Workforce Training & Education
Thames Valley & Wessex
Dental Directorate

NHS England South East

FORM B

Dental Foundation & Dental Therapy Training
2027-2028

Practice Owner & Educational Supervisors
Sole & Joint Application

This form should be completed by

All NEW Educational Supervisors and Training Practices

for dental foundation and dental therapy training posts 2027-2028

(This is not an application for employment)

To be completed in conjunction with
Dental Trainer Application Guidance 2027-2028

Application form must be completed electronically and returned to England.Dental.SouthEast@nhs.net
By 12 February 2027

To be completed and signed by PRACTICE OWNER and ALL APPLICANTS

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Application Process STEP BY STEP

Please refer to the Educational Supervisor Guidance 2027/2028 which provides comprehensive guidance for the recruitment process.

If you are REAPPLYING as an Educational Supervisor – refer to **FORM A.**

If you are applying as a NEW Educational Supervisor or applying as a NEW Educational Supervisor with an existing Educational Supervisor – please complete FORM B.

Completed forms and supporting documents should be submitted to: England.Dental.SouthEast@nhs.net

By **12 February 2027**

Section 1: Dental Practice Information

Please complete all fields below

Practice Details				
Practice Name				
Practice Full Address				
Postcode				
Practice Telephone Number				
Practice Manager Full Name				
Practice Manager email Address				
Practice Manager Tel No				
Practice NHS Contract Number		V/ODS Code		
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_				
Please indicate the ICS (Integrated Care System) the practice falls in: 1) Frimley Health ICB 2) Berkshire, Oxfordshire, Buckinghamshire West (BOB West) 3) Berkshire, Oxfordshire, Buckinghamshire South East (BOB SE) 4) Bedfordshire Luton and Milton Keynes ICB 5) Hants & IOW / S East	Please Select			
Do you agree for the practice details (name / address / website / tentative scheme) to be published on the national website?	Yes		No	

Practice Ownership		
Practice Ownership Type: 1) Corporate (more than 5 practices) 2) Limited Company (fewer than 5 practices) 3) Partnership 4) Sole Trader	Please Select	
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

Applicant 1

Applicant Full Name			
Applicant email address			
Applicant Mobile Number			
Gender	**Male / Female / Do not wish to disclose**		Please Select
GDC Number		Date of GDC first registration	
NHS Performer number			
Do you have current professional indemnity?		Yes / No	Please Select
Type of training post applied for*: 1) **Dental Foundation** 2) **Dental Foundation Therapy** 3) **Dental Foundation & Dental Therapy** ***You may apply for multiple posts***		Please Select	
Are you applying to be a sole or joint Educational Supervisor?		Joint / Sole	Please Select
Are you applying as a Clinical Supervisor?		Yes / No	Please Select
Will you be present in the practice with a trainee dentist for minimum 3 days a week?		Yes / No	Please Select
How long have you been employed at your current dental practice? **1-2 years | 3-4 years | 5+ years**			Please Select
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2027? **<2 years | 3 years | >4 years**			Please select
What is your minimum personal NHS UDAs commitment? **<500 UDAs** **500 – 3500 UDAs** **3500 – 7500 UDAs** **>7500 UDAs**			Please select
Please provide the number of UDAs personally achieved by 31 March 2026			
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**		Please Select
GDC Number		Date of GDC first registration	
NHS Performer number			
Do you have current professional indemnity?		Yes / No	Please Select
Type of training post applied for*: **1) Dental Foundation** **2) Dental Foundation Therapy** **3) Dental Foundation & Dental Therapy** ***You may apply for multiple posts***		Please Select	
Are you applying to be a sole or joint Educational Supervisor?		Joint / Sole	Please Select
Are you applying as a Clinical Supervisor?		Yes / No	Please Select
Will you be present in the practice with a trainee dentist for minimum 3 days a week?		Yes / No	Please Select
How long have you been employed at your current dental practice? **1-2 years | 3-4 years | 5+ years**			Please select
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2027? **<2 years | 3 years | >4 years**			Please select
What is your minimum personal NHS UDAs commitment? **<500 UDAs** **500 – 3500 UDAs** **3500 – 7500 UDAs** **>7500 UDAs**			Please select
Please provide the number of UDAs personally achieved by 31 March 2026			
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**		Please Select
GDC Number		Date of GDC first registration	
NHS Performer number			
Do you have current professional indemnity?		Yes / No	Please Select
Type of training post applied for*: **1) Dental Foundation** **2) Dental Foundation Therapy** **3) Dental Foundation & Dental Therapy** ***You may apply for multiple posts***		Please Select	
Are you applying to be a sole or joint Educational Supervisor?		Joint / Sole	Please Select
Are you applying as a Clinical Supervisor?		Yes / No	Please Select
Will you be present in the practice with a trainee dentist for minimum 3 days a week?		Yes / No	Please Select
How long have you been employed at your current dental practice? **1-2 years | 3-4 years | 5+ years**			Please Select
How many years' experience will you have working in General Dental Service or salaried service, including own foundation training year by 1st September 2027? **<2 years | 3 years | >4 years**			Please Select
What is your minimum personal NHS UDAs commitment? **<500 UDAs** **500 – 3500 UDAs** **3500 – 7500 UDAs** **>7500 UDAs**			Please Select
Please provide the number of UDAs personally achieved by 31 March 2026			
What is the Practice UDA target?			

Section 3: Dental Foundation and Dental Therapy Training Posts

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

One	☐

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

One	☐

	Please select 'Yes' / 'No'	
	Yes	No
Please confirm that all Foundation Dentists and 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 each post applied for

DFT POST 1_Timetable 1			
If ES works only 3 days a week, please provide the name of 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:	

Weekly Training Timetable

Working hours between 8am and 8pm • 35 total hours per week excluding breaks

Schedule detail	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly total
AM start time							
AM finish time							
AM trainer initials							
Break							
PM start time							
PM finish time							
PM trainer initials							
Total daily hours worked excluding breaks				**7**			**35**

Section 5: Dental Foundation THERAPY Training Post Timetable

DTFT POST 1_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:	

Weekly Training Timetable

Working hours between 8am and 8pm • 35 total hours per week excluding breaks

Schedule detail	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly total
AM start time							
AM finish time							
AM trainer initials							
Break							
PM start time							
PM finish time							
PM trainer initials							
Total daily hours worked excluding breaks				**7**			**22.5**

Section 6: Declaration and 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

1. All information and documentation provided is accurate and up to date.
2. All prospective Educational and Clinical Supervisors have consented to their names being listed in this form.
3. Declaration for CQC compliance is truthful and accurate.
4. The practice will be able to offer a training place(s) from 1st September 2027 to 31st August 2028.
5. Approval as a training practice does not guarantee a place on any NHS England, Workforce Training & Education, Thames Valley & Wessex Local Office training schemes.
6. 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.
7. The practice is not applying to any other NHS England, Workforce Training & Education scheme this year.
8. The practice and the practice owner are not a subject of any disciplinary proceedings or investigations by the NHSE / ICB / GDC.
9. 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.
10. Professional references will be requested from GDC and NHSE Commissioners by NHS England, Workforce Training & Education, Thames Valley & Wessex Dental Directorate.
11. The decision of NHS England, Workforce Training & Education, Thames Valley & Wessex Dental Directorate shall be final.
12. Personal information provided in this application form will be used in accordance with the General Data Protection Regulation 2018.
13. I understand that the practice may be offered a LTFT (Less Than Full Time) trainee and payments will be pro-rata'd accordingly.
14. 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 2027 in the practice to supervise a Foundation Dentist/Therapist and intend to remain working in this practice until August 2028	**Yes**		**No**	
2	I will be available to attend all mandatory Dental Foundation meetings, conferences and events as listed in the Applicant Guidance 2027-2028	**Yes**		**No**	
3	I understand that approval/selection as an Educational Supervisor does not guarantee me a place on the Dental 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	
Applicant 4 Name	
Applicant signature	
Date	

EACH APPLICANT LISTED ABOVE IS REQUIRED 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	☐	☐	☐

Application form must be completed electronically and returned to

England.Dental.SouthEast@nhs.net

By 12 February 2027