Clár Oiliúna Náisiúnta na hÉireann d'Altraí Déidliachta

National Dental Nurse Training Programme of Ireland

Cork University Dental School & Hospital
and
Dublin Dental University Hospital

Supporting Documentation For Application

2026/27

Please email the completed pages of this 'Supporting Documentation' pdf (scanned) documents to dentalnursing@ucc.ie and siobhan.shakeshaft@ucc.ie .
Do not send photographs of/or multiple pages.

PRACTITIONER DECLARATION OF SUPPORT

The below declaration of support is in relation to the employed trainee dental nurse's intent to undertake the National Dental Nurse Training Programme of Ireland with University College Cork.

If you, the supervising dental practitioner, are willing to support the trainee dental nurse throughout these studies, please complete the following declaration and the prospective student will include it in his/her documentation to be submitted.

If you have any queries regarding this please contact Siobhán Shakeshaft, Dental Nurse Tutor at Siobhan.shakeshaft@ucc.ie.

EMPLOYER

I agree to support _____ (full name of employed trainee dental nurse) during the period of their training programme.

☐ **I will ensure all tasks and duties will be completed by the above employed trainee dental nurse, according to the guidelines and standards recommended in the programme handbook.**

Signature of Supervising Dentist: _____

Name of Supervising Dentist (please print): _____

_____

Email address:_____
Supervising Dentist email address

Date: _____

The signature of the supervising dentist is verification that they understand their role as supporting dental practitioner to the student /trainee dental nurse throughout the programme.

Name of current Employer (*if applicable*):

_____

Current Employers Address:

_____

_____

Employers Email 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 □ Private Practice □ Other □

If other please 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 Employed		Position (i.e. administrator, dental nurse)	Name of employer and address of dental surgery	Signature of Employing Dentist
Start Date (dd,mm,yyyy)	Finish Date (dd,mm,yyyy)			