**PR1 - Peer Review Group Application Form**

The facilitator is responsible for submitting all relevant documentation for all members of the group.

All three sections of this form should be completed by the facilitator once a peer review group has been established.

This form should be returned electronically to **england.swdental@nhs.net**

Please note meetings cannot commence until approval has been given by NHS England South West.

**Section 1** – Please complete the following:

**Facilitator Information**

|  |  |
| --- | --- |
| **Title** | [ ] Mr [ ] Mrs [ ] Miss [ ] Ms [ ] Dr [ ] Prof [ ] Other (please specify below)……………………………………………………………… |
| **Forename** |  |
| **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify …………………………………………. |
| **GDC number** |  |
| **Performer number (if applicable)** |  |
| **Place of work** |  |
| **Place of work address** |  |
| **Place of work contact number** |  |
| **Email address** |  |
| **Name of peer review group**  |  |
| **Proposed date of first meeting** |  |
| **Proposed topic for meeting 1** |  |
| **Proposed topic for meeting 2** |  |

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| **Date of peer review training course attended (if applicable)** |  |
| **Total number of members in the group** |  |
| **Number of practices involved in the group (does not apply to CDS, secure settings or secondary care)** |  |

**Section 2** – Please provide details of all members in the group (use a separate sheet if needed)

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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
| **Place of work address** |  |
| **Place of work contact number** |  | **Email address** |  |

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| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
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| **Place of work contact number** |  | **Email address** |  |

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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
| **Place of work address** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
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| **Title** |  | **Forename** |  | **Surname** |  |
| **Status** | [ ] Dentist [ ] DCPIf DCP please specify………………………… | **GDC number** |  |
| **Performer number (if applicable)** |  | **Place of work** |  |
| **Place of work address** |  |
| **Place of work contact number** |  | **Email address** |  |

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| **Title** |  | **Forename** |  | **Surname** |  |
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| **Performer number (if applicable)** |  | **Place of work** |  |
| **Place of work address** |  |
| **Place of work contact number** |  | **Email address** |  |

**Section 3** – Information to be Assessed

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| **Please explain the intended benefits to dental professionals involved in this peer review group? (300 words)** |
|  |
| **Please explain the intended benefits to patients from dental professionals being involved in this peer review group? (300 words)** |
|  |
| **Please explain how you would cascade any information or insight to NHS England, Local Dental Committees and Managed Clinical Networks to ensure that learning is shared within the region? (300 words)** |
|  |

**Section 4** – Declaration (to be completed by the facilitator)

[ ] Under guidance issued by the **NHS England South West**, I confirm that all the information provided above is correct and I agree to provide a report on completion of the peer review cycle.

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| **Full name:** |  |
| **Date:** |  |

This form, once completed and signed by the facilitator, should be returned electronically to **england.swdental@nhs.net.**

The facilitator must keep a record of any meeting agendas, minutes, attendance records, meeting evaluations and CPD certificates.