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).

YOU MUST INCLUDE: (HIGH QUALITY DIGITAL COPIES WILL BE ACCEPTED)	FOR OFFICIAL USE ONLY
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: □□ 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: □□ Day □□ Month □□□□ Year

Date of United Kingdom Registration as a dentist: □□ 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) (If applicable) _____ Name of Employer (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 ☐ Southern Trust ☐ Northern Trust ☐
Western Trust ☐ South Eastern Trust ☐ 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 ☐ Southern Trust ☐ Northern Trust ☐
Western Trust ☐ South Eastern Trust ☐ 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_____

Clinical Reference

This clinical reference must be from the principal dentist, clinical lead dentist or most senior dentist in the applicant's current or most recent post (last three months). The information provided will be helpful in assessing the applicant's fitness for inclusion in the Northern Ireland Dental List. The Strategic Planning and Performance Group, SPPG, reserves the right to contact referees.
Thank you in advance for taking the time to provide this clinical reference.

Applicant's Name:	
Current Practice/Organisation:	
Name of person providing reference: (Capitals)	
Position / role:	
In what capacity is the applicant known to you?	
For how long have you known this person?	

Please tick the relevant box	**Very Good**	**Good**	**Average**	**Poor**
Performance in their role including quality of care				
Commitment & motivation				
Time keeping / punctuality				
Absence record (not to include maternity and related illness)				
Conduct & values				
Cooperation with staff and other stakeholders.				

Indicate if the applicant worked full-time, part-time or in multiple practices where appropriate (no. of sessions).
Please use this section to include any other comments that you feel are relevant or in support of the above answers – feel free to attach an additional sheet if necessary.

Declaration

- I am not a relative of the applicant.
- I am satisfied that the applicant is fit for inclusion on the SPPG Dental List.
- I agree to be contacted by the SPPG about the reference
- I consent to share reference information over email

Signature	
Telephone	
Email	
Date	

Character reference for **……** (*full name of applicant).*
This reference should be a character reference from a person of good standing who has known the applicant for at least a year. The information provided will be helpful in assessing the applicant's fitness for inclusion in the Northern Ireland Dental List.
The Strategic Planning and Performance Group, SPPG, reserves the right to contact referees.

Full name of referee

Occupation

In what capacity is the applicant known to you? For how long have you known the applicant?

Address

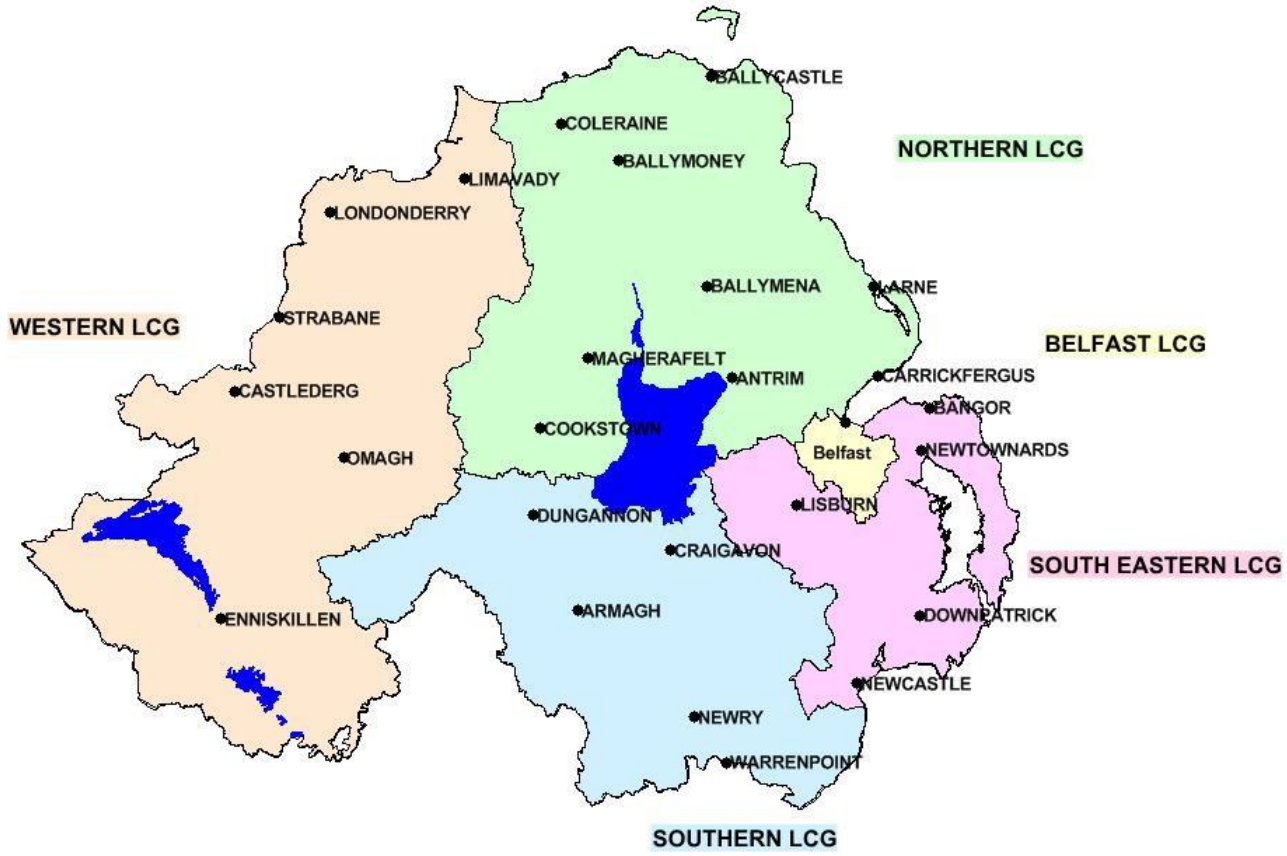
Email	telephone no.

Declaration

- I am not a relative of the applicant.
- I am satisfied that the applicant is of good character.
- I agree to be contacted by the SPPG about the reference
- I consent to share reference information over email

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

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

Dr ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** ☐

What is your marital status?

Married ☐ **Single** ☐ **Civil Partners** ☐

Divorced ☐ **Separated** ☐ **Widowed** ☐

Your present address

Postcode

Telephone Number – please provide a telephone number we can contact you on if we require further information.

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 ☐ No ☐

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**