic Group

- Arab
- Any other ethnic background (write in)

- Prefer not to say**

Do you consider your first language to be English?

- Yes
- No
- Prefer not to say

Do you have a disability under the terms of the Equality Act 2010? (The Equality Act defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities).

- Yes
- No
- Prefer not to say

What is your sexual orientation?

- Bisexual
- Heterosexual
- Lesbian or Gay
- Prefer not to say

Marital Status

- Single
- Married
- Cohabiting
- Civil partnership
- Separated/divorced
- Widowed
- Prefer not to say

What is your religion or belief?

- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Other religion/belief
- No religion
- Prefer not to say