

APPLICATION IN RESPECT OF _____ NHS BOARD FOR A SEDATION
PRACTICE ALLOWANCE

Full details of this allowance are contained in Part II of Determination XIV of the Statement of Dental Remuneration. This allowance is only payable to eligible dentists or dental bodies corporate whose names are included in sub-part A of the first part of the dental list. Please read Determination XIV before you fill in this form.

The allowance shall be paid to a named contractor within the practice on behalf of all the contractors at that practice. Only one allowance shall be payable per practice. Please provide at Part 1 the details of the contractor who has to receive the allowance.

Please complete Part 3.1. Part 3.2 should only be completed if the practice provided more than 250 sedation treatments in each of the 2 years prior to that in respect of which this claim is made.

Details of all other contractors and assistants on the dental list within the practice should be provided in the Annex.

PART 1 PERSONAL DETAILS OF CONTRACTOR MAKING CLAIM

1. Contractor's Name/Surname	<input type="text"/>	4. List numbers of practice
2. Other Name(s), where dentist is a contractor	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Practice address in respect of which I am making the claim	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Postcode	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

PART 2 CONDITIONS FOR CLAIMING

The dentists in respect of whom the claim is being made must meet the following conditions in order to receive payment:

- the names of the dentists must be included in the dental list of the NHS Board for the area in respect of which the claim is being made;
- the practice must have undertaken, in the year prior to that in respect of which the allowance is to be paid, a minimum of 40 sedation treatments. Where the practice used both relative analgesia and intravenous sedation then at least 30 of the 40 sedation treatments must have been intravenous; and
- the practice must have been satisfactorily inspected by the relevant NHS Board within the 3 years prior to that in respect of which the allowance is to be paid.

PART 3 CLAIM

3.1 For the year prior to that in respect of which the allowance is to be paid:

the practice undertook (*please select*)

- relative analgesia treatments only
- intravenous sedation treatments only
- both relative analgesia and intravenous sedation treatments, with less than 20 relative analgesia treatments being provided
- both relative analgesia and intravenous sedation treatments, with 20 or more relative analgesia treatments being provided

under general dental services; and

the percentage which the practice's NHS earnings, as set out in Determination XIV, bore to total earnings were: %

Amount of allowance: £ .

% of abatement of allowance: %

Total allowance claimed: £ .

3.2 The practice undertook more than 250 sedation treatments in each of the last 2 years prior to that in respect of which the allowance is to be paid and I claim an additional allowance, subject to abatement:

Amount of additional allowance: £ .

% of abatement of additional allowance: %

Total additional allowance claimed: £ .

PART 4 DECLARATION

I declare that:

- no other claim has been made by me or any other contractors within the practice in respect of the amount now claimed;
- I undertake to make the practice available for a two yearly sedation practice inspection;
- I shall notify the CSA within one month of any change in circumstances of any dentist included in this claim which may affect entitlement to a sedation practice allowance; and
- the information I have given on this form is correct and complete and I understand that if it is not action may be taken against me.

Signature of contractor at Part 1 _____

Date - -

Email completed forms to Practitioner Services from your NHS.Scot email address to ensure secure transfer of personal information, alternative email addresses should only be used in the absence of a NHS email address.

Send completed form to NSS.psd-dental-payments@nhs.scot with 'GP223 Sedation Practice Allowance Form' in the subject field.

Do not send this form by post.

DETAILS OF ALL OTHER CONTRACTORS AND ASSISTANTS WITHIN THE PRACTICE ON THE NHS BOARD LIST

I/we declare that:

- no other claim has been made by me or any other contractors within the practice in respect of the amount now claimed;
- I/we undertake to make the practice available for a two yearly sedation practice inspection;
- the contractor making the claim shall notify the CSA within one month of any change to my/our circumstances which may affect entitlement to a sedation practice allowance; and
- the information I/we have given on this form is correct and complete and I/we understand that if it is not action may be taken against me/us.

*Contractor/Assistant 2:

1. Surname/Name

2. Other Name(s)

5. List numbers for practice

Signature _____

Date --

*Contractor/Assistant 3:

1. Surname/Name

2. Other Name(s)

5. List numbers for practice

Signature _____

Date --

* delete as appropriate

*Contractor/Assistant 4:

1. Surname/Name

2. Other Name(s)

Signature _____

5. List numbers for practice

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Date --

*Contractor/Assistant 5:

1. Surname/Name

2. Other Name(s)

Signature _____

5. List numbers for practice

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Date --

*Contractor/Assistant 6:

1. Surname/Name

2. Other Name(s)

Signature _____

5. List numbers for practice

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Date --

* delete as appropriate