NEBDN Level 4 Qualification in Oral Health Education and Fluoride Varnish Application

| **Personal Details** |
| --- |
| Full Name |  |
| GDC Number |  |
| D.O.B (Required by NEBDN) |  |
| Do you have GCSE in English or Equivalent Functional Skills C or above? (If not, we will need to do a formal initial assessment for literacy. |  |
| Email Address(If you have multiple email addresses please provide the email address you will have frequent access to.) |  |
| Mobile Telephone |  |
| Home Address |  |
| Please list the courses you have completed. Do not include CPD hours. |  |
| Special Learning Requirements.Do you have any special learning needs? Will you require extra time for examinations? |  |
| **Employment Details** |
| Employer Name |  |
| Employer Address |  |
| Work Telephone |  |
| Please confirm you are employed: | Part - timeFull - time |
| **Witness Details** |
| Witness Name |  |
| Main Witness GDC |  |
| Witness email address |  |
| Please confirm your witness is dedicated to your learning and will ensure they guide and support you throughout your training.  | Please underline.Yes, I confirmNo, I do not confirm |
| Commitment to the course |
| What is your main reason for applying for the Oral Health Education Course? |  |
| Please confirm you are aware you must have access to a computer and internet access to view the online tutorials/video recordings. | Please underline.Yes, I confirmNo, I do not confirm |
| As this course is online, do you believe you are capable of self-directed learning? |  |
| Out of 10 what rating would you give your motivation to learn online? | 1 - Unmotivated5 - Moderately motivated10 - Extremely motivated |
| Have you considered how you will meet the online learning requirements and make time to complete your record of experience? | I.e When will you see your patients? When will you make time to study online?Do you have printing facilities? |
| **Oral Health Education Record of Competence Assessment Requirements** |
| To complete your Record of Competence you require access to a range of patient groups. Please tick or underline which patient groups you will have access to. You **must** have access to 5 of 7 groups to complete the course. | Pregnant / nursing mothers Parents of preschool children (4 and under)Parents of primary school children (5 – 11) Adolescent (12 – 15) Adult (16 – 64)Seniors (65 and older)Special Needs / Medically compromised |
| To complete your Record of Competence assessment you require access to a range of topics. Please tick or underline which topics you will have access to. You **must** have access to all topics to complete the course. | Prevention of CariesPeriodontal DiseaseNon-Carious Tooth Surface LossOral ConditionsCare of Dentures Care of Fixed ProsthesisCare of Orthodontic Appliance |
| **Learning Preferences** |
| What is your most preferred learning style?Please underline. | Please tick appropriate options:Visual (spatial):You prefer using pictures, images, and spatial understanding. Aural (auditory-musical): You prefer using sound and music. Verbal (linguistic): You prefer using words, both in speech and writing.Physical (kinesthetic): You prefer using your body, hands and sense of touch. |
| What is your least preferred learning style? Please underline. | Visual (spatial):You prefer using pictures, images, and spatial understanding. Aural (auditory-musical): You prefer using sound and music. Verbal (linguistic): You prefer using words, both in speech and writing.Physical (kinesthetic): You prefer using your body, hands and sense of touch. |