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**Diploma in Orthodontic Therapy**

Applicant Name:

**Trainer Application Form 2015**

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| **A. PERSONAL DETAILS** | | | | |
| **Title:** | **Forename(s):** | | **Surname:** | |
| **Registration Number Dental Council Specialist Register of Orthodontists:** | | | | |
| **Date of entry onto Dental Council Specialist Register of Orthodontists:** | | | | |
| **Name of prospective Student Orthodontic Therapist** | | | | |
| **Practice name:**  **Address:** | | | | |
| **Contact email address:**  **Website address:**  **Contact telephone number:** | | | | |
| **Address for correspondence** *(If different from above)*: | | | | |
| **Professional Qualifications:** | | **Awarding Body:** | | **Date awarded:** |

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| **B. TRAINING ENVIRONMENT** | | |
| **1.** | **What is your status within the practice / unit / department?**  **Sole owner / Partner / Associate / Consultant**  (Please circle or delete) | |
|  | | |
| **2.** | **Are you the prospective student’s employer** | **Yes / No** |
| **3.** | **Would other Specialists in the practice / unit / department wish to be involved in training?** | **Yes / No** |
|  | | |
|  | **If so, please list their names and qualifications/date of entry onto Specialist List:** | |
|  | **a) Name:** |  |
|  | **Partner / Associate / Consultant / other** | **Full / Part time** |
|  | **Qualifications/Date of entry onto Specialist List:** |  |
|  |  |  |
|  | **b) Name:** |  |
|  | **Partner / Associate / Consultant / other** | **Full / Part time** |
|  | **Qualifications/Date of entry onto Specialist List** |  |
|  |  |  |
|  | **c) Name:** |  |
|  | **Partner / Associate / Consultant / other** | **Full / Part time** |
|  | **Qualifications/Date of entry onto Specialist List:** |  |
|  |  |  |
|  | **d) Name:** |  |
|  | **Partner / Associate / Consultant / other** | **Full / Part time** |
|  | **Qualifications/Date of entry onto Specialist List:** |  |
|  | | |
| **4.** | **Do you have sufficient space, nursing support and patients to provide a Student Orthodontic Therapist with 7-8 sessions of supervised clinical training per week?** | **Yes / No** |
|  | | |
| **5.** | **How many fully operational chairs are there in the practice / unit / department?** |  |
|  | | |
| **6.** | **How many surgeries are there in the practice / unit / department?** |  |
|  | | |
| **7.** | **Will the Student Orthodontic Therapist have their own designated chair?** | **Yes / No** |
|  | | |
| **8.** | **Will a qualified Dental Council registered nurse work with the Student Orthodontic Therapist?** | **Yes/ No** |
|  | | |
| **9.** | **Will the Student Orthodontic Therapist work between two practices / units / departments? If so, please provide details.** | **Yes / No** |
|  | | |
| **10.** | **What percentage of your clinical practice are:**   * **< 18years of age** * **> 18 years of age** * **Routine orthodontic treatments** * **Multidisciplinary cases** | **%**  **%**  **%**  **%** |
|  | | |
| **11.** | **Do you use:**   * **Removable Appliances** * **Functional Appliances** * **EOT** * **Straight-wire Appliances** | **Yes / No**  **Yes / No**  **Yes / No**  **Yes / No** |
|  | | |
| **12.** | **What educational resources are available in the practice / unit /department to support a Student Orthodontic Therapist?** | |
|  | | |
| **13.** | **Do you have internet and email access in the practice / unit / department?** | **Yes / No** |
|  | | |
| **14.** | **Do you use digital photography in the practice / unit / department?** | **Yes / No** |
|  | | |
| **15.** | **Are you prepared to engage in a formal weekly discussion/seminar session with the Student Orthodontic Therapist?** | **Yes / No** |
|  | | |
| **16.** | **Are you willing to formally assess and monitor the Student Orthodontic Therapist’s development and provide regular reports on their progress?** | **Yes / No** |
|  | | |
| **17.** | **Are you or any other members of your practice / unit / department’s training team already involved in training?** | **Yes / No** |
|  | | |
| **18.** | **Are you prepared to act as a local coordinator for your Student Orthodontic Therapist’s trainers within the practice / unit / department?** | **Yes / No** |
|  | | |
| **19.** | **Please state briefly your reasons for wishing to be involved with this course?** |  |
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**Falsifying information on this application will be deemed as acting in an unprofessional manner. This will have implications on registration with the regulatory body.**

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