GENERAL DENTAL COUNCIL

Registration Department

1 Colmore Square, Birmingham B4 6AJ

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 1 Colmore Square Birmingham

B4 6AJ

**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\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_
2. Period of any overseas training which took place during the Postgraduate Training included under (d) above (state number of years and months)\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_
3. 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**

**1 Colmore Square, Birmingham B4 6AJ**