Royal Australasian College of Dental Surgeons
Let knowledge conquer disease

FOMS09 – Application for selection for Surgical Training Positions

Please type or print in BLOCK letters your responses in this form
Completed forms should be submitted:
By Email: oms@racds.org
OR
By post or in person: RACDS, Level 13, 37 York St, Sydney, NSW 2000, Australia

Personal Details

First Name		RACDS ID *(if known)*	
Last Name			
Other Names		Date of Birth *(dd/mm/yy)*	
Email			*Please enclose passport size photograph here*
Phone	M	H	W
Mailing Address			

Are you of Aboriginal, Torres Strait Islander or Māori heritage?
- ☐ No
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Māori

Training

1	Are you a citizen of Australia or New Zealand?	☐ Yes *(Go to Q2)*	☐ No
	If **NO**, are you a permanent resident of Australia or New Zealand?	☐ Yes	☐ No
	i. If you are a permanent resident of Australia, have you passed the Australian Dental Council examinations?	☐ Yes	☐ No
	If **NO**, do you have full dental registration in New Zealand?	☐ Yes	☐ No
	ii. If you are a permanent resident of Australia, have you passed both components of the Australian Medical Council Examinations?	☐ Yes	☐ No
	If **NO**, do you have full medical registration in New Zealand?	☐ Yes	☐ No

2 Please provide your Dental and Medical Registration Number and State/Region of Registration (attach certified documents from Dental and Medical Boards):

Dental Registration Number		State/Region of Registration	
Medical Registration Number		State/Region of Registration	

Qualifications

1 List **ALL** the Qualifications/Fellowships/Memberships/Primary Examination successfully completed.

Degree/Fellowship	Institution	Year Completed

2 **Curriculum Vitae –** Please **attach** a detailed curriculum vitae that includes the following:

- Certified copies of your undergraduate academic results (official transcript)
- Certified copies of your undergraduate medical and dental degrees
- Certified copies of your medical and dental registration
- Any awards, scholarships or notable achievements you have received during your Dental and Medical Courses under the relevant headings etc. Provide details including institution, year, type of award and documentary evidence (if available).
- Details of all positions
- Published articles
- Papers / posters presented
- List formal courses/meetings attended e.g. plating or implant courses, RACDS convocation, implant, risk management, ANZAOMS conference
- Significant achievements outside of medicine / dentistry

3	Are you an OMS enrolled candidate of the Royal Australasian College of Dental Surgeons?	☐ Yes *(Go to Q4)*	☐ No *(Go to Q5)*
4	Have you completed the RACDS Basic Surgical Training Program?	☐ Yes	☐ No
	When did you complete your BST (OMS)?	_____	
	Have you completed a BST (OMS) year and presently doing your SIG year?	☐ Yes	☐ No

5 List **ALL PREVIOUS** hospital appointments for medicine and dentistry (Please attach separate sheet).

Date	Hospital	Rotation	Consultant Name	Duration
Intern:				
BST OMS:				
SIG Year:				

6 Have you taken any significant absences (longer than three (3) months) from your study or practice? If so, please provide details.

Referee Details

1 **Name and address of CURRENT employer or hospital supervisor:**

Name						
Hospital						
Department						
Address						
Telephone	M		H		W	
Fax			Email			

Additional information may be sought from any person at any hospital named on the application form.

2 In the space provided below, list the NAME and CURRENT EMAIL ADDRESS of four (4) consultants with whom you worked during the last 10 years during your training. Please include Consultants from intern/SIG rotations and if applicable, OMS/Dental rotations. All email addresses are to be printed in CAPITAL LETTERS and legible.

These will be your four (4) nominated referees used for the Professional Performance Appraisal.

On a separate sheet, list all medical/surgical resident, dental or OMS resident/house surgeon posts held. Please list all your Heads of Unit or Department including EMAIL ADDRESSES.

Information required for the Professional Performance Appraisal may be sought from ALL, SOME or NONE of the consultants named on this list.

In addition to your four (4) nominated referees, at least four (4) consultants will be selected by the Selection Committee of the Board of Studies – OMS from areas the applicant has worked in the previous five (5) years. For medical intern or resident posts, please provide the name of the Head of Unit or Supervisor and list all the consultants or specialists in each unit is not required.

Four (4) nominated referees:

i	Name	
	Position & Specialty	
	Email Address	
ii	Name	
	Position & Specialty	
	Email Address	
iii	Name	
	Position & Specialty	
	Email Address	
iv	Name	
	Position & Specialty	
	Email Address	

Declaration

I certify that information supplied in this application, for the purpose of processing my application for Surgical Training is true and correct. I understand that it may be disclosed to internal and external parties who provide administrative or organisational support to the process, or where the Royal Australasian College of Dental Surgeons (RACDS) is required to do so by law.

I understand that the RACDS may wish to verify this information with institutions or individuals, and gather additional information in order to process my application. I agree to such inquiries being undertaken as part of the RACDS Surgical Training program eligibility process. I understand that if I fail to provide this information the RACDS will be unable to process my application.

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I understand that no further updates to this application will be accepted after the closing date of 5.00pm AEST on Friday 10 May 2018.

I acknowledge that contact may be made with, and assessment scores may come from, anyone I have worked with in the last four (4) years.

Signature _____ *(Unsigned applications will not be processed)*	**Date** _____

Payment Options

Payment Amount	Application for selection for Surgical Training positions 2019 $AU _____ *(Please refer to the Fee Schedule on the College website for the applicable fee amount)*		
☐ Credit Card	Card Type	○ **MasterCard**	○ **Visa**
	Card Holder Name		
	Card Number		
	Expiry Date		
	CCV		
	Card Holder Signature		
☐ Cheque	1. Made payable to "Royal Australasian College of Dental Surgeons" 2. In Australian dollars and drawn on an Australian bank (bank fees may apply otherwise)		
☐ Electronic Transfer (Australian Dollars)	Bank	Westpac Banking Corporation	
	(BSB) Account No	(032-024) 80-1095 (swift code for overseas **WPACAU2S**)	
	Branch	60 Martin Place, Sydney Australia.	
	Account Name	Royal Australasian College of Dental Surgeons	
	Description	***(Please enter your surname and ID Number. Contact the College if you are not aware of your ID number)***	
	Please advise the College by telephone, email, fax or email of the date and amount you deposited. Please note that you are required to pay all bank fees incurred from this transaction.		