NHS
Health Education England

Dental Performers List Validation by Experience

Application Form for Appointment as a Validation Supervisor

(Where more than one Validation Supervisor is intended, a separate application form should be completed for each proposed Validation Supervisor)

Name of proposed Validation by Experience Dentist (VED):	

Part 1	**Validation Supervisors's details**

Surname:					
Other names:					
Gender:	**M**	**F**	Date of birth:		(dd/mm/yy)
Practice address (including postcode)					
Daytime telephone number (incl area code)					
Email address					

Part 2	**Registration and Qualifications**

GDC number:		NHS performer number:	
Date of GDC registration as a dentist:		(dd/mm/yy)	

List the qualifications that entitle you to be registered in the UK as a dentist in chronological order, with your primary qualification first.

Qualification	**Awarding body**	**Year gained**

Part 3	**Experience**

Number of years in practice as:	*(minimum 4 years in practice)*				
An owner:		Partner (equity or expense sharing			
Performer:		Current status:	Self-employed		Employed

If employed please state name and address of employer:

In the table below please indicate which sessions you intend to work in the practice to support a VED:						
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
am						
pm						

Does your practice NHS contract exclude any patient groups or mandatory treatment items?	**Y/N**
If yes, please give details:	

Do you practise solely within the NHS?	**Y/N**	Do you work in NHS Prototype arrangement?	**Y/N**

What are your personal UDAs (or equivalent) from NHS work per annum?		*Minimum requirement 1000*
Number of UDAs (or equivalent) in the practice contract overall per annum?		*Minimum requirement 4000*
Number of UDAs (or equivalent) to be assigned to proposed VED		
Net (after deductions) payment per UDA (or equivalent) to be made to proposed VED		
Who provides your professional indemnity or insurance?		

Have you previously been appointed as Validation Supervisor (or equivalent) in the PLVE/DFTQ programme?	**Y/N**
If yes, give dates and details	
Have you participated in a DFT/VT Scheme as a DFT Educational Supervisor/Trainer?	**Y/N**
If Yes, give year and scheme:	

Part 4 CPD

Have you submitted annual returns to the GDC that comply with the minimum CPD requirements during the last 4 year?	**Y/N**
If no, please provide reasons:	

Please enclose a copy of your CPD records for the last 12 months and evidence of any involvement with Clinical Audit/Peer Review.

Part 5	**Declarations**

Please read the following statements carefully before signing this application:

i. I confirm that I am not aware of any disciplinary proceedings or investigations by NHS England, NHS BSA or GDC in relation to me or my practice or other partners or registrants.

ii. I understand that the Local Office of NHS England may be contacted in connection with this application and the suitability of myself and / or the practice to support the PLVE process.

iii. I am able to offer a PLVE place for a period of up to twelve months pro rata.

iv. I agree to a practice inspection (if required) and will make approximately two hours available to the assessors.

v. I understand that approval as a Validation Supervisor for PLVE is not an appointment as an Educational Supervisor in Dental Foundation Training (DFT).

vi. I accept that the decision of **[INSERT HEE LOCAL OFFICE]** shall be final. (Feedback will be offered to all unsuccessful applicants).

vii. I understand that if I am approved as a Validation Supervisor, I or the practice will be required to either employ the VED under contract or have an Associate Agreement and will make this available to **[INSERT HEE LOCAL OFFICE]**.

viii. I accept that the UDA requirement placed on the VED and contractual payments to the VED will be subject to approval by **[INSERT HEE LOCAL OFFICE]**.

ix. I understand that I must be available from the date on which the VED starts in my practice to provide direct supervision.

x. I include the following documents with this application:

- Copy of current GDC Practising Certificate
- Copy of evidence of involvement in Clinical Audit/Peer Review
- Copy of CPD record for last 12 months
- Copy of most recent practice visit report from the CQC

Applicant's signature:		**Date:**	

If practising as a non-principal (i.e. as a salaried practitioner or as an associate) the practice owner / manager must also sign this application and the declaration below:

i. I confirm that the information set out in the application is correct to the best of my knowledge

ii. I confirm my agreement with and support for the statements set out in Part 5 (i to x)

iii. I confirm that I am prepared to allow the VED to participate in practice discussions on administrative and day-to-day financial matters relevant to the identified educational requirements

Practice owner/manager signature:		**Date:**	

NHS Practice Stamp

Once completed,
please return this form to:-
[INSERT HEE LOCAL OFFICE CONTACT DETAILS]