### INTERCOLLEGIATE SPECIALTY FELLOWSHIP EXAMINATIONS
#### APPLICATION FORM

**Specialty:**

(Please enter registration numbers below as applicable)

**Training Number (NTN/VTN/FTN):**

**GDC Registration or Dental Council Number**

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#### Section 1 – Personal Details
(Please complete this section in block capitals)

**Last Name:**

(block capitals)

**Other Name(s):**

(block capitals)

**Title:**

**Gender** (delete as appropriate): Male / Female

**Date of Birth:** ___/___/____

(Day/Month/Year)

**Address** (block capitals):


**Postcode:**

**E-mail Address:**

**Telephone:**  

**Daytime:** __________________________  

**Evening:** __________________________

**Mobile:** __________________________

Please note: If we need to contact you regarding your application we will do so by e-mail in the first instance

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#### Section 2 – Examination Entry and Eligibility

I am applying for the Intercollegiate Specialty Fellowship Examination in

- Dental Public Health
- Oral Medicine
- Oral Surgery
- Orthodontics
- Paediatric Dentistry
- Restorative Dentistry

Dates of examination: _____________________ and enclose the required fee of £_________

(See College website [www.rcpsg.ac.uk](http://www.rcpsg.ac.uk) for diets and fees)

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**RE-SIT CANDIDATES ONLY**

I am applying to re-sit the following examination section(s):

- Critical Appraisal
- Clinical
- Management
- Desktop Exercise (Dental Public Health Only)
Qualifying Degree and Postgraduate Qualifications

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Where Obtained</th>
<th>Date (month/year)</th>
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Present Post:

Grade: ____________________ Hospital/Base: ____________________

Date commenced Specialist Registrar training/FTTA post (day/month/year): _______________

Date of award of CCST/completion of FTTA (day/month/year): ____________________

Please note: after passing the examination, candidates are not eligible for the award of the diploma until confirmation of award of CCST/completion of FTTA is received by the College, from the Postgraduate Dental Dean/Director.

Name and Address of Training Programme Director: ________________________________

__________________________________________

E-mail Address: ________________________________

Name and Address of Postgraduate Dental Dean/Director: ________________________________

__________________________________________

E-mail Address: ________________________________

Declaration to be signed and stamped by Training Programme Director

If you are unable to obtain signatures on this part of the form, an email from your Training Programme Director confirming readiness to sit the examination should be submitted with your application form.

I confirm that ________________________________ has successfully undertaken his/her training to date and is sufficiently prepared to take the examination.

Name (please print): ________________________________

Signature: ________________________________

Date: ________________________________
DATA PROTECTION

All personal information held by the Examination Unit will be held in accordance with the Data Protection Act (1998) and the General Data Protection Regulation. Any data collected may be exchanged between the four Royal Surgical Colleges of the UK and Ireland but will not be released without your permission.

SPECIAL REQUIREMENTS

It is the responsibility of the candidate to notify the Secretariat of any special requirements when they submit their application.

Applications for special consideration must be supported by written evidence in the form of a medical report from their General Practitioner or a letter in support of the application from their Training Programme Director or Postgraduate Dental Dean. In certain cases, such as dyslexia, a current Dyslexia Assessment report from an educational psychologist will be required. In the case of a temporary disability due to ill health or accident which occurs after the application has been submitted, candidates must inform the Secretariat as soon as possible before the examination.

AFFILIATION

In accordance with the Regulations, candidates who are successful in these examinations, and who have completed their training, will receive their Diploma from a College of their choice.

Queries relating to membership fees should be directed to Membership/Subscriptions at the relevant College.

Following completion of the Intercollegiate Specialty Fellowship Examination, and on award of my CCST/completion of my post CCST training I wish to affiliate to and receive my Diploma from:

RCPS Glasgow ☐  RCS Ed ☐  RCS Eng ☐  RCSI ☐

IMPORTANT NOTICE TO FELLOWS AND MEMBERS IN DENTAL SURGERY

As this is an Intercollegiate examination, it is a requirement of the four Royal Surgical Colleges of Great Britain and Ireland that Fellows and Members in Dental Surgery must be in good standing and have maintained payment of their subscriptions with their appropriate College.
Candidates must complete this application in full and sign the declaration below. The application form, method of payment form and all relevant documentation must then be submitted by the published closing date of entry to the appropriate email address:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Public Health</td>
<td><a href="mailto:isfedph@rcpsg.ac.uk">isfedph@rcpsg.ac.uk</a></td>
</tr>
<tr>
<td>Oral Medicine</td>
<td><a href="mailto:isfeom@rcpsg.ac.uk">isfeom@rcpsg.ac.uk</a></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td><a href="mailto:isfeos@rcpsg.ac.uk">isfeos@rcpsg.ac.uk</a></td>
</tr>
<tr>
<td>Orthodontics</td>
<td><a href="mailto:isfeortho@rcpsg.ac.uk">isfeortho@rcpsg.ac.uk</a></td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td><a href="mailto:isfepdent@rcpsg.ac.uk">isfepdent@rcpsg.ac.uk</a></td>
</tr>
<tr>
<td>Restorative Dentistry</td>
<td><a href="mailto:isferestdent@rcpsg.ac.uk">isferestdent@rcpsg.ac.uk</a></td>
</tr>
</tbody>
</table>

General queries can be directed to isfe@rcpsg.ac.uk

**DECLARATION** (To be signed by ALL candidates)

I have read and accept the current Regulations relating to the Intercollegiate Specialty Fellowship Examination for which I am applying.

I confirm that to the best of my knowledge all the information given on this form is a true statement of fact.

I note that, following the examination, my Training Programme Director and Postgraduate Dental Dean/Director will be notified of the result(s) of my examination

**Signature of Applicant:** ___________________________ **Date:** ____ / ____ / ____
(day/month/year)
Examination Payment form - PLEASE COMPLETE ALL SECTIONS

Candidate Name (Block Capitals) ____________________________________________________________

Examination ___________________________________________ Date of Examination ____________

Please indicate below your preferred method of payment (Tick as appropriate):

Bank draft ☐ Cheque ☐ Credit/debit card ☐ Bank Transfer ☐

PAYING BY BANK DRAFT OR CHEQUE

Bank Drafts and Cheques should be made payable to the Royal College of Physicians and Surgeons of Glasgow and should be included with your original application form. Please print your name clearly on the back of the cheque.

Candidates paying by bank draft or cheque, but submitting their application form via email, must attach the draft/cheque to a copy of this payment form and send it to the address below.

Bank Draft or Cheque number: ________________________________

PAYING BY CREDIT CARD/DEBIT CARD

Please note that candidates applying to the Royal College of Physicians and Surgeons of Glasgow should not send their credit card details with their application. Any details received will be destroyed upon receipt.

Once your application has been assessed for eligibility you will be sent details of how to make your payment.

PAYING BY BANK TRANSFER

Once your application has been assessed for eligibility you will be sent the College’s bank details and given advice as to how to make your payment.

The method of payment form should be completed by all candidates and must accompany your application form to reach the College by the closing date for applications. Failure to complete any part of this form may delay the application process and may result in you being unable to sit the examination at the requested diet.

WITHDRAWALS

Any candidate withdrawing an application for admission to an examination must do so in writing. Provided a withdrawal request is received before the application closing date, a full refund of the examination fee will be issued, less an administration fee. After the application closing date, refund of the fee will not normally be made to a candidate who withdraws or fails to attend.
EQUAL OPPORTUNITIES MONITORING

The Royal College of Physicians and Surgeons of Glasgow aims to ensure fair treatment in relation to admission and assessment of examination candidates. Completing this form will allow us to monitor our statistics and ensure that we are delivering a fair examination to all candidates. In line with UK legislation and good practice guidelines, we are asking all applicants to complete this section. You are not obliged to provide any of the information in this section, but if you do so, it will enable us to monitor our business processes and ensure that we provide equality of opportunity to all.

This information will be recorded electronically with your other data in accordance with the UK Data Protection Act 2018 and the General Data Protection Regulation, but used only for monitoring our business practices.

Gender
- Female
- Male
- Transgender
- Prefer not to say

Marital Status
- Single
- Married
- Cohabiting
- Civil partnership
- Separated/divorced
- Widowed
- Prefer not to say

Do you consider your first language to be English?
- Yes
- No
- Prefer not to say

Ethnicity
Choose one selection from the list below to indicate your ethnic group or background.

a) White
- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background (write in)

b) Mixed / Multiple Ethnic Groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background (write in)

c) Asian or Asian British
- Bangladeshi
- Chinese
- Indian
- Pakistani
- Any other Asian background (write in)

d) Black or Black British
- African
- Caribbean
- Any other Black background

e) Other Ethnic Group
- Arab
- Any other ethnic background (write in)

What is your religion or belief?
- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Other religion/belief
- No religion
- Prefer not to say

Do you have a disability under the terms of the Equality Act 2010? (The Equality Act defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities).
- Yes
- No
- Prefer not to say

What is your sexual orientation?
- Bisexual
- Heterosexual
- Lesbian or Gay
- Prefer not to say