 **Post Registration Application Form**

**DENTAL SUPPORT SERVICES**

**ABBEY Road Health Centre**

**28a Abbey Road, Stratford, London E15 3LT**

**0208 555 9000**

Please indicate which course you are applying for:

|  |  |
| --- | --- |
|  | Certificate in Oral Health Education |
|  | Certificate in Dental Radiography |
|  | Certificate for Competence in Impression Taking |
|  | Assessor Award |

Title (Mr/Mrs/Miss)…………… Surname: ………………………………… First Name: ……………………………

Date of Birth: …………………………………………………………………………………………………………………………

Address: …………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………….

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Post Code: ……………………………………………………………………………………………………………………………..

Tel. (work): …………………………………………………………………………………………………………………………….

Tel. (home):……………………………………………………………………………………………………………………………

Tel. (mobile):………………………………………………………………………………………………………………………….

Email: …………………………………………………………………………………………………………………………………….

GDC Registrations Number:……………………………………………………………………………………………………

Please enclose a copy of your Qualification Certificate and GDC Registration Certificate and a completed Record of Experience Request form with your application. Course fees will be due on first day by either cash or cheque (made payable to Dental Support Services).

Applications will only be accepted if all required items are enclosed.

Practice details

Dentist’s Name: ……………………………………………………………………………………………………………………………

Practice Name: ……………………………………………………………………………………………………………………………..

Practice address: ……………………………………………………………………………………………………………………………

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Postcode: ……………………………………………………………………………………………………………………………………….

Email: …………………………………………………………………………………………………………………………………………….