

APPLICATION FOR INCLUSION IN THE DENTAL LIST OF THE STRATEGIC PLANNING AND PERFORMANCE GROUP (SPPG)

PLEASE COMPLETE ALL RELEVANT SECTIONS OF THIS FORM

Return the completed form to the SPPG local office according to the LCG area in which you will be working (See map on page 14 for details):

- **Belfast and South East LCG areas:** Directorate of Primary Care, SPPG, 12-22 Linenhall St, Belfast, BT2 8BS (028 9536 3926)
- **Northern LCG area:** Directorate of Primary Care, SPPG, County Hall, 182 Galgorm Rd, Ballymena, BT42 1QB (028 9536 2812)
- **Southern LCG area:** Directorate of Primary Care, SPPG, Tower Hill, Armagh, BT61 9DR (028 9536 2104 / 028 9536 2086)
- **Western LCG area:** Directorate of Primary Care, SPPG, 15 Gransha Park, Clooney Rd, Londonderry BT47 6FN (028 9536 1010).

FOR
OFFICIAL
USE
ONLY

YOU MUST INCLUDE: (HIGH QUALITY DIGITAL COPIES WILL BE ACCEPTED)

- a current **Certificate of Registration with the General Dental Council**
- a current **Certificate of Professional Indemnity** which meets the requirements of the GDC Standards for the Dental Team
- a **Certificate of completion of Dental Foundation Training** if you have one, or evidence of exemption or equivalence
- a completed **Statement on the use of Intra-Venous Sedation** in your clinical practice (Part 6 of this application form)
- a **Certificate of an approved English Language Test** - if English is not your first language
- a **Certificate of Health Clearance and/or signed Declaration** (see page 9)
- **Proof of attendance at a New Start Information Session** - held bi-monthly – (please see: <https://bso.hscni.net/directorates/operations/family-practitioner-services/dental-services/contractor-information/new-entrants-to-the-ni-dental-list/> for dates.)
OR **Proof of completion of online New Start Information Session** (see FAQs for eligibility)
- **Two References**, one must be your most recent employer/Principal or equivalent clinician (pro forma attached – see pages 13 & 14)

For FAQs please see:

https://bso.hscni.net/wp-content/uploads/2023/10/HS48_FAQs_updated_Sept_2022.pdf

PART 1 - PERSONAL DETAILS

MR MRS MISS MS DR OTHER _____

SURNAME _____
(Please Print)

FIRST NAME (S) _____
(Please Print)

PRIVATE ADDRESS _____

POST CODE _____

NATIONALITY: _____ GENDER: Male Female

DATE OF BIRTH:

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Day Month Year

DENTAL QUALIFICATION(S) / REGISTRATION AS A DENTIST IN THE UNITED KINGDOM

Qualification that entitles you to be registered as a dentist: _____

Country where this qualification was gained? _____

Date of gaining this qualification:

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Day Month Year

Date of United Kingdom Registration as a dentist:

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Day Month Year

General Dental Council registration number _____

Details of any Additional Qualifications held: _____

Are you on the General Dental Council Specialist Lists register? YES NO

Details: _____

EMPLOYMENT HISTORY

Are you currently providing or have you previously provided General Dental Services?
YES NO

If **YES** provide details of your current position or, if not working at present, your most recent position

PRINCIPAL ASSOCIATE ASSISTANT TRAINEE

Contract Number (s) _____ Name of Employer _____
(If applicable) (If applicable)

Between Period: _____ to _____

At address: _____
(Please Print) _____

If currently on the Dental List for Northern Ireland and providing General Dental Services, please confirm that you have read, understood and carried out the advice detailed in the “Dealing with Practice Changes” guidance document, available at the following link:

<https://bso.hscni.net/directorates/operations/family-practitioner-services/dental-services/contractor-information/governance/>

Signature _____

Date _____

PART 2 – DENTAL FOUNDATION TRAINING STATEMENT

NB. All dentists who wish to be included on the dental list must have a dental foundation number.

- PLEASE SUBMIT YOUR DENTAL FOUNDATION CERTIFICATE AND DENTAL FOUNDATION NUMBER with your HS48 application
- All applicants without a DF number must complete an HS48-A form and submit as per the instructions on the application form: https://bso.hscni.net/wp-content/uploads/2023/10/HS48-A_Form_Sept_2022.pdf). This includes all those who are exempt from the requirement to complete Dental Foundation Training under 2.2 a), b), c), d) and 2.3 as outlined below.

2.1 I have completed foundation training/ vocational training, which commenced on or after 1st October 1993 YES NO

F NO, COMPLETE PART 2.2 OR 2.3 AS APPROPRIATE and please supply evidence from a UK Deanery of your DF number

2.2 I am exempt from the requirement to complete Dental Foundation Training because:

a) I am a European Economic Area national holding a recognised European dental diploma YES NO

or

b) My name has been included in a dental list of a UK NHS Commissioning Organisation (Insert name of organization) within the period of five years immediately before this application to be included in the SPPG dental list YES NO

or

c) I have previously practiced in primary dental care for at least four years full-time (or an equivalent period part-time), in either the Community Dental Service or the Armed Forces of the Crown and part or all of that period fell within the period of four years immediately before this application to be included in the SPPG dental list YES NO

or

d) I would have been exempted under previous versions of the

GDS regulations YES NO

PLEASE ATTACH EVIDENCE (TRANSLATED INTO ENGLISH IF APPROPRIATE)

OR

2.3 I consider that I have acquired experience and/or training which should be regarded as equivalent to Dental Foundation Training

YES NO

PLEASE ATTACH EVIDENCE (TRANSLATED INTO ENGLISH IF APPROPRIATE)

PART 3 – DETAILS OF PROFESSIONAL INDEMNITY

Please read the GDC “Guidance on professional indemnity and insurance cover” document which is effective from 10th February 2024. A copy is available at the link below:

<https://www.gdc-uk.org/docs/default-source/consultations-and-responses/guidance-on-professional-indemnity-and-insurance.pdf?sfvrsn=906330a6>

Please submit a copy of your current Indemnity Certificate from your indemnifier (not a payment schedule). This certificate should confirm:

- Your name and GDC number
- The number of hours or sessions of cover - this should be sufficient for the number that you have indicated on the form that you will be working.
- That you are covered for working as a General Dental Practitioner.
- The period of cover (must be current in order for the application to be processed)
- The certificate applies to Northern Ireland/UK
- The nature, scope and extent of practice, i.e. if you are a specialist in practice or work in 2 areas e.g. GDS and hospital this should be stated

PART 4 – DETAILS OF PRACTICE(S) WHERE YOU WILL BE PROVIDING GDS TREATMENT AND CARE

Include information about all practice premises where you will be providing General Dental Services*. Please show information separately for each address for which you require a new DS number.

***NB. Dentists will not be included on the dental list unless they will be providing GDS treatment and care. Applications for inclusion on the dental list for purely administrative purposes will not be permitted.**

Please detail your intended working hours

Practice Address 1		Morning	Afternoon	Evening
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			
Telephone Number:				

Is there access to treatment room(s) without using stairs? YES NO

Please detail your intended working hours

Practice Address 2		Morning	Afternoon	Evening
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			
Telephone Number:				

Is there access to treatment room(s) without using stairs? YES NO

Do you restrict your practice to certain items of treatment? YES NO

If yes, please provide details _____

What arrangements have you made for your patients at each address to access emergency advice and treatment within normal working hours, when you are absent, e.g. at times of sickness/holidays?

What arrangements have you made for your patients at each address to access emergency advice and treatment out of hours?

DENTISTS

PRACTICE 1: Provide details of other dentists in the same practice(s) as you:

NAME(S)	PRINCIPAL / PARTNER / ASSOCIATE / ASSISTANT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

PLEASE INCLUDE ANY ADDITIONAL INFORMATION ON SEPARATE SHEET

PRACTICE 2: Provide details of other dentists in the same practice(s) as you:

NAME(S)	PRINCIPAL / PARTNER / ASSOCIATE / ASSISTANT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

PLEASE INCLUDE ANY ADDITIONAL INFORMATION ON SEPARATE SHEET

PART 5 - YOUR PROFESSIONAL PRACTICE

▶ Have you ever been the subject of a National Health Service Tribunal hearing? No Yes

If **YES**, please detail findings _____

▶ Have you ever been the subject of a Disciplinary hearing? No Yes

If **YES**, please detail findings _____

▶ Have you ever been the subject of a General Dental Council investigation? No Yes

If **YES**, please detail findings _____

▶ Have you ever been the subject of an investigation by a National Regulatory Body?
(Including outside of the United Kingdom) No Yes

If **YES**, please detail findings _____

▶ Have you ever been referred to National Clinical Assessment Service? No Yes

If **YES**, please detail findings _____

▶ Have you ever had conditions placed on your professional practice? No Yes

If **YES**, please detail findings _____

▶ Have you any Criminal convictions (to include Police Caution)? No Yes

If **YES**, please detail findings _____

▶ Have you ever had issues raised in Criminal Records Bureau, Access Northern Ireland, a Police check, or equivalent in United Kingdom or elsewhere? No Yes

If **YES**, please detail findings _____

▶ Have you ever been taken off a performers list under the performers' list regulations? No Yes

If **YES**, please detail findings _____

▶ Have you ever been refused admission to the Dental List of any UK NHS Commissioning Organisation, the SPPG (NI) or equivalent in the Republic of Ireland?

No Yes

If **YES**, please detail findings _____

▶ Have you ever been asked to undergo remedial training by an employer or an NHS/HSC primary care commissioning organisation or equivalent organisation in the Republic of Ireland, or an indemnity provider? No Yes

If **YES**, please detail findings _____

▶ Are you subject to any ongoing investigations by a regulatory/commissioning body or employing organisation? No Yes

If **YES**, please detail findings _____

PLEASE INCLUDE ANY ADDITIONAL INFORMATION ON SEPARATE SHEET

PART 6 – STATEMENT ON THE USE OF CONSCIOUS SEDATION

Does your practice provide Inhalation Sedation? No Yes

Does your practice provide IV Sedation? No Yes

If yes to either, please sign the following declaration:

I declare that I will comply with recommended best practice with regard to the use of conscious sedation in line with the Professional Dental Guidance issued by the DOH September 2022 at the link below:

<https://bso.hscni.net/wp-content/uploads/2023/10/Letter from CDO Guidelines for the use of Conscious Sedation in Dentistry in NI-PDF.pdf>

DENTIST SIGNATURE: _____

PART 7 – NEW DENTAL PRACTICES

Are you about to commence work in a newly established dental practice/premises or undertaking health service treatment for the first time?

No Yes

If yes, has the premises been inspected by the SPPG?

No Yes

Please note: Until the premises are approved by SPPG you cannot be issued with a DS number. (For further information or to arrange an inspection please contact your local SPPG office.)

PART 8 - DECLARATION

- I am a registered dentist and undertake to provide General Dental Services under the Health and Personal Social Services (Northern Ireland) Order 1972 on the current and future terms in operation in Northern Ireland. I now apply to have my name included in the Dental List.
- I am not disqualified from undertaking service by reason of my name having been removed from the Dental List; from any corresponding list in Great Britain; or from any National Regulatory Body in the United Kingdom or elsewhere.
- I am aware of and will comply fully with my obligations as required by the GDC "Standards for the Dental Team".
- I am aware of and will comply fully with my obligations as required by Northern Ireland Minimum Standards for Dental Care and Treatment
- I am aware of and will comply fully with the relevant regulations and legislation relating to my providing care and treatment to patients in Northern Ireland.
- I am not currently subject to any restrictions which limit my ability to work in any capacity.
- I am fit and healthy to work.
- **I WILL NOTIFY THE SPPG OF ANY CHANGES TO ANY OF THE DETAILS OR DECLARATIONS I HAVE SUBMITTED IN THIS DOCUMENT**

Signature _____

Date _____

Subject to my inclusion in the Dental List as requested, I intend to commence provision of General Dental Services on:

Date _____

Reason for requesting DS number: _____

In relation to this application I can be contacted at:

Tel No: _____ Mobile _____

E-mail _____

Will you be working in a practice that submits claims by EDI? YES NO Do you require HS45 forms to submit claims? YES NO **PART 9 – CERTIFICATE OF HEALTH CLEARANCE****Please complete either Section 1 (Dentists new to the SPPG NI List) or Section 2 (Dentists already on the SPPG NI List) ******Refer to FAQs for further advice****Section 1. A New Dentist to the SPPG Dental List**

All new health care workers (includes new dentists entering the SPPG Dental List) **must** present to a local Occupational Health Unit to be assessed or tested as appropriate in relation to assuring immunity to Hepatitis B and Tuberculosis and the results of testing for Hepatitis C and Human Immunodeficiency Virus.

Contact the Occupational Health Department for your local Trust area and inform them that you are a dentist wishing to book an appointment for assessment or testing as a new health care worker coming onto the SPPG Dental List. Please take with you this HS48 form, fully completed, and any relevant documentation or previous test results plus photographic ID in the form of a Passport or Driving Licence.

Contact details:

Belfast Trust (Belfast)	028 9504 0401
Southern Trust (Armagh)	028 3756 4800
Northern Trust (Antrim)	028 9442 4403
Western Trust (Derry)	028 7161 1407
Western Trust (Omagh)	028 8283 5395
Western Trust (Enniskillen)	028 6638 2342
South-Eastern Trust (Ulster Hospital)	028 9056 1300

Please also complete the box below. Following assessment Occupational Health will provide SPPG with your Certificate of Health Clearance.

Note: Your application cannot be processed until this is received by SPPG.

Occupational Health Department Attended (please tick):					
Belfast Trust	<input type="checkbox"/>	Southern Trust	<input type="checkbox"/>	Northern Trust	<input type="checkbox"/>
Western Trust	<input type="checkbox"/>	South Eastern Trust	<input type="checkbox"/>	Date attended: _____	

Or

Section 2. A Dentist already on the SPPG NI Dental List

Current DS Number: _____

If you have previously received an Occupational Health Certificate of Health Clearance for the purposes of entering the SPPG NI Dental List please tick the relevant box below:

Occupational Health Department Attended (please tick):					
Belfast Trust	<input type="checkbox"/>	Southern Trust	<input type="checkbox"/>	Northern Trust	<input type="checkbox"/>
Western Trust	<input type="checkbox"/>	South Eastern Trust	<input type="checkbox"/>	Date attended: _____	

I declare that I have no concern that my communicable disease status may have changed since:

1. The above Occupational Health Assessment or;
2. My initial inclusion on the dental list

I have not been in an at risk situation, e.g. sharps injury or blood contamination event, travelled to a high endemic tuberculosis area of the world for more than 4 weeks, or been in any other personal or work circumstance that is associated with transmission of Tuberculosis, Hepatitis B, Hepatitis C or HIV.

Note: It is your responsibility to notify Occupational Health if your health status has changed or you have been in an at risk situation.

Signed: _____ Date _____

Character and Identity Reference – Most Recent Employer/Principal

To be completed by the referee (Dental Professional registered with a national professional regulator)

The information provided in this form will be used to assess the applicant’s fitness for inclusion on the SPPG Dental List and to confirm the identity of the applicant. This character and identity reference must be from the applicant’s most recent employer/Principal or equivalent clinician.

Full name of applicant

Full name of referee

Position held

Registration number

Name of Regulator

Address

Email

Telephone

Declaration

I certify that I am not a relative of the applicant and that they are the person they declare themselves to be. I have known the applicant for ____ years ____ months and either (please tick):

I am satisfied that to the best of my knowledge, the applicant is of good character and fit for inclusion on the SPPG Dental List; or

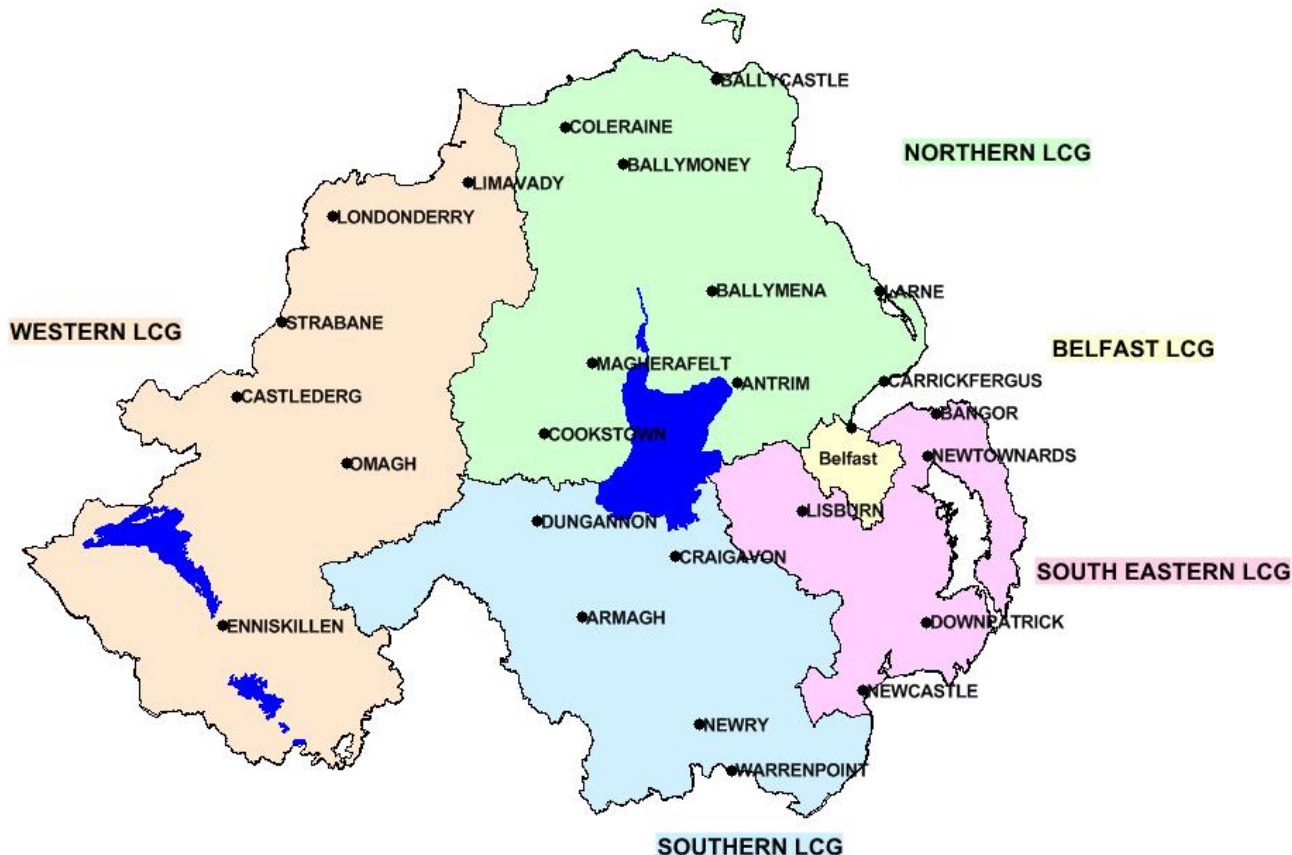
The SPPG should be aware of the following details of the applicant’s character which might affect their suitability for inclusion on the Dental List.

(Please continue on a separate sheet if required.)

Signature

Date

Northern Ireland SPPG LCG Boundaries



New Start Information Sessions

Date Attended:	___/___/___
PLEASE ATTACH CERTIFICATE	

Practitioners are required to attend/complete* a New Start Information Session **prior** to submitting an application to join the NI Dental List. HS48 applications cannot be processed without proof of attendance. Even those already on the Dental List who require a new DS number should attend/complete* a session if they have not already done so within the last two years.

*online option available for dentists already on dental list - see FAQs for details

If you have recently attended an information session (within the last two years) you should submit your certificate of attendance with your application form.

For dates of the New Start Information Sessions, please see the 'New Entrants to the NI Dental List' section of the BSO website -

<https://bso.hscni.net/directorates/operations/family-practitioner-services/dental-services/contractor-information/new-entrants-to-the-ni-dental-list/>

NI GDS Levy Fund:

All practitioners who are on the Dental List (i.e. all list numbers including new numbers issued) who do not currently pay levy fees, will automatically have them deducted from their monthly gross income at a rate of £1 per £1000 of gross fee generated.

If you wish at any stage to opt out of contributing to the levy fund, please click link below and complete and submit the form.

<https://fpsebusiness.hscni.net/dental-levy-fund-opt-out/>

Pension Schemes

HSC Pension Scheme

Do you wish to join the HSC Pension Scheme Yes * NO

(Information on the Scheme can be obtained via the following link):

<https://hscpensions.hscni.net/>

*** If Yes, the following section must be completed, or your application for inclusion in the Dental List will not be processed and will be returned to you.**

Notification of Start of Superannuable Employment Dental Practitioner/Dental Assistant Practitioner (SS14)

Dental Practitioner/Dental Assistant Name

GDC Number

National Insurance Number

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Date of Birth

Start Date

Please indicate if the post is:

Principal / Associate Dental Practitioner

Assistant Dental Practitioner

Email Address: _____

Part A Personal Details

Title						What is your marital status?		
Dr	Mr	Mrs	Miss	Ms	Married	Single	Civil Partners	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Divorced	Separated	Widowed	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your present address	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>							
	Postcode							
Telephone Number – please provide a telephone number we can contact you on if we require further information.	<input type="text"/>							

Part B - Complete this part if you are or were previously a member of another superannuation scheme or were contributing to a personal pension.

What is/was the name of the scheme you were in? _____
What is/was the name of your employer? _____
What are/were you employed as? _____
Where are/were you employed? _____
If the employment has ceased – on what date did you leave? _____/_____/_____
If you did not get a return of contributions when you left that superannuation scheme, it may be possible to transfer your service to the HSC Scheme
Do you wish to have a transfer arranged? Yes <input type="checkbox"/> No <input type="checkbox"/>

Part C - Complete this part if you require HSC Pension Service to communicate with any third party on your behalf, this may include your accountant or/and financial adviser, please complete this section.

Authority to Act
 If you require HSC Pension Service to communicate with any third party on your behalf, this may include your accountant or/and financial adviser, please complete this section.

Accountancy Firm: _____ Financial Adviser: _____

Tele No: _____ Tele No: _____

Email: _____ Email: _____

Member Declaration

I declare that the information I have given is correct and complete to the best of my knowledge and belief. I hereby agree to notify HSC Pension Service of any changes to the information provided.

By signing this declaration, I authorise the above Accountancy Firm/Financial Adviser and its' representatives to act on my behalf. I confirm that any changes to this instruction will be forwarded to HSC Pension Service without delay.

I have read the HSC Pension Scheme Guide.

Signature Date

FOR OFFICIAL USE ONLY

To be completed by Dental Payments:

GDS Number

Signature Date