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PERSONAL DETAILS

Title: ____________ Name: ____________________________ Surname: ____

Gender: ____ GDC Number: ______________________________________

Practice Address: ____

____

QUALIFICATIONS (please list professional qualifications below)

Qualification: ____ Date: ____

Qualification: ____ Date: ____

Qualification: ____ Date: ____

Qualification: ____ Date: ____

Qualification: ____ Date: ____

EXPERIENCE IN DENTISTRY SINCE QUALIFICATION

(please also include areas of special interest in dentistry and any awards or prizes)

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POSTGRADUATE TRAINING ACTIVITY & COURSES ATTENDED

(please list postgraduate courses and CPD events attended in the last 2 calendar years)

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PREVIOUS EXPERIENCE IN IMPLANT DENTISTRY

(please state any previous courses attended, surgical and restorative experience, supervised training, systems used/interested)

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SPECIAL REQUIREMENTS

Name: ______________________ Date: ______________________

Signature: ______________________

Once completed, please return this form (either printed or in PDF format) to:

Mel Hays, UCER Education, ICE Postgraduate Dental Institute & Hospital, 24 Furness Quay, Salford Quays, M50 3XZ

Or email to: mel@mdic.co