SUPPLEMENTARY INFORMATION FORM Certificate in Competency in Fluoride Application

litie	Forename	Surname
User ID		
Which course	are you attending	LEEDS () HULL () WAKEFIELD ()
Please identify if y	you are qualified in NEBD	ON OHE Cert. (please circle) Yes No
GDC Registration	Number*:	
Indemnity Insura	ance (Personal/Employe	er/Crown)*
Please indicate if	you are named on an inc	demnity insurance policy and indicate the type of policy
Yes I am named	on the policy type indicate	ed below:
	Indemnity Insurance (demnity Insurance () Employer Indemnity Insurance ())
Policy Number an	d provider:	
No, I am not coverejected)	ered by any Indemnity Ins	curance () (NOTE if this box is ticked your application will be
*please note tha	t without these requirer	ments your application will be rejected.
compsuccExam	nination)	neets ompetency written paper and an OSCE (Objective Structured Clinical n Yorkshire and the Humber Fluoride Application Competency
Signature:		Date:
Employing	g/Supervising [Dentist Control of the Control of th
Name: _		GDC Registration No:
	n from a GDC registrant e requirement of ten case	who is competent in clinical fluoride application and who is willing to mentor e studies:
Qualifications	»:	_
I agree to supervi Dental Nurses Co		nurse named above who is applying for the Clinical Fluoride Application for
I Confirm I will supstudies.	oport him/her throughout	the practical competence requirements and the completion of the case
Dentist Signa	ture:	Date:
Vour GDC registrat	ion may he at risk if you w	ittinaly make a false statement which you know to be untrue

Please return with your payment to: Dental Admin Team, Health Education Yorkshire and the Humber, Willow Terrace Road, University of Leeds, Leeds, LS2 9JT