



Dental Nurse Course in Conscious Sedation for Dentistry

PART II at Guy's

25th & 26th February 2012

APPLICATION (Please photocopy for multiple applications)

Please return to: SAAD Course Registrations, 114 High Street, Billingshurst, West Sussex, RH14 9QS

I wish to apply for the above course. I enclose a cheque for £535 (payable to 'SAAD') for the two day course, including lunch and refreshments, and the NEBDN examination fee.

Please complete in Block capitals

Last name

First Name

.....
Mr / Mrs / Miss / Ms

.....
GDC registration number

.....
Date of qualification

.....
How long have you been a Dental Nurse?

.....
Home address

.....
Work address

.....
Postcode

.....
Postcode

.....
Home telephone

.....
Work telephone

.....
Mobile telephone

.....
Email

Please circle area of employment

General Dental Practice / General Hospital / Community Dental Hospital
Armed Forces / Industry / Unemployed / Other

Signature of Applicant: Date:.....



NATIONAL EXAMINING BOARD FOR DENTAL NURSES

CANDIDATE REGISTRATION FORM POST-REGISTRATION QUALIFICATIONS

Please refer to the Notes for Guidance document prior to completion.
Please complete using block capital letters.

Examination details	
Award	
Exam date	

Candidate Details					
NEBDN No		GDC No		Title	
First name (s)			Surname		
Address	County: _____ Postcode: _____				
Home Tel No			Mobile		
Email			Date of birth		
<i>I have read the Terms and Conditions outlined in the Notes for Guidance document</i>					
Signature			Date		

Employing / Supervising Dentist details			
Full Name			
Practice Address	County: _____ Postcode: _____		
Tel No		GDC No	
Email			

Training Centre details						
Centre number						
Centre name						
Address	County: _____ Postcode: _____					
Contact name				Position		
Email				Tel No		
<i>I have read the Terms and Conditions outlined in the Notes for Guidance document</i>						
Signature			GDC No (if applicable)		Date	

TO BE COMPLETED BY THE EMPLOYING/SUPERVISING DENTIST:

Employing/supervising dentist details	
Full name	
Address	
	Town:
	County:
	Postcode:
Telephone No	
E-mail	



**NATIONAL EXAMINING BOARD
FOR DENTAL NURSES**

**CERTIFICATE
IN
DENTAL SEDATION NURSING**

**EXAMINATION
APPLICATION FORM**

Any false declaration made on this application form will render the application null and void. General Dental Council registration is at risk if a registrant knowingly makes a false declaration.

Personal information will be held and used in accordance with the Data Protection Act 1998. NEBDN will not disclose or transfer Personal Data to third parties for the purposes of marketing. However, this Personal Data may be disclosed or transferred to agents or third parties authorised to act on our behalf for purposes of providing designated services. If you do not want any information to be disclosed to third parties please tick the relevant box below

- Candidate Training Centre Dentist

Please ensure you have read the accompanying Notes for Guidance before submitting this application form for entry to the examination, particularly the sections regarding application forms and fees.

NEBDN, 110 London Street, Fleetwood, Lancashire FY7 6EU
Tel: 01253 778417

NEBDN is a limited company registered in England and Wales No. 5580200
Registered with the Charity Commissioners No. 1112331

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Please read the accompanying Notes for Guidance leaflet before completing this application form for entry to the examination.

PLEASE COMPLETE IN BLOCK CAPITALS

Candidate details	
NEBDN No	Title
First name(s)	
Surname	
Address	
	Town:
	County:
	Postcode:
E-mail	
Date of birth	/ /
Telephone No	
Mobile No	
I agree to the Terms and Conditions outlined in the Notes for Guidance	
Signature	Date

Special requirements (please tick and specify where applicable)

<input type="checkbox"/>	I have been assessed by a dyslexia specialist and require additional support.
<input type="checkbox"/>	I have the following medical condition:
<input type="checkbox"/>	I have an allergy to:
<input type="checkbox"/>	Other (please specify):

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Current Examination details	
Examination date	
Choice of centre	1
	2

TO BE COMPLETED BY THE COURSE DIRECTOR / TUTOR:

Training Centre details	
Centre No	
Centre name	
Centre address	
	Town:
	County:
	Postcode:

I certify that this candidate has completed a Dental Sedation Nursing course at the Training Centre. I agree to the Terms and Conditions outlined in the Notes for Guidance

Name	
Position	
Telephone No	
GDC No (if applicable)	Date
Signature	