

**APPLICATION FORM FOR**  
**THE EXTENSION OF**  
**A PERIOD OF TEMPORARY REGISTRATION**  
**IN THE REGISTER OF DENTISTS UNDER SECTION 28 OF THE DENTISTS ACT 1985.**

**IMPORTANT INFORMATION**

- Under the provisions of the Dentists Act 1985, temporary registration, whether continuous or in separate periods, may not exceed 5 years in total.
- Your completed application must reach the Dental Council at least two months prior to the date from which the extended period of temporary registration is requested.
- It is an offence for a person to make a false declaration for the purpose of obtaining registration. Any person who furnishes or attempts to furnish fraudulent or altered documents/certificates may have their application refused.
- The dates noted on your application form in Part B must not exceed one year unless you are taking part in a full time post graduate programme.
- Each application for extension of temporary registration must be accompanied by €220 registration fee, regardless of the length of the post.
- Please make a note of your temporary registration expiry date. You will find this information on your Certificate of Temporary Registration once the process has been completed. You will not receive a reminder of your expiry date, however, your name will be removed from the Register on this date.
- You are not entitled to practise dentistry, in any capacity, in the State after your temporary registration has expired or before it has been processed.

### Application check List

- €220.00 Extension of Temporary Registration Fee** - this fee can be paid via our online payment system. Please see “payments and online fees” under the registration menu on our homepage or the “pay now” button on any of the registration pages of our website. Please ensure that you choose the correct payment under “Application fees” select “Temporary Registration Application Fee” to avoid unnecessary refunds and **print a copy of your receipt** to attach to your application. We will also accept a personal cheque as an alternative method of payment.

**All** applications for extension of temporary registration are required to pay the €220 registration fee, regardless of the length of time you have been offered employment for. The maximum length you can apply for is one year per extension application.

- Application Form** – Please format all dates as DD/MM/YYYY. A scanned or photocopied version of any section of the completed application form will not be accepted. Please provide us with an address that we can contact you at.

This form has four parts.

**Part A** - this section must be completed and signed by you, the applicant.

**Part B** - this section must be completed by the institution/hospital you will be employed with. It must contain the signature and stamp of your employer. The dates provided to us on this page will indicate the period of temporary registration requested.

**Part C** - is to be completed by the Consultant that supervised you during the most recent period of temporary registration that you were granted.

**Part D** - is to be completed by the Consultant that will be supervising the period of temporary registration you are currently applying for.

- Photocopy of Passport** – this is used for identification purposes. It must be a clear photocopy of your passport and your signature must be visible.

**In the event that there is a gap between your last period of temporary registration and this application you must also provide the following;**

- Work History** – you must provide a typed account of your work history from the date your last period of temporary registration expired. This must include full dates (formatted as DD/MM/YYYY), name and full address of employer and the grade or title of your post in each position.
- Statement of Professional Registration** – this statement can be found on our website [www.dentalcouncil.ie](http://www.dentalcouncil.ie). You must complete and sign this statement.



**PART B:**

**TO BE COMPLETED BY THE EMPLOYING AUTHORITY**

This section must be signed by the chief officer of the hospital or a deputy duly authorised by the hospital authority.

(Please complete this form in block capitals and format dates as DD/MM/YYYY)

I certify that the applicant (named in Part A) \_\_\_\_\_  
has been offered, a full-time clinical position, as \_\_\_\_\_  
in \_\_\_\_\_ hospital/University  
for the period \_\_\_\_\_ to \_\_\_\_\_.

Please tick the appropriate box in relation the applicant's appointment;

- The post granted to the applicant (named in Part A) will encompass at least, 6 clinical sessions per week for the duration on their appointment.
- The post granted to the applicant (named in Part A) will not encompass at least, 6 clinical sessions per week for the duration on their appointment.

I understand that it is the responsibility of the hospital to ensure that the applicant, if granted temporary registration, will carry out his/her duties under the supervision of \_\_\_\_\_, who is a registered dentist, holding a consultant appointment in this hospital. Furthermore, I understand that the above named applicant will not be permitted to continue in this position following the expiry of their period of temporary registration.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Please print official stamp here
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**PART C:**      **TO BE COMPLETED BY THE CONSULTANT THAT SUPERVISED YOUR  
LAST PERIOD OF APPROVED TEMPORARY REGISTRATION**

(Please complete this form in block capitals and format dates as DD/MM/YYYY)

I certify that the applicant (named in Part A) \_\_\_\_\_  
practised dentistry under my supervision from \_\_\_\_\_ to \_\_\_\_\_.

**I further confirm that;** (tick appropriate box)

to the best of my knowledge this applicant is of good character and  
competent to practise dentistry under consultant supervision.

the Council should be aware of the following details of the character  
of this applicant which might affect his/her suitability for temporary  
registration in the Register of Dentists

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ (please print your name clearly)

Registration number: \_\_\_\_\_

Consultant in \_\_\_\_\_ hospital/University.

**PART D:**

TO BE COMPLETED BY THE CONSULTANT NAMED IN PART B

I understand that the applicant in Part A, if granted temporary registration, will practise dentistry under my supervision in a full-time position.

I understand that if an application is made for a further period of temporary registration, I will be required to certify the applicant's competence to practise dentistry under consultant supervision.

I confirm that I am a registered dentist, registration number \_\_\_\_\_, and I currently hold a consultant appointment in \_\_\_\_\_ hospital/University.

Please tick the appropriate box in relation the applicant's appointment;

- The post granted to the applicant (named in Part A) will encompass at least, 6 clinical sessions per week for the duration on their appointment.
- The post granted to the applicant (named in Part A) will not encompass at least, 6 clinical sessions per week for the duration on their appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ (please print your name clearly)