APPLICATION FORM

NEBDN Certificate in Dental Radiography

PERSONAL DETAILS

Surname		**Title**	
First names			
Preferred name		**Sex (M/F)**	
Date of Birth		**Age**	

HOME ADDRESS

Postcode	**Length of time at this address**
Tel No evening	**Tel No Daytime**
Mobile	
E-mail	

PERSON TO CONTACT IN EVENT OF EMERGENCY

Name:	**Tel No Daytime**
Relationship to you:	**Tel No Evening**

RESIDENCY

SECTION A

Country of Birth	**Nationality**	**National Insurance No**
What country or countries have you lived in the last 3 years?		

Please circle your ethnicity code on the list below.

CODE	**ETHNIC GROUP**
11	Asian or Asian British – Bangladeshi
12	Asian or Asian British – Indian
13	Asian or Asian British – Pakistani
14	Asian or Asian British – any other Asian background
15	Black or Black British – African
16	Black or Black British – Caribbean
17	Black or Black British – any other Black background
18	Chinese
19	Mixed – White and Asian
20	Mixed – White and Black African
21	Mixed – White and Black Caribbean
22	Mixed – any other Mixed background
23	White – British
24	White – Irish
25	White – any other White background
98	Any other

If you were born outside the UK, please complete Section B.

SECTION B

Please give date of arrival in the UK (DD/MM/YYYY)					
What is your current visa/passport status					
Asylum Seeker	☐	**Refugee**	☐	**Visitor's Visa**	☐
Work Permit	☐	**Student's Visa**	☐	**For permanent**	☐
Other	☐	**EU passport**	☐		
Are there any restrictions or limitations on your stay in the UK? If yes, please give details.					
Passport reference number:					
Issue date		**Expiry date**			

PERSONAL STATUS

Are you: (Please tick only 1 box)

Single – living with parents		**Divorced or separated - no children**	
Single – living alone (or share flat)		**Divorced or separated – living with children**	
Married or living with partner – no children		**Any other (Please specify below)**	
Married or living with partner - with children		**Number of dependents**	

If there is any further information you may wish to give about your personal status that may affect your course please do so here:

QUALIFICATIONS

Please provide us with a full list of the qualifications that you have attained;

Name of qualification	Grade/ level / GDC Number	Year obtained

EMPLOYMENT DETAILS

Are you currently employed as a dental nurse? Yes / No Part-time / Full time

Have you had experience in dental Radiology? Yes / No……years ……months

Name of Practice / Current employer	
Address	
Postcode	**Tel No**
Contact Person	**No of Employees**
Practice email address	

EMPLOYMENT HISTORY

Name & Address of Previous and present Employer(s) & Nature of Business (Starting with the most recent)	Position Held	From Month /Year	To Month / Year	Final Salary at Each Appointment	Reasons for leaving

MEDICAL DETAILS

Do you suffer from any medical conditions? **(If yes, please give details)**	**Yes / No**
Are you taking any medication? **(If yes, please give details)**	**Yes / No**
Are you allergic to anything?	**Yes/No**
Have you had a Hepatitis B vaccination, if so when is your booster due?	**Yes / No** **Booster due …**

Do you consider yourself to have any learning difficulties? (If yes, please give details) Yes No

Do you have a criminal record? Yes No

How did you hear about SmileWisdom?

What are your reasons for wanting to do this course?

The SmileWisdom accredited course is suitable for qualified dental nurses who currently assist, or shortly will assist in the field of Dental Radiology.

In no less than 100 words, please tell us about yourself and why you want to complete the dental nurse radiology course. You should include strengths and weaknesses, difficulties you may have and how you feel you can contribute to this course and the dental profession.

By signing this application form below, you confirmed that you have read and agreed to the Term & Conditions for the NEBDN Certificate in Dental Radiography .

Student's Name: _____

Signed: _____

Date: _____

Admission Director signed:_____

Date: _____