Workforce Training & Education
Thames Valley & Wessex
Dental Directorate

NHS England South East

FORM B

Dental Foundation & Dental Therapy Training 2025-2026

Practice Owner & Educational Supervisors Joint Application

This form should be completed by

ALL NEW

Educational Supervisors and Training practices applying for dental foundation training posts 2025-2026

(This is not an application for employment)

To be completed in conjunction with
Dental Trainer Application Guidance 2025-2026

Application Form must be completed electronically and returned to
England.Dental.SouthEast@nhs.net
by
31 January 2025

To be completed and signed by PRACTICE OWNER and ALL APPLICANTS

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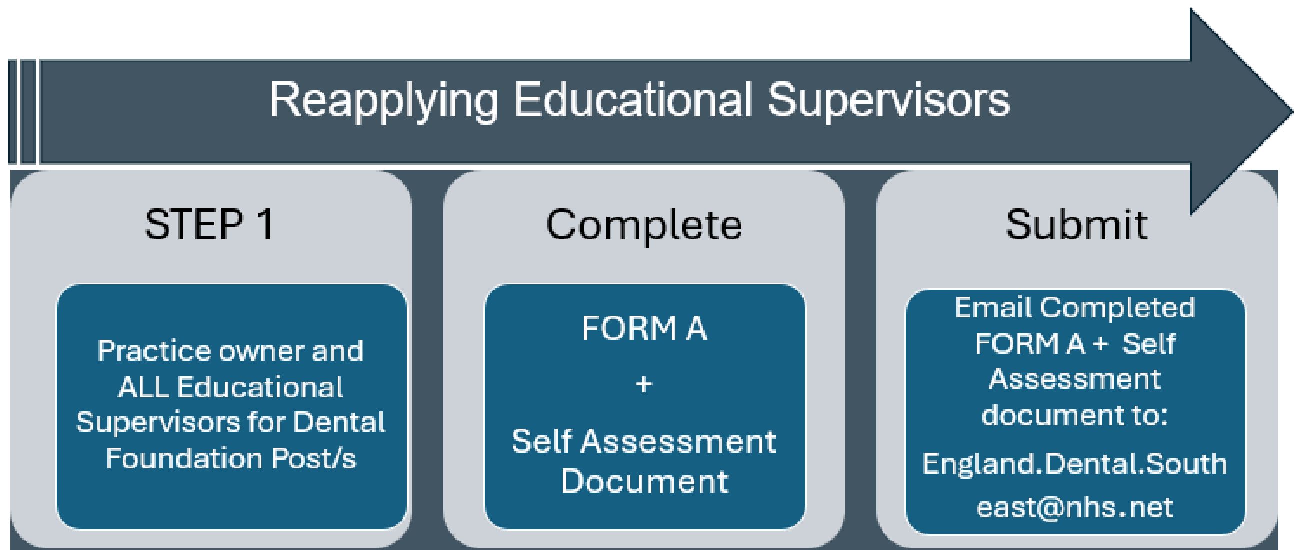
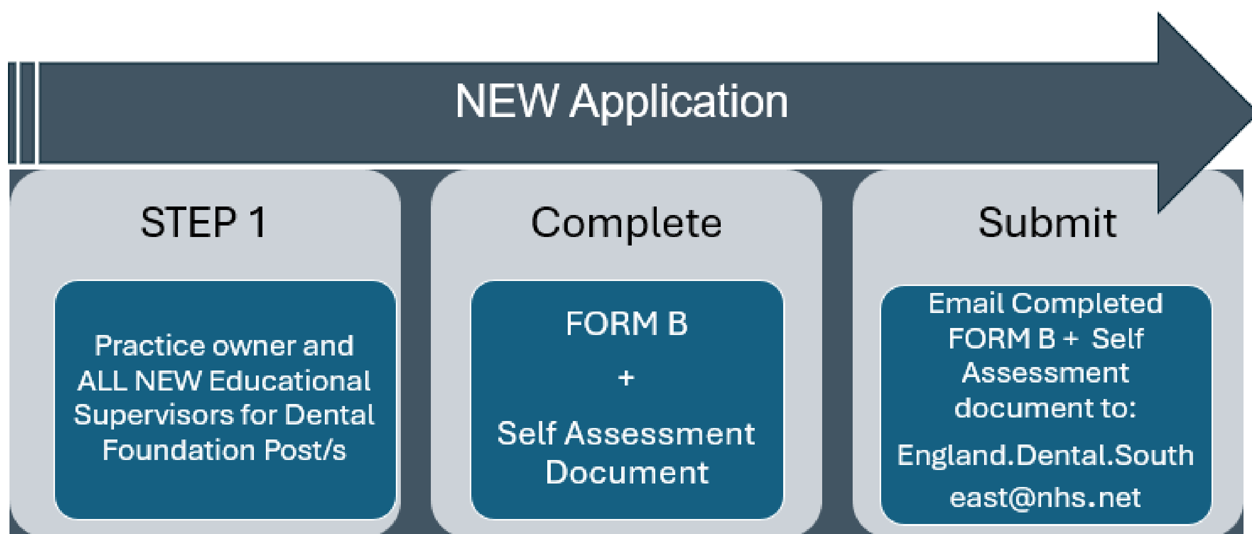
Application Process STEP BY STEP

Please refer to the ES Guidance 2025/2026 which provides comprehensive guidance for the recruitment process.



This form should not be completed if you are applying as a NEW Practice or NEW Educational Supervisor – please refer to FORM B.



Section 1: Dental Practice Information

Practice Details				
Practice Name				
Practice Full Address				
	Postcode			
Practice Telephone Number				
Do you agree for the practice details (name / address / website / tentative scheme) to be published on the national website?	Yes		No	
Latest practice CQC visit – date & rating ******If your CQC report rating is 'Requires improvement' or 'Inadequate', please include a copy of the CQC report when submitting your application*	All standards met			
	Requires improvement* / Inadequate			
	Practice has not had a CQC visit in past 5 years			
Practice Manager Full Name				
Practice Manager email Address				
Practice Manager Tel No				
Please indicate the ICS (Integrated Care System) the practice falls in	Frimley Health ICB			
	Berkshire, Oxfordshire, Buckinghamshire West			
	Berkshire, Oxfordshire, Buckinghamshire South East			
	Bedfordshire Luton and Milton Keynes ICB			
	Hants & IOW / S East			
Practice Ownership				
Practice Ownership Type	Corporate (more than 5 practices)			
	Limited Company (fewer than 5 practices)			
	Partnership			
	Sole Trader			
Please state Limited Company/ Corporate name (if applicable)				
Clinical Director Name				
Clinical Director email Address				
Please list partners and their email addresses (if applicable)	Partner Name 1			
	Email Address			
	Partner Name 2			
	Email Address			
Please provide the name of the Sole Practice Owner and email address (if applicable	Sole Practice Owner Name			

Section 2: Applicant Details: To be completed by all Applicants (Educational Supervisors & Clinical Supervisors)

Applicant 1

Applicant Full Name				
Applicant email address				
Applicant Mobile Number				
Gender	Male			
	Female			
	Do not wish to disclose			
GDC Number		Date of GDC first registration		
NHS Performer number				
Do you have current professional indemnity?	Yes		No	
Are you applying to be a sole or joint ES?	Joint		Sole	
Are you applying as a Clinical Supervisor?	Yes		No	
Type of training post applied for: ***tick all that apply***	Dental Foundation			
	Dental Therapy			
Will you be present in the practice with a trainee dentist for minimum 3 days a week?	Yes		No	
How long have you been employed at your current dental practice?			1-2 years	
			3-4 years	
			5+ years	
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2024			<2 years	
			3 years	
			>4 years	
What is your minimum personal NHS UDAs commitment	<500 UDAs			
	500-3,500 UDAs			
	3,500-7,500 UDAs			
	>7,500 UDAs			
Please provide the number of UDAs personally achieved by 31 March 2024				
What is the Practice UDA target?				

Applicant 2

Applicant Full Name					
Applicant email address					
Applicant Mobile Number					
Gender	Male				
	Female				
	Do not wish to disclose				
GDC Number		Date of GDC first registration			
NHS Performer number					
Do you have current professional indemnity?	Yes		No		
Are you applying to be a sole or joint ES?	Joint		Sole		
Are you applying as a Clinical Supervisor?	Yes		No		
Type of training post applied for: ***tick all that apply***	Dental Foundation				
	Dental Therapy				
Will you be present in the practice with a trainee dentist for minimum 3 days a week?	Yes		No		
How long have you been employed at your current dental practice?			1-2 years		
			3-4 years		
			5+ years		
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2024			<2 years		
			3 years		
			>4 years		
What is your minimum personal NHS UDAs commitment	<500 UDAs				
	500-3,500 UDAs				
	3,500-7,500 UDAs				
	>7,500 UDAs				
Please provide the number of UDAs personally achieved by 31 March 2024					
What is the Practice UDA target?					

Applicant 3

Applicant Full Name				
Applicant email address				
Applicant Mobile Number				
Gender	Male			
	Female			
	Do not wish to disclose			
GDC Number		Date of GDC first registration		
NHS Performer number				
Do you have current professional indemnity?	Yes		No	
Are you applying to be a sole or joint ES?	Joint		Sole	
Type of training post applied for: ****Tick all that apply***	Dental Foundation			
	Dental Therapy			
Are you applying as a Clinical Supervisor?	Yes		No	
Will you be present in the practice with a trainee dentist for minimum 3 days a week?	Yes		No	
How long have you been employed at your current dental practice?			1-2 years	
			3-4 years	
			5+ years	
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2024			<2 years	
			3 years	
			>4 years	
What is your minimum personal NHS UDAs commitment	<500 UDAs			
	500-3,500 UDAs			
	3,500-7,500 UDAs			
	>7,500 UDAs			
Please provide the number of UDAs personally achieved by 31 March 2024				
What is the Practice UDA target?				

Section 3: Dental Foundation & Dental Therapy Training Posts

How many **DENTAL FOUNDATION** posts are you applying for:

One

How many **DENTAL THERAPY FOUNDATION** posts are you applying for:

One

	Please select 'Yes' / 'No'	
	Yes	No
Please confirm that all Dental Foundation Therapists you are applying for will work in their own surgeries throughout the Foundation Training Year		

Section 4: Timetables (please complete a separate timetable for all posts applied for)

DFT POST_Timetable			
If ES works only 3 days a week, please provide the name of the Clinical Supervisor (CS)			
No more than one evening per week and one SATURDAY per month. If trainee attends study day on THURSDAY, please enter: 7hrs study day - these count towards a total of 35 weekly hours.			
ES 1 Full name		Initials:	
ES 2 Full name (if joint)		Initials:	
ES 3 Full name (if joint)		Initials:	
CS Full name (if applicable)		Initials:	

Working hours between 8am and 8pm 35 total hours per week excluding breaks													
	Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		
	Time	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Total weekly hours**
AM Start Time													
AM Finish Time													
Break													
PM Start Time													
PM Finish time													
Total daily hours worked excluding breaks													**35**

Section 5: Dental Foundation THERAPY Training Post Timetables (please complete a separate timetable for all posts applied for)

DTFT POST_Timetable			
If the ES does not work the same 3 days as the DTFT, then a Clinical Supervisor (CS) will need to be nominated for the other days.			
No more than one evening per week and one SATURDAY per month. If trainee attends study day on THURSDAY, please enter: 7hrs study day - these count towards a total of 22.5 weekly hours.			
ES 1 Full name		Initials:	
ES 2 Full name (if joint)		Initials:	
ES 3 Full name (if joint)		Initials:	
CS Full name (if applicable)		Initials:	

Working hours between 8am and 8pm 22.5 total hours per week excluding breaks													
	Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		
	Time	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Time**	**Trainer Initials**	**Total weekly hours**
AM Start Time													
AM Finish Time													
Break													
PM Start Time													
PM Finish time													
Total daily hours worked excluding breaks													**22.5 hrs**

Section 6: Declaration & Signatures

Practice Owner / Clinical Director

This section should be completed by the Practice Owner, Clinical Director or a designated person with the approval of the Practice Owner

Please answer: 'Yes, I confirm all the above' or provide a reason why you cannot confirm some of the points

All information and documentation provided is accurate and up to date.

1. All prospective Educational and Clinical Supervisors have consented to their names being listed in this form.
2. Declaration for CQC compliance is truthful and accurate.
3. The practice will be able to offer a training place(s) from 1st September 2025 to 31st August 2026.
4. Approval as a training practice does not guarantee a place on any NHS England, Workforce Training & Education, Thames Valley & Wessex Local Office training schemes.
5. If selected, the training practice and I will ensure that the Foundation Dentist is employed by the Lead Employer and hosted at the practice under the terms of the nationally agreed contract.
6. The practice is not applying to any other NHS England, Workforce Training & Education scheme this year.
7. The practice and the practice owner are not a subject of any disciplinary proceedings or investigations by the NHSE / ICB / GDC.
8. The practice agrees to be visited by NHS England, Workforce Training & Education, Thames Valley & Wessex Dental Directorate if deemed necessary, and understand that this may last between two and six hours.
9. Professional references will be requested from GDC and NHSE Commissioners by NHS England, Workforce Training & Education, Thames Valley & Wessex Dental Directorate.
10. The decision of NHS England, Workforce Training & Education, Thames Valley & Wessex Dental Directorate shall be final.
11. Personal information provided in this application form will be used in accordance with the General Data Protection Regulation 2018.
12. I understand that the practice may be offered a LTFT (Less Than Full Time) trainee and payments will be pro-rata'd accordingly.
13. This form has been completed with full approval of the Clinical Director and Practice Owner.

Applicant Declarations

This section should be completed by the Applicant (Educational Supervisor) only

	Applicant Declarations please enter Yes or No				
1	I will be available from 1st September 2025 in the practice to supervise a Foundation Dentist/Therapist and intend to remain working in this practice until August 2026	**Yes**		**No**	
2	I will be available to attend all mandatory Foundation meetings, conference and events as listed in the Applicant Guidance 2025-2026	**Yes**		**No**	
3	I understand that approval/selection as an Educational Supervisor does not guarantee me a place on the Foundation Training Scheme and that the decision of the recruitment panel shall be final	**Yes**		**No**	
4	I understand that I am providing you with personal information and that this will be used in accordance with the General Data Protection Regulation 2018	**Yes**		**No**	
5	I am not currently a subject of fitness to practice investigation or proceedings by a licensing or regulatory body in the UK and I do not have current conditions with the GDC or NHS England	**Yes**		**No**	
6	I agree for NHS England, Workforce Training & Education, Dental Office to seek references	**Yes**		**No**	
7	I hereby certify that the above facts are true to the best of my knowledge and belief	**Yes**		**No**	
Please provide further details if you are unable to certify that any of the above declarations are true					

Declaration Signatures

Practice Owner name	
Practice Owner signature	
Date	
Applicant 1 Name	
Applicant signature	
Date	
Applicant 2 Name	
Applicant signature	
Date	
Applicant 3 Name	
Applicant signature	
Date	

EACH APPLICANT LISTED ABOVE NEEDS TO COMPLETE AND SIGN THIS APPLICATION FORM

Section 7: Supporting Documents

Mandatory supporting documents for each practice to be submitted together with this application form:

Supporting Document	Please select 'Yes' if provided / 'No' if not provided or N/A if not applicable		
	Yes	No	N/A
Clinical Supervisor(s) CV *if applicable*			
Self-Assessment Declaration Form			

Completed forms and supporting documents should be submitted to:

England.Dental.SouthEast@nhs.net

By 31 January 2025