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

Professional Diploma in Orthodontic Therapy

Trainer Application Form

A. PERSONAL DETAILS		
Title:	**Forename(s):**	**Surname:**
Registration Number Dental Council Specialist Register of Orthodontists:		
Date of entry onto Dental Council Specialist Register of Orthodontists:		
Name of prospective Student Orthodontic Therapist		
Practice name: **Address:**		
Contact email address: **Website address:** **Contact telephone number:**		
Address for correspondence *(If different from above)*:		

Professional Qualifications:	**Awarding Body:**	**Date awarded:**

B. TRAINING ENVIRONMENT		
1.	**What is your status within the practice / unit / department?** **Sole owner / Partner / Associate / Consultant** (Please circle or delete)	
2.	**Are you the prospective student's employer?**	**Yes / No**
3.	**Would other Specialists in the practice / unit / department wish to be involved in training?**	**Yes / No**
	If so, please list their names and qualifications/date of entry onto Specialist List:	
	a) Name:	
	Partner / Associate / Consultant / other	**Full / Part time**
	Qualifications/Date of entry onto Specialist List:	
	b) Name:	
	Partner / Associate / Consultant / other	**Full / Part time**
	Qualifications/Date of entry onto Specialist List	
	c) Name:	
	Partner / Associate / Consultant / other	**Full / Part time**
	Qualifications/Date of entry onto Specialist List:	
	d) Name:	
	Partner / Associate / Consultant / other	**Full / Part time**
	Qualifications/Date of entry onto Specialist List:	
4.	**Do you have sufficient space, nursing support and patients to provide a Student Orthodontic Therapist with 7-8 sessions of supervised clinical training per week?**	**Yes / No**
5.	**How many fully operational chairs are there in the practice / unit / department?**	

6.	**How many surgeries are there in the practice / unit / department?**	
7.	**Will the Student Orthodontic Therapist have their own designated chair?**	**Yes / No**
8.	**Will a qualified Dental Council registered nurse work with the Student Orthodontic Therapist?**	**Yes/ No**
9.	**Will the Student Orthodontic Therapist work between two practices / units / departments? If so, please provide details.**	**Yes / No**
10.	**What percentage of your clinical practice are:** • **< 18years of age** • **> 18 years of age** • **Routine orthodontic treatments** • **Multidisciplinary cases?**	 **%** **%** **%** **%**
11.	**Do you use:** • **Removable Appliances** • **Functional Appliances** • **EOT** • **Straight-wire Appliances?**	 **Yes / No** **Yes / No** **Yes / No** **Yes / No**
12.	**What educational resources are available in the practice / unit /department to support a Student Orthodontic Therapist?**	
13.	**Do you have internet and email access in the practice / unit / department?**	**Yes / No**
14.	**Do you use digital photography in the practice / unit / department?**	**Yes / No**
15.	**Are you prepared to engage in a formal weekly discussion/seminar session with the Student Orthodontic Therapist?**	**Yes / No**

16.	**Are you willing to formally assess and monitor the Student Orthodontic Therapist's development and provide regular reports on their progress?**	**Yes / No**
17.	**Are you or any other members of your practice / unit / department's training team already involved in training?**	**Yes / No**
18.	**Are you prepared to act as a local coordinator for your Student Orthodontic Therapist's trainers within the practice / unit / department?**	**Yes / No**
19.	**Please state briefly your reasons for wishing to be involved with this course.**	

Falsifying information on this application will be deemed as acting in an unprofessional manner. This will have implications on registration with the regulatory body.

Signed: …… **Date: ……..**