TRI-COLLEGIATE DIPLOMA OF SPECIALTY MEMBERSHIP
Examination Application form

Last name of candidate: ……
(BLOCK LETTERS)

ATTACH PASSPORT SIZED PHOTOGRAPH HERE

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:

Qualification	**Awarding body**	**Date**
……	……	……
……	……	……
……	……	……

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

Official Hospital Stamp

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

Official Hospital Stamp

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): ……

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	☐	☐
2. Two recent passport sized photographs	☐	☐
3. Certified copy of your primary dental qualification certificate	☐	☐

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

4. Evidence of 30 months full time (or part-time equivalent) training	☐	☐

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	☐	☐

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.

6. Signed and dated the declaration confirming that you have read and understood the regulations	☐	☐
7. Confirmed which College you wish to affiliate to	☐	☐

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 *(<u>please tick as appropriate</u>)

***RCS Edinburgh** ☐ ***RCS England** ☐ ***RCPS Glasgow** ☐

*<u>*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</u>*

Candidates must complete this application in full and **sign the declaration.**
The application must then be returned along with the examination fee and all relevant documentation, by the published closing date of entry to:

Oral Surgery	Special Care Dentistry	Paediatric Dentistry
Examination Department The Royal College of Surgeons of England 35 – 43 Lincoln's Inn Fields London WC2A 3PE Telephone +44 (0) 20 7869 6281 Fax +44 (0)20 7869 6290 dentalexams@rcseng.ac.uk www.rcseng.ac.uk	**Examinations and Assessment Unit** The Royal College of Physicians and Surgeons of Glasgow 232 – 242 St Vincent Street Glasgow G2 5RJ Telephone + 44(0) 141 221 6072 Fax +44 (0) 141 221 1804 mscd@rcpsg.ac.uk www.rcpsg.ac.uk	**Examination Section** The Royal College of Surgeons of Edinburgh Nicolson Street Edinburgh, EH8 9DW Telephone +44 (0) 131 527 1600 dental.exams@rcsed.ac.uk www.rcsed.ac.uk

METHOD OF PAYMENT

> None of the Surgical Royal Colleges accept American Express.
> Three-digit credit/debit card security number is required by all three colleges

Name of candidate (BLOCK CAPITALS):

_____

Payment must be made in full by: Bank draft ☐ Cheque ☐ Credit/debit card ☐ (tick as appropriate)

CHEQUES should be made payable to the administering college for the examination (see above) not the College to which you wish to affiliate. Print your name on back of cheque.

Cheque number: _____

CREDIT CARD/DEBIT CARD

I wish to pay by: VISA ☐ Mastercard ☐ Delta ☐ (tick as appropriate)
JCB ☐ VISA debit ☐ Maestro ☐

Card number:

Valid from date (MM/YY): ___/___ Expiry date(MM/YY): ___/___ 3 digit security number:_____

Debit card issue number (if applicable): _____Amount authorised to be withdrawn: _____
For details of current examination fees, please refer to examinations calendar.

Name of cardholder:_____

Signature of cardholder:_____

Billing Address of Cardholder:_____

Email Address Of Cardholder:_____

Date:_____

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.

This information will be recorded electronically with your other data in accordance with the current General Data Protection Regulation (GDPR (EU) / Data Protection Bill, but used only for monitoring our business practices.

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)

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b) Mixed / Multiple Ethnic Groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background (write in)

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

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

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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