
Continuing Professional Development: Application for Special Consideration

Duration: Over what timeframe did the disadvantage occur

From date:/...../.....

To date:/...../.....

Section 3: Your rating of degree to which disadvantage affected your ability to undertake CPD

- Slight
- Moderate
- Severe

Section 4: To be signed by dental care provider

Signature:.....

Date:

Office Use Only

Recd:...../...../..... Evaluated :...../...../.....

Recommendation

DateToBoard:/...../..... BoardDecision.....

DCPNotified:...../...../.....