National Health Service Scotland
General Dental Services

Certification of Attendance / Application for
PART 1- ENHANCED SKILLS IN DOMICILIARY CARE
CONTINUING PROFESSIONAL DEVELOPMENT
(GP 214 ESD)

PART 1: PARTICULARS OF DENTIST

1. *Forename
2. *Surname
3. *Home Address
4. *Town
5. *Postcode
6. *List Number (This must be five digits)
7. *GDC Number (This can be less than/ equal to six digits)
8. *Practice Address
9. *Town
10. *Post Code
11. *HealthBoard (Where majority of services were undertaken)

PART 2: PARTICULARS OF COURSE

12. *Name of Centre (Venue)
13. *Name of Course
14. *Length of Course: **From** -Date: -Time:
    To -Date: -Time:
15. *Number of Sessions
16. *No. of Verifiable CPD Hours

This course meets the educational criteria set by the General Dental Council for the purpose of Recertification. Aims and expected learning outcomes are available from the Postgraduate Centre.

PART 3: CERTIFICATION OF ATTENDANCE

I certify that I attended this course and was present for:

☐ **No. of sessions** ☐ **Verifiable CPD Hours**

Name _____ **Date** _____

Please ensure this information is correct as this will be verified with the course organiser.

PART 4: CLAIM

Full details of Claims and Allowances can be accessed in Statement of Dental Remuneration

Amount Claimed: **Number of Sessions Claimed** ☐

CPDA CLAIMED ☐

I am a remote Island ☐ **/ Mainland** ☐ **/ Not a remote dentist** ☑ **as described in Determination VII of Statement of Dental Remuneration and claim the following additional sessions in respect of the NES training of the Training and Mentoring Programme. N.B. The mentoring component is not eligible for additional sessions and therefore the maximum number of sessions of additional CPD is 14.**

Amount Claimed: **Number of Sessions Claimed** ☐

Additional CPDA Amount ☐

PART 5: DECLARATION

☐ **I understand that Public Services Delivery (PSD) Scotland may request an Accountant's Certificate to confirm the figure provided in respect of any past year's Gross Earnings attributable to work in the General Dental Services and that I must provide it at my own expense within 3 months of the request being made.**

☐ **I agree that all the information I have provided is correct and completed to the best of my knowledge and understand that if I knowingly give wrong or incomplete information that results in a payment being made, this may be subject to court proceedings. I understand that PSD Scotland may use this information to assure accurate payments and for the prevention and detection of fraud and share it with other bodies responsible for auditing or administering public funds. Further information is available at: https://www.nss.nhs.scot/publications/practitioner-services-directorate-and-primary-care-contractor-finance-data-protection-notice/**

Full Name: _____ **Date:** _____

Personal Identification Number (PIN) ☐☐☐☐☐☐
(This is the 6 digit number you use for signing off eDental claims)

- **FORMS WILL ONLY BE ACCEPTED FROM A PERSONAL/PRACTICE NHS EMAIL ADDRESS.**
- **Hand written forms will not be accepted.**
- **Completed forms must be saved and submitted in a PDF format and sent via personal/practice NHS email to NSS.psd-dental-payments@nhs.scot labeling the subject field with "CPDA (ESD)-" and your individual List Number (e.g. 56789).**