**FORM B: To Be Completed by the Supervising Consultant**

Tier 5 – Dental Training Initiative

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| **PART 1: DETAILS OF SUPERVISING DENTIST / SPECIALIST** |
| Surname  |  |
| First Name(s) |  |
| GDC/ GMC Registration No.**(an active GDC registration is required for Temporary Registration Purposes)** |  |
| Specialist No. and details if applicable |  |
| Address  |  |
| Telephone number of Hospital/university department |  |
| Mobile number |  |
| Email address |  |
| Name and address of employing Trust |  |
| Job title / grade |  |
| How long have you been employed by or held an honorary appointment with the Trust?  |  |
| Name and address of Postgraduate Dental Deanery |  |

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| **PART 2: DETAILS OF DENTAL TRAINING INITIATIVE (DTI)** |
| Full name of overseas trainee to be supervised |  |
| Title of DTI post |  |
| Dental Specialty |  |
| Start and end date of the DTI post, OR number of months the trainee is required to undertake it*(Note: a maximum period of* ***24 months*** *is permitted by UKVI. The GDC only approves a minimum of 180 and a maximum of 365 days at a time. Temporary registration may be renewed, by means of applying, for up to a maximum of 1826 days (five years))*  |  |
| Average number of hours per week that the DTI post holder is likely to work(Maximum 48 hours per week) |  |
| Training level of post (DCT, SpR, other). |  |
| Please specify the source of funding for the International Training Fellow |  |
| Is the Trust/university making a charge? If yes-state amount. |  |
| Please check box to confirm that an agreed training programme and Personal Development Plan is in place for this trainee and will be appraised as directed by NACPDE **[ ]**  |
| Please check box to confirm you agree that the MTI applicant does not require public funds and is aware that they will have no recourse to public funds during their placement **[ ]**  |

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| Are your Medical Director Team & Director of Medical Education aware and in approval of the post? |  |
| Does the Trust, Medical Director and supervising consultant take full clinical responsibility of the Tier 5 trainee? |  |
| Has the Director of Medical Education ensured the DTI post will not have a negative impact on trainees in the Trust? |  |

**Note: Please supply the NACPDE with a full written job description for the DTI post including main duties and responsibilities of the post holder, plus a copy of the contract of employment to support this application.**

Please fill in details of the weekly timetable that will be undertaken by the post-holder

Please also indicate the name of the dentist giving direct supervision for that session.

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| --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| AM |  |  |  |  |  |  |
| PM |  |  |  |  |  |  |

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| Details of trainees in your unit; e.g. SHO/DCT 1,2 or 3, StR / Fellow |
| Numbers of DCT1, 2 or3 |  |  |  |
| Number of Specialty Level Trainees - StR’s/Fellows |  |  |  |

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| **DETAILS OF ANY OTHER CONSULTANTS INVOLVED IN THIS TRAINING** |
| **Name of Consultant** | **GDC/GMC Number** |
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| What training experience are you hoping to provide to this International Training Fellow whilst he/she is in your unit? |  |

**For the Employer/Trust/University**

I confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been offered the post listed above and fulfils the above conditions.

Name (Medical Director):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GDC/GMC No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Director of Medical Education): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GDC/GMC No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On behalf of (Trust/University/Other):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervising Consultant (Educational Supervisor)**

* I confirm that the information supplied above is accurate and that supporting documentation is included. I will inform the NACPDE immediately of any changes to the information supplied in relation to this trainee
* I confirm that the training of existing trainees will not be adversely affected nor disadvantage the training of existing trainees at the training location

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GDC No (& GMC No if appropriate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information that you have provided will be handled in accordance with the General Data Protection Regulation (GDPR). It will be used to obtain the Dentist’s visa, to obtain Postgraduate Dental Dean’s approval for the placement and to facilitate the dentist’s registration with the GDC.

**Please return completed forms to:**

**nacpde@rcseng.ac.uk**

Or by post: National Advice Centre for Postgraduate Dental Education

Royal College of Surgeons of England

35-43 Lincoln’s Inn Fields

London WC2 A 3PE

**Any enquiries can be made via telephone (020 7869 6804) or email**