

Dental Postgraduate Department

Welsh Dental Therapist Foundation Training Programme
Registration Form for Therapists

Intake Month: ☐ March ☐ September

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Full Name: _____

Contact Address: _____

 _____ Postcode: _____

Contact Telephone: _____

Email: _____

Current Employment Status: _____

Main Place of Work: _____

Date of Qualification: _____

Dental School: _____

Other Post Basic Qualifications: _____

GDC Registration Number *(if applicable)* _____

Please tick the location you would prefer:

☐ South East Wales ☐ South West Wales ☐ North Wales

Signature: _____

If you are completing this form electronically, please print your name here and email the form to Kath Liddington at : Katherine.liddington@wales.nhs.uk

Please return completed form to:

Mrs Kath Liddington
Administrative Officer (WDTFT)
Dental Postgraduate Dept
Health Education and Improvement Wales
1st Floor, Ty Dysgu
Cefn Coed
Nantgarw, CF15 7QQ