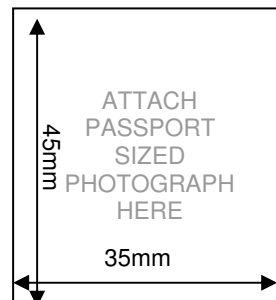


# THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

## Membership in Orthodontics Examination



**Last name of candidate:** .....  
(BLOCK LETTERS)

**Other names in full:** .....  
(BLOCK LETTERS)

**Date of birth (dd/mm/yyyy):** ..... **Male/Female:** .....

**College username (if known):** .....

**Full postal address:** .....

.....

.....

**Daytime telephone no:** ..... **E-mail:** .....

**Mobile No:** .....  
(Including full international dialling code for overseas trainees)

**I wish to enter the Membership Examination in Orthodontics (MOrth RCSEd) at the following centre**

Examination centre .....

Date of examination .....

**I am exempt from either:**

Written component.....Case Histories.....

*(Please refer to paragraph 14 in the Regulations for further information on these exemptions. You may be required to provide documentary evidence in support of your request for an exemption. Please contact the Examinations Section for further information)*

**1. Please give details of your qualifications:**

<u>Qualification</u>	<u>Awarding body</u>	<u>Date</u>
.....	.....	.....
.....	.....	.....
.....	.....	.....

**GDC registration number:** *(if applicable)*  
.....

*(Candidates whose names do not appear in the current UK Dentists Register must submit evidence of their qualifications and the date of acquisition.)*

**2. Have you ever submitted an application for the Membership in Orthodontics of the Royal College of Surgeons of Edinburgh? YES/NO**

## CANDIDATES MUST COMPLETE *EITHER* PAGE 2 *OR* PAGE 3

Award of the Membership in Orthodontics RCSEd (M Orth RCSEd) is dependent on evidence that the candidate will have completed a period of three years full-time (or part-time equivalent) training in this specialty. Candidates may, however, enter themselves for examination after two and a half years (or part-time equivalent) training.

### **FOR CANDIDATES WITH A NATIONAL TRAINING NUMBER**

*If you do not have a National Training Number you should ignore this page and complete Page 3*

Title of post/course: .....

NTN: .....

Dates (dd/mm/yyyy): From ..... To .....

Signature of:  
Training Programme Director: .....

PRINT NAME: .....

<u>Official Hospital Stamp</u>          
--

Date of signing (must be completed): .....

I certify that the above named candidate has occupied the training post above and that all RITA/ARCP interviews have been satisfactory:

Signature of Postgraduate Dental Dean: .....

PRINT NAME: .....

Date of signing (must be completed): .....

Please indicate the Deanery to which you are appointed by ticking the appropriate box:

South West	<input type="checkbox"/>	London	<input type="checkbox"/>	Eastern	<input type="checkbox"/>
Defence	<input type="checkbox"/>	North West	<input type="checkbox"/>	Scotland	<input type="checkbox"/>
Wales	<input type="checkbox"/>	Northern	<input type="checkbox"/>	South Yorkshire/East Midlands	<input type="checkbox"/>
Yorkshire	<input type="checkbox"/>	Northern Ireland	<input type="checkbox"/>	Kent, Surrey & Sussex (KSS)	<input type="checkbox"/>
Mersey	<input type="checkbox"/>	Oxford	<input type="checkbox"/>	West Midlands	<input type="checkbox"/>

## CANDIDATES WHO DID NOT COMPLETE PAGE 2 MUST COMPLETE THIS PAGE

Award of the Membership in Orthodontics RCSEd (M Orth RCSEd) is dependent on evidence that the candidate will have completed a period of three years full-time (or part-time equivalent) training in this specialty. Candidates may, however, enter themselves for examination after two and a half years (or part-time equivalent) training.

### FOR CANDIDATES WHO HAVE OBTAINED THEIR TRAINING AT AN OVERSEAS CENTRE OR IN A UK CENTRE BUT WITHOUT A NATIONAL TRAINING NUMBER:

Title of post/course: .....

Post identifier No. (if applicable): .....

Dates (dd/mm/yyyy): From ..... To .....

Signature of  
Specialist in charge of training: .....

PRINT NAME: .....

Position held: .....

Date of signing (must be completed): .....

#### AND

I certify that the above named has occupied a training post as specified above and that all in-service assessments have been satisfactory:

Signature of Head of Hospital: .....

PRINT NAME: .....

Date of signing (must be completed): .....

Official Hospital Stamp

Official Hospital Stamp

*Candidates who are unable to have the above sections signed must produce certified confirmation of the posts they have held and attach to this form.*

### 3. CANDIDATE CHECKLIST

#### Is your application form complete?

Failure to provide the documentation listed below may result in your application form being returned

Have you included the following:

YES

NO

1. Complete and up-to-date contact information

2. Two recent passport sized photographs

3. Certified copy of your primary dental qualification certificate

**If your name appears on the current UK Dentists Register a certified copy of your certificate is not required.**

4. Evidence of 3 years full time (or part-time equivalent training)

(Candidates may apply for entry to the Examination after two and a half years (or part-time equivalent) training

**If you are unable to obtain the signature and stamp of your Trainer on your application form then you must submit certificates confirming your training posts.**

5. Evidence in support of the request for an exemption (if applicable)

**If you are unable to obtain the signature and stamp of your Trainer on your application form then you may submit certificates confirming your training posts.**

6. Full examination fee

**If paying by cheque, ensure that the cheque has been signed, dated and has the amount written in words and numbers. Cheques and bank / demand drafts must be drawn on a UK bank. Ensure that your name is written on the back of the cheque or draft.**

7. Signed and dated the declaration confirming that you have read and understood the regulations

**Copies of letters and certificates will only be accepted if they have been verified as a true copy by your Trainer or authorised hospital official and stamped with the official hospital stamp. (The signature and stamp must be original.) Please also note that if the official hospital stamp is not in English applicants will be required to obtain an official English translation from a translation agency.**

#### NOTIFICATION OF APPLICATION STATUS AND RESULT

You will automatically be kept up to date with the progress of your application by email.

Tick this box if you would like to receive updates about your application to your mobile phone via SMS

Tick this box if you would like your examination results to be sent to your mobile phone via SMS in addition to receiving them by post\*

Tick this box if you would like to receive your examination results by email\*

**\* The College is working towards offering Examination results to candidates by email and/or SMS. We cannot guarantee that this will be in effect by the time your Examination result is available.**

#### CANDIDATE DECLARATION

I declare that I have read and understood the Regulations relating to the Examination for which I wish to apply and I now confirm that to the best of my knowledge all the information given on this form is a true statement of fact. I understand that success in this Examination will not automatically confer entry onto the United Kingdom's General Dental Council Specialist List. (This is dealt with by the GDC not the College).

I acknowledge that my performance in the examination may be discussed with my Training Programme Director and Postgraduate Dental Dean/Director. (This only applies to UK candidates with an NTN).

Candidate Signature: ..... Date: .....

**PAYMENT METHOD**

**Name of Candidate** .....

Payment must be made in full by cheque, bank/demand draft or credit or debit card. For details of current examination fees, please refer to the Examinations Database on the College website [www.rcsed.ac.uk](http://www.rcsed.ac.uk)

**By Cheque / Draft**

Enter cheque/draft number in box provided. Cheque/draft should be made payable to: "The Royal College of Surgeons of Edinburgh"  
Please print candidate name on back of cheque/draft

**By Credit / Debit Card**

**Important Note:** Candidates applying for an examination for which the fees are not paid in pounds sterling (GBP) or for which the application form, fees and documentation have to be sent directly to an overseas centre **cannot pay by credit or debit card**

**I wish to pay by:** VISA / MASTERCARD / SWITCH / DELTA / VISA DEBIT / SOLO / MAESTRO\*  
(\*Circle appropriate card)

**Card Number:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Valid From Date:**

(month)		(year)			

**Expiry Date:**

(month)		(year)			

**Debit Card Issue Number (if applicable):**

**Card Security Number\*:**

\* (Last three digits of the number found on the signature strip on the reverse of your card)

**Total Examination fee to be withdrawn from my account: £.....**

**Name of Card Holder:** .....

**Signature of Card Holder:** .....

**Date:** .....

**Completed Applications must be posted to:**

**Examination Section  
Royal College of Surgeons of Edinburgh  
3 Hill Place  
Edinburgh  
EH8 9DS**

## **Release of Information to UK Dental Regional Advisers**

From time to time the College's Dental Regional Advisers in the United Kingdom may wish to contact you regarding your Examination application form or your performance in the Examination. If you would like the College to supply your contact information and details of your performance in the Examination to your local Dental Regional Adviser please complete the form below.

Any information given to a College Adviser upon the request of the candidate will be handled in accordance with the Data Protection Act.

### **Candidate Authorisation**

I authorise the College to release details relating to my application form and performance in the Examination to the Regional Adviser upon request:

**Candidate Name:** .....

**Candidate Signature:** .....

The tables below list the areas in which the College has Dental Regional Advisers. Please indicate with a tick (✓) the Region to which you are closest:

#### **SCOTLAND**

Grampian	
Tayside	
Highland	
South East Scotland	
West of Scotland	

#### **WALES**

North	
South	
South East	

#### **IRELAND**

Northern Ireland	
Republic of Ireland	

#### **ENGLAND**

North West	
Mersey	
Eastern	
South Yorkshire/East Midlands	
West Midlands	
Kent/Surrey/Sussex	
Yorkshire	
Northern	
South West	
North Thames	
South Thames	
Oxford	
Wessex	

## EQUAL OPPORTUNITIES MONITORING (OPTIONAL)

The Royal College of Surgeons of Edinburgh aims to ensure fair treatment in relation to admission and assessment of examination candidates. The College aims to assess candidates on the basis of ability, regardless of gender, colour, ethnic or national origin, race, disability, age, socio-economic background, religious or political beliefs, family circumstances, marital status, sexual orientation or other irrelevant distinction. Completing this form will allow us to monitor our statistics and ensure that we are not discriminating in any way.

In line with UK legislation and good practice guidelines, we are asking everyone to complete this section. You are not obliged to provide any of the information in this section, but if you do so, it will enable us to monitor our business processes and ensure that we provide equality of opportunity to all.

### Gender

Female  
Male

Nationality.....

1st language.....

**Do you have a disability** under the terms of the Disability Discrimination Act 1995 (a person with a physical or mental impairment that affects your ability to carry out normal day to day activities which are substantial, adverse and long term)?

Yes  
No

### What is your sexual orientation?

Bisexual  
Heterosexual  
Lesbian or Gay

### What is your religion or belief?

Buddhist  
Christian  
Hindu  
Jewish  
Muslim  
Sikh  
Other religion/belief

Indicate a more specific category here:

### Ethnicity

Choose one selection from the list below to indicate your cultural background:

#### a) White

British  
Irish  
Any other White background  
Please specify \_\_\_\_\_

#### b) Mixed

White and Black Caribbean  
White and Black African  
White and Asian  
Any other mixed background  
Please specify \_\_\_\_\_

#### c) Asian or Asian British

Indian  
Pakistani  
Bangladeshi  
Any other Asian background  
Please specify \_\_\_\_\_

#### d) Black or Black British

Caribbean  
African  
Any other Black background  
Please specify \_\_\_\_\_

#### e) Chinese or other ethnic group

Chinese  
Any other background  
Please specify \_\_\_\_\_

Indicate a more specific category here:

This information will be recorded electronically with your other data in accordance with the Data Protection Act 1998, but used only for monitoring our business practices.