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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) |
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| **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** |
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|  | **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:** |  |
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| **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** |
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| **5.** | **How many fully operational chairs are there in the practice / unit / department?**  |  |
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| **6.** | **How many surgeries are there in the practice / unit / department?** |  |
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| **7.** | **Will the Student Orthodontic Therapist have their own designated chair?** | **Yes / No** |
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| **8.** | **Will a qualified Dental Council registered nurse work with the Student Orthodontic Therapist?** | **Yes/ No** |
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| **9.** | **Will the Student Orthodontic Therapist work between two practices / units / departments? If so, please provide details.** | **Yes / No** |
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| **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** |
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| **12.** | **What educational resources are available in the practice / unit /department to support a Student Orthodontic Therapist?** |
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| **13.** | **Do you have internet and email access in the practice / unit / department?** | **Yes / No** |
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| **14.** | **Do you use digital photography in the practice / unit / department?** | **Yes / No** |
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| **15.** | **Are you prepared to engage in a formal weekly discussion/seminar session with the Student Orthodontic Therapist?** | **Yes / No** |
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| **16.** | **Are you willing to formally assess and monitor the Student Orthodontic Therapist’s development and provide regular reports on their progress?** | **Yes / No** |
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| **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: .………………………...** |