

# APPENDIX 7

General Dental Council

Registration Department  
43-45 Portman Square, London, W1H 6HN  
Tel: 020 7167 6000 Email: assessments@gdc-uk.org

Registration Department Office Hours:   
Monday to Friday, 9.00am to 5.00pm

Recommendation for the Award of a Certificate of Completion of Specialist Training

**General Instructions**

This form must be completed and signed by the Postgraduate Dental Dean/Director and returned to the General Dental Council.

**Please ensure that all sections of the form are completed in type or black ink in BLOCK CAPITALS.Send to:**

General Dental Council  
Registration Department  
43-45 Portman Square  
London, W1H 6HN



**FOR GDC USE ONLY**GDC Registration Number: \_ \_ \_ \_ \_ \_ \_ \_ \_Surname:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Forenames:\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Specialty \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Recommendation for the Award of a Certificate of Completion of Specialist Training**

TO BE COMPLETED BY THE POSTGRADUATE DENTAL DEAN/DIRECTOR

(a) Surname \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Mr/Mrs/Miss/Ms \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Forenames \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_   
(b) GDC Registration No. \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ (c) National (or Visiting) Training No. \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

1. Period spent in Specialist Training Programme (state number of years and months)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Date Training started \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date training ended \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  
Date exit examination passed\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

1. Period of any overseas training which took place during the Postgraduate Training included under (d) above (state number of years and months)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

(e) Specialty (name in full)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Declaration**I confirm that \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ has satisfactorily completed the above specialist training programme on (specify date)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ and I recommend him/her for the award of the Certificate of Completion of Specialist Training in the specialty stated.  
 To be signed by the Postgraduate Dental Dean/Director, or his/her designated nominee.

Name (surname underlined)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Region \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_  
Signed \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Date \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**When this form has been completed and signed, please send it to:**

**General Dental Council  
Registration Department  
43-45 Portman Square, London, W1H 6HN**

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