



**Dental Nurse Course in Conscious Sedation for Dentistry**

**PART II at Guy's**

**1<sup>st</sup> & 2<sup>nd</sup> September 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			