# Clár Oiliúna Náisiúnta na hÉireann d'Altraí Déidliachta

National Dental Nurse Training Programme of Ireland

# **Application Form 2012**



Cork University Dental School & Hospital and Dublin Dental School & Hospital



Tel: 353-21-4903571 Fax: 353-21-4903233 E-mail: f.grant@ucc.ie

## **APPLICATION FORM**

Diploma in Dental Nursing 2012/2013

#### (Complete in BLOCK LETTERS using a black pen) Closing Date for receipt of completed forms: Friday, 23<sup>rd</sup> March, 2012 before 5pm

SURNAME:		
(As on Birth Certificate)		
MARRIED NAMES:		
(if applicable)		
FORENAMES:		
(As on Birth Certificate)		
TITLE:	DATE OF BIRTH:	SEX:
e.g. Ms., Mr., Rev., etc	(dd/mm/yyyy)	(F or M) (For statistical purposes only, NOT part of the selection process)
ADDRESS FOR CORRES (Please specify dates for which this		
TEL. NO:		
COUNTRY OF BIRTH: _	COUNTY OF BIRTH:	
NATIONALITY:	PPS. NO	
<b>PERMANENT HOME AD</b> (This address will be used at times of		

#### **EDUCATION:**

Leaving Certificate in 2012)           Qualification achieved e.g. Leaving         Year         Subjects         Level/Gr				
Quannearion achieved e.g. Leaving	I Cal	Subjects	Achieved	

Post-Secondary Education (Highest Level obtained)			
Qualification achieved e.g. Certficate/Diploma/Degree	Year	Subjects	Level/Grade Achieved
Use ar	n additional page if ne	cessary.	

## **OTHER COURSES:**

Have you completed the European Computer Driving License (ECDL)?			
Yes 🗆 No 🗆	Date obtained		
Have you completed a Basic Life Support for the Healthcare Provider Course in Cardio-Pulmonary			
Resuscitation (CPR)?			
Yes $\Box$ No $\Box$			
Date Obtained:			

Year

### **GENERAL:**

FOR RECORD PURPOSES, PLEASE INDICATE IF:

Have you previously applied for admission to UCC?

🗆 No

If so, state course(s) \_\_\_\_\_

## **PREVIOUS EMPLOYMENT:**

Previous Relevant Experience (tha Employer Name and Address	Dates (From To)	Duties
Employer Name and Address	Dates (From, 10)	Duties
**		
Us	e an additional page if necessary.	

Name of current Employer:		
Current Employers Address:		
Main Duties:		
Date of commencement:		
Work Telephone:		
Hours per week worked:		
Employment Status (please tick):	Full-time   Part-time	
Place of Employment (Please tick):	Health Board $\Box$ Private Practice $\Box$ Other $\Box$	
If other p	lease specify:	

#### **VERIFICATION OF EMPLOYMENT:**

Please fill in the following table to verify clinical experience and ensure that each employing practitioner has signed to verify the duration of employment. (Not necessary if applying for a position within the Cork University Dental School & Hospital).

Dates E	mployed	Position	Name of employer and	
Start Date (dd,mm,yyyy)	Finish Date (dd,mm,yyyy)	(i.e. administrator, dental nurse)	address of dental surgery	Signature of Employing Dentist

#### **SPECIAL NEEDS:**

Do you have any special needs?

Yes 
No 
D

If yes, please explain:

#### ADDITIONAL INFORMATION:

Using the space below, please tell us why you should be considered for a place on this programme?

PREFERRED TRAINING CENTRE:		
Which training centre do you wish to attend?		
Dublin 🗆 Galway 🗆		
Cork $\Box$ or Cork with clinical training $\Box$		
Waterford   Limerick   Tralee		
Please Note: If you are currently in employment as a trainee Dental Nurse in practice you need only select the centre of your choice. If you are applying for a full time clinical training placement in the Cork University Dental School and Hospital, you must only select <u>ONE</u> of the Cork options.		

#### HOW DID YOU HEAR ABOUT THE PROGRAMME:

Newspaper 🗆	Mail 🗆	Previous Graduate
Dental Practitioner	Other $\square$	If other, please state:

### **DECLARATION:**

#### Applicant

I certify that the information provided in this application form is accurate and true to the best of my knowledge. I understand that providing incomplete or false information may result in my application not being processed.

Signature of Applicant: \_\_\_\_\_

Date: \_

#### Employer

I agree to support the above applicant during the period of their training programme to ensure that all relevant tasks and duties as outlined in the programme syllabus will be completed according to the guidelines and standards recommended. (Not for internal applicants).

Signature of Employer: \_\_\_\_\_

Date: \_\_\_

# CHECK THAT YOU HAVE ACCURATELY COMPLETED ALL QUESTIONS.

The following should accompany this form.

- (i) A <u>non refundable</u> application fee of €35. Fee payment should be made by cheque, Postal Order, etc. and made payable to University College, Cork. Cash will <u>NOT</u> be accepted.
- (ii) Original Birth Certificate (or certified copy\*) and original Marriage Certificate (or certified copy) (if applicable)
- (iii) Full academic transcript(s) of University (if not previously a student at UCC)
- (iv) Documentary evidence of degrees/diplomas from institutions other than UCC, must be lodged if you wish to have these on record at UCC.

\*A certified photocopy is a copy that has been signed and stamped by an authorised person such as a Garda.

• Verification of experience (page 5): this must be signed by <u>each Dental practitioner</u> <u>for which you were employed</u>. This is essential for verification of clinical experience. (This is not necessary when applying for a position within the Cork University Dental School & Hospital).

Nursing, Administrative Assistant/Nursing	Ms. Fiona Grant	
Dublin Dental School and Hospital	Admissions Office	
Lincoln Place	UCC	
Dublin 2	Cork	
Telephone: 01 612 7315	Telephone: 021 490 3571	
E-mail: dentalnursetutor@dental.tcd.ie	E-mail: <u>f.grant@ucc.ie</u>	
Internet address: http://dentalnurse.learnonline.ie Applications available under area titled information for prospective students		

This form should be completed and returned to the Admissions Office, University College Cork no later than Friday, 23<sup>rd</sup> March, 2012.