**Performers List Validation of Experience (PLVE)**

**Validation Supervisor’s Declaration**

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| --- | --- | --- | --- | --- |
| **Name of Validation by experience dentist (VED):** |  | | | |
|  | | | | |
| **Name of Validation Supervisor:** | | | **GDC Number:** | |
|  | | | | |
| ***Please complete Parts 1 to 3 below and return to the HEE local Office/Deanery*** | | | | |
|  | | | | |
| **Part 1** I confirm that I have carried out a Direct Observation of Procedural Skills (DOPS) of the above named dentist on both a New Patient Examination and on a Simple Restoration. I attach the completed forms. | | | | |
|  | | | | |
| **Part 2** As a result of the above observed procedures, I confirm that:  (***please tick one only of a), b), c) or d))*** | | | | |
| 1. I have no specific concerns with the abilities of the VED with regard to clinical or communication skills | | | |  |
| 1. As a result of my observation procedural skills, I propose to carry out further supervision in the areas set out in the attached action plan | | | |  |
| 1. I believe that specific training is required in the topics identified in the attached action plan before the VED carries out work in the these areas   I would / would not *(delete as applicable)* like to discuss the training requirements with a HEE Local Office/Deanery representative | | | |  |
| 1. I have serious concerns with regard to the abilities of the VED in the following areas and would like to discuss these with a HEE Local Office/Deanery representative as soon as possible | | | |  |
| *NB: It is the responsibility of the VS and the employer (where different) of the VED to ensure that the dentist is providing safe dental care.* | | | | |
|  | | | | |
| **Part 3** Signed: | | Date: | | |
| Practice Address: | | | | |

**Please return this completed form to [Insert Co-ordinator’s Name and Contact Details] by [Insert Date]**

**(Please include completed both DOPS forms (and action plan(s) if required)**