**KING’S HEALTH PARTNERS (KHP)**

 **ORTHODONTIC THERAPIST TRAINING PROGRAMME**

**APPLICATION FORM 2025 Cohort**

*(Please complete this form electronically, or legibly, using black ink only)*

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| **A. PERSONAL DETAILS** |
| **TITLE** (Mr/Ms/Miss/Mrs etc)**:** | **FORENAME:** |
| **SURNAME:** | **PREVIOUS SURNAME** (if applicable)**:** |
| **GDC NUMBER:** |  |
| **HOME ADDRESS** (This is your permanent home/residing address. This address will be the address used to send all course correspondence)**:** |
| **EMAIL ADDRESS:** |
| **MOBILE:** | **HOME:** |
| **PRACTICE DETAILS** |
| **ADDRESS OF PROPOSED TRAINING SITE** (Please also state if you would like this practice address to be used to send any correspondence instead of your home address)**:** |
| **EMAIL ADDRESS:** |
| **PRACTICE NUMBER:** |
| **NAME OF LEAD TRAINER:** |
| **GDC NO. OF LEAD TRAINER:** |
| **NAME OF ADDITIONAL TRAINER(S)** (if applicable): **2.** |
| **GDC NO OF ADDITIONAL TRAINER 1** (if applicable)**:****GDC NO OF ADDITIONAL TRAINER 2** (if applicable)**:** |
| **ADDITIONAL PRACTICE INFORMATION:** |
| **What percentages of patients are likely to be NHS?** |
| **What will be the hours you will be expected to work as a student orthodontic therapist?** |
| Please show the sessions when you are present in the practice or department and state hours:

|  |  |
| --- | --- |
|  Monday Tuesday Wednesday Thursday Friday  |  Saturday  |
| A.M |  |
| P.M |  |

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| **Have you been employed and working at the above proposed training site for more than 3 months?** **Yes □ No □** **If yes, please confirm your start date.****If no, by the start of the training programme will you have been working in the proposed training site for more than 3 months?** **Yes □ No □** |
| **Is your trainer(s) already registered on to the Specialist ‘Orthodontist’ General Dental Council (GDC) register?** **Yes □ No □**  |
| **QUALIFICATIONS (INCLUDING DATES):** *Please clearly state all of the qualifications that you have achieved.* |
| **TYPE OF QUALIFICATION:** | **AWARDING BODY:** | **DATE ACHIEVED:** |
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| **B. EMPLOYMENT DETAILS: (***Dental employment history details only)* **(*Please give a full employment history with dates since leaving school):*** |
| **Name and Address of Employer(s)** | **No of sessions** | **Dates of Employment** |
| **1.** |  |  |
| **2.** |  |  |
| **3.** |  |  |
| **4.** |  |  |
| **5.** |  |  |
| **6.** |  |  |
| **7.** |  |  |
| **8.** |  |  |
| **PLEASE GIVE DETAILS OF ALL ORTHODONTIC EXPERIENCE:** *Including dates and the number of sessions per week (****300 words or less****):* |
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| **PLEASE LIST ALL RELEVANT TRAINING COURSES ATTENDED WITHIN THE LAST 5 YEARS:** |
| **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |
| **6.** |
| **7.** |
| **8.** |
| **9.**  |
| **10.**  |
| *Please continue on a separate sheet if necessary.* |

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| **C. ADDITIONAL INFORMATION REQUIRED FROM APPLICANT:**  |
| **Do you hold the NEBDN Certificate in Orthodontic Dental Nursing?** **Yes □ No □** **If no, do you hold a supporting letter from your supervising orthodontist to support your application? (Please ensure supporting letter is included within the submission of the application).** **Yes □ No □**  |
| **Have you applied for any other Orthodontic Therapist Training Programmes due to commence in the following year?** **Yes □ No □** **If yes, please state where:** |
| **Are you planning to apply for any other Orthodontic Therapist Training Programmes commencing in the following year?** **Yes □ No □** **If yes, please state the name of the course provider and where:** |
| **Have you applied for any other training courses commencing in the following year?** **Yes □ No □** **If yes, please state the name and location of the course that you have applied for:** |
| **Are you currently enrolled or have you recently started any other course(s) that you will be studying alongside the KHP Orthodontic Therapy programme if you were accepted?** **Yes □ No □** **If yes, please state the name of the course and course provider that you have enrolled onto or are due to start:****Please confirm, course anticipated completion date:** |
| **Will this KHP Orthodontic Therapy course you have applied for be funded by you or your proposed training site?** **Applicant (You) □ Training Site □**  |
| **If the course is being funded by your proposed training site, do you have a contract and/or written confirmation to support this funding arrangement?** **Yes □ No □** **If yes, please provide a letter/ email of written confirmation to support this application and funding agreement.** |
| **Have you gained prior approval from the Supervising Orthodontist(s) at your proposed training site to support this application and support your clinical supervision at the proposed training site for the duration of the programme?** **Yes □ No □**  |
| **Do you have the appropriate personal indemnity cover for the duration of the course?** **Yes □ No □** **If no, will you take out the appropriate personal indemnity cover if accepted onto the KHP orthodontic Therapy Programme (prior to the start of the course)?** **Yes □ No □** *The KHP team will not accept applicants who do not hold the correct personal indemnity for the duration of the training programme. The KHP team recommend that all individuals take out the appropriate personal indemnity. A copy of the personal indemnity insurance certificate will need to be provided prior to the start of the course.* |
| **D. REASON FOR APPLICATION** *Describe why you wish to undertake training to become an Orthodontic Therapist at King’s* ***(300 words or less).*** |
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| **E. STATEMENT IN SUPPORT OF YOUR APPLICATION** *Taking into account the person specification for Students, please provide any other information that may be relevant to your application. This could include examples of working in a team, illustrations of your communication and interpersonal skills, examples of organisation and setting priorities drawn from work or from other outside activities.* ***(300 words or less)*** |
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| **F. REFEREES** |
| Please provide the names and addresses of **two professional referees**, one of which must be your current employer, who will support your application. Please inform both referees that they may be requested to provide a reference on your behalf.Referees must be able to confirm your:* Suitability for the course
* Performance ability
* Personal qualities
* Supporting/ additional information to support your application
 |
| **REFEREE 1.** |
| **TITLE:** | **NAME:** |
| **OCCUPATION:** |
| **ADDRESS:** |
| **EMAIL ADDRESS:** |
| **TELEPHONE NUMBER:** |
| **How many years has this person known you?** |
| **In what capacity?** |
| **Is this referee your current employer?** **Yes □ No □**  |
| **REFEREE 2.** |
| **TITLE:** | **NAME:** |
| **OCCUPATION:** |
| **ADDRESS:** |
| **EMAIL ADDRESS:** |
| **TELEPHONE NUMBER:** |
| **How many years has this person known you?** |
| **In what capacity?** |
| **Is this referee your current employer?** **Yes □ No □**  |

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| *KHP welcomes applications from people with special needs and considers them on the same academic grounds as those from other candidates. It is helpful to know about your special needs in advance so that we can discuss whether facilities are available. If you have special needs please tick the appropriate box.* |
|  | **Please specify** |  | **Please specify** |
| **Dyslexia** |  | **Need Personal Care Support** |  |
| **Blind/partially sighted** |  | **Mental Health Difficulties** |  |
| **Deaf/hearing impaired** |  | **Wheelchair user/mobility difficulties** |  |
| **Other special needs please specify:** |  | **An unseen special need e.g. Diabetes, epilepsy, asthma** |  |
|  | **Yes** | **No** |
| **Are you a registered disabled person?** |  |  |
| **Do you have any criminal convictions or cautions?** |  |  |
| **If you have answered yes to any of the above please give details:** |

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| **DECLARATION & TERMS AND CONDITIONS****Falsifying information on this application will be deemed as acting in an unprofessional manner. This will have implications on registration with the regulatory body (Standards for Dental Professionals 2006 GDC).** |
| The information you provide will be held by King’s Health Partners (KHP). The information will not be shared with any other body without your express consent. It will be used solely in connection with the operation of the Diploma in Orthodontic Therapy and stored in accordance with the Data Protection Act 1998.We will only use the information you have supplied for administrative purposes. The course may occasionally be requested to supply data to members of staff for research purposes, such as mailing of questionnaires.Please tick box if you DO NOT wish your personal data to be used in this way □While we make every effort to run courses as advertised, we reserve the right to change the timetable where necessary and /or the teaching staff without prior notice and to cancel any courses without liability.As the candidate you will comply with the standards and regulations set out by the course leads. Failure to do so may result in course dismissal.**Please tick to indicate below the term that is applicable to you and the written funding agreement that has been made between you and the proposed training site.** |
| **Term 1** |
| I understand that the course fee is a **non- refundable** fee and that the **work** **place (proposed training site)** is **liable** for the full course fee of £13,000 regardless of whether or not **I** the trainee complete the course to its entirety. | Yes  | No |
| **Term 2** |
| I understand that the course fee is a **non- refundable** fee and that **I will** be **liable** for the full course fee of £13,000 regardless of whether or not I complete the course to its entirety. | Yes  | No |

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| **CANDIDATE DECLARATION & PRACTICE AUTHORISATION**I confirm that I have read, understood and agree to comply with the terms and conditions of the KHP*Orthodontic Therapy Course* above.  |
| **Signature (to be signed by the applicant):** |
| **Name in full of applicant:**  |
| **Signature**  |
| **Date:** |
| **Signature (to be signed by the proposed training site):** |
| **Name in full of authoriser to support applicant:**  |
| **Date:** |
| **Please send all completed applications to the following address:****Service Development Co-ordinator** Dental Team Education CentreKing's College Hospital NHS Foundation Trust3rd Floor, Dental ExtensionCaldecot RoadLondon SE5 9RW***Incomplete applications will not be accepted and will be returned to the sender. This will include applications that have not been completed to its entirety and have missing information.*** |

**PLEASE INFORM US HOW YOU HEARD ABOUT THE PROGRAMME.**

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|  | **Tick**  |  | **Tick** |
| **Advertisement** |  | **Internet** |  |
| **Recommendation** |  | **Poster** |  |
| **Friend** |  | **Prospectus** |  |
| **Employer** |  | **Careers Office** |  |
| **Other (please specify)** |  | **GDC** |  |

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| **EQUAL OPPORTUNITIES MONITORING***Please help us to make our equal opportunities policy effective by placing a tick in the appropriate box which is applicable to you* |
| **Asian or Asian British** |
| **Indian** |  | **Pakistani** |  |  **Bangladeshi** |  |
| **Chinese** |  | **Other Asian background** |  |  |  |
| **Black or Black British** |
| **Caribbean** |  | **African** |  | **Other black background** |  |
| **Mixed Race** |
| **White and black Caribbean** |  | **White and Asian** |  | **Other mixed background** |  |
| **White and black African** |  |  |  |  |  |
| **White** |
| **British** |  | **Irish** |  | **Other white background** |  |
| **Other** |
| **Other Ethnic Background** | **Please state:** |  |  |  |