

The Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
LONDON WC2A 3PE

Tel no: 020-7869-6281
Fax no: 020 7869-6290
E-mail address:
dentalexams@rcseng.ac.uk
Charity No. 212808

The Royal College of Physicians and Surgeons of Glasgow
232-242 St Vincent Street
GLASGOW G2 5RJ

Tel no: 0141-221-6072
Fax no: 0141-248-3414
E-mail address:
exam.office@rcpsglasg.ac.uk
Charity No. SC000847

**Examination Application Form
for**

**INTERCOLLEGIATE DIPLOMA OF MEMBERSHIP IN
ORTHODONTICS PART 2 APPLICATION FORM**

This form is to be completed and returned to the Examination Office, The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE not later than the published closing date for the examination. The examination fee must accompany this form. Cheques, banker's drafts or credit card payments should be made payable to the Royal College of Surgeons of England.

1 Surname : Title :

Block Capitals

2 Other Names :

Block Capitals

3 Male / Female (delete as required) Date of Birth :/...../.....

4 Address :

.....
.....

Post Code : Tel. No. :

Fax. No. : Email:.....

5 Primary Dental Qualification:..... Date Conferred:...../...../.....

University/Dental College:.....

Country of Qualification:.....

GDC Registration No(if applicable): Date:/...../..... Limited / Provisional / Full

Please send original, or attested copies, of all certificates.

6 Date of obtaining FDS/ MFDS /or equivalent (delete as appropriate): Date:...../...../.....

Awarding College :

(Candidates must provide evidence of having passed FDS/MFDS/or equivalent)

7 Date of Examination for which candidate wishes to appear: Date:...../...../.....

8 Have you previously sat this examination before: YES/NO Date:...../...../.....

9 Which College do you wish to affiliate to? (delete as appropriate)England Glasgow

PLEASE INCLUDE
2
PASSPORT
PHOTOS

10 Declaration (To be signed by ALL candidates)

I have read the current Regulations of this examination and understand the eligibility criterion and I now confirm that to the best of my knowledge all the information given on this form is a true statement of fact.

Signature of Applicant : Date:...../...../.....

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. Any data collected may be exchanged between the RCS England and RCPS Glasgow and will not be released elsewhere without your permission but may be used to verify qualifications and to prevent fraudulent activity. Your information will be held in line with the relevant College retention schedule.

Sections A, B or C are to be completed and signed by the Orthodontic Training Programme Director. (Candidates re-entering for the examination do not need to complete certificates A and B).

A. SPECIALTY TRAINING

I certify that will have completed a recognised specialty training programme at :-

Name of Centre :

Training Number : Whole time / part time (sessions per week) :

From : To :

Name : Status :
(Block Capitals) (Please refer to top of page)

Signature : Date :/...../.....

Please note candidates may enter for the examination after two and a half years (or part time equivalent) training.

B EXEMPTIONS

(i) Candidates who have passed a written paper on subjects covered by the SAC syllabus as a component of that Masters Degree will be exempt from the written paper.

Candidates holding a Masters Degree based solely on research must take the written paper.

I certify that has passed a written paper on subjects covered by the SAC approved syllabus (Delete as appropriate).

Name : Status :
(Block Capitals) (Block Capitals)

Signature : Date :/...../.....

(ii) Candidates having failed the examination but passed the treated cases section will be exempt from this section for the following examination.

(iii) Candidates must be able to demonstrate experience in research methodology and this will normally be illustrated by completion of the research methodology component of a recognised Masters Degree (or equivalent) awarded by a university in the United Kingdom. Candidates not able to demonstrate research experience will be required to take an additional oral examination.

I certify that has satisfactorily completed the research methodology component of a recognised Masters Degree (or equivalent).

Name : Status :
(Block Capitals) (Block Capitals)

Signature : Date:...../...../.....
(Block Capitals)

C TREATED CASES

A signed statement should accompany clinical case records from the accredited supervisors confirming the candidate's substantial involvement in the treatment of the cases.

Clinical case records must be submitted to the designated examination centre by noon on the day of the written examination. The clinical case records will be available for collection by the candidate following the adjudication and candidates should note that this is their personal responsibility.

Candidates are urged to make sure they are familiar with the Regulations of the Membership Examination. Copies are available from: - The Royal College of Surgeons of England or The Royal College of Physicians and Surgeons of Glasgow.

Method of Payment

Payment must be made in full by cheque or credit card. For details of current examination fees, please refer to examinations calendar.

By Cheque Tick the box and enclose a cheque made payable to:
 'The Royal College Of Surgeons Of England'
NB please print candidate name on back of cheque.

By Credit / Debit Card Tick the box and fill in your Credit / Debit Card details below :

I wish to pay by: VISA/MASTERCARD/SWITCH/DELTA/SOLO
 (Delete where not appropriate)

Name of candidate (BLOCK CAPITALS)

Card No:

Start Date Expiry Date Three digit security numbers: _____
 (Found on the reverse of your card)

Switch Card Issue Number: Name of card holder:

Signature: Date:

Examination Date: / /
Day / Month / Year

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 applications. Failure to complete any part of this form may result in your application being returned to you.

SPECIAL NEEDS:

It is the responsibility of the candidate to notify the Examinations Office of the College of any special circumstances when they submit their application.

Applications for special consideration must be supported by written evidence in the form of a medical report from their General Practitioner or their Consultant trainer or Postgraduate Dean. In certain cases, such as dyslexia, a current Dyslexia Assessment report from an educational psychologist will be required. In the case of a temporary disability due to ill health or accident which occurs after the application has been submitted, candidates must inform the Examinations Office as soon as possible before the examination.

EQUAL OPPORTUNITIES MONITORING (OPTIONAL)

As part of its Equal Opportunities policy the College will monitor admissions and examination results in relation to changes in the candidate population. Part of this monitoring process requires that we gather information on candidates' ethnic origin. This information will not be used in a negative or discriminatory manner but will be used to ensure that the examinations provide equal opportunities for all.

All such information will be held in strictest confidence. This information will not be available to anyone involved in examining you or to anyone involved in processing your results. Any use made of this data will not allow any individual to be identified.

Although we urge you to complete this form whether you do so or not is entirely voluntary. Whatever your decision it will not affect how we process your results.

Nationality:..... First language:.....

Choose one selection from the list below to indicate your cultural background.

a) White

British

Irish

Any other white background, please specify _____

b) Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other mixed background, please specify _____

c) Asian or Asian British

Indian

Pakistani

Bangladeshi

Any other Asian background please specify _____

d) Black or Black British

Caribbean

African

Any other Black background, please specify _____

e) Chinese or other ethnic group

Chinese

Any other ethnic background, please specify _____

f) Middle East/Arabic

Arabic

Any other Middle Eastern background, please specify _____

Please return the completed form with your application. Thank you for your co-operation.