Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

OSPIDÉAL DÉADACH BHAILE ÁTHA CLIATH
DUBLIN DENTAL HOSPITAL

TRINITY COLEGE DUBLIN DIRECT ENTRY APPLICATION FORM

PLEASE USE BLOCK CAPITALS

Personal Details

Surname……Title……..

First Name……Second Name……

Date of Birth…… M/F

Home Address…… Other, if applicable……

…… ……

…… ……

…… ……..

Mobile Number…….

Home Number……

Email address – personal……

work……..

Employer details

Name of current employer (supervising specialist orthodontist) ……

Address ……..

……..

……..

Employer's email address ……

Phone number …… Hours per week worked ……

Place of Employment

Health Service Executive ☐ Specialist Dental Practice ☐

Applicant Status

EU Status – Please tick ONE of the following categories :-

☐ 1. Are you ordinarily resident in the EU and have you received full-time primary education in the EU for three of the five years immediately preceding admission to Trinity College Dublin?

☐ 2. Are you ordinarily resident in the EU and have you worked full-time in the EU for three of the five years immediately preceding admission to Trinity College Dublin?

☐ 3. Do you hold a passport from an EU State and have you received all full-time post primary education in the EU?

☐ 4. Do you have official refugee status or have you been granted humanitarian leave to remain in the state and have you been ordinarily resident in the EU for three of the five years immediately preceding admission to Trinity College Dublin?

☐ 5. I do not fall under any of the categories outlined above.

Country of Birth …….Nationality……

Country of permanent residence prior to entry……..

Personal Public Service (PPS) Number……

Have you been admitted to Trinity College Dublin before? Yes ☐ No ☐

If so, year admitted…… Most recent course taken……..

Do you require a Visa to study? Yes ☐ No ☐

Do you have a disability/specific learning difficulty? Yes ☐ No ☐

(Please note that disclosure of a disability and/or specific learning difficulty will not adversely affect your application in any way).

If so, please indicate whether you wish to be contacted by the Disability Service in order to discuss the support services you require. Yes ☐ No ☐

Second Level Education

Please provide the details of School(s) you have attended. Please note that the most recent one should be entered first.

Name of School……From …….. To……

Address……..

……

……

Please enter the results for your final year subjects.

Qualification……

Subject	Level	Grade/Mark	Date of exam

Have you completed the European Computer Driving Licence (ECDL)? Yes ☐ No ☐

If so, date obtained……..

Have you completed a Basic Life Support for the Healthcare Provider Course in Cardio-Pulmonary Resuscitation (CPR)? Yes ☐ No ☐

Date obtained……..

Highest 3rd Level Qualification or Equivalent (Diploma, Degree, Masters, etc)

Please enter the full details of your highest qualification that you are either currently studying or have obtained.

Period of attendance from……. to ……

Name of Institution attended…….

Qualification…….Course Title…….

Result/Level/Class of Award…….

Name of awarding body…….

Main subject studied……Full time ☐ Part time ☐

Have you completed the programme? Yes ☐ No ☐

If No, date on which Final results will be available ……

Date of Graduation…….

Please enter full details of any additional relevant qualifications that you have obtained.

Period of attendance from……. to……

Name of Institution attended…….

Qualification…….Course Title…….

Result/Level/Class of Award…….

Name of awarding body…….

Main subject studied……..Full time ☐ Part time ☐

Have you completed the programme? Yes ☐ No ☐

If No, date on which Final results will be available ……

Date of Graduation…….

Please enter the details of any other courses you have undertaken that may be relevant to your application.

Title of course……

Location…… Year taken……

Duration of course (in months)…… Certificate awarded……

Subjects……

Level…… Result……

Title of course……

Location…… Year taken……

Duration of course (in months)…… Certificate awarded……

Subjects……

Level…… Result……

English Language Proficiency

Is English your first language? Yes ☐ No ☐

If No, what is your first language? .....

What is your second language? .....

If English is not your first language, please provide evidence of English language competence.

English Language Qualification……

Date of test taken or to be taken…… Score/Grade ……

Employment History/Work Experience

NB: Please include details of ORTHODONTIC experience, Including dates and the number of sessions per week

Date from…… Date to……..

Name and Address of Company/Organisation ……

……

……

Position held……..

In the space below, outline your responsibilities, the skills you used or experience you gained while working in this position.

Date from…… Date to…….

Name and Address of Company/Organisation ……

……

……

Position held……

In the space below, outline your responsibilities, the skills you used or experience you gained while working in this position.

Voluntary Work

Give details in chronological order of any voluntary (unpaid) work you have carried out.

Date from…… Date to……..

Name and Address of Organisation ……

……..

……..

Job Title ……..

In the space below, outline your involvement and how you benefited from your experience.

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Where did you hear about this programme?

Practitioner ☐ IDHA/IDNA/IDA website ☐ DDUH/Dental School website ☐

Other (please give details) ……..

How do you intend to fund your studies? (Please tick all that apply)

Self-funding ☐ Employer Funding ☐ Parent/Guardian ☐ Other ☐

Please include any additional information in support of your application.

NB: You must include your Dental Council Registration Number here

…….

Describe briefly why you wish to undertake training to become an Orthodontic Therapist.

Personal Statement

Which aspects of this course interest you most?

Please explain the relevance of your life and/or educational experience to this course.

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Declaration

I certify that the information given in this course application is complete and accurate to the best of my knowledge and understand that any misrepresentation may render my application void.

I understand that this application is an expression of interest in the course for which I have applied. It does not constitute a contract between the applicant and Trinity College Dublin, the University of Dublin.

I understand that this application and any supporting documentation become the confidential property of Trinity College Dublin, the University of Dublin, and (an)other education institution(s), or where required to do by law.

I understand that the information supplied as part of the application process may be used for compiling general statistical reports and will not identify any individual applicant.

I understand that I must have access to a computer and internet access to enable access to programme material.

Please tick box ☐

Prior to submitting your application, please check that you have enclosed:

1. Student Application form	Yes/No
2. Trainer Application form	Yes/No
3. Outline of Work Placement form	Yes/No
4. Trainer/Supervisor Commitments form	Yes/No
5. €35 cheque / postal money order made payable to Dublin Dental Hospital Board or call 01 612 7361 for credit card payment.	Yes/No

N.B. Candidates must be prepared to show evidence of Hepatitis B and C as per instructions on Page 2 of Information Pack if offered a place.