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

OSPIDÉAL DÉADACH BHAILE ÁTHA CLIATH
DUBLIN DENTAL HOSPITAL

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:**		
Practice email: **Trainer's personal email address:** **Practice telephone number:** **Trainer's mobile 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: ……..**