**Dental Performers List Validation by Experience**

**Application Form for Appointment as a Validation Supervisor**

**(Where more than one Validation Supervisor is intended, a separate application form should be completed for each proposed Validation Supervisor)**

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| **Name of proposed Validation by Experience Dentist (VED):** |  |
|  |  |
| **Part 1** | **Validation Supervisor’s details** |  |
| Surname: |  |
| Other names: |  |
| Gender: | **M** | **F** | Date of birth: |  | (dd/mm/yy) |
| Practice address (including postcode) |  |
| Daytime telephone number (incl area code) |  |
| Email address |  |
|  |  |
| **Part 2** | **Registration and Qualifications** |  |
| GDC number: |  | NHS performer number: |  |
| Date of GDC registration as a dentist: |  | (dd/mm/yy) |
| List the qualifications that entitle you to be registered in the UK as a dentist in chronological order, with your primary qualification first. |
| **Qualification** | **Awarding body** | **Year gained** |
|  |  |  |
|  |  |  |
|  |  |
| **Part 3** | **Experience** |  |
| Number of years in practice as: | *(minimum 4 years in practice)* |
| An owner: |  | Partner (equity or expense sharing |  |
| Performer: |  | Current status: | Self-employed |  | Employed |  |
| If employed please state name and address of employer: |

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| In the table below please indicate which sessions you intend to work in the practice to support a VED: |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| am |  |  |  |  |  |  |
| pm |  |  |  |  |  |  |
| Does your practice NHS contract exclude any patient groups or mandatory treatment items? | **Y/N** |
| *If yes, please give details:* |  |
| Do you practise solely within the NHS? | **Y/N** | Do you work in NHS Prototype arrangement? | **Y/N** |
| What are your personal UDAs (or equivalent) from NHS work per annum? |  | *Minimum requirement 1000* |
| Number of UDAs (or equivalent) in the practice contract overall per annum? |  | *Minimum requirement 4000* |
| Number of UDAs (or equivalent) to be assigned to proposed VED |  |  |
| Net (after deductions) payment per UDA (or equivalent) to be made to proposed VED |  |  |
| Who provides your professional indemnity or insurance?  |  |
| Have you previously been appointed as Validation Supervisor (or equivalent) in the PLVE/DFTQ programme? | **Y/N** |
| If yes, give dates and details  |  |
| Have you participated in a DFT/VT Scheme as aDFT Educational Supervisor/Trainer? | **Y/N** |
| If Yes, give year and scheme: |  |
|  |  |
| **Part 4** | **CPD**  |  |
| Have you submitted annual returns to the GDC that comply with the minimum CPD requirements during the last 4 year? | **Y/N** |
| If no, please provide reasons: |  |
| **Please enclose a copy of your CPD records for the last 12 months and evidence of any involvement with Clinical Audit/Peer Review.** |

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| **Part 5** | **Declarations** |  |
| Please read the following statements carefully before signing this application: |
| 1. I confirm that I am not aware of any disciplinary proceedings or investigations by NHS England, NHS BSA or GDC in relation to me or my practice or other partners or registrants.
 |
| 1. I understand that the Local Office of NHS England may be contacted in connection with this application and the suitability of myself and / or the practice to support the PLVE process.
 |
| 1. I am able to offer a PLVE place for a period of up to twelve months pro rata.
 |
| 1. I agree to a practice inspection (if required) and will make approximately two hours available to the assessors.
 |
| 1. I understand that approval as a Validation Supervisor for PLVE is not an appointment as an Educational Supervisor in Dental Foundation Training (DFT).
 |
| 1. I accept that the decision of Health Education England – East Midlandsshall be final. (Feedback will be offered to all unsuccessful applicants).
 |
| 1. I understand that if I am approved as a Validation Supervisor, I or the practice will be required to either employ the VED under contract or have an Associate Agreement and will make this available to Health Education England – East Midlands.
 |
| 1. I accept that the UDA requirement placed on the VED and contractual payments to the VED will be subject to approval by Health Education England – East Midlands.
 |
| 1. I understand that I must be available from the date on which the VED starts in my practice to provide direct supervision.
 |
| 1. I include the following documents with this application:
 |
| * Copy of current GDC Practising Certificate
 |
| * Copy of evidence of involvement in Clinical Audit/Peer Review
 |
| * Copy of CPD record for last 12 months
 |
| * Copy of most recent practice visit report from the CQC
 |
| **Applicant’s signature:** |  | **Date:** |  |
| If practising as a non-principal (i.e. as a salaried practitioner or as an associate) the practice owner / manager must also sign this application and the declaration below: |
| 1. I confirm that the information set out in the application is correct to the best of my knowledge
 |
| 1. I confirm my agreement with and support for the statements set out in Part 5 (i to x)
 |
| 1. I confirm that I am prepared to allow the VED to participate in practice discussions on administrative and day-to-day financial matters relevant to the identified educational requirements
 |
| **Practice owner/manager signature:** |  | **Date:** |  |

**NHS Practice Stamp**

Once completed,

 please return this form to:

PLVE Team

Health Education England – East Midlands Westbridge Place

1 Westbridge Close

Leicester

LE3 5DR