**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):** | | | | | | | | | |  | | | | | | | | | | |
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| **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 | | | | | | | | |  | | | | | | | | | | | |
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| **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** | | | |
|  | | | | | | |  | | | | | | | | | |  | | | |
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| **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 (electronic signature accepted):** | |  | | **Date:** |  |

Once completed, please return this form to: [PLVE.EM@hee.nhs.uk](mailto:PLVE.EM@hee.nhs.uk)

Please note applications will only be accepted electronically in Word or PDF format.