

## APPLICATION FOR INCLUSION IN THE DENTAL LIST OF THE HEALTH AND SOCIAL CARE BOARD

**PLEASE COMPLETE ALL RELEVANT SECTIONS OF THIS FORM.**

Return the completed form to the Health and Social Care Board local office according to the LCG area in which you will be working (See map on page 13 for details):

- **Belfast and South East LCG areas:** Directorate of Integrated Care, HSCB, 12-22 Linenhall St, Belfast, BT2 8BS (028 9536 3926)
- **Northern LCG area:** Directorate of Integrated Care, HSCB, County Hall, 182 Galgorm Rd, Ballymena, BT42 1QB (028 9536 2849)
- **Southern LCG area:** Directorate of Integrated Care, HSCB, Tower Hill, Armagh, BT61 9DR (028 9536 2104 / 028 9536 2086)
- **Western LCG area:** Directorate of Integrated Care, HSCB, 15 Gransha Park, Clooney Rd, Londonderry BT47 6FN (028 9536 1010).

**YOU MUST INCLUDE: (ORIGINAL COPIES ONLY, PHOTOCOPIES NOT ACCEPTABLE)**

- a current **Certificate of Registration with the General Dental Council**
- a current **Certificate of Professional Indemnity** issued by a Medical/Dental Protection Society
- a **Certificate of completion of Vocational Training** if you have one, or evidence of exemption or equivalence
- a completed **Statement on the use of Intra-Venous Sedation** in your clinical practice (Part 5 of this application form)
- a **Certificate of an approved English Language Test** - if English is not your first language
- a **Certificate of Health Clearance and/or signed Declaration** (see page 9)
- **Proof of attendance at a New Start Information Session.** (Held monthly - please see page 14 for a list of dates and details on how to book a place.)
- **Two References**, one must be your most recent employer/Principal or equivalent (pro forma attached – see pages 11 & 12)

FOR  
OFFICIAL  
USE  
ONLY

**PART 1 - PERSONAL DETAILS**

MR  MRS  MISS  MS  DR  OTHER \_\_\_\_\_

SURNAME \_\_\_\_\_  
(Please Print)

FIRST NAME (S) \_\_\_\_\_  
(Please Print)

PRIVATE ADDRESS \_\_\_\_\_  
\_\_\_\_\_

POST CODE \_\_\_\_\_

NATIONALITY: \_\_\_\_\_ GENDER: Male  Female

DATE OF BIRTH: 

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Day Month Year

**DENTAL QUALIFICATION(S) / REGISTRATION AS A DENTIST IN THE UNITED KINGDOM**

Qualification that entitles you to be registered as a dentist: \_\_\_\_\_

Country where this qualification was gained? \_\_\_\_\_

Date of gaining this qualification: 

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Day Month Year

Date of United Kingdom Registration as a dentist: 

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Day Month Year

General Dental Council registration number \_\_\_\_\_

Details of any Additional Qualifications held: \_\_\_\_\_

Are you on the General Dental Council Specialist Lists register? YES  NO

Details: \_\_\_\_\_

**EMPLOYMENT HISTORY**

Are you currently providing or have you previously provided General Dental Services? YES  NO

If **YES** provide details of your current position or, if not working at present, your most recent position

PRINCIPAL  ASSOCIATE  ASSISTANT  TRAINEE

Contract Number (s) \_\_\_\_\_ Name of Employer \_\_\_\_\_  
(If applicable) (If applicable)

Between Period: \_\_\_\_\_ to \_\_\_\_\_

At address:  
(Please Print) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART 2 – VOCATIONAL TRAINING STATEMENT**

2.1 I have completed Vocational Training, which commenced on or after 1<sup>st</sup> October 1993 YES  NO

***IF YES, PLEASE SUBMIT YOUR VOCATIONAL TRAINING CERTIFICATE***

*IF NO, COMPLETE PART 2.2 OR 2.3 AS APPROPRIATE*

2.2 I am exempt from the requirement to complete Vocational Training because:

a) I am an European Economic Area national holding a recognised European dental diploma YES  NO

*or*

b) My name has been included in a dental list of \_\_\_\_\_  
\_\_\_\_\_  
(United Kingdom) Health Board, or Primary Care Trust within the period of five years immediately before this application to be included in the Health and Social Care Board dental list YES  NO

**or**

- c) I have previously practiced in primary dental care for at least two years full-time (or an equivalent period part-time), in either the Community Dental Service or the Armed Forces of the Crown and part or all of that period fell within the period of four years immediately before this application to be included in the Health and Social Care Board dental list YES  NO

**or**

- d) I would have been exempted under previous versions of the GDS regulations YES  NO

**PLEASE ATTACH EVIDENCE (TRANSLATED INTO ENGLISH IF APPROPRIATE)**

OR

- 2.3 I consider that I have acquired experience and/or training which should be regarded as equivalent to Vocational Training YES  NO

**PLEASE ATTACH EVIDENCE (TRANSLATED INTO ENGLISH IF APPROPRIATE)**

**PART 3 - PRACTICE INFORMATION**

Include information about all practice premises where you will be providing General Dental Services. Please show information separately for each address.

**Please insert times**

Practice Address 1		Morning	Afternoon	Evening
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			
Telephone Number:				

- Is there access to treatment room(s) without using stairs? YES  NO

**Please insert times**

Practice Address 2		Morning	Afternoon	Evening
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			
Telephone Number:				

Is there access to treatment room(s) without using stairs? YES  NO

Do you restrict your practice to certain items of treatment? YES  NO

If yes, please provide details \_\_\_\_\_

What arrangements have you made for your patients at each address to access emergency advice and treatment within normal working hours, when you are absent, e.g. at times of sickness/holidays?

\_\_\_\_\_

\_\_\_\_\_

What arrangements have you made for your patients at each address to access emergency advice and treatment out of hours?

\_\_\_\_\_

\_\_\_\_\_

**DENTISTS**

Provide details of other dentists in the same practice(s) as you:

NAME(S) PRINCIPAL / PARTNER / ASSOCIATE / ASSISTANT

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**PLEASE INCLUDE ANY ADDITIONAL INFORMATION ON SEPARATE SHEET**

**PART 4 - YOUR PROFESSIONAL PRACTICE**

▶ Have you ever been the subject of a National Health Service Tribunal hearing? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been the subject of a Disciplinary hearing? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been the subject of a General Dental Council investigation? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been the subject of an investigation by a National Regulatory Body?  
(Including outside of the United Kingdom) No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been referred to National Clinical Assessment Service? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever had conditions placed on your professional practice? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you any Criminal convictions (to include Police Caution)? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever had issues raised in Criminal Records Bureau, Access Northern Ireland, a Police check, or equivalent in United Kingdom or elsewhere? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been taken off a performers list under the performers' list regulations? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been refused admission to the Dental List in any Primary Care Trust or Health Board, Health and Social Care Board or equivalent in the Republic of Ireland? No  Yes

If **YES**, please detail findings \_\_\_\_\_

▶ Have you ever been asked to undergo remedial training by an employer or a primary care commissioning or other organisation e.g. HSCB, HB, PCT, HSE in the Republic of Ireland, an indemnity provider? No  Yes

If **YES**, please detail findings \_\_\_\_\_

**PLEASE INCLUDE ANY ADDITIONAL INFORMATION ON SEPARATE SHEET**

**PART 5 – STATEMENT ON THE USE OF INTRA-VENOUS SEDATION**

I use Midazolam in my practice (Please specify) YES  NO

**If NO, then please go to part 6. If YES, then please complete the following:**

I declare that I comply with recommended best practice and;

- (i) ensure that only low strength Midazolam is used routinely; No  Yes
- (ii) ensure that in other clinical areas, storage and use of high strength Midazolam, is replaced with low strength Midazolam (1mg/ml in 2ml or 5ml ampoules); No  Yes
- (iii) review therapeutic protocols to ensure that guidance on use of Midazolam is clear and that the risks, particularly for the elderly or frail, are fully assessed; No  Yes
- (iv) ensure that I have the necessary knowledge, skills and competencies required when involved directly or when participating in sedation techniques; No  Yes
- (iv) ensure that stocks of Flumazenil are available where Midazolam is used and that the use of Flumazenil is regularly audited as a marker of excessive dosing of Midazolam; No  Yes
- (vi) ensure that sedation is covered by organisational policy and that overall responsibility is assigned to a senior clinician which, in most cases, will be an Anaesthetist. No  Yes
- (vii) ensure that my assistant/nurse has recognised training and experience in IV sedation No  Yes

**PART 6 – NEW DENTAL PRACTICES**

Are you about to commence work in a new dental practice/premises?

No  Yes

If yes, has the premises been inspected by the HSCB?

No  Yes

**Please note:** Until the premises are inspected by the Board you cannot be issued with a DS number. (For further information or to arrange an inspection please contact your local HSCB office.)

## **PART 7 - DECLARATION**

- I am a registered dentist and undertake to provide General Dental Services under the Health and Personal Social Services (Northern Ireland) Order 1972 on the current and future terms in operation in Northern Ireland. I now apply to have my name included in the Dental List.
- I am not disqualified from undertaking service by reason of my name having been removed from the Dental List; from any corresponding list in Great Britain; or from any National Regulatory Body in the United Kingdom or elsewhere.
- I am aware of and will comply fully with my obligations as required by the "Standards for the Dental Team 2013".
- I am aware of and will comply fully with my obligations as required by Northern Ireland Minimum Standards for Dental Care and Treatment'
- I am aware of and will comply fully with the relevant regulations and legislation relating to my providing care and treatment to patients in Northern Ireland.
- I am not currently subject to any restrictions which limit my ability to work in any capacity.
- I am fit and healthy to work.
- **I WILL NOTIFY THE HEALTH AND SOCIAL CARE BOARD OF ANY CHANGES TO ANY OF THE DETAILS OR DECLARATIONS I HAVE SUBMITTED IN THIS DOCUMENT**

Signature \_\_\_\_\_

Date \_\_\_\_\_



Subject to my inclusion in the Dental List as requested, I intend to commence provision of General Dental Services on: Date \_\_\_\_\_

In relation to this application I can be contacted at:

Tel No: \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail \_\_\_\_\_

Will you be working in a practice that submits claims by EDI? YES  NO

Do you require HS45 forms to submit claims? YES  NO

**PART 8 – CERTIFICATE OF HEALTH CLEARANCE**

Please complete either Section 1 (Dentists new to the HSCB NI List) or Section 2 (Dentists already on the HSCB NI List)

**Section 1. A New Dentist to the Health & Social Care Board Dental List**

All new health care workers (includes new dentists entering the Health and Social Care Board Dental List) **must** present to a local Occupational Health Unit to be assessed or tested as appropriate in relation to assuring immunity to Hepatitis B and Tuberculosis and the results of testing for Hepatitis C and Human Immunodeficiency Virus.

**Contact the Occupational Health Department for your local Trust area and inform them that you are a dentist wishing to book an appointment for assessment or testing as a new health care worker coming onto the HSCB Dental List.** Please take with you this HS48 form, fully completed, and any relevant documentation or previous test results plus photographic ID in the form of a Passport or Driving Licence.

**Contact details:**

Belfast Trust (Belfast)	028 9504 0401
Southern Trust (Armagh)	028 3741 2473
Northern Trust (Antrim)	028 9442 4403
Western Trust (Derry)	028 7161 1407
Western Trust (Omagh)	028 8283 5395
Western Trust (Enniskillen)	028 6638 2342
South-Eastern Trust (Ulster Hospital)	028 9056 1300

Please also complete the box below. Following assessment Occupational Health will provide the Board with your Certificate of Health Clearance.  
**Note:** Your application cannot be processed until this is received by HSCB.

Occupational Health Department Attended (please tick):

Belfast Trust  Southern Trust  Northern Trust

Western Trust  South Eastern Trust  Date attended: \_\_\_\_\_

Or

**Section 2. A Dentist already on the Health & Social Care Board NI Dental List**

If you have previously received an Occupational Health Certificate of Health Clearance for the purposes of entering the HSCB NI Dental List please sign the following declaration:

Occupational Health Department Attended (please tick):

Belfast Trust  Southern Trust  Northern Trust

Western Trust  South Eastern Trust  Date attended: \_\_\_\_\_

I declare that I have no concern that my communicable disease status may have changed since the above Occupational Health Assessment. I have not been in an at risk situation, e.g. sharps injury or blood contamination event, travelled to a high endemic tuberculosis area of the world for more than 4 weeks, or been in any other personal or work circumstance that is associated with transmission of Tuberculosis, Hepatitis B, Hepatitis C or HIV.

**Note: It is your responsibility to notify Occupational Health if your health status has changed or you have been in an at risk situation.**

Signed: \_\_\_\_\_ Date \_\_\_\_\_



### Character and Identity Reference

#### To be completed by the referee

The information provided in this form will be used to assess the applicant's fitness for inclusion on the HSCB Dental List and to confirm the identity of the applicant. This reference should be signed by a person of professional standing (in any country) such as a dentist, doctor, person entitled to practice law, minister of religion or a civil servant.

**Full name of applicant**

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**Full name of referee**

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**Position held**

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**GDC Registration number (if appropriate)**

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**Address**

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**Email**

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**Telephone**

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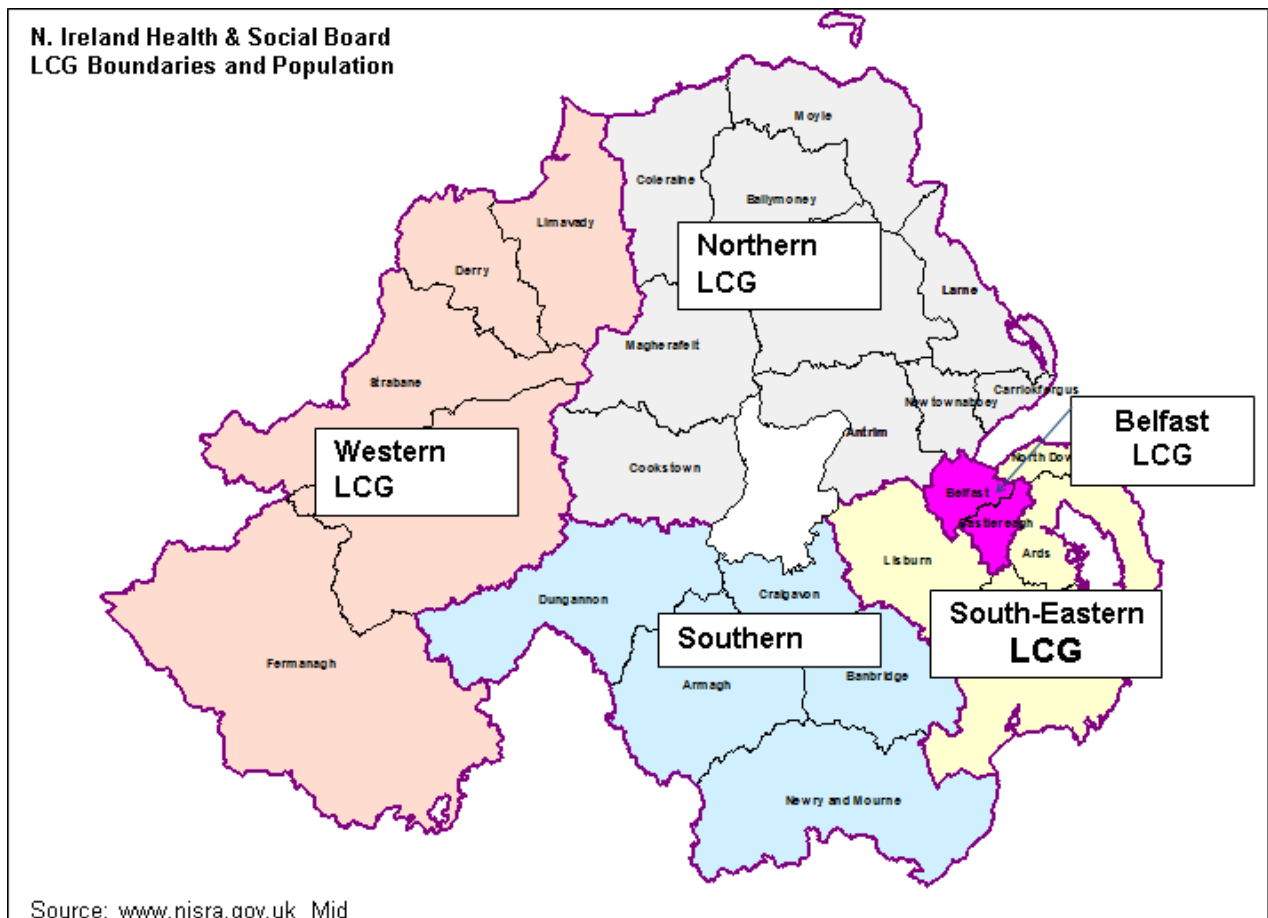
#### Declaration

I certify that I am not a relative of the applicant, I have known the applicant for **at least one year** and that they are the person they declare themselves to be; and either (please tick):  
 I am satisfied that to the best of my knowledge, the applicant is of good character and fit for inclusion on the HSCB Dental List; or  
 The HSCB should be aware of the following details of the applicant's character which might affect their suitability for inclusion on the Dental List. **(Please continue on a separate sheet if required.)**

Signature

Date

## Northern Ireland Health & Social Care Board LCG Boundaries



## DATES FOR NEW START INFORMATION SESSIONS 2014/15

Practitioners are required to attend a New Start Information Session **prior** to submitting an application to join the NI Dental List. HS48 applications cannot be processed without proof of attendance. Even those already on the Dental List who require a new DS number should attend a session if they have not already done so.

If you have recently attended an information session you should submit your certificate of attendance with your application form.

To book a place, please contact the named person for the session you wish to attend as below. **PLEASE DO NOT ATTEND WITHOUT BOOKING FIRST.**

**Venue:** All sessions are held in County Hall, 182 Galgorm Road, Ballymena, BT42 1QB

**Time:** 9.30am – 12.30pm

<b>Date</b>	<b>Dental Adviser</b>	<b>Contact Admin Person</b>	<b>Contact Telephone Number</b>
Tuesday, 21 April 15	Brid Hendron	Janice Brown /Angela Neilly	028 9536 2104
Tuesday, 19 May 15	Joe McGrady	Deaglan Stanton	028 9536 3097
Tuesday, 16 June 15	Gerry Cleary	Evelyn Curry	028 9536 1010
Tuesday, 21 July 15	Philip Colgan	Deaglan Stanton	028 9536 3097
Tuesday, 18 August 15	Julie Kelly	Deaglan Stanton	028 9536 3097
Tuesday, 15 September 15	Jonathan Montgomery	Julie Wilson	028 9536 2812
Tuesday, 20 October 15	Derek Maguire	Thomas Quinn	028 9536 3357
Tuesday, 17 November 15	Peter Jackson	Evelyn Curry	028 9536 1010
Tuesday, 15 December 15	William Priestley	Thomas Quinn	028 9536 3357