Advanced Education Program in Prosthodontics
Resident Training Manual
2014-2015

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University of Minnesota School of Dentistry Educational Mission Statement

Mission, Vision and Core Values

Mission:

The University Of Minnesota School Of Dentistry improves oral and craniofacial health by educating clinicians and scientists who translate knowledge and experience into clinical practice.

The School is committed to:

- graduating professionals who provide the highest quality care and service to the people of the state of Minnesota and the world;
- discovering new knowledge through research, which will inspire innovation in the biomedical, behavioral and clinical sciences; and
- providing oral health care to a diverse patient population in a variety of settings.

Vision:

The University Of Minnesota School Of Dentistry sets the standard for the rest of the world.

Core Values:

- Excellence in all we do
- Strong sense of vision and purpose
- Serve the community/contribute to society
- Continual pursuit of knowledge
- Respect for the individual
- Personal and institutional integrity

Objectives:

- The SOD recruits, matriculates and retains quality, diverse students to all educational programs.
- The SOD presents quality educational programs incorporating new and appropriate knowledge, technology and skills. These programs ensure student learning resulting in graduates competent in their respective fields. The goal of the predoctoral dental program is to prepare graduates who possess the knowledge, skills and values to begin the practice of general dentistry.
- The SOD devotes time and resources to the discovery and dissemination of new knowledge.
- The SOD serves as a source of continuing education to the dental profession and a resource to the local and global communities.
The SOD reviews its strategic direction, consistent with those of the University of Minnesota, on a systematic and ongoing basis including regular assessment of its strategic progress.

The UMNSOD provides quality, patient centered, oral health care within its clinics and its community.

The SOD supports faculty, staff and students with a congenial, well-functioning and pleasant working environment.

The SOD is fiscally responsible.
Graduate Program in Prosthodontics Mission Statement

The thirty-three month long Graduate Program in Prosthodontics at the University of Minnesota School of Dentistry offers in-depth instruction in fixed, removable, and implant prosthodontics. This educational experience is structured to provide residents with diagnostic and treatment planning as well as the associated clinical skills necessary for the practice of prosthodontics as a specialty and/or to prepare them for a career in discipline related teaching and research. In addition, instruction provided in the critical evaluation of available dental literature, didactic concepts, and research methodology is focused on creating young professionals with the ability to become effective life-long learners.

Note: At the last site-visit of the Commission on Dental Accreditation in October of 2006, the University of Minnesota School of Dentistry Graduate Program In Prosthodontics received an accreditation classification of Approval (without reporting requirements). This accreditation classification is granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation. The programs next site-visit by the Commission on Dental Accreditation is scheduled for October of 2013.
## Graduate Program in Prosthodontics Goals

### Goals

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>To develop the diagnostic and treatment planning skills necessary for successful provision of complex prosthodontic treatment.</td>
</tr>
<tr>
<td>2</td>
<td>To provide advanced didactic instruction in all phases of prosthodontics.</td>
</tr>
<tr>
<td>3</td>
<td>To provide advanced clinical instruction in all phases of prosthodontics so that a graduating resident will have the clinical skills necessary to successfully practice prosthodontics as a specialty.</td>
</tr>
<tr>
<td>4</td>
<td>To create an atmosphere that supports the development of a research protocol, completion of an associated project, interpretation of the results, preparation of a thesis and the ability to mount a successful defense, all leading to the awarding of an MS degree at the end of the program.</td>
</tr>
<tr>
<td>5</td>
<td>To provide encouragement and the professional skills necessary for successful completion of the American Board of Prosthodontics Examination.</td>
</tr>
<tr>
<td>6</td>
<td>To develop life-long learning skills.</td>
</tr>
<tr>
<td>7</td>
<td>To foster an interest on the part of our residents in community health care, community service, and dental education.</td>
</tr>
<tr>
<td>8</td>
<td>To offer the best educational experience possible.</td>
</tr>
</tbody>
</table>
## Graduate Program in Prosthodontics Objectives

### Objectives

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<th>Objective</th>
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<tr>
<td>1</td>
<td>To ensure successful completion and presentation of treatment plans / treatment for patients requiring complex restorative care as required in the prosthodontics treatment planning seminar course.</td>
</tr>
<tr>
<td>2</td>
<td>To ensure successful completion of all didactic courses associated with the program.</td>
</tr>
<tr>
<td>3</td>
<td>To ensure successful completion of all clinical courses associated with the program.</td>
</tr>
<tr>
<td>4</td>
<td>To ensure development of a research protocol, completion of an associated project, interpretation of the results, preparation of a thesis and the ability to mount a successful defense, all leading to the awarding of an M.S. degree at the end of the program.</td>
</tr>
<tr>
<td>5</td>
<td>To ensure the development of a desire and the professional skills necessary for successful completion of American Board of Prosthodontics examination.</td>
</tr>
<tr>
<td>6</td>
<td>To ensure that residents can successfully prepare and present topical seminars in Prosthodontics and engage in a review of current and classic literature as required in the current and classical Prosthodontics literature review seminar courses.</td>
</tr>
<tr>
<td>7</td>
<td>To ensure the opportunity for development of an interest not only in teaching and related skills but also in the importance of service to the community.</td>
</tr>
<tr>
<td>8</td>
<td>To solicit input on a regular basis from residents, program graduates and faculty to identify program strengths and any weaknesses requiring correction and to make any necessary corrective changes.</td>
</tr>
</tbody>
</table>
1. Outcomes Assessment Plan

**Goal #1 To develop the diagnostic and treatment planning skills necessary for successful provision of complex prosthodontic treatment.**

A. Successful completion of PROS 7200 Advanced Clinical Prosthodontics by Prosthodontics residents. Measured using:
   - Course rubric which evaluates the residents on:

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production</td>
<td>Progress is being made toward final target production.</td>
</tr>
<tr>
<td>Progress</td>
<td>Progress is being made toward completion of clinical requirements and toward board certification. Patient treatment is entered in the Patient Tracking System.</td>
</tr>
<tr>
<td>Productivity</td>
<td>Uses available clinic time for patient appointments.</td>
</tr>
<tr>
<td>Preparation and Attendance</td>
<td>Prepared for patient appointments including instruments, supplies, implant parts, laboratory work. Attends all continuing education courses and guest speaker presentations.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Uses patient clinic time efficiently and dismisses patients on time</td>
</tr>
<tr>
<td>Quality</td>
<td>Quality of clinical restorative dentistry and laboratory procedures is of the highest. Infection control procedures are followed.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Thorough SOAP notes are written in axiUm for all patient appointments.</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Daily clinic/lab/class/teaching schedules are recorded in axiUm 24 hours in advance.</td>
</tr>
<tr>
<td>Financial</td>
<td>Collection of appropriate fees is arranged prior to sending cases to the lab and prior to delivery, treatment plans are entered and signed in axiUm, charges are billed correctly on the day of service.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Exhibits the character, standards, appearance, and behavior of a professional. Written and verbal patient testimonials of satisfaction are presented, patient calls/emails are appropriately returned, patient questions are answered, treatment options are thoroughly explained to the patient.</td>
</tr>
</tbody>
</table>

B. Successful completion of DENT 7112 Treatment Planning Seminar by Prosthodontics residents. Measured using:
   - Course rubric which evaluates the residents on:

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of case presentation</td>
<td>The selection of an appropriate case(s) to present to your fellow residents that is interesting. Cases may vary from simple to complex but should offer a valuable learning opportunity for everyone.</td>
</tr>
</tbody>
</table>
## Preparation for seminar
The act of being ready beforehand for a specific session and exercise. Having your computer and projector ready to present by 12:10 pm.

## Time management
Presentation time is 30-40 minutes followed by 10-20 minutes of questions and discussion.

## Effective use of presentation software
The appropriate use of presentation software including:
- Using slides as a visual aid and not overloading them
- Using an appropriate size and style of font
- Selection of readable colors and contrasting backgrounds
- Avoid using too many animation effects – keep it simple
- Avoid simply reading the visual presentation
- Avoid spelling and grammatical errors

## Ability to engage your audience
The ability to draw favorable attention or interest from your audience.

## Case presentation
Includes documentation of: patient demographics/resources/expectations, chief complaint, medical/dental history, soft/hard tissue exam, periodontal charting, mounted diagnostic casts and wax-up, TMJ evaluation, esthetic evaluation, psychological/social appraisal, results of consultations, diagnosis, prognosis

## Discussion of treatment plan options and techniques
Demonstration of diagnostic and treatment planning skills necessary for successful completion of advanced prosthodontics treatment. Presentation of treatment plan options and techniques used is supported by classic or current literature.

## Quality of photos
The selection of an appropriate amount and quality of pre-, mid-, and post-treatment clinical photographs. Photos are high resolution and have been cropped/rotated/flipped for viewing.

## Quality of radiographs
The selection of an appropriate amount and quality of pre-, mid-, and post-treatment clinical radiographs. Non-digital radiographs have been scanned by a computer and cropped for viewing.

## Ability to respond to questions
The capacity and competence to reply to questions and discuss important prosthodontic philosophies/principles.

## Participation in supplemental discussion
The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.

## Punctual for seminar
The ability to be present at a designated time. Present in the conference room by 12:10 pm.

## Attendance
The action of being present at scheduled seminars. Excused absences permitted.

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C. Successful completion of DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning by Prosthodontics residents. Measured using:
- Course rubric which evaluates the residents on:

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary analysis</td>
<td>The capacity and competence to comprehend, interpret, and express</td>
</tr>
</tbody>
</table>
of articles | verbally a complete understanding of historically-based, widely accepted philosophies and principles in prosthodontics. The aptitude to discuss the scientific merit of the article in question. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.

Preparation for seminar | The act of being ready beforehand for the seminar by carefully reading and understanding all articles provided. The ability to demonstrate an in-depth knowledge and understanding of historically- and scientifically-based philosophies and principles in prosthodontics presented within the seminar.

Participation in supplemental discussion | The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.

Punctual for seminar | The ability to be present at a designated time. Present in the conference room by 8:00 am.

Attendance | The action of being present at scheduled seminars. Excused absences permitted.

D. Completed treatment plans reviewed and approved by faculty for all patients of record. Measured using:

- At the end of each semester, the program director completes a patient electronic health record chart audit during which completed treatment plans are reviewed and patient, resident, and faculty electronic signatures are verified.

E. Response from program graduates. Measured using:

- Exit Interview Form
- Outcome Assessment by Program Alumni Form

Refer to Standard 5:

Appendix W – A copy of the written material given to entering students/residents, describing their rights and responsibilities to the institution, program and faculty (Resident Training Manual, University of Minnesota School of Dentistry Clinical Manual)

- Tab I – Graduate Program in Prosthodontics Individual Course Syllabi

Goal #2 To provide advanced didactic instruction in all phases of prosthodontics.

A. Successful completion of all didactic Prosthodontics course work by residents. Measured using:

- DENT 7111 Current Literature Seminar Rubric
<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection of articles</td>
<td>The ability to select 4 appropriate peer-reviewed manuscripts published in well recognized journals with relevant and current information on the specialty of prosthodontics including but not limited to complete dentures, fixed partial dentures, removable partial dentures, and implant prosthodontics.</td>
</tr>
<tr>
<td>Forwarding of articles to faculty and classmates</td>
<td>The deed of forwarding all selected articles to the faculty, program associate, and fellow residents electronically by 4:00 pm on the Friday preceding your Friday assigned seminar.</td>
</tr>
<tr>
<td>Analysis of primary or secondary articles</td>
<td>The capacity and competence to comprehend, interpret, and express verbally a complete understanding of the article presented without reading directly from the article. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.</td>
</tr>
<tr>
<td>Preparation for seminar</td>
<td>The act of being ready beforehand for the seminar by carefully reading and understanding all articles provided. The ability to demonstrate an in-depth knowledge and understanding of current philosophies and principles in prosthodontics presented within the seminar.</td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.</td>
</tr>
<tr>
<td>Punctual for seminar</td>
<td>The ability to be present at a designated time. Present in the conference room by 8:00 am.</td>
</tr>
<tr>
<td>Attendance</td>
<td>The action of being present at scheduled seminars. Excused absences permitted.</td>
</tr>
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</table>

- PROS 7110 Classic Literature Review Seminar Rubric

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary analysis of articles</td>
<td>The capacity and competence to comprehend, interpret, and express verbally a complete understanding of historically-based, widely accepted philosophies and principles in prosthodontics. The aptitude to discuss the scientific merit of the article in question. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.</td>
</tr>
<tr>
<td>Preparation for seminar</td>
<td>The act of being ready beforehand for the seminar by carefully reading and understanding all articles provided. The ability to demonstrate an in-depth knowledge and understanding of historically- and scientifically-based philosophies and principles in prosthodontics presented within the seminar.</td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.</td>
</tr>
<tr>
<td>Punctual for seminar</td>
<td>The ability to be present at a designated time. Present in the conference room by 8:00 am.</td>
</tr>
<tr>
<td>Attendance</td>
<td>The action of being present at scheduled seminars. Excused absences permitted.</td>
</tr>
</tbody>
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• PROS 7210 Advanced Technical Restorative Dentistry

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quizzes</td>
<td>&lt;70%</td>
<td>≥70%</td>
<td>≥80%</td>
<td>≥90%</td>
<td></td>
</tr>
<tr>
<td>Final Written Exam</td>
<td>&lt;70%</td>
<td>≥70%</td>
<td>≥80%</td>
<td>≥90%</td>
<td></td>
</tr>
<tr>
<td>Laboratory Exercises</td>
<td>Junior DDS level or lower</td>
<td>Senior DDS level</td>
<td>Top 20% new DDS graduate or experienced dentist</td>
<td>Specialty level achievement or potential</td>
<td></td>
</tr>
<tr>
<td>Clinical Exercises</td>
<td>Junior DDS level or lower</td>
<td>Senior DDS level</td>
<td>Top 20% new DDS graduate or experienced dentist</td>
<td>Specialty level achievement or potential</td>
<td></td>
</tr>
<tr>
<td>Preparation for sessions</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>Analysis and participation</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
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• DENT 7112 Treatment Planning Seminar Rubric
  • See Goal #1 for rubric

• DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning Rubric
  • See Goal #1 for rubric

• PROS 7200 Advanced Clinical Prosthodontics Rubric
  • See Goal #1 for rubric

• University of Minnesota Academic Record – GRAD Career Form obtained for each resident at the end of each semester

B. Successful completion of all basic science course work by residents. Measured using:

• University of Minnesota Academic Record – GRAD Career form obtained for each resident at the end of each semester

C. Response from program graduates. Measured using:

• Exit Interview Form
• Outcome Assessment by Program Alumni Form
Refer to Standard 5:

Appendix W – A copy of the written material given to entering students/residents, describing their rights and responsibilities to the institution, program and faculty (Resident Training Manual, University of Minnesota School of Dentistry Clinical Manual)

- Tab I – Graduate Program in Prosthodontics Individual Course Syllabi

**Goal #3 To provide advanced clinical instruction in all phases of prosthodontics so that a graduating resident will have the clinical skills necessary to successfully practice prosthodontics as a specialty.**

A. Successful completion of all clinical courses by Prosthodontics residents. Measured using:

- DENT 7111 Current Literature Seminar Rubric
- DENT 7112 Treatment Planning Seminar Rubric
- DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning Rubric
- PROS 7110 Classic Literature Review Seminar Rubric
- PROS 7200 Advanced Clinical Prosthodontics Rubric
- PROS 7210 Advanced Technical Restorative Dentistry
- University of Minnesota Academic Record – GRAD Career Form obtained for each resident at the end of each semester

B. Management of a variety of clinical treatment experiences by all residents. Measured using:

- Progress towards completion of clinical requirements
- Reviewing production codes in the patients’ electronic health record
- Reviewing treatment entered in the Graduate Program in Prosthodontics Patient Tracking System
- PROS 7200 Advanced Clinical Prosthodontics Rubric
- PROS 7210 Advanced Technical Restorative Dentistry

C. Response from program graduates. Measured using:

- Exit Interview Form
- Outcome Assessment by Program Alumni Form

Refer to Standard 5:

Appendix W – A copy of the written material given to entering students/residents, describing their rights and responsibilities to the institution, program and faculty (Resident Training Manual, University of Minnesota School of Dentistry Clinical Manual)

- Tab I – Graduate Program in Prosthodontics Individual Course Syllabi
Goal #4 To create an atmosphere that supports the development of a research protocol, completion of an associated project, interpretation of the results, preparation of a thesis and the ability to mount a successful defense, all leading to the awarding of an MS degree at the end of the program.

A. Successful completion of a written research protocol by Prosthodontics residents at the end of their research course. Measured using:
   - Satisfactory completion of OBIO 5001 Methods in Research and Writing
   - University of Minnesota Academic Record – GRAD Career Form obtained for each resident at the end of each semester

B. Successful completion of a written research protocol, the associated project, its analysis and the development of a completed thesis. Measured using:
   - Written research protocol approved by academic advisor
   - Completed thesis approved by academic advisor
   - Successful thesis defense and awarding of M.S. degree.

Goal #5 To provide encouragement and the professional skills necessary for successful completion of the American Board of Prosthodontics Examination.

A. Successful completion of the Classic and Current Literature Review Seminar courses as well as the Treatment Planning Seminar course. (Two questions from the ACP annual mock board examination are assigned as part of the Current Literature Review Seminar course on an every week basis. Residents are expected to be able to answer / discuss questions if called upon). Measured using:
   - DENT 7111 Current Literature Seminar Rubric
   - DENT 7112 Treatment Planning Seminar Rubric
   - DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning Rubric
   - PROS 7110 Classic Literature Review Seminar Rubric
   - PROS 7200 Advanced Clinical Prosthodontics Rubric
   - PROS 7210 Advanced Technical Restorative Dentistry
   - University of Minnesota Academic Record – GRAD Career Form obtained for each resident at the end of each semester

B. Completion of clinical requirements as described in the Resident Training Manual. Measured using:
   - Progress towards completion of clinical requirements
   - Reviewing production codes in the patients’ electronic health record
• Reviewing treatment entered in the Graduate Program in Prosthodontics Patient Tracking System
• PROS 7200 Advanced Clinical Prosthodontics Rubric – evaluating production, progress, productivity, preparation and attendance, efficiency, quality, documentation, scheduling, financial, professionalism, patient testimonials and communication

C. Residents are strongly encouraged to complete treatment for patients meeting the requirements for the Section B Examination (formerly Parts 2, 3, or 4) of the ABP examination. Measured using:

• PROS 7200 Advanced Clinical Prosthodontics Rubric – evaluating production, progress, productivity, preparation and attendance, efficiency, quality, documentation, scheduling, financial, professionalism, patient testimonials and communication
• Exit Interview Form
• Outcome Assessment by Program Alumni Form

D. Residents are strongly encouraged to participate in the Board certification process during and after program completion. Measured using:

• PROS 7200 Advanced Clinical Prosthodontics Rubric – evaluating production, progress, productivity, preparation and attendance, efficiency, quality, documentation, scheduling, financial, professionalism, patient testimonials and communication
• Second year resident participation in the Board Preparation Course hosted by the American College of Prosthodontists at its Annual Session.
• Third year resident participation in the Section A Written Examination (former Part 1), of the ABP examination in April
• Third year resident participation in the Section B candidate-generated patient presentations during the February examination period
• Exit Interview Form
• Outcome Assessment by Program Alumni Form

Goal # 6 To develop life-long learning skills.

A. Successful completion of the literature review courses and other program related course work. Measured using:

• Classic and Current Literature Seminar Evaluation Form.
• DENT 7111 Current Literature Seminar Rubric
• DENT 7112 Treatment Planning Seminar Rubric
• DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning Rubric
• PROS 7110 Classic Literature Review Seminar Rubric
• PROS 7200 Advanced Clinical Prosthodontics Rubric
Goal #7 To foster an interest on the part of our residents in community health care, community service and dental education.

A. Successful completion of the literature review courses and other program related course work. Measured using:
   - PUBH 6751 Principles of Management in Health Services Organizations
   - University of Minnesota Academic Record – GRAD Career Form obtained for each resident at the end of each semester

B. Graduate participation in dental education. Measured using:
   - Outcome Assessment by Program Alumni Form.

C. Graduates participating in community health care and service. Measured using:
   - Outcome Assessment by Program Alumni Form.

Goal #8 To offer the best educational experience possible.

A. Resident evaluation of faculty. Measured using:
   - Graduate Program in Prosthodontics Resident Faculty Evaluation Form.

B. Resident evaluation of program. Measured using:
   - Resident Year End Evaluation of the Graduate Program in Prosthodontics Form
   - Meetings with all residents on a continuous basis – every Monday, Wednesday, and Friday morning
   - Written student complaints

C. Graduate evaluation of program. Measured using:
   - Outcome Assessment by Program Alumni Form
   - Exit Interview Form
D. Faculty evaluation of program. Measured using:

- Individual faculty input to program director as well as from scheduled faculty meetings

E. Program Director evaluation of program. Measured using:

- Monitoring of resident performance
- Resident evaluation forms
- Advanced Dental Education Committee meetings
2. Outcomes Measurements

Refer to Standard 2:
Appendix K1
- Resident Evaluation of Faculty

Refer to Standard 5:
Appendix U
- Resident Exit Interview
- Outcome Assessment by Program Alumni
- Resident Year End Evaluation of Program
3. Outcomes Assessment Results

**Goal #1 To develop the diagnostic and treatment planning skills necessary for successful provision of complex prosthodontic treatment.**

A. Successful completion of PROS 7200 Advanced Clinical Prosthodontics by Prosthodontics residents.
   All residents have successfully completed this clinical course which runs continuously throughout the program. Residents have clinical requirements that provide them with repeated experiences in diagnosis and treatment planning of complex patient cases.

B. Successful completion of DENT 7112 Treatment Planning Seminar by Prosthodontics residents.
   All residents have successfully completed this prosthodontics seminar course by presenting numerous formal treatment planning and completed treatment presentations.

C. Successful completion of DENT 7220 Prosthetically-Driven Implant Surgery & Treatment Planning by Prosthodontics residents.
   All residents successfully completed this course in its initial offering of fall 2012. This course has offered the residents additional experience in treatment planning implant placement with the prosthetic goal in mind.

D. Completed treatment plans reviewed and approved by faculty for all patients of record.
   At the end of each semester, the program director completes a patient electronic health record chart audit during which completed treatment plans are reviewed and patient, resident, and faculty electronic signatures are verified.

E. Response from program graduates.
   Completed exit interviews and alumni surveys (Outcome Assessment by Program Alumni form) indicate that graduates from this program received information regarding treatment planning that was appropriate and sufficient for the successful practice of prosthodontics as a specialty.

**Goal #2 To provide advanced didactic instruction in all phases of prosthodontics.**

A. Successful completion of all didactic Prosthodontics course work by residents.

- All residents have successfully completed all prosthodontic related coursework associated with the Prosthodontics residency program.
B. Successful completion of all basic science course work by residents.

- All residents have successfully completed the basic science coursework associated with the Prosthodontics residency program.

C. Response from program graduates.

- Alumni outcome assessment forms and exit interviews indicate that graduates from this program are generally satisfied with the knowledge of Prosthodontics and basic science that they receive and that it is appropriate for the successful practice of Prosthodontics as a specialty.

Goal #3 To provide advanced clinical instruction in all phases of prosthodontics so that a graduating resident will have the clinical skills necessary to successfully practice prosthodontics as a specialty.

A. Successful completion of all clinical courses by Prosthodontics residents.

- All residents have been successful in completing clinical coursework associated with the program.

B. Management of a variety of clinical treatment experiences by all residents.

- All residents who have graduated from this program have met the clinical requirements as described in the program manual. These clinical requirements provide a measurement standard that assures each resident will have a sufficient number of patients with differing treatment needs such that they will be able to develop a satisfactory level of proficiency in all aspects of Prosthodontics.

C. Response from program graduates.

- Outcome assessment questionnaires received from program alumni indicate that they felt the program offered them a level of instruction sufficient to allow them to practice Prosthodontics successfully as a specialty.

Goal #4 To create an atmosphere that supports the development of a research protocol, completion of an associated project, interpretation of the results, preparation of a thesis and the ability to mount a successful defense, all leading to the awarding of an MS degree at the end of the program.

A. Successful completion of a written research protocol by Prosthodontics residents at the end of their research course.
• All residents in our program have satisfactorily completed a research protocol as required by their participation in the research course.

B. Successful completion of a written research protocol, the associated project, its analysis and the development of a completed thesis.

• Over the last seven years (2006-2012), 15/21 individuals completed our program receiving both their Master’s Degree and their Certificate in Prosthodontics. Three of the six who have not defended their thesis graduated a year ago and are currently preparing their thesis. One of the other six residents plans to defend her thesis but has been delayed due to personal reasons.

**Goal #5 To provide encouragement and the professional skills necessary for successful completion of the American Board of Prosthodontics Examination.**

A. Successful completion of the Classic and Current Literature Review Seminar courses as well as the Treatment Planning Seminar course. (Two questions from the ACP annual mock board examination are assigned as part of the Current Literature Review Seminar course on an every week basis. Residents are expected to be able to answer / discuss questions if called upon).

• All residents have successfully completed these courses. The outcome assessments from program alumni indicated they are a particular strength of the program.

B. Completion of clinical requirements as described in the Resident Training manual.

• All residents who graduated from this program have completed these requirements
• Reviewing production codes in the patients’ electronic health record
• Reviewing treatment entered in the Graduate Program in Prosthodontics Patient Tracking System
• PROS 7200 Advanced Clinical Prosthodontics Rubric – evaluating production, progress, productivity, preparation and attendance, efficiency, quality, documentation, scheduling, financial, professionalism, patient testimonials and communication

C. Residents are strongly encouraged to complete treatment for patients meeting the requirements for the Section B Examination (formerly Parts 2, 3, or 4) of the ABP examination.

• With the advent of new Guidelines for the Board, residents are mentored and encouraged to complete patient requirements for the Section B Examination.
D. Residents are strongly encouraged to participate in the Board certification process during and after program completion.

- Second year residents participate in the ACP hosted Board Preparation Course during its Annual Session and it is a requirement to take the Section A Examination in the third year of the program. Both of these requirements are funded by the Advanced Education Program in Prosthodontics. Second and third year residents also take the mock examination offered by the ACP.
- The Program Director annually presents to the residents on Board Certification in Prosthodontics, including what Board Certification means, the ABP Mission Statement, how to become Board Eligible, changes to the certification process, and the Section A, B, and C, examinations.
- While treatment planning patients with residents, the Program Director is always considering if the patient could be a board examination patient and encourages the resident to treat the case as it could be.
- In the past 7 years (2007-2013) and out of 20 alumni, we have had 4 become Fellows of the American College of Prosthodontists, 4 become Fellows of the Royal College of Dentists of Canada, 2 become fellows of both the ACP and RCDC, and 6 others have completed one or more parts of the American Board Certification process. To have 80% participation in board certification of our alumni is a significant increase over the previous seven year period of 2000-2006 where only 1/21 alumni became a fellow of both the ACP and RCDC (myself). I am proud to have encouraged and supported the recent alumni in their board certification pursuit.

**Goal # 6 To develop life-long learning skills.**

A. Successful completion of the literature review courses and other program related course work.

- All residents completing the program have successfully completed the literature review courses and other program related course work associated with the Prosthodontics residency program.

B. Examples of teaching affiliations, study clubs, publications, research, etc., from previous program graduates.

- Outcome assessment surveys from program alumni indicated that respondents are involved in one or more activities associated with life-long learning.

**Goal #7 To foster an interest on the part of our residents in community health care, community service and dental education.**
A. Successful completion of the literature review courses and other program related course work.

- All residents completing the program have successfully completed the literature review courses and other program related course work associated with the Prosthodontics residency program.

B. Graduates participating in dental education.

- Outcome assessments from program alumni indicate that ten of our recent graduates are actively involved in dental education.

C. Graduates participating in community health care and service.

- Outcome assessments from program alumni indicate that all of them are actively involved in the practice of Prosthodontics and nearly all are full time.

**Goal #8 To offer the best educational experience possible.**

A. Resident evaluation of faculty.

- Resident evaluations of faculty generally indicate a satisfaction with faculty teaching and participation in the educational process. The program director reviews all faculty evaluations. Identified problems are addressed and resolved through the department chair.

B. Resident evaluation of program.

- In addition to information gleaned from evaluation forms filled out by our residents, individual residents meet with the program director throughout each year. Residents appear reasonably satisfied with various aspects of the program.

C. Graduate evaluation of program.

- Alumni outcome assessments and exit interviews offer a means whereby recent graduates and program alumni can respond to questions about the strengths and weaknesses of the program. This information is considered by the program director in planning any changes associated with the program. Respondents indicated a general satisfaction with most aspects of the program.

D. Faculty evaluation of program.
Scheduled faculty meetings provide a forum for faculty to discuss problems and implement change. The faculty is generally satisfied with the performance of the program.

E. Program Director evaluation of program.

The program director is responsible to assure the proper function of the residency program. The program director receives information from numerous sources to monitor program function and assesses the program on a yearly basis. In addition, the program director meets with other program directors (during the ACP Annual Session and the Spring Educators Meeting), to discuss issues associated with graduate Prosthodontics and graduate dental education.
MS Dentistry Program

Contact Information

Graduate Studies Office: MS Program in Dentistry
15-136 Moos Tower
515 Delaware Street. SE
Minneapolis, MN 55455
Telephone: 612-624-7934
Fax: 612-624-0027

University of Minnesota Graduate School:

Johnston Hall
Web site: http://www.grad.umn.edu

PLEASE NOTE:
Graduate Studies Bulletin Board on 15th floor (outside 15-136) includes latest:
• Current Faculty Rosters
• Course Announcements
• General Information

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<td>School of Dentistry, 9-423 Moos Tower</td>
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<tr>
<td>Director of Graduate Studies,</td>
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<td>School of Dentistry, 15-137 Moos Tower</td>
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<td>International Student &amp; Scholar Services</td>
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<tr>
<td>190 Hubert H. Humphrey Center</td>
<td>612-626-7100</td>
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Helpful Website:

Tuition and Fees
(Full-time and per credit rates)
http://onestop.umn.edu/finances/costs_and_tuition/index.html
Graduate Student Services
University of Minnesota Graduate School

Master’s Degree
Summary of Procedures from Initial Registration to Graduation

This summary has been prepared to assist students in completing the steps necessary for graduation. It should be used in conjunction with the current Graduate School Bulletin and University Class Schedule, which detail in full the requirements and regulations for which all students are responsible.

You must register in the Graduate School the semester you are admitted or readmitted. To maintain active student status, you must register in the Graduate School every Fall and Spring semester. If you do not currently have active student status, you must file a Change of Status/Readmission form to request readmission to the Graduate School.

Forms for Masters Students

- All forms and requests are available online on the Graduate School web site at: [http://www.grad.umn.edu/current_students/forms/masters.html](http://www.grad.umn.edu/current_students/forms/masters.html)

- Online forms and processes at this web site include:
  - [Graduate Degree Plan](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Assign/Update Examination Committee](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Quick Start Guide](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Petition Form](http://www.grad.umn.edu/current_students/forms/masters.html) (request changes on approved programs or extension of time to complete degree)
  - [Application for Advanced Master's Status](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Letter of Certification Request](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Thesis or Dissertation Hold Request](http://www.grad.umn.edu/current_students/forms/masters.html)
  - [Leave of Absence (policy and forms)](http://www.grad.umn.edu/current_students/forms/masters.html)

- [Graduation Packet](https://apps.grad.umn.edu/secure/gradpacket/) is available at: [https://apps.grad.umn.edu/secure/gradpacket/](https://apps.grad.umn.edu/secure/gradpacket/)

Helpful Website:

Information for Masters Students:

[http://www.grad.umn.edu/students/masters/index.html](http://www.grad.umn.edu/students/masters/index.html)
MASTER'S DEGREE

Plan A (with Thesis)

1. **After completion of about 15 credits towards the degree**, file a Degree Program form. *(NOTE: It is in students’ best interests to do this by the end of the first year. Delays in filing the Degree Program could result in failure to identify problems in meeting Graduate School degree requirements that could delay graduation!)*

2. **At least one semester before anticipated thesis exam**, select Thesis Examination Committee by initiating online committee request at the following Graduate School web site:

   http://www.grad.umn.edu/students/assignmasterscommittee/index.html

3. Once the Degree Program and Examination Committee have been approved by the Graduate School and the thesis is ready to go to the reviewers (Plan A), you can obtain a graduation packet online from the Graduate School. The Thesis Reviewers Report form will be issued at that time. Remember to allow your committee at least two weeks to read the thesis.

4. Submit the Application for Degree to 200 Fraser or 130 Coffey by the first working day of the intended month of graduation.

5. Submit a signed Thesis Review's Report form to receive the Final Examination Report form prior to the final exam.

6. Return the Final Examination Report form by the last working day of the intended month of graduation.

7. Submit two unbound copies of your thesis, both signed by your advisor(s), by the last working day of the intended month of graduation.

Plan B (with 3 Papers)

1. After completion of about 15 credits, file a Degree Program form. *(NOTE: It is students’ best interests to do this by the end of the first year. Delay in filing the Degree Program could result in failure to identify problems in meeting Graduate School degree requirements that could delay graduation!)*

2. **At least one semester before anticipated thesis exam**, select Plan B Examination Committee by initiating online committee request at the following Graduate School web site:

   http://www.grad.umn.edu/students/assignmasterscommittee/index.html

3. Once the Degree Program and Examination Committee have been approved by the Graduate School, pick up the Final Examination Report form and the Graduation Packet before your final oral examination.
4. Submit an Application for Degree to 200 Fraser or 130 Coffey by the first working day of the intended month of graduation.

5. Return the Final Examination Report form by the last working day of the intended month of graduation.

If you have specific questions, please contact the MS-Dentistry Program Assistant:
Mark Wegner
9-423 Moos Tower
wegne009@umn.edu
(612) 624-7934
GRADUATION

Graduate School degrees are awarded monthly; the Application for Degree must be turned in to Student Relations, 200 Fraser Hall (East Bank) on or before the first working day of the intended month of graduation. All other Graduate School requirements must be completed by the last working day of the intended month of graduation. Graduating in any month before the end of the quarter may affect your eligibility for student loans, housing, etc.; check with the appropriate office if you have questions. The award of the degree should appear on transcripts within one month following graduation. The diploma is mailed from the Registrar three to four months after graduation.

All Graduate School requirements for graduation are listed below. Unless stated otherwise, you should submit all forms to 316 Johnston Hall. Forms are available online at the Graduate School website. Note: all students must submit an Application for Degree to 200 Fraser Hall or 130 Coffey Hall on or before the first working day of the intended month of graduation.

Preparation of Master's Thesis / Project Guidelines
Available from the Graduate School web site at:

http://www.grad.umn.edu/students/ThesisSubmission/index.html

Note: The Graduate School will accept only theses that meet these guidelines. If you have any questions, you may contact the Graduate School staff in 316 Johnston Hall (612/625-4019).

Helpful Website:

Masters Degree Completion Procedures:

http://www.grad.umn.edu/students/masters/index.html
University of Minnesota
School of Dentistry
and
Graduate School

Master of Science: Dentistry
OVERVIEW
M.S. in Dentistry

(Plan A and Plan B)
Curriculum – The M.S program in Dentistry offers training designed to prepare dentists with clinical expertise for positions of leadership in education, research, and programs administration in the oral health field. The program is housed in the School of Dentistry and is taught by a multidisciplinary faculty educators, researchers and clinicians. All students complete core coursework in teaching and evaluation in dentistry, research methods, and health care administration. Additional advanced coursework is offered in these same focus areas, as well as in selected clinical and oral science topics with interdisciplinary impact, including conscious sedation, craniofacial pain, geriatrics, oral biology, oral medicine and radiology, oral pathology, practice administration, and psychology. Flexibility is available in planning individualized programs to accommodate students’ specific areas of interest, and courses from other disciplines may be included for credit in the major area.

Prerequisites for Admission – The graduate program in Dentistry is designed for individuals who have a strong desire to prepare for careers in dental education, research, or program administration. Applicants must have received a D.D.S. or D.M.D. degree from an accredited U.S. institution. Students with comparable foreign degrees from recognized colleges or universities may also apply for admission. Applications from individuals who have completed or are enrolled in an advanced clinical dental training program (general dentistry or specialty residency program) are encouraged. Per Graduate School requirements, an undergraduate grade point average (GPA) of 3.0 is the preferred performance level for admission. Applicants for whom English is a second language must also take the Test of English as a Foreign Language (TOEFL). The preferred performance levels on the TOEFL are as follows:

- Paper-Based Total Score: 600
- Computer Based Total Score: 250
- Internet Based Total Score: 80

Special Admission Requirements – Applicants should submit three letters of recommendation from individuals familiar with their academic capabilities. Also required is a brief essay (under 500 words) which relates the applicant’s career goals to the goals of the program. Applications are received and reviewed throughout the year. Students may enter the program in any semester at the discretion of program faculty.

Commitment to Diversity: The M.S. Dentistry Program and the Graduate School embrace the University of Minnesota’s position that promoting and supporting diversity among the student body is central to the academic mission of the University. A diverse student body enriches graduate education by providing a multiplicity of views and perspectives that enhance research, teaching, and the development of new knowledge. A diverse mix of students promotes respect for, and opportunities to learn from other with the broad range of backgrounds and experiences that constitute modern society. Higher education trains the next generation of leaders of academia and society in general, and such opportunities for leadership should be accessible to all members of society. The M.S. Dentistry Program and the Graduate School are therefore committed to providing equal access to educational opportunities through recruitment, admission, and support programs that promote diversity, foster successful academic experiences, and cultivate the leaders of the next generation.

Concurrent Residency and M.S. Studies – Students who are enrolled in an advanced clinical dental training program (general dentistry or specialty residency) may be admitted to the Dentistry graduate program for concurrent study. However, students must carefully plan their studies with their faculty advisor and the Director of Graduate Studies so that their residency and M.S. programs are appropriately integrated and satisfy Graduate School registration and degree requirements.

Master’s Degree Requirements – The M.S. degree program usually requires at least 18 months and may be completed as either Plan A (with thesis) or Plan B (without thesis). Students in both plans must complete a minimum of 14 credits in the major field, including four core courses in: 1) teaching and evaluation in dentistry; 2) basic research methodology; 3) introductory biostatistics; and; 4) fundamentals of health care administration. All students must also complete a minor or related field option of at least 6 credits. Courses for credit in the major may also be taken from other disciplines with the approval of the student’s advisor and the Director of Graduate Studies. Students are also required to complete training in Research Ethics in accordance with Graduate School requirements.
For Plan A students, a minimum of 10 thesis credits are required for the M.S. degree. Plan B students do not complete a thesis, but take an additional 10 credits of coursework and submit three Plan B papers, one of which must involve the analysis and reporting of research information. Students must maintain a cumulative grade point average (GPA) of at least 3.0 and no more than 6 incomplete credits during their program. A final oral examination is required for both Plan A and Plan B programs. A minimum cumulative grade point average (GPA) of at least 2.8 in MS Dentistry Degree Program coursework is required for graduation.

**Use of 4xxx Courses** – Inclusion of 4xxx courses on degree program forms is subject to adviser and director of graduate studies approval. Under **NO** circumstances are courses below 4000 level allowed for graduate degree credit by the Graduate School.

**Language Requirements** - None
DETAILED DESCRIPTION
M.S. in Dentistry

1. PROGRAM DESCRIPTION

The M.S. degree program in Dentistry is designed to prepare dentists and dental hygienists for leadership positions in dental and dental hygiene education, research, and program administration that will complement their areas of clinical expertise. The specific objectives of the program are to develop skills in:

- Designing and conducting research
- Teaching
- Administration of clinical and educational programs
- Advanced multidisciplinary clinical care

The program is housed in the School of Dentistry and taught by Dentistry’s multidisciplinary graduate faculty of dental educators, researchers, and clinicians. Core elements of the program include required courses in teaching and evaluation, research methods, biostatistics, and program administration. Additional advanced coursework may be taken in these focus areas, as well as selected areas of clinical and oral science that are of multidisciplinary concern, including anatomy, conscious sedation, craniofacial pain, geriatrics, oral biology, oral medicine and radiology, oral pathology, physical diagnosis, practice administration, and psychology. Flexibility is encouraged in planning individualized programs that will accommodate students’ specific areas of interest, and courses from other disciplines may be included for credit in the major area.

Students are responsible for developing their program of education and professional growth in conjunction with the Dentistry graduate faculty. Selection of an advisor is of critical importance, since the student and advisor will jointly plan the student’s curriculum and thesis or other projects. New students will be under the general supervision of the Director of Graduate Studies or assigned a temporary advisor by the Director of Graduate Studies. Students will be expected to choose an advisor by the end of their first year in the graduate program and will be encouraged to familiarize themselves with the graduate faculty as soon as possible via seminars, tutorials, and informal contacts. Students may change advisors subsequently with the advice and consent of the Director of Graduate Studies.

2. CURRICULUM

The program will require a minimum of 18 months of study and may be completed as either Plan A (with thesis) or Plan B (without thesis). Students in both plans must complete a minimum of 14 credits in the major, which includes credit for four core courses in dental education (Teaching and Evaluation in Dentistry); basic research methodology (Methods in Research and Writing); introductory biostatistics (Biostatistics I or equiv.); and fundamentals of health care administration (Principles of Management in Health Services Organizations). At the discretion of the student’s advisor and the Director of Graduate Studies, core course requirements may be waived upon demonstration of previous completion of equivalent course(s) at the University of Minnesota or elsewhere. All students must complete a related field or a minor option of at least 6 credits, as well as training in research ethics per Graduate School requirements. Potential related field offerings of likely interest to Dentistry Program students are listed in Appendix A, while potential minors of possible interest are listed in Appendix B. Courses for credit in the major may also be taken from other disciplines outside to the Dentistry Program with the approval of the student’s advisor and the Director of Graduate Studies.

**Plan A Program:** In addition to the requirements outlined above, students in the Plan A program will complete a research project under the supervision of the faculty, and write and successfully defend a thesis. The Graduate School requires that Plan A students register for at least 10 Master’s thesis credits (DENT 8777) before receiving the degree. A final oral examination is required. Students will be encouraged to submit their thesis in the form of one or more manuscripts or published papers for the scientific literature in keeping with current Graduate School policies.

**Plan B Program:** Plan B students will not complete a thesis, but take an additional 10 credits of coursework and submit three Plan B papers. Titles of the three Plan B papers should be submitted with the student’s program registration no later than the second semester of enrollment. Papers may consist of
critical reviews of literature, comprehensive clinical case reports, or research papers. At least one of the three Plan B papers involves the reporting of research information conducted under the guidance of a faculty member. Research papers may be based on experimental work and discussions conducted as part of a tutorial experience arranged with the faculty. There is no specified format or length for Plan B papers. Their content and scope will be determined in consultation with the faculty supervising each paper. The student will defend the three Plan B papers via an oral examination.

3. **ADMISSION REQUIREMENTS**

Applicants must have received a D.D.S or D.M.D. degree from an accredited U.S. institution. Students with comparable foreign degrees from recognized colleges or universities may also apply for admission. Applications from individuals who have already completed, or are enrolled in, an advanced clinical training program (e.g., general dentistry or specialty residency program) are encouraged. As per Graduate School Requirements, an undergraduate grade point average (GPA) of 3.0 is the preferred performance level for admission. Applicants for whom English is a second language must also take the Test of English as a Foreign Language (TOEFL). The preferred performance levels on the TOEFL are as follows:

- Paper-Based Total Score: 600
- Computer Based Total Score: 250
- Internet Based Total Score: 80

The graduate program in Dentistry is designed for individuals who have a strong desire and capacity to prepare for careers in advanced clinical care, dental education, research, or program administration as evidenced by three letters of recommendation from individuals familiar with their academic capabilities. Also required is a brief essay (under 500 words) which relates the applicant’s career goals to the goals of the program. Applications will be received and reviewed throughout the year. Students may enter the program in any semester.

4. **COMMITMENT TO DIVERSITY:**

The M.S. Dentistry Program and the Graduate School embrace the University of Minnesota’s position that promoting and supporting diversity among the student body is central to the academic mission of the University. A diverse student body enriches graduate education by providing a multiplicity of views and perspectives that enhance research, teaching, and the development of new knowledge. A diverse mix of students promotes respect for, and opportunities to learn from other with the broad range of backgrounds and experiences that constitute modern society. Higher education trains the next generation of leaders of academia and society in general, and such opportunities for leadership should be accessible to all members of society. The M.S. Dentistry Program and the Graduate School are therefore committed to providing equal access to educational opportunities through recruitment, admission, and support programs that promote diversity, foster successful academic experiences, and cultivate the leaders of the next generation.

5. **EVALUATION OF STUDENT PROGRESS**

A. Minimum Grade Point Average (GPA) Requirements: Students in the Dentistry Graduate Program must maintain a cumulative GPA of at least 3.0 and no more than 6 incomplete credits in order to remain in good standing within the program. This standard is higher than the minimum Graduate School requirements for M.S. candidates. A student who does not obtain a GPA of 3.0 in any one semester will be placed on academic probation for the following semester. Students who, for two consecutive semesters, have a cumulative GPA of less than 3.0 will be terminated from the program. A minimum cumulative GPA of at least 2.8 in MS Dentistry Degree Program coursework is required for graduation.

B. Data Requirements: Students must also satisfy all Graduate School requirements for the M.S. degree as outlined in the Graduate School Bulletin.

C. Concurrent Residency and M.S. Studies: Students who are enrolled in an advanced clinical dental training program (general dentistry or specialty residency) may be admitted to the Dentistry graduate program for concurrent study. However, students must carefully plan their studies with their faculty advisor and the Director or Graduate Studies so that their residency and the M.S. programs can be
integrated while accommodating University policies prohibiting simultaneous registration in two colleges. Up to 40 percent of the credits required for the M.S. degree program that are taken outside of the University of Minnesota from another recognized institution or source may be transferred for credit at the discretion of the student’s advisor and the Director of Graduate Studies in accordance with University policies.

6. LEAVES OF ABSENCE

Graduate students are now permitted to take a leave of absence per Graduate School Policies. A leave of absence allows students to return to the University under the same rules and policies that were in place when they left, and without affecting their time to degree.

MS-Dentistry graduate students who are enrolled in clinical residency programs and/or receive fellowships, stipends, or other financial aid from the University must talk with their program director and/or department, Student Financial Aid, International Student and Scholar Services, or a One Stop counselor to learn about any effects a leave of absence will have on completion of their residency training and financial support or student loan repayments. Students who receive funding from a source outside of the University should talk with that agency to learn about any effects a leave of absence might have.

During the period of an approved leave of absence, students may not use student amenities and services, laboratories, equipment, and other research facilities, nor may they use the services of faculty or administrative staff, except as needed to return to active status. For more information and leave request forms, please refer to the complete policy:

http://www.policy.umn.edu/Policies/Education/Education/GRADSTUDENTLEAVE.html

7. DENTISTRY COURSES*

Listed below are the core required courses for the Dentistry M.S. Program, along with those interdisciplinary graduate level courses in the focus areas of teaching, administration, and clinical care that will be taught by program faculty. Additional related field courses are also included in Appendix A. Descriptions of these courses may be found in the Graduate School Bulletin or online at http://www.catalogs.umn.edu/courses.html under Twin Cities campus courses.

A. CORE COURSES (REQUIRED)

Dent 7033 – Teaching and Evaluation in Dentistry (3 cr.)

OBio 5001 – Methods in Research and Writing (2 cr.)

PubH 6751 – Principles of Management in Health Services Organizations (2 cr.); or PubH 6724 – The Health Care System and Public Health (3 cr)

PubH 6414 – Biostatistical Methods I (3 cr.) or PubH 6450 Biostatistics I (4 cr.)¹

B. DENTISTRY PROGRAM CLINICAL ELECTIVES

Dent 7021 – Contemporary Diagnosis and Management of Orofacial Pain (1 credit)
Dent 7031 – Advanced Seminar in Clinical Geriatric Dentistry (2 credit)
Dent 7051 – Advanced Theory and Principles of Oral Medicine (2 credit)
Dent 7052 – Oral and Maxillofacial Radiologic Interpretation (2 credits)
Dent 7061,7062 – Special Oral Pathology I and II (2 credits)
Dent 7101 – Management Philosophy for Dental Practices (1 credit)
Dent 7102 – Conscious Sedation (2 credits)
Dent 7111 – Current Literature Review in Dentistry (2 credits)
Dent 7112 – Treatment Planning Seminar (2 credits)
Dent 7121 – Psychological Issues in Medical and Dental Patient Mgmt (1 cr.)
Dent 7122 – Advanced Topics in TMD: Issues in Pain, Focus on Head and Neck (3 credits)

¹ PubH 6450, Biostatistics I is a more intensive course.
Dent 7991 – Independent Study (1-4 credits) Staff
Dent 8031 – Topics and Problems in Dental Education (credits arr.)
Dent 8090 – Evidence-based Clinical Pediatric Dentistry (2 credits)
Dent 8091 – Interdisciplinary Care of the Cleft Palate Patient (1 credit)
Dent 8100 – Topics in Advanced Periodontology: Literature Review (2 credits)
Dent 8101 – Dental Implantology: A Multidisciplinary Approach (2 credits)
Dent 8120 – Advanced Principles and Techniques of Orofacial Pain Disorders (3 credits)
Dent 8121 – Current Literature in TMJ and Craniofacial Pain (1 credit)
Dent 8123 – Advanced Topics in Orofacial Pain (3 credits)
Dent 8333 – FTE: Advanced Master’s Status (1 credit)
Dent 8777 – M.S. Thesis Credits (variable 1 – 10 credits)

* Note: Course availability is subject to change and should be verified by students at least one semester in advance of planned registration.
APPENDIX A: COURSE LISTING*

REQUIRED COURSES FOR THE DENTISTRY MAJOR

- Dent 7033 - Teaching and Evaluation in Dentistry (3 cr.)
- OBio 5001 - Methods in Research and Writing (2 cr.)
- PubH 6414 - Biostatistical Methods I (3 cr.); PubH 6450 Biostatistics I (4 cr.)\(^1\) or equivalent
- PubH 6751 - Principles of Management in Health Services Organizations (2 cr.)
  OR PubH 6724 - The Health Care System and Public Health (3 cr)

EXAMPLES OF OTHER COURSES COUNTED FOR CREDIT IN THE MAJOR

<table>
<thead>
<tr>
<th>Focus Area</th>
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<tbody>
<tr>
<td>1. Education</td>
<td>Dent 8031 - Topics and Problems in Dental Education (cr. arr.)</td>
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<td>Grad 8101 - Teaching in Higher Education (3 cr.)</td>
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<td>Grad 8150 - Practicum for Future Faculty (3 cr.)</td>
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<td>Grad 8200 - Professional Communication Skills (2 cr.)</td>
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<td>EPsy 5115 - Psychology of Adult Learning and Instruction (3 cr.)</td>
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<td>EPsy 5221 - Basic Principles of Educational Measurement (3 cr.)</td>
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| 2. Research    | Dent 8777 - Thesis Credits: Masters required, Plan A only (10 cr.)     |
|                | PubH 6301 - Fundamentals of Clinical Research (3 cr.)                   |
|                | PubH 6320 - Fundamentals of Epidemiology - online course               |
|                | PubH 6341 - Epidemiologic Methods I (3 cr.)                            |
|                | PubH 6342 - Epidemiologic Methods II (3 cr.)                           |
|                | PubH 6415 - Biostatistical Methods II (3 cr.)                           |
|                | PubH 6451 - Biostatistics II (4 cr.)                                   |
|                | PubH 7420 - Clinical Trials (3 cr.)                                    |

| 3. Administration | Dent 7101 - Management Philosophy for Dental Practices (1 cr.)         |
|                   | PubH 6557 - Healthcare Finance I (3 cr.)                               |
|                   | PubH 6547 - Healthcare Human Resource Management (2 cr.)               |
|                   | PubH 6556 - Health and Health Systems (2 cr.)                           |
|                   | PubH 6541 - Statistics for Health Management Decision Making (3 cr.)   |
|                   | PubH 6568 - Inter-professional Teamwork in Health Care (2 cr.)         |
|                   | PubH 6558 - Healthcare Finance II (3 cr.)                              |

|                           | Dent 7051 - Advanced Study in the Theory and Principles of Oral Medicine (2 cr.) |
|                           | Dent 7052 - Oral and Maxillofacial Radiologic Interpretation (2 cr.) |
|                           | Dent 7061 - Special Oral Pathology I (0 cr.)                          |
|                           | Dent 7062 - Special Oral Pathology II (2 cr.)\(^3\)                   |
|                           | Dent 7101 - Management Philosophy for Dental Practices (1 cr.)        |
|                           | Dent 7102 - Topics in Conscious Sedation (2 cr.)                      |
|                           | Dent 7111 - Current Literature Review in Dentistry (2 cr.)            |
|                           | Dent 7112 - Treatment Planning Seminar (2 cr.)                        |
|                           | Dent 7991 - Independent Study (1-4 cr.)                               |
|                           | Dent 8090 - Evidence-based Clinical Pediatric Dentistry (2 cr.)        |
|                           | Dent 8091 - Interdisciplinary Care of Cleft Palate Patient (1 cr.)     |
|                           | Dent 8100 - Topics in Advanced Periodontology (2 cr.)                 |
|                           | Dent 8101 - Dental Implantology: A Multidisc. Approach (2 cr.)        |
|                           | Dent 8120 - Adv. Prin. & Tech. of TMJ/Craniofacial Pain (3 cr.)       |

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\(^1\) PubH 6450, Biostatistics I is a more intensive course.
\(^2\) Other existing coursework in Oral Biology, Biomaterials, Immunology, and other areas pertinent to multiple dental disciplines can also be taken for credit in this category.
\(^3\) Dent 7061 & Dent 7062 is a sequential course. Students need to take both sessions to receive credit.
4. Clinical Sciences² (continued)

- Dent 8121 - Current Lit. in TMJ & Craniofacial Pain (1 cr.)
- Dent 8123 - Advanced Topics in Orofacial Pain (3 cr.)
- Anat 7999 - Head & Neck Anat. for Med/Dent Residents (3 cr.)
- OBio 8011 - Oral Biology (2 cr.)
- OSur 5277 - Physical Diagnosis (2 cr.)
- Gero 5110 - Biology of Aging (3 cr.)

* Note: Course availability is subject to change and should be verified by students at least one semester in advance of planned registration

TRAINING IN THE RESPONSIBLE CONDUCT OF RESEARCH

All students are required to complete formal training in the responsible conduct of research as part of their graduate education. To fulfill this requirement, MS-Dentistry Students must complete the online Collaborative Institutional Training Initiative (CITI) course in Responsible Conduct of Research:

https://www.citiprogram.org

To supplement this course, graduate faculty and students are encouraged to incorporate discussions of research ethics into their existing didactic courses, seminars, research projects, and advising wherever possible. The following bibliography of pertinent articles is offered to facilitate such discussions:

**Bibliography -- Ethics in Dental Research**


² Other existing coursework in Oral Biology, Biomaterials, Immunology, and other areas pertinent to multiple dental disciplines can also be taken for credit in this category.
APPENDIX B: POTENTIAL MINOR PROGRAMS

(Note: This list provides a few examples only. Students must consult with the Director of Graduate Studies for the Minor Field of interest to them to verify eligibility and specific requirements. If a Minor Field is selected, one examiner from that Minor must also serve on the student’s final examination committee.)

1. Public Health Minor (M.S. level)
   
   Credit Requirements: 8 semester credits
   
   Courses:
   1) PubH 6341 - Epidemiologic Methods I (3 cr.)
   2) PubH 6414 - Biostatistics I (3 cr)
   3) PubH 6102 - Issues in Environmental & Occupational Health (2 cr)
   4) Electives

2. Educational Psychology Minor (M.S. level)
   
   Credit Requirements: 6 semester credits
   
   Courses: Any graduate level courses in EPsy

3. Gerontology Minor (M.S. level)
   
   Credit Requirements: 8 semester credits
   
   Courses:
   1) Gero 5105 - Multidisciplinary Perspectives on Aging (3 cr)
   2) Electives in one of four tracks in aging-related courses (5 cr)
APPENDIX C

Masters Examination Committee Information
(see: http://www.grad.umn.edu/students/examiningcommitteesnew/index.html)

The MS-Dentistry Program requires that examination committee members have Graduate Education Responsibilities in the field they represent (major field or minor/outside field). Advisers and committee members must also meet college-specific requirements to carry out graduate education responsibilities. Please note that not all faculty members teaching in the School of Dentistry have Graduate Education Responsibilities in the MS-Dentistry Program.

Verification of faculty in the major field of Dentistry and/or minor-outside fields (e.g., Oral Biology, Public Health, etc.) can be found by searching via faculty name or graduate program at:

https://apps.grad.umn.edu/programs/faculty.aspx

Final examination committee:
The final examination committee must consist of at least three members, including the adviser/s. All members of the committee and the student must participate in the final examination.

- At least one member must represent a field outside the student’s major field.
- If the student has a declared minor(s), the outside member(s) must be from the minor field(s).
- Members cannot satisfy the requirement with respect to more than one field.

Adviser:

- Must represent the major field on the examination committee.
- May serve as chair for the final examination

Co-adviser (if any):

- May represent the major field or the outside/minor field
- May serve as chair for the final examination.

Thesis reviewers (Plan A only):

- Assigned committee members also serve as thesis reviewers for the Plan A.
Graduate Program in Prosthodontics Core Curriculum
Outline

Listed below are the core required courses for the Dentistry MS Program

**Dent 7033 Teaching and Evaluation in Dentistry (3 credits) Born, Bebeau**
This course introduces students to specific concepts and tools that will help them plan and implement dental education programs, to provide participants with practical teaching experiences, and to promote critical thinking about teaching and student assessment (and evaluation) in dentistry. Through classroom activities, reflection and analysis, and assignments, students will explore and develop teaching skills that promote learning in the dental practice, in continuing education settings, and in the formal classroom.

**OBio 5001 Methods in Research and Writing (2 cr.) Michalowicz, Rudney**
This course focuses on the development of basic research skills including the preparation of a research proposal typically related to an MS program project. The purpose of this course is to help you plan your graduate research project by following these steps: begin a critical review of the literature, identify a problem worthy of investigation, formulate a specific hypothesis, develop a study design, and give two oral presentations describing various components of your research proposal and prepare a written proposal.

**PubH 6414 Biostatistical Methods I (3 credits) Menk**
This is a basic course in biostatistics that includes descriptive statistics, probability models, and several fundamental hypothesis-testing techniques.

**PubH 6751 Principles of Management in Health Services Organizations (2 credits) Begun**
This course draws primarily from the fields of organizational theory and behavior to equip students with management and leadership competencies that enable them to make a positive difference in their work organizations and in the health of populations. In addition to facilitating more effective management and leadership, the competencies enable those who will not be in management positions to better understand managers and to more effectively contribute to their organizations.
Graduate Program in Prosthodontics Overall Curriculum Outline

**Seminars**
Residents participate in a number of seminars conducted each year during the fall and spring semesters. These seminars are designed to provide an interactive learning experience. Residents are expected to actively participate based on their understanding of the dental literature, the scientific method and their developing clinical experience.

**Dent 7111 Current Literature Review in Dentistry (2 credits) Conrad**
This course reviews articles taken from the “Current Literature” of the discipline of Prosthodontics. Topics covered include (but are not limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and Implant Prosthodontics. Residents will develop the capacity and competence to comprehend, interpret, and express verbally a complete understanding of the article presented and the ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.

**Dent 7112 Treatment Planning Seminar (2 credits) Conrad**
This seminar is designed to assist residents in being able to meet related goals and objectives of the Graduate Program in Prosthodontics as listed in the programs Resident Training manual. Specifically, Goal #1 “To develop the diagnostic and treatment planning skills necessary for successful provision of complex Prosthodontics treatment” and Objective #1 “To ensure successful completion and presentation of treatment plans for patients requiring complex restorative care as required in the Prosthodontics treatment planning seminar course”. To accomplish this task, the seminar incorporates two approaches. The first approach requires a resident to present a detailed treatment plan (on a scheduled basis using a described format) for a number of complex patients over the thirty-three months of his / her program. The resident will also be expected to share the results of any treatment completed for these same patients (using a described format). The second approach uses scheduled presentations by faculty and guests (using a seminar format) to address topics related to the ability to successfully treatment plan / treat patients requiring complex restorative care.

**DENT 7220 Prosthetically-Driven Implant Surgery and Treatment Planning (1 credit) Conrad, Birdi**
The objectives of this course are to provide in-depth didactic instruction in: patient selection & treatment planning for implant therapy from simple cases to esthetically demanding cases to full-arch cases, indications & contra-indications of various types of implants with respect to final restoration, surgical anatomical considerations, flap design, suture types and suturing methods, materials and methods for socket grafting and ridge augmentation, surgical placement of implants, immediate versus delayed implant placement protocols, management of surgical complications, maintenance of dental implants, the management and prevention of peri-implantitis. Upon completion of this course, residents will clinically be able to plan treatment, perform dental implant surgeries and simple bone grafting procedures with an advanced understanding of the anticipated and desired prosthetic result. The residents will also be able to distinguish important anatomical landmarks for implant surgeries and how to deal with potential complications.
Dent 7322 Multidisciplinary Treatment Seminar (1 credit) Hinrichs
This class will utilize DVD videos of national and internationally recognized experts employing a lecture format followed by an in-depth discussion of the topic. A selected list of references to be cited by that day’s lecturer will be distributed to course participants prior to class so they can read the articles in order to establish their biological rationale for employing the therapy and thereby contribute to the discussion. This course is intended to enhance the participants aware of the following treatment approaches and their biological rationale: use of bone grafting procedures to re-establish horizontal/vertical dimensions of edentulous ridges, restoring and preserving soft tissue esthetics around implants, provisional restorations for dental implants, and periodontal plastic surgery procedures to enhance esthetics for teeth.

Pero 7321 Periodontics/Orthodontics Seminar (1 cr.) Hinrichs, Langsjoen
This course will present a series of lectures that explain the rationale for combined orthodontic and periodontal treatment for malocclusion cases that have experienced periodontal disease. The course objectives are to: 1) enhance the orthodontist’s periodontal diagnostic and treatment planning skills of malocclusion cases with periodontitis. 2) enhance the periodontist’s understanding of orthodontic treatment options for malocclusions and 3) illustrate how joint treatment efforts by an orthodontist and a periodontist can be combined to result in successful treatment of malocclusions for patients that have experienced periodontal disease.

Pros 7110 Classic Prosthodontic Literature Review (2 credits) Holtan
This course reviews articles taken from the “Classic Literature” of the discipline of Prosthodontics. Topics covered include (but are not limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and Implant Prosthodontics. Residents will develop the capacity and competence to comprehend, interpret, and express verbally a complete understanding of historically-based, widely accepted philosophies and principles in prosthodontics, the aptitude to discuss the scientific merit of the article in question, and the ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.
Didactic Courses

Anat 7999 Head and Neck Anatomy (3 credits) Cook
This course includes a detailed examination of head and neck anatomy from the gross morphological, functional, developmental, and radiographic aspects. The objectives are to understand regional anatomy of the head and neck, to demonstrate 3-dimensional relationships of structures in the head and neck, to be able to correlate head and neck anatomy with common clinical procedures, and to be able to perform and interpret cranial nerve testing.

Dent 7033 Teaching and Evaluation in Dentistry (3 credits) Born (*Core Course)
This course introduces students to specific concepts and tools that will help them plan and implement dental education programs, to provide participants with practical teaching experiences, and to promote critical thinking about teaching and student assessment (and evaluation) in dentistry. Through classroom activities, reflection and analysis, and assignments, students will explore and develop teaching skills that promote learning in the dental practice, in continuing education settings, and in the formal classroom.

Dent 7051 Advanced Principles and Practice of Oral Medicine (2 cr) Rhodus
This is a reading, lecture, and case-based, course designed to expand upon the graduate students understanding of medical-systemic problems encountered in dental practice and to emphasize the principles of recognition and management of dental patients with medical problems. The foundation upon which the principle of medical management is based is thorough evaluation and recognition of the medically compromised patient. The series of lectures in this course will be dedicated to these objectives. A thorough understanding of the textbook is essential to accomplishing the specific objectives.

Dent 7052 Oral and Maxillofacial Radiologic Interpretation (2 cr) Ahmad
This course consists of a systematic study of intraoral and extraoral radiographs emphasizing radiographic, anatomy; radiologic interpretation of developmental and acquired anomalies of teeth, osseous structures, maxillary sinus and temporomandibular joints and manifestations of systemic diseases in jaws and associated structures. The purpose of this course is to assist students to recognize radiographic patterns of normal tissues and to detect and to evaluate radiographic evidence of deviations from normal so that they can make valid recommendations and judgments on the basis of radiographs alone or in conjunction with other procedures in arriving at a differential diagnosis, a tentative diagnosis, and the definitive or final diagnosis, treatment plan and prognosis. Emphasis is placed on developing the ability to use concepts already learned in oral and general pathology and basic biological science courses in understanding and evaluating the nature of the disease process.

Dent 7061/62 Special Oral Pathology I & II (2 cr) Rohrer
This course of advanced oral and maxillofacial pathology is for residents/graduate students. The emphasis will be on clinical-pathologic correlation of diseases of the oral and maxillofacial region. The course will be a discussion format with student descriptions of pathologic conditions from clinical and radiographic images, student descriptions of histopathology from biopsy material, and discussion of disease management.

Dent 7102 Conscious Sedation (2 cr) Hinrichs
This course will utilize a seminar-discussion format. Each participating individual will be expected to have read that day's assignment prior to class and be prepared to contribute to the discussion. This
course is designed to enhance the student's knowledge and ability to a) assess physical risk for dental patients, b) recognize and manage ECG dysrhythmias, c) administer local anesthetics and manage any associated complications, d) know the advantages, limitations and be able to manage possible complications associated with the administration of agents used to control anxiety during dental procedures [including the following routes of administration: oral, intramuscular, inhalation and intravenous] and e) prevent, recognize and manage medical emergencies which might arise within the dental setting.

Dent 7123 Temporomandibular Disorders and Orofacial Pain (1 cr) Nixdorf
The purpose of this course is to provide graduate students with the basic didactic information needed to recognize and manage patients with temporomandibular disorders. It will also give an overview of the scope and complexity of the clinical practice of TMD and Orofacial Pain management. At the conclusion of this course, graduate students will be able to: delineate the scope of practice within the area of TMD & Orofacial Pain, outline the components of a patient history needed to obtain a diagnosis of TMD, outline the components of a physical exam needed to obtain a diagnosis of TMD, know the general differential diagnosis for pain presenting in the orofacial region, provide patients with TMD self-care, provide medical management for patients with acute TMD pain, explain various treatment options available for TMD patient care, discuss the various care providers, and their roles, typically involved in TMD patient care, list the various types of pain that may present in the orofacial region, apply diagnosis and treatment planning skill to patients in the TMD and Orofacial Pain Clinic.

Dent 7411 Dental Biomaterials in Prosthodontics (1 cr.) Aparicio
Almost every course of dental treatment involves the use of biomaterials. This is particularly relevant in the field of prosthodontics. Use of the wrong material, or wrong usage of the correct material, can contribute significantly to failure of treatment. Thus the general course purpose is stated as: “the application of scientific principles to the selection and utilization of dental biomaterials in prosthodontics.” The emphasis will be in understanding (i) the structure-properties relationship and (ii) the role and performance of synthetic materials in a living environment.

Dent 8100 Topics in Advanced Periodontology: Literature Review Bacteriology/Immunology (2 cr.) Costalonga
Discussion and/or lecture presentations addressing recent literature as related to etiology and pathogenesis of periodontal diseases. The course will be directed to graduate students in periodontology and other interested students in postgraduate programs in the School of Dentistry.

Dent 8101 Dental Implantology: A Multidisciplinary Approach (2 cr.) Hinrichs
The objectives of this course are to provide in-depth didactic instruction in: historical development of implants, biological principles of dental implants, indication & contra-indications of various implants, prosthetic requirements of dental implants, patient selection & treatment planning for placement of implants, use of appropriate sterile & aseptic techniques, surgical preparation of implant sites, surgical placement of implants, prosthodontic principals for restoring implants, construction of provisional restorations for dental implants, impression and scanning techniques used in conjunction with fabrication of restorations, maintenance of dental implants, the management of peri-implantitis, and the surgical removal & replacement of implants.

Obio 5001 Methods in Research and Writing (2 cr.) Michalowicz, Rudney (*Core Course)
This course focuses on the development of basic research skills including the preparation of a research proposal typically related to an MS program project. The purpose of this course is to help you plan your
graduate research project by following these steps: begin a critical review of the literature, identify a problem worthy of investigation, formulate a specific hypothesis, develop a study design, and give two oral presentations describing various components of your research proposal and prepare a written proposal.

**Pros 7171 Principles of Maxillofacial Care (2 credits) Brosky**

This course introduces the residents to literature and patient care in maxillofacial prosthodontics. The goal of the course is to didactically provide adequate knowledge and understanding of Maxillofacial Prostodontic/Prosthetic principals so that the Prosthodontic resident has an understanding of this specific patient population. i.e., Maxillectomy, Mandibullectomy, Cleft lip and Cleft Palate, Craniofacial, and Trauma patients. This information and knowledge will allow the resident answer basic questions proposed by this specific patient population as to potential treatment options and outcomes. i.e., complete dentures, removable partial dentures, implants prosthodontics (fixed or removable), speech prosthesis, obturators, extra-oral prosthetics, and pre-radiation dental screening.

**PubH 6414 Biostatistical Methods I (3 credits) Menk (*Core Course)**

This is a basic course in biostatistics that includes descriptive statistics, probability models, and several fundamental hypothesis-testing techniques. At the conclusion of the course, the students will be able to recognize fundamentals of biostatistics in health-related fields, calculate basic descriptive statistics, use a statistical software package to graphically display data, have a basic understanding of probability models and how these relate to statistics, estimate population parameters from sample data and calculate confidence intervals, understand the principles of hypothesis testing and the correct interpretation of hypothesis test results, generate regression analysis and ANOVA summaries and correctly interpret the results, determine the appropriate test to use based on how the data were collected and on the outcome variable of interest.

**PubH 6751 Principles of Management in Health Services Organizations (2 credits) Begun (*Core Course)**

Principles of Management in Health Services Organizations draws primarily from the fields of organizational theory and behavior to equip students with management and leadership competencies that enable them to make a positive difference in their work organizations and in the health of populations. In addition to facilitating more effective management and leadership, the competencies enable those who will not be in management positions to better understand managers and to more effectively contribute to their organizations. After completing this course, students will be better able to describe and understand the key competencies of managers of healthcare and public health organizations, understand their own strengths and weaknesses in management competencies, communicate with and mentor others in the workplace, effectively contribute to organizational teams and teamwork, use participative decision-making in groups and organizations, apply quality and performance improvement concepts to address organizational performance issues, manage interpersonal conflict in the workplace, develop and communicate organizational vision/mission/goals/objectives, mange change in organizations, use power and politics for personal and organizational effectiveness, communicate clearly and concisely in writing, and espouse a collaborative leadership philosophy.
### Clinical Experiences

Residents are assigned complex patients whose treatment needs may require the use of fixed, removable, and/or implant prosthodontics. Each patient assigned receives a comprehensive evaluation. This evaluation is followed by the development of a comprehensive treatment plan that must be reviewed and signed by a faculty member prior to the initiation of any actual patient treatment. Resident clinical progress is monitored by faculty on a daily basis and by evaluating their performance during treatment planning seminars. Written grading instruments are used for this seminar performance evaluation. Following completion of the seminar, the performance evaluation is reviewed with the resident by the program director. Resident clinical performance is closely tied to their understanding of the literature. Accordingly, their performance in current and classic literature seminars is evaluated using written instruments. Residents overall performance is evaluated at the end of each semester. Residents are given the opportunity to formally discuss this semester end evaluation (as well as any other evaluation) with the program director.

In addition, first and third year residents participate in a clinical rotation in prosthodontics at Hennepin County Medical Center, Dental Clinic. The objective for this rotation is to give residents additional exposure to techniques related to all areas of prosthodontics, including maxillofacial prosthodontics. The teaching staff consists of Dr. Brandon DeWitt, a Prosthodontist and Dr. Todd Lund, a Maxillofacial Prosthodontist. The rotation for each resident will be for one day per week for three to four months in each of their first and third years. Drs. DeWitt and Lund provide a written evaluation of the individual resident performance on completion of his/her rotation to the Program Director.

**Pros 7200 Advanced Clinical Prosthodontics (5 credits) Conrad, Dryer, Seong**

This course is the clinical training portion of the Advanced Education Program in Prosthodontics. This course runs continuously (M-F) for the entire thirty-three month long program and represents approximately 60% of a resident’s educational time commitment. This course offers clinical instruction in all areas of prosthodontics, i.e., complete dentures, fixed partial dentures, removable partial dentures, and implant prosthodontics. It is designed to assure sufficient clinical experiences for a resident to become proficient in the comprehensive treatment of a wide range of complex prosthodontic patients.

**Pros 7210 Advanced Technical Restorative Dentistry (2 credits) Conrad, Adarve, Seong, Stendahl, Holtan**

This course encompasses the disciplines of complete dentures, fixed partial dentures, removable partial dentures, and implant prosthodontics (dental materials are interspersed as appropriate). For the most part, each section will utilize demonstrations, clinical exercises, laboratory exercises, assigned readings, and a seminar format to accomplish the overall goals and objectives.

### Clinical Requirements

- Complete dentures (including immediate dentures) – 30 units
- Removable partial dentures – 10 units
- Crowns – natural teeth – 80 units
- Crowns – implants – 80 units
- Implant dentures – 7 units
- Implant placement – 20 units
Graduate Program in Prosthodontics Program Training
Schedule
### Advanced Education Program in Prosthodontics

#### June 2014 | Year 1

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Advanced Education Program in Prosthodontics
# November 2014 | Year 1

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**Advanced Education Program in Prosthodontics**

**AAFP Conference**
February 27 - 28, 2015
Marriott Downtown Chicago

**Dent 7033 - Teaching and Evaluation in Dentistry - Dr. Bebeau - Thursdays 5:00-7:00 pm**

**Dent 7052 - Oral/Max Radiol Interp - Dr. Ahmad - Tues 7:45-9:45 am - **even calendar years**

**Dent 7111 - Current Literature Review Seminar - Dr. Conrad - Fridays 8:00-9:30 am**

**Dent 7112 - Treatment Planning Seminar - Dr. Conrad - Wednesdays 12:00-1:00 pm**

**Dent 7322 - Multidisciplinary Tx Sem - Dr. Hinrichs - Wed 6:00-7:30 pm **odd calendar years**

**Dent 8100 - Bacterio/Immuno - Dr. Costalonga - Tuesdays 9:15-11:00 am **odd calendar years**

**Dent 8777 - MS Thesis Credits**

**Pero 7321 - Periodontics/Orthodontics Seminar - Thurs 12:05-12:50 pm **odd calendar years**

**Pros 7110 - Classic Literature Review Seminar - Dr. Holtan - Wednesdays 8:00-9:30 am**

**Pros 7200 - Adv Clinical Prosthodontics - Drs. Conrad, Dryer, Seong - 8:00 am-4:00 pm**
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### May 2015 | Year 1

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**Note:** All residents are encouraged to attend the Annual Meetings/Sessions of the:

- **American Academy of Maxillofacial Prosthetics**
  - November 1 - 4, 2014 - New Orleans, Louisiana - The Westin
  - Before July 2 - $175
  - July 2 - Oct 12 - $275
- **American College of Prosthodontists**
  - November 5 - 8, 2014 - New Orleans, Louisiana - Hyatt Regency
  - Before Sept 21 - $165
  - After Sept 21 - $265
- **American Academy of Fixed Prosthodontics**
  - February 27 - 28, 2015 - Chicago, Illinios - Marriott Downtown
  - After Oct 12 - $350
- **ACP Registration**
  - $145
- **AAFP Registration**
  - $145

**Welcome Breakfast**
8:15 - 9:00 am

**Welcome Lunch**
11:30 am to 1:00 pm

**AAMP Registration**
Before July 2 - $175
After July 2 - $275

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### November 2014 | Year 2

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<td>9-10 Dent 7102 - Conscious Sedation - Dr. Hinrichs - Tuesdays 10:00 am - noon</td>
<td>10-11 Dent 7111 - Current Literature Review Seminar - Dr. Conrad - Fridays 8:00-9:30 am</td>
<td>11-12 Dent 7112 - Treatment Planning Seminar - Dr. Conrad - Wednesdays 12:00-1:00 pm</td>
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<td>3-4 Pros 7110 - Classic Literature Review Seminar - Dr. Holtan - Wednesdays 8:00-9:30 am</td>
<td>4-5 Pros 7200 - Adv Clinical Prosthodontics - Drs. Conrad, Dryer, Seong - 8:00 am-4:00 pm</td>
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**Advanced Education Program in Prosthodontics**

**February 2015 | Year 2**

- **8-9**: Dent 7052 - Oral/Max Radiol Interp - Dr. Ahmad - Tues 7:45-9:45 am - **even calendar years**
- **9-10**: Dent 7062 - Special Oral Pathology II - Dr. Rohrer - Thursdays 3:30-5:00 pm
- **10-11**: Dent 7111 - Current Literature Review Seminar - Dr. Conrad - Fridays 8:00-9:30 am
- **11-12**: Dent 7112 - Treatment Planning Seminar - Dr. Conrad - Wednesdays 12:00-1:00 pm
- **12-1**: Dent 7322 - Multidisciplinary Tx Sem - Dr. Hinrichs - Wed 6:00-7:30 pm **odd calendar years**
- **1-2**: Dent 8100 - Bacterio/Immunology - Dr. Costalonga - Tuesdays 9:15-11:00 am **odd calendar years**
- **2-3**: Dent 8777 - MS Thesis Credits
- **3-4**: Pero 7321 - Periodontics/Orthodontics Seminar - Thurs 12:05-12:50 pm **odd calendar years**
- **4-5**: Pros 7110 - Classic Literature Review Seminar - Dr. Holtan - Wednesdays 8:00-9:30 am
- **5-6**: Pros 7200 - Adv Clinical Prosthodontics - Drs. Conrad, Dryer, Seong - 8:00 am-4:00 pm
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**Advanced Education Program in Prosthodontics**
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**Advanced Education Program in Prosthodontics**

**Note:** All residents are encouraged to attend the Annual Meetings/Sessions of the:

- **American Academy of Maxillofacial Prosthetics**
  - November 1 - 4, 2014 - New Orleans, Louisiana - The Westin
- **American College of Prosthodontists**
  - November 5 - 8, 2014 - New Orleans, Louisiana - Hyatt Regency
- **American Academy of Fixed Prosthodontics**
  - February 27 - 28, 2015 - Chicago, Illinios - Marriott Downtown

**AAMP Registration**
- Before July 22 - $175
- July 23 - Oct 11 - $275

**ACP Registration**
- Before Sept 21 - $165
- After Sept 21 - $265

**AAFP Registration**
- $145
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<td>8-9 Dent 7411 - Dental Materials - Dr. Aparacio - Thurs 3:00 - 5:00 pm</td>
<td>8-9 Pros 7200 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
<td>8-9 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
<td>8-9 Dent 8101 Dental Implantology Pros 7200 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
<td>8-9 Pros 7171 Maxillofacial Pros 8:00 am - 4:00 pm</td>
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<td>9-10 Pros 7200 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
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<td>10-11 Dent 8101 - Dental Implantology - Dr. Hinrichs - Thurs 9:00 - 11:00 am</td>
<td>10-11 Pros 7200 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
<td>10-11 Advanced Clinical Prosthodontics 8:00 am - 4:00 pm</td>
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Advanced Education Program in Prosthodontics
## September 2014 | Year 3

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<td>Dent 7111 Current Lit Review</td>
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### Advanced Education Program in Prosthodontics
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**Advanced Education Program in Prosthodontics**
### February 2015 | Year 3

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Advanced Education Program in Prosthodontics
## Advanced Education Program in Prosthodontics

### March 2015 | Year 3

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### Notes:
- **Monday, Tuesday, Wednesday, Thursday, Friday** refer to the days of the week.
- **Advanced Clinical Prosthodontics** courses are scheduled from 8:00 am to 4:00 pm.
- **Ad Clin Pros** refers to Advanced Clinical Prosthodontics.
- **Ad Clin** refers to Advanced Clinical.
- **Dent** refers to Dentistry.
- **Prosthodontics** courses are scheduled from 8:00 am to 4:00 pm.
- **Tx Planning Seminar** is scheduled at 1:00 - 4:00 pm.
- **MS Thesis Credits** is scheduled at 8:00 am - 4:00 pm.
- **Current Lit Review** is scheduled at 8:00 am - 4:00 pm.
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**Notice:** Good Friday Clinics Open

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**Advanced Education Program in Prosthodontics**
## May 2015 | Year 3

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<td>Clinics Closed</td>
<td>Memoria</td>
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<td>Memorial Day</td>
<td>Day</td>
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Advanced Education Program in Prosthodontics
Graduate Program in Prosthodontics Individual Course
Syllabi
University of Minnesota School of Dentistry  
Advanced Education Program in Prosthodontics  
Course Syllabus

DENT 7111  
Current Literature Review Seminar  
Fall & Spring Semesters  
Year 1, 2, 3

CONTACT INFORMATION FOR COURSE DIRECTOR
Course Director: Heather J. Conrad  DMD, MS, FACP, FRCD(C)  
Office Address: 9-176c Moos Tower  
Phone Number: 612-624-5046  
Email Address: conr0094@umn.edu  
Office Hours: M-F 8:00 am – 4:30 pm

COURSE PURPOSE

Overview
This current literature review course meets Friday mornings from 8:00 to 9:30 am during the fall and spring semesters of each academic year. Its purpose is to review articles taken from the “Current Literature” of the discipline of Prosthodontics. Topics covered include (but are not limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and Implant Prosthodontics. A seminar format is used to accomplish the goals and objectives listed below.

Goals
- To develop in the minds of Prosthodontics residents, an in-depth knowledge and understanding of current or newly developed philosophies / principles that are described in the “Current Prosthodontic Literature” that pertain to (but may not be limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and Implant Prosthodontics. Note: The learning process initiated in this seminar will be supported by numerous in-depth topic-specific seminars and clinical experiences over the thirty-three month period of the program.
To develop on the part of a resident in Prosthodontics, the ability to relate the knowledge base gathered from articles reviewed in this seminar course to the clinical care he / she will provide to patients requiring treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics.

**COURSE OBJECTIVES**

*Upon successful completion of DENT 7111, the resident dentist should be able to:*

- During this course (and following its completion), the resident will be able to demonstrate his / her ability to initiate and carry on a discussion of current or newly developed philosophies / principles underlying the clinical treatment of a patient with to Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics.

- During this course (and following its completion), the resident will be able to demonstrate his / her ability to provide clinical care that reflects current or newly developed philosophies / principles they have learned to a patient requiring treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics.

**REQUIRED TEXTBOOK AND READINGS**

- Required readings
  - Current literature articles distributed electronically weekly.

**CREDITS**

*DENT 7111 ➔ 2.0 credit hours*

**GRADING AND EVALUATION POLICIES**

*Guidelines for Participation in this Course*

Individual residents are assigned weekly by the course director to select 4 appropriate peer-reviewed manuscripts published in well recognized journals with relevant and current information on the specialty of prosthodontics including but not limited to complete dentures, fixed partial dentures, removable partial dentures, and implant prosthodontics (suggested topics are listed below). The resident assigned to the week is responsible for forwarding all selected articles to the faculty, program associate, and fellow residents electronically by 4:00 pm on the Friday preceding the resident’s Friday assigned seminar. Residents are expected to carefully read and understand all articles provided for each seminar. During the seminar, the resident who selected the articles is responsible to review the first article. Following that, the course director will ask (on a random basis) individual residents to summarize and identify salient points contained within the other remaining articles. Residents will also be expected to discuss the scientific merit of the article in question. The resident asked to review a particular article should expect his / her peers to actively participate in any discussion related to the article.
Evaluation Process for this Seminar
Successful completion of this Current Literature Review Seminar by individual prosthodontic residents will be determined by the course director using results of the weekly seminar grading forms. A copy of this form and the criteria for its use are attached. A resident’s ability to provide clinical care that reflects current or newly developed philosophies / principles they have learned to a patient requiring treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics will also be observed in the clinic by faculty and may have a bearing on the letter grade assigned.

Schedule & Topics
- See attached schedule.

<table>
<thead>
<tr>
<th>Implants</th>
<th>TMD</th>
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<tbody>
<tr>
<td>Microgap</td>
<td>TMD etiology</td>
</tr>
<tr>
<td>Implant design</td>
<td>Occlusion</td>
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<tr>
<td>Implant surface texture</td>
<td>Articulators</td>
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<tr>
<td>Implant spacing</td>
<td>Electronic pantographs</td>
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<tr>
<td>Implant survival rates</td>
<td>Computerized tomography</td>
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<td>Implant failures</td>
<td>Internal derangement</td>
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<td>Implant esthetics</td>
<td>Osteoarthritis of TMJ</td>
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<tr>
<td>Implant complications</td>
<td>Ceramic Systems</td>
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<tr>
<td>Interproximal papilla</td>
<td>Impression materials</td>
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<td>Implants &amp; cantilevers</td>
<td>Dental cements</td>
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<tr>
<td>Mini-implants</td>
<td>Gingival retraction techniques</td>
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<td>Sinus lift/graft</td>
<td>Gingival retraction agents</td>
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<tr>
<td>Ridge augmentation</td>
<td>Restoration of endodontically treated teeth</td>
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<tr>
<td>Implant length/diameter</td>
<td>Practice management</td>
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<tr>
<td>Immediate provisionalization</td>
<td>Prosthodontic demographics</td>
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<tr>
<td>Immediate loading</td>
<td>Geriatric prosthodontics</td>
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<tr>
<td>Implants with RPDs</td>
<td>Infection control/HIV/Hepatitis C</td>
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<tr>
<td>RPD design</td>
<td>Color/operatory lighting</td>
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<tr>
<td>Fixed partial dentures</td>
<td>Complete dentures</td>
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<td>Alloys</td>
<td>Treatment Planning</td>
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</tbody>
</table>

Assessment Format DENT 7111
- The course objectives can be achieved by reviewing and studying the reading assignments
- Professionalism and attendance are expected and required for all sessions.
• Participation is expected and required during the seminar.
• Final point accumulation is at the discretion of the course director.

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<thead>
<tr>
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<th>Grade</th>
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<tbody>
<tr>
<td>≥90%</td>
<td>A</td>
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<tr>
<td>80-89%</td>
<td>B</td>
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<tr>
<td>70-79%</td>
<td>C* (Probation at the discretion of the resident’s program director)</td>
</tr>
<tr>
<td>&lt;70%</td>
<td>F* (Remediation required with dismissal pending overall performance in program)</td>
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</tbody>
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Additional Notes
• The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
• Any change of venue will be announced during the lecture period or sent via email.
• Any student(s) found to have cheated, deceived, or procured help from another student(s) or individual during an examination will subject all parties involved to disciplinary actions that are consistent with the School of Dentistry and University policies.
• The administration and design of examinations will be at the discretion of the course director.

Student Expectations
The policy on grading and academic practices, remediation, attendance, and professional attire, can be found on the SOD website at:


Residents’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Residents will evaluate the course and faculty through the year end evaluation form and the evaluation of faculty form.

Distance Delivery of Course Material
This course does not offer distance delivery of the course material.

Grade Disputes
Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

Remediation Policies
Residents with an overall course grade of ‘C’ for DENT 7111 will be placed on probation during the following term at the discretion of the resident’s program director. Residents with an overall course grade of ‘F’ for DENT 7111 must remediate during the following term to the satisfaction of the resident’s program director. Residents may also be
considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

MAKE-UP EXAM POLICIES
Any scheduled examinations missed due a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

ATTENDANCE
Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

FEEDBACK
Any feedback is welcome and should be forwarded to the course directors by writing, emailing, or visiting the course director’s office.

STUDENT INTEGRITY
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

COMMUNICATION
All individual and full class communication will be through your University of Minnesota email account. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

STUDENT ON-LINE PRIVACY AND SECURITY
Any online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.

DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

**Mental Health Resources**
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

*Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006*

**Wellness Program for Dental Students**
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

**Appropriate Student Use of Class Notes**
Residents may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

**Changes Made in Response to Student Feedback**
Constructive criticism is welcomed to improve this course for future residents.

**Faculty Information**
Participating Faculty: Dr. Conrad

**Course Times, Rooms, and Titles for Each Seminar Session**
*Course Times:* See attached schedule.
*Room:* Conference room 9-170 Moos Tower
<table>
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<tr>
<th>Session #/Date</th>
<th>Topic Selected by Resident</th>
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<th>Grading Criteria ²</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score ¹</th>
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<td>Resident Assigned to Seminar</td>
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<td>Selection of articles</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
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<td>Forwarding of articles electronically</td>
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<td>Late by ≤48 hours</td>
<td>Late by ≤24 hours</td>
<td>Sent by 4:00 pm on the preceding Friday</td>
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<td>Acceptable</td>
<td>Strong</td>
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<td>Yes/No</td>
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<td>Analysis of secondary article</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
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<tr>
<td>All Residents</td>
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<td>Yes</td>
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<tr>
<td>Preparation for seminar</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
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<tr>
<td>Participation in supplemental discussion</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
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<tr>
<td>Punctual for seminar</td>
<td>Late by &gt;10 minutes</td>
<td>Late by ≤10 minutes</td>
<td>Late by ≤5 minutes</td>
<td>Ready to begin at 8:00 am</td>
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Feedback
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<td>Selection of articles</td>
<td>The ability to select 4 appropriate peer-reviewed manuscripts published in well recognized journals with relevant and current information on the specialty of prosthodontics including but not limited to complete dentures, fixed partial dentures, removable partial dentures, and implant prosthodontics.</td>
</tr>
<tr>
<td>Forwarding of articles to faculty and classmates</td>
<td>The deed of forwarding all selected articles to the faculty, program associate, and fellow residents electronically by 4:00 pm on the Friday preceding your Friday assigned seminar.</td>
</tr>
<tr>
<td>Analysis of primary or secondary articles</td>
<td>The capacity and competence to comprehend, interpret, and express verbally a complete understanding of the article presented without reading directly from the article. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.</td>
</tr>
<tr>
<td>Preparation for seminar</td>
<td>The act of being ready beforehand for the seminar by carefully reading and understanding all articles provided. The ability to demonstrate an in-depth knowledge and understanding of current philosophies and principles in prosthodontics presented within the seminar.</td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.</td>
</tr>
<tr>
<td>Punctual for seminar</td>
<td>The ability to be present at a designated time. Present in the conference room by 8:00 am.</td>
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<tr>
<td>Attendance</td>
<td>The action of being present at scheduled seminars. Excused absences permitted.</td>
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<tr>
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<td>A</td>
<td></td>
<td>≥90%</td>
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<td>B</td>
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<td>≥80%</td>
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<tr>
<td>C* (Probation)</td>
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<td>F* (Remediation)</td>
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<td>&lt;70%</td>
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### Schedule for Current Literature Seminar 2014-2015

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<th>Date</th>
<th>Article Selection</th>
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<tbody>
<tr>
<td>09/05/14</td>
<td>Michael Lassle</td>
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<tr>
<td>09/12/14</td>
<td>John Keyes</td>
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<td>09/19/14</td>
<td>Fouad Badr</td>
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<tr>
<td>09/26/14</td>
<td>Saad Bassas</td>
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<tr>
<td>10/03/14</td>
<td>Jason Kiangsoontra</td>
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<td>10/10/14</td>
<td>Sae Eun Schlottke</td>
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<tr>
<td>10/17/14</td>
<td>Samuel Hickman</td>
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<td>10/24/14</td>
<td>Joseph Lucero</td>
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<td>10/31/14</td>
<td>Michael Lassle</td>
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<tr>
<td>11/07/14</td>
<td>ACP Annual Session, New Orleans, LA</td>
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<td>11/14/14</td>
<td>John Keyes</td>
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<td>11/21/14</td>
<td>Fouad Badr</td>
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<td>11/28/14</td>
<td>Thanksgiving Holiday</td>
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<td>Jason Kiangsoontra</td>
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<td>12/26/14</td>
<td>Christmas Holiday</td>
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<td>Floating Holiday</td>
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<td>Saad Bassas</td>
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<td>01/16/15</td>
<td>Sae Eun Schlottke</td>
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<td>01/23/15</td>
<td>Samuel Hickman</td>
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<td>01/30/15</td>
<td>Joseph Lucero</td>
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<tr>
<td>02/06/15</td>
<td>Michael Lassle</td>
</tr>
<tr>
<td>02/13/15</td>
<td>John Keyes</td>
</tr>
<tr>
<td>02/20/15</td>
<td>Saad Bassas</td>
</tr>
<tr>
<td>02/27/15</td>
<td>American Academy of Fixed Prosthodontics, Chicago, IL</td>
</tr>
<tr>
<td>03/06/15</td>
<td>Fouad Badr</td>
</tr>
<tr>
<td>03/13/15</td>
<td>Jason Kiangsoontra</td>
</tr>
<tr>
<td>03/20/15</td>
<td>Spring Break</td>
</tr>
<tr>
<td>03/27/15</td>
<td>Sae Eun Schlottke</td>
</tr>
<tr>
<td>04/03/15</td>
<td>Samuel Hickman</td>
</tr>
<tr>
<td>04/10/15</td>
<td>Joseph Lucero</td>
</tr>
<tr>
<td>04/17/15</td>
<td>Fouad Badr</td>
</tr>
<tr>
<td>04/24/15</td>
<td>MDA Star of the North</td>
</tr>
<tr>
<td>05/01/15</td>
<td>Saad Bassas</td>
</tr>
<tr>
<td>05/08/15</td>
<td>Jason Kiangsoontra</td>
</tr>
</tbody>
</table>
University of Minnesota School of Dentistry
Advanced Education Program in Prosthodontics
Course Syllabus

CONTACT INFORMATION FOR COURSE DIRECTOR
Course Director: Heather J. Conrad  DMD, MS, FACP, FRCD(C)
Office Address: 9-176c Moos Tower
Phone Number: 612-624-5046
Email Address: conr0094@umn.edu
Office Hours: M-F 8:00 am – 4:30 pm

COURSE PURPOSE

Overview
This seminar is designed to assist residents in being able to meet related goals and objectives of the Graduate Program in Prosthodontics as listed in the programs Resident Training manual. Specifically, Goal #1 “To develop the diagnostic and treatment planning skills necessary for successful provision of complex Prosthodontics treatment” and Objective #1 “To ensure successful completion and presentation of treatment plans for patients requiring complex restorative care as required in the Prosthodontics treatment planning seminar course”. To accomplish this task, the seminar (Wednesdays from 12:00 noon to 1:00 PM during the fall and spring semesters each academic year) incorporates two approaches. The first approach requires a resident to present a detailed treatment plan (on a scheduled basis using a described format) for a number of complex patients over the thirty-three months of his / her program. The resident will also be expected to share the results of any treatment completed for these same patients (using a described format). The second approach uses scheduled presentations by faculty and guests (using a seminar format) to address topics related to the ability to successfully treatment plan / treat patients requiring complex restorative care.
Goals

- To assist with the development in the mind of a Prosthodontic resident, an in-depth knowledge (and the ability to apply that knowledge) of all aspects of the discipline of Prosthodontics, i.e., Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and Implant Prosthodontics. Note: The information covered in this seminar course will be supplemented by other in-depth topic-specific lectures and clinical experiences over the thirty-three month period of the program.
- To develop on the part of a Prosthodontics resident, the ability to formulate and successfully present a treatment plan / completed treatment for patients requiring complex restorative care with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics or any combination thereof.

**COURSE OBJECTIVES**

*Upon successful completion of DENT 7112, the resident dentist should be able to:*

- During this course (and following its completion), the resident will be able to demonstrate his / her ability to carry on a discussion of important philosophies / principles specific to Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and Implant Prosthodontics.
- During this course (and following its completion), the resident will be able to demonstrate his / her ability to develop and successfully present a treatment plan / completed treatment, for a patient requiring complex restorative care with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics or any combination thereof.

**REQUIRED TEXTBOOK AND READINGS**

- Required readings
  - Current literature articles as distributed.

**CREDITS**

*DENT 7112 → 2.0 credit hours*

**GRADING AND EVALUATION POLICIES**

**Guidelines for Participation in this Course**

**Guidelines for the treatment plan presentation portion of this seminar course:**

1. An oral presentation of a treatment plan (along with any other treatment options) developed by the resident for a patient requiring complex restorative care will be given (on a scheduled basis) to the course director, faculty and his / her fellow residents. The presentation will be made using a computer projector. Supplemental materials, i.e., mounted casts, original radiographs and a written handout describing the treatment plan to be presented should be available for viewing. A copy of the CD covering this presentation will be given to the course director at the end of the seminar. Schedules
covering fall and spring semesters of any given academic year will be distributed to the residents one month prior to the fall semester.

A treatment plan presentation should include the following:

<table>
<thead>
<tr>
<th>A treatment plan presentation should include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient demographics</td>
</tr>
<tr>
<td>Patient chief complaint</td>
</tr>
<tr>
<td>Patient expectations – ranking of cost, esthetics, function, comfort, longevity</td>
</tr>
<tr>
<td>Psychological/social appraisal</td>
</tr>
<tr>
<td>Medical history</td>
</tr>
<tr>
<td>Dental history</td>
</tr>
<tr>
<td>Extraoral/intraoral photographs (look ahead in course syllabus for list)</td>
</tr>
<tr>
<td>Panoramic radiograph and full mouth periapical radiographs (CT cone beam if applicable)</td>
</tr>
<tr>
<td>Soft tissue examination – extraoral/intraoral</td>
</tr>
<tr>
<td>Hard tissue examination</td>
</tr>
<tr>
<td>Periodontal evaluation and charting</td>
</tr>
<tr>
<td>Esthetic evaluation</td>
</tr>
<tr>
<td>Cross-mounted diagnostic casts/diagnostic wax-up – using a facebow and centric relation record</td>
</tr>
<tr>
<td>TMJ evaluation</td>
</tr>
<tr>
<td>Results of any consultations</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Consequence of non-treatment</td>
</tr>
<tr>
<td>Treatment objectives</td>
</tr>
<tr>
<td>Treatment plan options</td>
</tr>
<tr>
<td>Primary treatment plan – appropriately sequenced and including maintenance therapy</td>
</tr>
<tr>
<td>Prognosis</td>
</tr>
</tbody>
</table>

2. Procedure for developing a treatment plan for any patient requiring complex restorative care.

   a. First appointment (usually an entire morning or afternoon with additional lab time required) – Carefully review patient record prior to appointment, meet patient, record demographics, determine patient resources, chief complaint and expectations, check medical and dental history and update if necessary, complete two sets of preliminary alginate impressions, face-bow, centric and protrusive records, extraoral/intraoral photographs, verify patient has necessary radiographic records, mount both sets of casts (one set to be used for diagnostic wax-up).

   b. Second appointment (may require an entire morning or afternoon with additional laboratory time required) – Complete data collection (verify records, complete soft and hard tissue exam, periodontal evaluation and charting, TMJ examination, esthetic evaluation and psychological appraisal etc.), determine if any consultations are necessary, schedule as appropriate, complete diagnostic wax-up, develop primary treatment plan and any associated options, (for purposes of this course and when scheduled, present a developed treatment plan with options at seminar to faculty and
fellow residents and if appropriate, make any necessary changes), review with faculty.

c. Third appointment (may require an entire morning or afternoon) – Review patient concerns, present examination findings and diagnosis, present primary treatment plan along with any other options, determine final treatment plan, fill out treatment planning form and get patients signature, have faculty sign immediately.


Guidelines for the completed treatment presentation portion of this seminar course:

1. An oral presentation of the treatment completed by the resident for this patient will be given at a scheduled time to the course director, faculty and his / her fellow residents. The presentation will be made using a computer projector. A copy of the CD covering this presentation will be given to the course director at the end of the seminar. Mounted pre- and post-treatment casts, pre- and post-operative radiographs and a written handout detailing the original treatment plan and the actual treatment provided should be available for viewing.

A completed treatment presentation should include the following:

<table>
<thead>
<tr>
<th>Patient demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient chief complaint</td>
</tr>
<tr>
<td>Patient expectations – ranking of cost, esthetics, function, comfort, longevity</td>
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<td>Psychological/social appraisal</td>
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<tr>
<td>Medical history</td>
</tr>
<tr>
<td>Dental history</td>
</tr>
<tr>
<td>Extraoral/intraoral photographs (see below for list)</td>
</tr>
<tr>
<td>Panoramic radiograph and full mouth periapical radiographs (CT cone beam if applicable)</td>
</tr>
<tr>
<td>Soft tissue examination – extraoral/intraoral</td>
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<td>Hard tissue examination</td>
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<td>Esthetic evaluation</td>
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<tr>
<td>Cross-mounted diagnostic casts/diagnostic wax-up – using a facebow and centric relation record</td>
</tr>
<tr>
<td>TMJ evaluation</td>
</tr>
<tr>
<td>Results of any consultations</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Consequence of non-treatment</td>
</tr>
<tr>
<td>Treatment objectives</td>
</tr>
<tr>
<td>Treatment plan options</td>
</tr>
<tr>
<td>Sequencing of selected treatment plan</td>
</tr>
<tr>
<td>Esthetic evaluation of completed treatment</td>
</tr>
<tr>
<td>Post-treatment periapical radiographs (panoramic radiograph if applicable)</td>
</tr>
<tr>
<td>Prognosis</td>
</tr>
</tbody>
</table>
Suggestions to Assist with Treatment Plan Presentation Preparation

1. Patient demographic information should include: the patient’s name, age, gender, race, occupation, marital status, height and weight.

2. Medical history: Include any data that you consider relevant to the proper understanding, diagnosis and treatment of the patient. Among the points which might be included (if pertinent to the treatment) are: general health status, specific illnesses, medications used, evidences of infection, occupational diseases, evidence of emotional factors, laboratory tests and results.

3. Significant dental history: Any information that aids in understanding the development of the patient’s dental problem and arriving at a diagnosis and formulation of a treatment plan. This should be a comprehensive history of the patient’s dental disease and its treatment, including childhood problems, reasons for loss of teeth, prosthetic appliances, periodontal and TMD symptoms, trauma, abnormal habits, oral hygiene, family dental history, etc. The patient’s attitude concerning past and future dental treatment should also be determined.

4. Extraoral examination: A statement concerning the patient’s general appearance and more specifically, facial appearance including asymmetries, swelling, profile, extraoral lesions, eyes, etc. Results of palpation of nodes and a TMD examination should be noted along with speech abnormalities.

5. A description of the intraoral hard and soft tissues should be included. Pertinent charting and forms should be visually presented and discussed in detail (i.e. pocket depth, width of attached tissue / attachment level, and keratinized tissue quantity for all teeth). Note existing restorations, caries, failing treatment, etc. on a tooth-by-tooth basis.

6. Radiographic examination: Current (within 6 months), mounted diagnostic quality full mouth periapical radiographs as well as a Panorex are required (and should be visually presented). Report radiographic appearance of bone, vertical and horizontal bone loss, density, contour, etc., and teeth including any unerupted teeth, root tips, foreign bodies, root canal appearance, evidence of pathology, root size, form and proximity, periodontal membrane shadow, existing restorations, crown-root ratio, and any other changes in radiolucency or radiopacity.

7. Diagnosis and problem list: Give a comprehensive diagnosis of the patient based on all findings. Diagnostic casts. Complete arch pre-treatment study casts mounted in centric relation on a semi- or fully-adjustable articulator. Additional casts with diagnostic wax-ups and proposed restorations drawn on the casts are also required.
Evaluate diagnostic casts and note arch form and length, tooth position, wear, clinical crown length, degree of eruption, crown form, occlusal anatomy, palatal form, muscle and frena attachments, tori, exostoses, size and shape of edentulous areas, etc. Give a detailed description of the patient’s occlusion by noting the initial point of contact, presence and magnitude of occlusal discrepancies, horizontal and vertical overlap, intruded and extruded teeth, type of occlusal scheme (group function, canine disclusion, mutually protected occlusion, etc.), orientation of the occlusal plane, curve of Spee, Wilson, Pleasure, etc.

8. Photographs: Digital projection is required. The photographs should be properly exposed with high resolution, be cropped/rotated/flipped for proper viewing, and reveal all pertinent structures. Radiographs must be scanned and cropped by a computer. The presentation of photographs should be organized in a logical progression. To evaluate the occlusion, show three photographs (frontal and lateral views) together that pertain to each of the four particular mandibular positions (MIP, right working, left working, protrusion). The following photographs are required:

<table>
<thead>
<tr>
<th>Required Photos</th>
<th>Extraoral views</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full face portrait in repose – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>Full face portrait maximum smile – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>Close-up of mouth – incisal display in repose</td>
</tr>
<tr>
<td></td>
<td>Close-up of mouth – incisal display with partial smile</td>
</tr>
<tr>
<td></td>
<td>Close-up of mouth – incisal display with maximum smile</td>
</tr>
<tr>
<td></td>
<td>Intraoral views</td>
</tr>
<tr>
<td></td>
<td>Maxillary and mandibular occlusal views</td>
</tr>
<tr>
<td></td>
<td>Maximum intercuspation – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>Right working – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>Left Working – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>Protrusion – frontal and lateral views</td>
</tr>
<tr>
<td></td>
<td>All intraoral views with and without any removable prosthesis</td>
</tr>
<tr>
<td></td>
<td>Other photos</td>
</tr>
<tr>
<td></td>
<td>Polished and intaglio surfaces of any existing prosthesis</td>
</tr>
<tr>
<td></td>
<td>Preliminary impressions</td>
</tr>
<tr>
<td></td>
<td>Mounted diagnostic casts</td>
</tr>
<tr>
<td></td>
<td>Diagnostic wax-up</td>
</tr>
<tr>
<td></td>
<td>Tooth preparations</td>
</tr>
<tr>
<td></td>
<td>Provisional restorations</td>
</tr>
<tr>
<td></td>
<td>Definitive impressions</td>
</tr>
<tr>
<td></td>
<td>Jaw relation records</td>
</tr>
<tr>
<td></td>
<td>Mounted definitive casts</td>
</tr>
<tr>
<td></td>
<td>Any other procedural photos that would enhance the presentation</td>
</tr>
</tbody>
</table>

Description of the scheduled presentation portion of this seminar course:
1. Using a seminar format, scheduled guest presenters will cover a number of important topics directly related to a resident’s ability to successfully treatment plan / treat patients requiring complex restorative care. Residents will be expected to thoroughly review any associated assigned reading and be active participants in these seminars. Topics to be covered will include (but may not be limited to) the following: pharmacology, infection control, craniofacial growth and development, immunology, oral microbiology, risk assessment for oral disease, wound healing, implant placement, TMD, medical emergencies, diagnostic radiology, Prosthodontics classification systems, endodontics, periodontics, orthodontics, sleep disorders, intraoral photography, practice management, behavioral sciences and ethics. Due to the difficulties associated with scheduling guest presenters, schedules for this seminar course should be viewed as subject to change on short notice. Schedules covering fall and spring semesters of any given academic year will be provided to residents at the end of the preceding summer session.

**Evaluation Process for this Seminar**
Successful completion of this Treatment Planning Seminar by individual prosthodontic residents will be determined by the course director using results of the weekly seminar grading forms. A copy of this form and the criteria for its use are attached. A resident’s ability to provide clinical care that reflects current or newly developed philosophies / principles they have learned to a patient requiring treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics will also be demonstrated during the presentation.

**Grading Criterion for Completed Treatment Presentation**

**PREOPERATIVE RECORDS**

**Acceptable (A-B)**
The appropriate radiographs have been obtained and are of diagnostic quality. The proper casts have been obtained. Casts are clean, neat, securely mounted and accurately reproduce oral structures. If necessary, modifications to articulated casts in the form of correction to the occlusion and the occlusal plane have been performed. Diagnostic wax-ups have been performed and are of high quality. Survey analysis of diagnostic casts was performed if appropriate for the patient. All the required photographs are present and record the desired structures. If all the required photographs are not present, the patient’s clinical condition can clearly be observed. The photographs are properly exposed. The narrative conforms to the established format, is complete, succinct and accurately describes the patient. Typed copies are available for all seminar participants.

**Marginal (C)**
Some, but not all the appropriate radiographs have been obtained. The radiographs are adequate but demonstrate slight variations in contrast. All the proper casts have been obtained, but are not of optimal quality. The proper modifications to diagnostic casts have been performed, but are not of high quality. All or some required photographs are present but do not clearly record the patient’s clinical condition. Photographs have less than ideal contrast and sharpness. The
narrative conforms to the established format but is incomplete in some areas and contains minor inaccuracies. Copies are available for all participants but are difficult to read.

**Unacceptable (D-F)**

Note, if the records are unacceptable, the presentation can be terminated at any time by the faculty and the student will be asked to return at a subsequent seminar to complete the treatment plan.

Appropriate radiographs have not been obtained. The diagnostic quality of existing radiographs is seriously compromised. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Appropriate diagnostic alterations to casts have not been performed or are of poor quality. Photographs are of poor quality and insufficient in number to clearly record the patient’s clinical condition. The narrative is not present or does not conform to the established format. If present, the narrative is incomplete, contains many inaccuracies and is difficult to read and understand.

**POSTOPERATIVE RECORDS**

**Acceptable (A-B)**

The appropriate radiographs have been obtained and are of diagnostic quality. The proper casts have been obtained. Casts are clean, neat, securely mounted and accurately reproduce oral structures. All the required photographs are present and record the desired structures. If all the required photographs are not present, the patient’s clinical condition can clearly be observed. The photographs are properly exposed.

**Marginal (C)**

Some, but not all the appropriate radiographs have not been obtained. The radiographs are adequate but demonstrate slight variations in contrast. All the proper casts have been obtained, but are not of optimal quality. All or some required photographs are present but do not clearly record the patient’s clinical condition. Photographs have less than ideal contrast and sharpness.

**Unacceptable (D-F)**

Appropriate radiographs have not been obtained. The diagnostic quality of existing radiographs is seriously compromised. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Photographs are of poor quality and insufficient in number to clearly record the patient’s clinical condition.

**TREATMENT**

**Acceptable (A-B)**

The overall treatment is consistent with accepted prosthodontic principles. Restoration is physiologically compatible and well integrated with other elements of care. The treatment procedures have been accomplished with a great deal of care and skill.

**Marginal (C)**

The overall treatment is only partially consistent with accepted prosthodontics principles and may contain some controversial components. Integration of other elements of care has been considered but is lacking. The restorations are physiologically compatible but exhibit significant compromising aspects. The treatment procedures are adequate but lacking in care and skill.
Unacceptable (D-F)
The overall treatment is not consistent with accepted Prosthodontics principles. The restorations are physiologically incompatible. Existing or future damage to the surrounding tissues has or will occur. Gross neglect of integration of other elements of care is evident.

PRESENTATION SKILL

Acceptable (A-B)
The presentation was highly organized and clearly presented. The student was able to relate dental basic science and clinical literature to the diagnosis and treatment plan. The student demonstrated a superior knowledge of Prosthodontics and related fields. The student responded well to questioning associated with the patient presentation.

Marginal (C)
The presentation was not very well organized and/or was not clearly presented. The student was able to utilize some of the appropriate visual aids available to enhance the presentation with a fair level of skill. The student related information from the dental basic science and clinical literature to the diagnosis and treatment plan, but was incomplete or presented with some inaccuracies. The student demonstrated an adequate understanding of the broad scope of Prosthodontics and related dental fields. The student responded adequately to questioning associated with the patient presentation.

Unacceptable (D-F)
The presentation was poorly organized and not clearly presented. The student was unable to use the appropriate visual aids to enhance the presentation. The student was unable to relate information from the dental basic science literature to the diagnosis and treatment. The student did not demonstrate an adequate understanding of the principles and concepts of Prosthodontics. The students’ understanding of the broad scope of Prosthodontics and related fields is not adequate. The student responded poorly to questioning associated with the patient presentation.

Schedule & Topics
- See attached schedule.

Assessment Format DENT 7112
- The course objectives can be achieved by preparing your case presentations, reviewing and studying the reading assignments, and participating in the seminar discussions.
- Professionalism and attendance are expected and required for all sessions.
- Participation is expected and required during the seminar.
- Final point accumulation is at the discretion of the course director.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥90%</td>
<td>A</td>
</tr>
<tr>
<td>80-89%</td>
<td>B</td>
</tr>
<tr>
<td>70-79%</td>
<td>C* (Probation at the discretion of the resident’s program director)</td>
</tr>
<tr>
<td>&lt;70%</td>
<td>F* (Remediation required with dismissal pending overall performance in program)</td>
</tr>
</tbody>
</table>
Additional Notes

- The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
- Any change of venue will be announced during the lecture period or sent via email.
- Any student(s) found to have cheated, deceived, or procured help from another student(s) or individual during an examination will subject all parties involved to disciplinary actions that are consistent with the School of Dentistry and University policies.
- The administration and design of examinations will be at the discretion of the course director.

Student Expectations

The policy on grading and academic practices, remediation, attendance, and professional attire, can be found on the SOD website at:


Residents’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Residents will evaluate the course and faculty through the year end evaluation form and the evaluation of faculty form.

Distance Delivery of Course Material

This course does not offer distance delivery of the course material.

Grade Disputes

Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

Remediation Policies

Residents with an overall course grade of ‘C’ for DENT 7112 will be placed on probation during the following term at the discretion of the resident’s program director. Residents with an overall course grade of ‘F’ for DENT 7112 must remediate during the following term to the satisfaction of the resident’s program director. Residents may also be considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

Make-Up Exam Policies

Any scheduled examinations missed due a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

Attendance
Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or Vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

**Feedback**
Any feedback is welcome and should be forwarded to the course directors by writing, emailing, or visiting the course director’s office.

**Student Integrity**
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

> Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

**Communication**
All individual and full class communication will be through your University of Minnesota email account. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

**Student On-Line Privacy and Security**
Any online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.

**Disabilities**
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website [http://ds.umn.edu](http://ds.umn.edu).

**Mental Health Resources**
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

*Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006*

**Wellness Program for Dental Students**
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

**Appropriate Student Use of Class Notes**
Residents may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

**Changes Made in Response to Student Feedback**
Constructive criticism is welcomed to improve this course for future residents.

**Faculty Information**
Participating Faculty: Dr. Conrad

**Course Times, Rooms, and Titles for Each Seminar Session**
*Course Times:* See attached schedule.
*Room:* Conference room 9-170 Moos Tower
<table>
<thead>
<tr>
<th>Grading Criteria ²</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score ¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Assigned to Seminar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes/No</td>
</tr>
<tr>
<td>Type of case presentation</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Preparation for seminar</td>
<td>Late by &gt;10 minutes</td>
<td>Late by ≤10 minutes</td>
<td>Late by ≤5 minutes</td>
<td>Ready to present at 12:10 pm</td>
<td></td>
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<tr>
<td>Time management</td>
<td>≤20 minutes</td>
<td>≤25 minutes</td>
<td>≤30 minutes</td>
<td>30-40 minutes</td>
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</tr>
<tr>
<td>Effective use of presentation software</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Ability to engage your audience</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Case presentation</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Thorough</td>
<td></td>
</tr>
<tr>
<td>Discussion of treatment plan options</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Thorough</td>
<td></td>
</tr>
<tr>
<td>Quality of photos</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Quality of radiographs</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Ability to respond to questions</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>All Other Residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>Not evident</td>
<td>Subtle</td>
<td>Observed</td>
<td>Evident</td>
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</tr>
<tr>
<td>Punctual for seminar</td>
<td>Late by &gt;10 minutes</td>
<td>Late by ≤10 minutes</td>
<td>Late by ≤5 minutes</td>
<td>On time</td>
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<tr>
<td>Attendance</td>
<td>Absent</td>
<td></td>
<td></td>
<td>Present</td>
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<tr>
<td>Total</td>
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**Feedback**
<table>
<thead>
<tr>
<th><strong>2 Grading Criteria</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of case presentation</strong></td>
<td>The selection of an appropriate case(s) to present to your fellow residents that is interesting. Cases may vary from simple to complex but should offer a valuable learning opportunity for everyone.</td>
</tr>
<tr>
<td><strong>Preparation for seminar</strong></td>
<td>The act of being ready beforehand for a specific session and exercise. Having your computer and projector ready to present by 12:10 pm.</td>
</tr>
<tr>
<td><strong>Time management</strong></td>
<td>Presentation time is 30-40 minutes followed by 10-20 minutes of questions and discussion.</td>
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</table>
| **Effective use of presentation software** | The appropriate use of presentation software including:  
  - Using slides as a visual aid and not overloading them  
  - Using an appropriate size and style of font  
  - Selection of readable colors and contrasting backgrounds  
  - Avoid using too many animation effects – keep it simple  
  - Avoid simply reading the visual presentation  
  - Avoid spelling and grammatical errors |
| **Ability to engage your audience** | The ability to draw favorable attention or interest from your audience. |
| **Case presentation** | Includes documentation of: patient demographics/resources/expectations, chief complaint, medical/dental history, soft/hard tissue exam, periodontal charting, mounted diagnostic casts and wax-up, TMJ evaluation, esthetic evaluation, psychological/social appraisal, results of consultations, diagnosis, prognosis |
| **Discussion of treatment plan options and techniques** | Demonstration of diagnostic and treatment planning skills necessary for successful completion of advanced prosthodontics treatment. Presentation of treatment plan options and techniques used is supported by classic or current literature. |
| **Quality of photos** | The selection of an appropriate amount and quality of pre-, mid-, and post-treatment clinical photographs. Photos are high resolution and have been cropped/rotated/flipped for viewing. |
| **Quality of radiographs** | The selection of an appropriate amount and quality of pre-, mid-, and post-treatment clinical radiographs. Non-digital radiographs have been scanned by a computer and cropped for viewing. |
| **Ability to respond to questions** | The capacity and competence to reply to questions and discuss important prosthodontic philosophies/principles. |
| **Participation in supplemental discussion** | The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents. |
| **Punctual for seminar** | The ability to be present at a designated time. Present in the conference room by 12:10 pm. |
| **Attendance** | The action of being present at scheduled seminars. Excused absences permitted. |

<table>
<thead>
<tr>
<th><strong>1 Grade</strong></th>
<th><strong>Total Point Accumulation</strong></th>
<th><strong>Total Points</strong></th>
<th><strong>Resident Grade</strong></th>
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<tr>
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<td>B</td>
<td>≥80%</td>
<td></td>
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<tr>
<td>C* (Probation)</td>
<td>≥70%</td>
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<tr>
<td>F* (Remediation)</td>
<td>&lt;70%</td>
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# Schedule for Treatment Planning Seminar 2014-2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>09/03/14</td>
<td>John Keyes, Completed Treatment</td>
</tr>
<tr>
<td>09/10/14</td>
<td>Michael Lassle, Completed Treatment</td>
</tr>
<tr>
<td>09/17/14</td>
<td>Sae Eun Schlottke, Completed Treatment</td>
</tr>
<tr>
<td>09/24/14</td>
<td>Jason Kiangsoonthra, Completed Treatment</td>
</tr>
<tr>
<td>10/01/14</td>
<td>Saad Bassas, Completed Treatment</td>
</tr>
<tr>
<td>10/08/14</td>
<td>Fouad Badr, Completed Treatment</td>
</tr>
<tr>
<td>10/15/14</td>
<td>Joseph Lucero, Treatment Planning</td>
</tr>
<tr>
<td>10/22/14</td>
<td>Samuel Hickman, Treatment Planning</td>
</tr>
<tr>
<td>10/29/14</td>
<td>John Keyes, Completed Treatment</td>
</tr>
<tr>
<td>11/05/14</td>
<td>ACP Annual Session, New Orleans, LA</td>
</tr>
<tr>
<td>11/12/14</td>
<td>Michael Lassle, Completed Treatment</td>
</tr>
<tr>
<td>11/19/14</td>
<td>Sae Eun Schlottke, Completed Treatment</td>
</tr>
<tr>
<td>11/26/14</td>
<td>Jason Kiangsoonthra, Completed Treatment</td>
</tr>
<tr>
<td>12/03/14</td>
<td>Saad Bassas, Completed Treatment</td>
</tr>
<tr>
<td>12/10/14</td>
<td>Fouad Badr, Completed Treatment</td>
</tr>
<tr>
<td>12/17/14</td>
<td>Samuel Hickman, Treatment Planning</td>
</tr>
<tr>
<td>12/24/14</td>
<td>Christmas Holiday</td>
</tr>
<tr>
<td>12/31/14</td>
<td>Christmas Holiday</td>
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<td>01/07/15</td>
<td>Joseph Lucero, Treatment Planning</td>
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<td>01/14/15</td>
<td>John Keyes, Completed Treatment</td>
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<tr>
<td>01/21/15</td>
<td>Michael Lassle, Completed Treatment</td>
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<tr>
<td>01/28/15</td>
<td>Sae Eun Schlottke, Completed Treatment</td>
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<tr>
<td>02/04/15</td>
<td>Jason Kiangsoonthra, Completed Treatment</td>
</tr>
<tr>
<td>02/11/15</td>
<td>Saad Bassas, Completed Treatment</td>
</tr>
<tr>
<td>02/18/15</td>
<td>Fouad Badr, Completed Treatment</td>
</tr>
<tr>
<td>02/25/15</td>
<td>Joseph Lucero, Treatment Planning</td>
</tr>
<tr>
<td>03/04/15</td>
<td>Samuel Hickman, Treatment Planning</td>
</tr>
<tr>
<td>03/11/15</td>
<td>John Keyes, Completed Treatment</td>
</tr>
<tr>
<td>03/18/15</td>
<td>Spring Break</td>
</tr>
<tr>
<td>03/25/15</td>
<td>Michael Lassle, Completed Treatment</td>
</tr>
<tr>
<td>04/01/15</td>
<td>Sae Eun Schlottke, Completed Treatment</td>
</tr>
<tr>
<td>04/08/15</td>
<td>Jason Kiangsoonthra, Completed Treatment</td>
</tr>
<tr>
<td>04/15/15</td>
<td>Saad Bassas, Completed Treatment</td>
</tr>
<tr>
<td>04/22/15</td>
<td>Fouad Badr, Completed Treatment</td>
</tr>
<tr>
<td>04/29/15</td>
<td>Joseph Lucero, Treatment Planning</td>
</tr>
<tr>
<td>05/06/15</td>
<td>Samuel Hickman, Treatment Planning</td>
</tr>
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</table>
University of Minnesota School of Dentistry
Advanced Education Program in Prosthodontics
Course Syllabus

DENT 7220
Prosthetically-Driven Implant Surgery and Treatment Planning
Fall Semester
Years 1 & 2

CONTACT INFORMATION FOR COURSE DIRECTORS
Course Director: Heather J. Conrad  DMD, MS, FACP, FRCD(C)
Faculty: Bobby S. Birdi  DMD, MS, FACP, FRCD(C)
        Richard R. Dryer  DDS
        Kendall W. James  DMD
Office Address:  9-176 Moos Tower
Phone Numbers:  612-624-5046 (Conrad)
Email Addresses:  conr0094@umn.edu
                  bobbirdi@gmail.com
Office Hours: M-F 8:00 am – 4:30 pm

COURSE PURPOSE
The objectives of this course are to provide in-depth didactic instruction in: patient selection &
treatment planning for implant therapy from simple cases to esthetically demanding cases to full-
arch cases, indications & contra-indications of various types of implants with respect to final
restoration, surgical anatomical considerations, flap design, suture types and suturing methods,
materials and methods for socket grafting and ridge augmentation, surgical placement of
implants, immediate versus delayed implant placement protocols, management of surgical
complications, maintenance of dental implants, the management and prevention of peri-
implantitis.

Upon completion of this course, residents will clinically be able to plan treatment, perform dental
implant surgeries and simple bone grafting procedures with an advanced understanding of the
anticipated and desired prosthetic result. The residents will also be able to distinguish important
anatomical landmarks for implant surgeries and how to deal with potential complications.
**COURSE OBJECTIVES**

**Upon successful completion of DENT 7220, the resident dentist should be able to:**

- Recognize the significance of providing dental implant prosthetic and surgical therapy at a specialty level
- Select the appropriate armamentarium for prosthetic and surgical clinical procedures
- Demonstrate advanced knowledge in the procedures involved with the assessment, planning, placement, restoration, and maintenance of dental implants
- Articulate verbally in seminars and in writing on the final examination an advanced understanding of:
  - Implant dentistry as a prosthetic discipline with a surgical component
  - Surgical diagnosis and treatment planning starting with the anticipated and desired prosthetic result
  - Treatment plan options for partially and completely edentulous patients who desire fixed or removable prostheses
  - Sequencing of prosthetic and surgical aspects of treatment
  - Technical, cosmetic, and surgical limitations of implant dentistry
  - Pre-surgical laboratory procedures and preparation
  - Diagnostic imaging procedures for the assessment of available bone quantity and quality
  - Maxillary and mandibular anatomical considerations and limitations in relation to implant placement
  - Selection of the appropriate implant diameter and length
  - Tissue management as it relates to dental implant surgical procedures including incision design, flap preparation, osteotomy preparation, controlled pressure and heat generation implant placement, and suturing
  - Socket preservation procedures
  - Bone grafting procedures related to dental implants
  - Pharmacologic protocol for implant surgery
  - Clinical techniques for dental implant restorative procedures
  - Ideal implant occlusion for fixed and removable prostheses
  - Protocols for immediate versus delayed implant placement and loading
  - Interventions and approaches to manage potential complications
  - The role of implant dentistry in the future dental practice

**TEXTBOOK AND READINGS**

- Optional textbook

- Required readings
  - Current literature articles distributed electronically weekly.

**CREDITS**

DENT 7220 \(\rightarrow\) 19 hours of seminar \(\rightarrow\) 1.0 credit hour
**Grading and Evaluation Policies**

Each week a designated subject with corresponding reading materials will be assigned. A lecture presentation will be given followed by discussion of the reading material. All class members will be responsible to have read the materials and are expected to join in on the discussion. Approximately 50% of your course grade will be based upon your contributions to weekly discussions with the remaining 50% being determined by your score on a written final examination.

**Weighting of factors:**

- 50% Participation in Weekly Discussions
- 50% Final Written Examination

- Attendance: Attendance for all sessions is mandatory.
- Readiness: Residents are expected complete all assigned readings.
- Participation: Active participation from the resident is expected during all seminar discussions.
- Final exam: The final exam for this course will be in a written format.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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<tbody>
<tr>
<td>≥90%</td>
<td>A (Pass)</td>
</tr>
<tr>
<td>80-89%</td>
<td>B (Pass)</td>
</tr>
<tr>
<td>70-79%</td>
<td>C* (Probation at the discretion of the resident’s program director)</td>
</tr>
<tr>
<td>&lt;70%</td>
<td>F* (Remediation required with dismissal pending overall performance in program)</td>
</tr>
</tbody>
</table>

**Assessment Format DENT 7220:**

- The course objectives can be achieved by reviewing and studying the reading assignments in addition to information presented in the seminars.
- The final written examination may use any identification format such as multiple choice, true/false, matching type, short answer, essay, and drawings.
- Professionalism and attendance are expected and required for all sessions.
- Participation is expected and required during the seminar.
- Final point accumulation is at the discretion of the course director.

**Schedule**

- Seminar topics are listed in the course schedule.

**Additional Notes**

- The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
- Any change of venue will be announced during the lecture period or sent via email.
- Any student(s) found to have cheated, deceived, or procured help from another student(s) or individual during an examination will subject all parties involved to disciplinary actions that are consistent with the School of Dentistry and University policies.
• The administration and design of make-up examinations will be at the discretion of the course directors.

**STUDENT EXPECTATIONS**
The policy on grading and academic practices, remediation, attendance, and professional attire, can be found on the SOD website at:


Residents’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Residents will evaluate the course and faculty through the year end evaluation form and the evaluation of faculty form.

**DISTANCE DELIVERY OF COURSE MATERIAL**
This course does not offer distance delivery of the course material.

**GRADE DISPUTES**
Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

**REMEDIATION POLICIES**
Residents with an overall course grade of ‘C’ for DENT 7220 will be placed on probation during the following term at the discretion of the resident’s program director. Residents with an overall course grade of ‘F’ for DENT 7220 must remediate during the following term to the satisfaction of the resident’s program director. Residents may also be considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

**MAKE-UP EXAM POLICIES**
Any scheduled examinations missed due a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

**ATTENDANCE**
Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

**FEEDBACK**
Any feedback is welcome and should be forwarded to the course directors by writing, emailing, or visiting the program director’s office.
STUDENT INTEGRITY
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

COMMUNICATION
All individual and full class communication will be through your University of Minnesota email account. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

STUDENT ON-LINE PRIVACY AND SECURITY
Any online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.

DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

MENTAL HEALTH RESOURCES
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006
WELLNESS PROGRAM FOR DENTAL STUDENTS
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

APPROPRIATE STUDENT USE OF CLASS NOTES
Students may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

CHANGES MADE IN RESPONSE TO STUDENT FEEDBACK
Constructive criticism is welcomed to improve this course for future residents.

FACULTY INFORMATION
Participating Faculty: Drs. Conrad, Birdi, Dryer, and James
### COURSE TIMES, ROOMS, AND TITLES FOR EACH SEMINAR SESSION

**Course Times:** 19.5 hours including seminars and final written exam  
**Room:** Conference room 9-170 Moos Tower

<table>
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<th>Date</th>
<th>Seminar Topic</th>
<th>Faculty Leader</th>
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<tbody>
<tr>
<td>1</td>
<td>September 8 Monday</td>
<td>Patient Selection Medical Evaluation</td>
<td>Dr. Richard Dryer</td>
</tr>
<tr>
<td>2</td>
<td>September 15 Monday</td>
<td>Treatment Planning Posterior Implants</td>
<td>Dr. Kendall James</td>
</tr>
<tr>
<td>3</td>
<td>September 22 Monday</td>
<td>Treatment Planning Anterior Implants Prosthetic/Surgical Sequencing</td>
<td>Dr. Kendall James</td>
</tr>
<tr>
<td>4</td>
<td>September 29 Monday</td>
<td>Treatment Planning Removable Cases Prosthetic/Surgical Sequencing</td>
<td>Dr. Richard Dryer</td>
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<tr>
<td>5</td>
<td>October 6 Monday</td>
<td>Treatment Planning Fixed-Arch Cases and Hybrid Cases Prosthetic/Surgical Sequencing All-On-4 Protocol</td>
<td>Dr. Kendall James</td>
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<tr>
<td>6</td>
<td>October 13 Monday</td>
<td>Flap Design, Anatomy Suturing Materials/Methods</td>
<td>Dr. Bobby Birdi</td>
</tr>
<tr>
<td>7</td>
<td>October 20 Monday</td>
<td>Bone Grafting Materials Soft Tissue Grafting Indications</td>
<td>Dr. Bobby Birdi</td>
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<tr>
<td>8</td>
<td>October 27 Monday</td>
<td>Socket Grafting Techniques</td>
<td>Dr. Richard Dryer</td>
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<td>9</td>
<td>November 3 Monday</td>
<td>No Class - AAMP New Orleans</td>
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<td>10</td>
<td>November 10 Monday</td>
<td>Ridge Augmentation Methods</td>
<td>Dr. Bobby Birdi</td>
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<td>11</td>
<td>November 17 Monday</td>
<td>Surgical Implant Placement Immediate &amp; Delayed Placement and Loading</td>
<td>Dr. Bobby Birdi</td>
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<tr>
<td>12</td>
<td>November 24 Monday</td>
<td>Management of Complications Surgical/Post-Op Complications</td>
<td>Dr. Richard Dryer</td>
</tr>
<tr>
<td>Date</td>
<td>Day</td>
<td>Time</td>
<td>Event</td>
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<td>---------------</td>
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<tr>
<td>12</td>
<td>December 1</td>
<td>Monday 8:00 – 9:30 am</td>
<td>Peri-Implantitis Maintenance</td>
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<tr>
<td>13</td>
<td>December 8</td>
<td>Monday 8:00 – 9:30 am</td>
<td>FINAL WRITTEN EXAM</td>
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### DENT 7220
Prosthetically-Driven Implant Surgery & Treatment Planning

<table>
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<tr>
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<tr>
<td>Semester/Year</td>
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### Session #/Date

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<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score 1</th>
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<tbody>
<tr>
<td>Primary analysis of articles</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
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</tr>
<tr>
<td>Preparation for seminar</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Punctual for seminar</td>
<td>Late by &gt;10 minutes</td>
<td>Late by ≤10 minutes</td>
<td>Late by ≤5 minutes</td>
<td>Ready to begin at 8:00 am</td>
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<tr>
<td>Attendance</td>
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### Feedback

<table>
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<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Primary analysis of articles</td>
<td>The capacity and competence to comprehend, interpret, and express verbally a complete understanding of historically-based, widely accepted philosophies and principles in prosthodontics. The aptitude to discuss the scientific merit of the article in question. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.</td>
</tr>
<tr>
<td>Preparation for seminar</td>
<td>The act of being ready beforehand for the seminar by carefully reading and understanding all articles provided. The ability to demonstrate an in-depth knowledge and understanding of historically- and scientifically-based philosophies and principles in prosthodontics presented within the seminar.</td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>The ability to connect yourself with the information presented in the seminar and to actively volunteer to advance and share your knowledge/experience with your fellow residents.</td>
</tr>
<tr>
<td>Punctual for seminar</td>
<td>The ability to be present at a designated time. Present in the conference room by 8:00 am.</td>
</tr>
<tr>
<td>Attendance</td>
<td>The action of being present at scheduled seminars. Excused absences permitted.</td>
</tr>
<tr>
<td>Grade</td>
<td>Total Point Accumulation</td>
</tr>
<tr>
<td>------------------</td>
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</tr>
<tr>
<td>A</td>
<td></td>
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<tr>
<td>B</td>
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<tr>
<td>C* (Probation)</td>
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<tr>
<td>F* (Remediation)</td>
<td></td>
</tr>
</tbody>
</table>

1 Grade
University of Minnesota School of Dentistry
Advanced Education Program in Prosthodontics
Course Syllabus

PROS 7110
Classic Literature Review Seminar
Fall & Spring Semesters
Year 1 & 2

CONTACT INFORMATION FOR COURSE DIRECTOR
Course Director:  Heather J. Conrad  DMD, MS, FACP, FRCD(C)
                James R. Holtan  DDS, FACP
Office Address:  9-176 Moos Tower
Phone Number:    612-624-5046
                  612-625-5650
Email Address:   conr0094@umn.edu
                 holta001@umn.edu
Office Hours:    M-F 8:00 am – 4:30 pm
                 Wednesdays 8:00 am – 12:00 pm (Dr. Holtan)

COURSE PURPOSE

Overview
This classic literature review course meets Wednesday mornings from 8:00 to 9:30 am during the
fall and spring semesters of each academic year.  This course reviews articles taken from the
“Classic Literature” of the discipline of Prosthodontics. Topics covered include (but are not
limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and
Implant Prosthodontics. A seminar format is used to accomplish the goals and objectives listed
below.

Goals
- To develop in the minds of first and second year Prosthodontics residents, an in-depth
  knowledge and understanding of historically based, widely accepted philosophies /
  principles described in the “Classic Prosthodontics Literature” that pertain to (but may
  not be limited to), Complete Dentures, Fixed Partial Dentures, Removable Partial
  Dentures, and Implant Prosthodontics. Note: The learning process initiated in this
A seminar will be supported by numerous in-depth topic-specific seminars and clinical experiences over the thirty-three month period of the program.

- To help develop on the part of a resident in Prosthodontics, the ability to relate the knowledge base gathered from articles reviewed in this seminar course to the clinical care he / she will provide to patients requiring treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics.

**COURSE OBJECTIVES**

**Upon successful completion of PROS 7110, the resident dentist should be able to:**

- During this course (and following its completion), the resident will be able to demonstrate his / her ability to initiate and carry on a discussion of historically and scientifically based, widely accepted philosophies / principles that support the clinical treatment of a patient with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics or any combination thereof.

- During this course (and following its completion), the resident will be able to demonstrate his / her ability to provide clinical care that reflects historically and scientifically based, widely accepted philosophies / principles that support the clinical treatment of a patient with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics or any combination thereof.

**REQUIRED TEXTBOOK AND READINGS**

- Required readings
  - Current literature articles distributed electronically weekly.

**CREDITS**

PROS 7110 → 2.0 credit hours

**GRADING AND EVALUATION POLICIES**

**Guidelines for Participation in this Course**

Residents are expected to carefully read and understand all articles provided for each seminar (15 + or – articles per weekly seminar). The program will provide copies of the articles to be reviewed for each seminar. These articles will be placed in the resident’s mailbox one week prior to the convening date. During the seminar, the course director will ask on a random basis, individual residents to summarize and identify salient points contained within a particular article. That person will also be expected to discuss the scientific merit of the article in question. The resident asked to review a particular article should expect his / her peers to actively participate in any discussion related to the article.

**Evaluation Process for this Seminar**

Successful completion of the Classic Literature Seminar by individual prosthodontic residents will be determined by the course director using results of the weekly seminar grading forms. A
copy of this form and the criteria for its use are attached. A resident’s ability to apply historically and scientifically based, widely accepted philosophies / principles that support the clinical treatment of his / her patients will also be observed in the clinic by faculty and may have a bearing on the letter grade assigned.

Schedule & Topics

- See attached schedule.
<table>
<thead>
<tr>
<th>Session #</th>
<th>Fall Semester – Cycle Year 1 Topic</th>
<th>Session Code Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Prosthodontic Patient</td>
<td>A1</td>
</tr>
<tr>
<td>2</td>
<td>Prosthodontics Diagnosis</td>
<td>A2</td>
</tr>
<tr>
<td>3</td>
<td>Hinge Axis I</td>
<td>A3</td>
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<tr>
<td>4</td>
<td>Incisal Guidance</td>
<td>A6</td>
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<td>5</td>
<td>Articulators I – Overview</td>
<td>A7</td>
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<td>6</td>
<td>Centric Relation</td>
<td>A10</td>
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<tr>
<td>7</td>
<td>Geriatrics</td>
<td>A15</td>
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<td></td>
<td><em>ACP Annual Session</em></td>
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<tr>
<td>8</td>
<td>Nutrition</td>
<td>A16</td>
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<td>9</td>
<td>Color</td>
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<td>10</td>
<td>TMJ-MPD Syndrome I – Anatomy &amp; Etiology</td>
<td>A21</td>
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<tr>
<td></td>
<td>TMJ-MPD Syndrome II – Diagnosis &amp; Treatment</td>
<td>A22</td>
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<tr>
<td>11</td>
<td>Treatment Planning – Removable Partial Dentures</td>
<td>B23</td>
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<tr>
<td>12</td>
<td>Removable Partial Dentures – Clasp Design</td>
<td>B25</td>
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<tr>
<td>13</td>
<td>Eating Disorders</td>
<td>B27</td>
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<td>14</td>
<td><strong>Final Exam</strong></td>
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<tr>
<td>Session #</td>
<td>Spring Semester – Cycle Year 1 Topic</td>
<td>Session Code Number</td>
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<tr>
<td>15</td>
<td>Edentulous Histology/Tissue Conditioning</td>
<td>B28</td>
</tr>
<tr>
<td>16</td>
<td>Tissue Conditioning Materials &amp; Soft Liners</td>
<td>B29</td>
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<tr>
<td>17</td>
<td>Complete Denture Impressions</td>
<td>B30</td>
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<td>18</td>
<td>Posterior Palatal Seal – Denture Retention</td>
<td>B33</td>
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<tr>
<td>19</td>
<td>Bone Physiology</td>
<td>B38</td>
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<tr>
<td>20</td>
<td>Trouble Shooting</td>
<td>B39</td>
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<tr>
<td>21</td>
<td>Phonetics/Gagging in Prosthodontic Patients</td>
<td>B40</td>
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<td>22</td>
<td>Acrylic Resins</td>
<td>B42</td>
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<td>23</td>
<td>Restoration of Endodontically Treated Teeth</td>
<td>C45</td>
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<tr>
<td>24</td>
<td>Dies and Casts</td>
<td>C48</td>
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<td>25</td>
<td>Retainers – Principles of Preparation</td>
<td>C50</td>
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<tr>
<td>26</td>
<td>Restorative Contours</td>
<td>C51</td>
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<tr>
<td>27</td>
<td>Framework Design &amp; Assembly</td>
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<tr>
<td>28</td>
<td>Pontic Design</td>
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<tr>
<td>29</td>
<td>Hydrocolloid Impressions &amp; Gypsum Products</td>
<td>C58</td>
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<tr>
<td>30</td>
<td>Cephalometrics</td>
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<tr>
<td>31</td>
<td>Obstructive Sleep Apnea</td>
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<tr>
<td>32</td>
<td>Hyperbaric Oxygen</td>
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<tr>
<td>33</td>
<td>CAD/CAM</td>
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<p>| 32 | Final Exam |</p>
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<thead>
<tr>
<th>Session #</th>
<th>Fall Semester – Cycle Year 2 Topic</th>
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<tbody>
<tr>
<td>1</td>
<td>Hinge Axis II</td>
<td>A4</td>
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<tr>
<td>2</td>
<td>Eccentric Movements</td>
<td>A5</td>
</tr>
<tr>
<td>3</td>
<td>Articulators II – Semi-adjustable</td>
<td>A8</td>
</tr>
<tr>
<td>4</td>
<td>Articulators III – Fully-adjustable</td>
<td>A9</td>
</tr>
<tr>
<td>5</td>
<td>Centric Relation Recording Methods</td>
<td>A11</td>
</tr>
<tr>
<td>6</td>
<td>Vertical Dimension</td>
<td>A12</td>
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<tr>
<td>7</td>
<td>Recording Vertical Dimension</td>
<td>A13</td>
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</tbody>
</table>

*ACP Annual Session*

| 8         | Functionally Generated Path       | A14                 |
| 9         | Implantology                      | A17                 |
| 10        | Pre-prosthetic Surgery            | A18                 |
| 11        | Esthetics                         | A19                 |
| 12        | RPD Design                        | B24                 |
| 13        | Immediate Dentures                | B26                 |
| 14        | **Final Exam**                    |                     |


<table>
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<tr>
<th>Session #</th>
<th>Spring Semester – Cycle Year 2 Topic</th>
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<tbody>
<tr>
<td>15</td>
<td>Complete Dentures – Neutral Zone Techniques</td>
<td>B31</td>
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<td>16</td>
<td>Removable Partial Denture Impressions</td>
<td>B32</td>
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<tr>
<td>17</td>
<td>Masticatory Efficiency</td>
<td>B34</td>
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<tr>
<td>18</td>
<td>Denture Occlusion Overview</td>
<td>B35</td>
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<tr>
<td>19</td>
<td>Denture Occlusion – Balanced</td>
<td>B36</td>
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<tr>
<td></td>
<td>Denture Occlusion – Non-balanced</td>
<td>B37</td>
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<tr>
<td>20</td>
<td>Overdentures</td>
<td>B41</td>
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<tr>
<td>21</td>
<td>Treatment Planning</td>
<td>C43</td>
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<td>22</td>
<td>Margin Placement</td>
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<td>23</td>
<td>Tissue Control &amp; Electrosurgery Impressions</td>
<td>C46</td>
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<td>C47</td>
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<td>24</td>
<td>Retainer Preparations</td>
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<td>Porcelain</td>
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<td>Alloys</td>
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<td>Cementation</td>
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<td>27</td>
<td>Delivery</td>
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<td>28</td>
<td>Resin-Retained Fixed Partial Dentures</td>
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<td>Framework Assembly</td>
<td>C60</td>
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<td>29</td>
<td>Porcelain Laminate Veneers</td>
<td>C61</td>
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<tr>
<td>30</td>
<td>Titanium</td>
<td>C70</td>
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<tr>
<td>31</td>
<td>Ceramics II</td>
<td>C67</td>
</tr>
<tr>
<td>32</td>
<td><strong>Final Exam</strong></td>
<td></td>
</tr>
</tbody>
</table>
Assessment Format PROS 7110
- The course objectives can be achieved by reviewing and studying the reading assignments.
- Professionalism and attendance are expected and required for all sessions.
- Participation is expected and required during the seminar.
- Final point accumulation is at the discretion of the course director.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>≥90%</td>
<td>A</td>
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<tr>
<td>80-89%</td>
<td>B</td>
</tr>
<tr>
<td>70-79%</td>
<td>C* (Probation at the discretion of the resident’s program director)</td>
</tr>
<tr>
<td>&lt;70%</td>
<td>F* (Remediation required with dismissal pending overall performance in program)</td>
</tr>
</tbody>
</table>

Additional Notes
- The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
- Any change of venue will be announced during the lecture period or sent via email.
- Any student(s) found to have cheated, deceived, or procured help from another student(s) or individual during an examination will subject all parties involved to disciplinary actions that are consistent with the School of Dentistry and University policies.
- The administration and design of examinations will be at the discretion of the course director.

Student Expectations
The policy on grading and academic practices, remediation, attendance, and professional attire, can be found on the SOD website at:

Residents’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Residents will evaluate the course and faculty through the year end evaluation form and the evaluation of faculty form.

Distance Delivery of Course Material
This course does not offer distance delivery of the course material.

Grade Disputes
Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

Remediation Policies
Residents with an overall course grade of ‘C’ for PROS 7110 will be placed on probation during the following term at the discretion of the resident’s program director.
Residents with an overall course grade of ‘F’ for PROS 7110 must **remediate** during the following term to the satisfaction of the resident’s program director. Residents may also be considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

**MAKE-UP EXAM POLICIES**

Any scheduled examinations missed due to a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

**ATTENDANCE**

Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

**FEEDBACK**

Any feedback is welcome and should be forwarded to the course directors by writing, emailing, or visiting the course director’s office.

**STUDENT INTEGRITY**

Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

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**Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.**

**COMMUNICATION**

All individual and full class communication will be through your University of Minnesota email account. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

**STUDENT ON-LINE PRIVACY AND SECURITY**

Any online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.
DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

MENTAL HEALTH RESOURCES
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006

WELLNESS PROGRAM FOR DENTAL STUDENTS
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

APPROPRIATE STUDENT USE OF CLASS NOTES
Residents may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

CHANGES MADE IN RESPONSE TO STUDENT FEEDBACK
Constructive criticism is welcomed to improve this course for future residents.

FACULTY INFORMATION
Participating Faculty: Dr. Conrad (see page 1)

COURSE TIMES, ROOMS, AND TITLES FOR EACH SEMINAR SESSION
Course Times: See attached schedule.
Room: Conference room 9-170 Moos Tower
<table>
<thead>
<tr>
<th>Grading Criteria 2</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
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<tr>
<td>Primary analysis of articles</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
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</tr>
<tr>
<td>Preparation for seminar</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
<td></td>
</tr>
<tr>
<td>Participation in supplemental discussion</td>
<td>Weak</td>
<td>Modest</td>
<td>Acceptable</td>
<td>Strong</td>
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<tr>
<td>Punctual for seminar</td>
<td>Late by &gt;10 minutes</td>
<td>Late by ≤10 minutes</td>
<td>Late by ≤5 minutes</td>
<td>Ready to begin at 8:00 am</td>
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### Feedback

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<tr>
<th>2 Grading Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Primary analysis of articles</td>
<td>The capacity and competence to comprehend, interpret, and express verbally a complete understanding of historically-based, widely accepted philosophies and principles in prosthodontics. The aptitude to discuss the scientific merit of the article in question. The ability to relate the knowledge base gathered from the article reviewed to the clinical care you will provide.</td>
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</tr>
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<td>A</td>
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<td></td>
</tr>
<tr>
<td>F* (Remediation)</td>
<td></td>
</tr>
</tbody>
</table>
CONTACT INFORMATION FOR COURSE DIRECTOR
Course Director: Heather J. Conrad  DMD, MS, FACP, FRCD(C)
Office Address: 9-176c Moos Tower
Phone Number: 612-624-5046
Email Address: conr0094@umn.edu
Office Hours: M-F 8:00 am – 4:30 pm

COURSE PURPOSE

Overview
The course “Advanced Clinical Prosthodontics” is the clinical training portion of the Graduate Program in Prosthodontics. This course runs continuously (M-F) for the entire thirty-three month long program and represents approximately 60% of a resident’s educational time commitment. This course offers clinical instruction in all areas of Prosthodontics, i.e., Complete Dentures, Fixed Partial Dentures, Removable Partial Dentures, and Implant Prosthodontics. It is designed to assure sufficient clinical experiences for a resident to become proficient in the comprehensive treatment of a wide range of complex Prosthodontics patients.

Goals
- To assist with the development in the mind of a Prosthodontics resident, an in-depth knowledge of all aspects (but with special emphasis on those that are clinically related) of the following Prosthodontics disciplines; Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and Implant Prosthodontics. Note: Clinical procedures taught in this course are supported by numerous inter-related in-depth seminars, lectures and courses over the thirty-three month period of the program.
• To develop on the part of a resident in Prosthodontics, the ability to provide clinical care at a specialty level to patients requiring complex treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics.

**COURSE OBJECTIVES**

*Upon successful completion of PROS 7200, the resident dentist should be able to:*

• As this course progresses, the resident will be able to demonstrate his / her ability to initiate and carry on a discussion of important factors / principles (especially those that are clinically related) peculiar to Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and Implant Prosthodontics.

• As this course progresses, the resident will be able to demonstrate his / her ability to provide clinical care at a specialty level for any patient requiring complex treatment with Complete Dentures, Removable Partial Dentures, Fixed Partial Dentures and / or Implant Prosthodontics or any combination thereof.

**REQUIRED TEXTBOOK AND READINGS**

• Required readings
  o Current literature articles distributed electronically weekly.

**CREDITS**

PROS 7200 → 2.0 credit hours

**GRADING AND EVALUATION POLICIES**

*Patient Assignment*

A variety of individuals with different treatment needs and complexity from the programs patient pool are assigned to each resident on an as-needed basis. Assignments are made by the program director. The intent is to assure sufficient clinical experiences for each resident such that he / she may become proficient in the comprehensive treatment of a wide range of complex Prosthodontics patients.

*Evaluation*

• Participation: Residents are expected to be in clinic during all scheduled clinical sessions.

• Performance: Performance in this course is evaluated using the Advanced Clinical Prosthodontic Rubric. A copy of this form and the criteria for its use are attached. Continuous informal feedback on all aspects of each resident’s clinical progress is provided on a daily basis by attending clinical faculty. Individual residents are also welcome to speak with any of the program’s attending faculty at any time about their progress in the clinical treatment of their patients.

*Schedule & Topics*

• See resident calendars.
Assessment Format PROS 7200

- The course objectives can be achieved by reviewing and studying the reading assignments
- Professionalism and attendance are expected and required for all sessions.
- Participation is expected and required during the seminar.
- Final point accumulation is at the discretion of the course director.

\[
\begin{array}{c|c}
\text{Grade} & \text{Description} \\
\hline
\geq 90\% & A \\
80-89\% & B \\
70-79\% & C^* (\text{Probation at the discretion of the resident’s program director}) \\
<70\% & F^* (\text{Remediation required with dismissal pending overall performance in program})
\end{array}
\]

Additional Notes

- The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
- Any change of venue will be announced during the lecture period or sent via email.
- Any student(s) found to have cheated, deceived, or procured help from another student(s) or individual during an examination will subject all parties involved to disciplinary actions that are consistent with the School of Dentistry and University policies.
- The administration and design of examinations will be at the discretion of the course director.

Student Expectations

The policy on grading and academic practices, remediation, attendance, and professional attire, can be found on the SOD website at:


Residents’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Residents will evaluate the course and faculty through the year end evaluation form and the evaluation of faculty form.

Distance Delivery of Course Material

This course does not offer distance delivery of the course material.

Grade Disputes

Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

Remediation Policies

Residents with an overall course grade of ‘C’ for PROS 7200 will be placed on probation during the following term at the discretion of the resident’s program director.
Residents with an overall course grade of ‘F’ for PROS 7200 must remediate during the following term to the satisfaction of the resident’s program director. Residents may also be considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

**MAKE-UP EXAM POLICIES**
Any scheduled examinations missed due a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

**ATTENDANCE**
Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

**FEEDBACK**
Any feedback is welcome and should be forwarded to the course directors by writing, emailing, or visiting the course director’s office.

**STUDENT INTEGRITY**
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

*Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.*

**COMMUNICATION**
All individual and full class communication will be through your University of Minnesota email account. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

**STUDENT ON-LINE PRIVACY AND SECURITY**
Any online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.
**Disabilities**
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

**Mental Health Resources**
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

*Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006*

**Wellness Program for Dental Students**
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

**Appropriate Student Use of Class Notes**
Residents may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

**Changes Made in Response to Student Feedback**
Constructive criticism is welcomed to improve this course for future residents.

**Faculty Information**
Participating Faculty: Dr. Conrad (see page 1)

**Course Times, Rooms, and Titles for Each Seminar Session**
*Course Times:* See attached schedule.
*Room:* 9 South Clinic Cubicles #33-40 Moos Tower
<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production</td>
<td>&gt;20% away from target production level</td>
<td>Within 20% of target production level</td>
<td>Within 10% of target production level</td>
<td>Within 5% of target production level</td>
<td></td>
</tr>
<tr>
<td>Progress</td>
<td>Extended delay of completion expected</td>
<td>Moderate delay of completion expected</td>
<td>Effort needed to resume schedule</td>
<td>On schedule</td>
<td></td>
</tr>
<tr>
<td>Productivity</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Preparation &amp; Attendance</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Scheduling</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>All of the time</td>
<td></td>
</tr>
<tr>
<td>Professionalism &amp; Patient Testimonials</td>
<td>Not evident</td>
<td>Improvement needed</td>
<td>Moderately satisfied</td>
<td>High satisfaction</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Total Points</th>
<th>Resident Score</th>
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<tbody>
<tr>
<td>A</td>
<td>36-40</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>32-35</td>
<td></td>
</tr>
<tr>
<td>C* (Probation)</td>
<td>28-31</td>
<td></td>
</tr>
<tr>
<td>F* (Dismissal)</td>
<td>≤27</td>
<td></td>
</tr>
</tbody>
</table>

Total production goal at end of 3 year program:

<table>
<thead>
<tr>
<th>Month</th>
<th>Goal</th>
<th>Resident Total Production</th>
<th>Resident % Target Production Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>August Year 1</td>
<td>$0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>December Year 1</td>
<td>$30,000</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>April Year 1</td>
<td>$75,000</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>August Year 2</td>
<td>$120,000</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>December Year 2</td>
<td>$165,000</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>April Year 2</td>
<td>$210,000</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>August Year 3</td>
<td>$255,000</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>December Year 3</td>
<td>$285,000</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>April Year 3</td>
<td>$300,000</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
### Progress

<table>
<thead>
<tr>
<th>Clinical Requirements</th>
<th>Resident Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete dentures (including immediate dentures)</td>
<td>30</td>
</tr>
<tr>
<td>Removable partial dentures</td>
<td>10</td>
</tr>
<tr>
<td>Crowns – natural teeth</td>
<td>80</td>
</tr>
<tr>
<td>Pontics – natural teeth or implant supported</td>
<td></td>
</tr>
<tr>
<td>Crowns – implants</td>
<td>80</td>
</tr>
<tr>
<td>Implant dentures</td>
<td>7</td>
</tr>
<tr>
<td>Implant placement</td>
<td>20</td>
</tr>
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</table>

### Grading Criteria

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Production</td>
<td>Progress is being made toward final target production.</td>
</tr>
<tr>
<td>Progress</td>
<td>Progress is being made toward completion of clinical requirements and toward board certification. Patient treatment is entered in the Patient Tracking System.</td>
</tr>
<tr>
<td>Productivity</td>
<td>Uses available clinic time for patient appointments.</td>
</tr>
<tr>
<td>Preparation and Attendance</td>
<td>Prepared for patient appointments including instruments, supplies, implant parts, laboratory work. Attends all continuing education courses and guest speaker presentations.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Uses patient clinic time efficiently and dismisses patients on time.</td>
</tr>
<tr>
<td>Quality</td>
<td>Quality of clinical restorative dentistry and laboratory procedures is of the highest. Infection control procedures are followed.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Thorough SOAP notes are written in axiUm for all patient appointments.</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Daily clinic/lab/class/teaching schedules are recorded in axiUm 24 hours in advance.</td>
</tr>
<tr>
<td>Financial</td>
<td>Collection of appropriate fees is arranged prior to sending cases to the lab and prior to delivery, treatment plans are entered and signed in axiUm, charges are billed correctly on the day of service.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Exhibits the character, standards, appearance, and behavior of a professional. Written and verbal patient testimonials of satisfaction are presented, patient calls/emails are appropriately returned, patient questions are answered, treatment options are thoroughly explained to the patient.</td>
</tr>
</tbody>
</table>

### Feedback

<table>
<thead>
<tr>
<th>Program Director</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Dentist</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signatures</th>
</tr>
</thead>
</table>


University of Minnesota School of Dentistry
Advanced Education Program in Prosthodontics
Course Syllabus

PROS 7210
Advanced Technical Restorative Dentistry
Summer Semester
Year 1

CONTACT INFORMATION FOR COURSE DIRECTOR
Course Director:  Dr. Heather J. Conrad, DMD, MS, FACP, FRCD(C)
Section Directors:  Dr. Ranier Adarve, DMD, MS, MHPE
Dr. Charles Stendahl, DDS, MS, FACP
Dr. James Holtan, DDS, FACP
Dr. Wook-Jin Seong, DDS, MS, PhD, FACP
Office Address:  9-176 Moos Tower
Phone Number:  612-624-5046
Email:  conr0094@umn.edu
Office Hours:  M-F 8:00 am – 4:30 pm

COURSE PURPOSE
PROS 7210 encompasses the disciplines of complete dentures (Conrad), fixed dental prostheses (Adarve), removable dental prostheses (Stendahl), occlusal morphology (Holtan), and implant prosthodontics (Seong). As a result, the course is divided into five separate yet related sections with each section being scheduled as time and circumstances warrant. The first four sections will be taught in the Year 1 Summer semester while the fifth section on implants will be taught in the following semester and included in your Fall Semester grade for PROS 7200. Each section will utilize demonstrations, clinical exercises, laboratory exercises, assigned readings and a seminar format to accomplish the overall goals and objectives listed below.

COURSE OBJECTIVES

Upon successful completion of PROS 7210, the resident dentist should be able to:

- Demonstrate an in-depth knowledge of all aspects of prosthodontics including techniques. The learning process initiated in prosthodontic treatment will be supported by numerous in-depth, related, topic-specific seminars and clinical experiences over the thirty-three-month period of the program.
• Demonstrate ability and potential to provide clinical care at a specialty level

**Complete Dentures (Conrad)**

*Upon successful completion of PROS 7210, the resident dentist should be able to:*

- Identify procedures to be completed during an edentulous patient examination
- Evaluate any pretreatment records and assess a patient’s prosthodontic needs
- Develop a treatment plan for an edentulous patient
- Identify and relate anatomical landmarks to complete denture construction
- Relate the process of residual ridge resorption to complete denture construction
- Recognize oral pathology that is related to complete denture therapy
- Interpret patient case records using the diagnostic criteria of complete edentulism
- Evaluate clinical treatment photos and identify clinically acceptable treatment procedures
- Select appropriate equipment, tools, and instruments, to assist in the fabrication of complete dentures
- Identify the age and gender of patients based on characteristics of their dentition
- Evaluate and select an appropriate incisal display for a patient
- Arrange the steps of maxillomandibular records in the correct sequence
- Recognize the difference between evaluating the vertical dimension of occlusion and the physiologic rest position
- Select an appropriate vertical dimension of occlusion for a patient
- Understand the importance of centric relation in complete denture construction and recognize how it is recorded
- Interpret code numbers and letters in the Teeth Mould Chart
- Choose the most appropriate anterior or posterior tooth mould and shade for a patient
- Compare natural and denture occlusal relationships in intercuspal and eccentric occlusal contacts and eccentric occlusal schemes
- Identify characteristics of an ideal morphologic and functional occlusion for complete dentures
- Evaluate anterior and posterior tooth arrangements
- Apply Hanau’s Quint to complete denture tooth arrangements
- Identify and evaluate procedures to be completed at a wax trial denture appointment
- Recognize the importance of the posterior palatal seal to retention of the maxillary denture
- Identify laboratory procedures in the processing and finishing of complete dentures
- Identify procedures to be completed at the delivery and post-insertion appointments
- Apply patient signs and symptoms to possible post-insertion complications
- Apply complete denture sequencing and procedures to immediate complete dentures
- Compare a denture reline to a rebase or a remake and identify the appropriate treatment need based on the patient presented

*Upon successful completion of PROS 7210, the resident dentist should CLINICALLY be able to:*

- Select the appropriate armamentarium for clinical and laboratory procedures
- Demonstrate competency in making preliminary and final impressions of the maxillary and mandibular edentulous arch
• Demonstrate competency in boxing and pouring impressions with dental stone and properly trimming the resultant cast
• Demonstrate competency in the fabrication of custom trays, record base and wax rims
• Demonstrate competency in making maxillomandibular records from a clinical patient and transfer this record to the semi-adjustable articulator
• Demonstrate competency in the arrangement of anterior and posterior artificial denture teeth and the final wax contouring and characterization of denture bases
• Demonstrate competency in the finishing, polishing, remount, and selective grinding of a processed set of complete dentures
• Demonstrate competency in the utilization of the semi-adjustable articulator and mounting of edentulous master casts

Fixed Dental Prostheses (Adarve)
• Review and apply the fundamental concepts and procedures in Fixed Prosthodontics for new residents prior to providing patient treatment and clinical care
• Apply the Principles of Tooth Preparation
• Prepare Different Types of Full Crown Restoration at clinically acceptable standards:
  o Full Gold Crown
  o Porcelain Fused-to-Metal Crown
  o All Ceramic Restoration
• Prepare Fixed Partial Denture at clinically acceptable standards
• Fabricate Master Cast
  o Take accurate primary impression
  o Fabricate clean and void-free diagnostic cast
  o Fabricate custom tray
  o Pack retraction cord
  o Take accurate final impression
  o Appropriately box the final impression
  o Fabricate die accurately
  o Full contour wax up
• Mount the master casts accurately and cleanly on the articulator
• Demonstrate Direct and Indirect Fabrication of Provisional Crown
  o Single tooth provisional restoration
  o Fixed Partial Denture provisional restoration

Removable Dental Prostheses (Stendahl)
• This section will utilize seminars and hands-on laboratory exercises to accomplish the below listed goals and objectives. Stress will be placed on RPD treatment planning and design, tooth modification, impression procedures and techniques related to the fabrication of a RPD. General concepts of occlusion including centric relation, mandibular movements and tooth guidance will be introduced.
• Following completion of this section, the resident will be able to discuss all aspects (especially those that are technically related) of Removable Partial Denture fabrication.
• Following completion of this section, the resident will be able to demonstrate his/her ability to; diagnose and treatment plan a patient requiring removable partial dentures, use
a surveyor, draw a RPD design clearly on a diagnostic cast and explain the rationale for the design, plan and carry out any necessary tooth modifications (including the fabrication of surveyed crowns if necessary), utilize different final impression techniques and different material options when called for, fit a RPD framework to the mouth, correctly fabricate and mount a master cast / casts on a semi or fully adjustable articulator using appropriate records, choose the occlusal scheme appropriate to the patients, deliver an RPD to the patient using all appropriate procedures and lastly, appreciate the importance of clinician - laboratory communication.

- Following completion of this section, the resident will be able to explain general concepts of occlusion, use a facebow and articulator that is appropriate for the patient, and use this new found ability / understanding to achieve optimum patient care.

**Occlusal Morphology (Holtan)**

- The purpose of this section on occlusal morphology is to familiarize the student with a technique for the rapid waxing of opposing posterior quadrants. Dr. Everitt V. Payne originally developed the technique we will use. Dr. Harry Lundeen further refined this technique while he was Professor and Coordinator of Occlusion at the University of Florida College of Dentistry. The technique is described in his manual “Introduction To Occlusal Anatomy” which is used for this section. The manual and all other necessary materials will be provided.
- The section consists of six eight-hour hands-on sessions as listed below. Slides, a lecture format and discussion will supplement the hands-on portion of the course.

**Implant Prosthodontics (Seong)**

- The resident will be able to discuss all aspects of Implant Prosthodontics including those that are technically related.
- Following completion of this section, the resident will be able to demonstrate his/her ability to diagnose and treatment plan a patient requiring dental implants, explain the unique differences that exist in treatment planning for dental implants versus natural teeth, explain the scientific rationale for dental implants, explain the options available for treating edentulous and partially edentulous patients with dental implants, understand the factors that are important when placing and restoring dental implants in the esthetic zone, explain the clinical procedures related to implant dentistry, recognize the advantages / disadvantages of different dental implant systems, recognize the most common complications associated with implant dentistry and communicate with other health care providers concerning the use of dental implants.
- Define osseointegration, understand osseointegration process in cellular level, the differences between natural teeth and dental implants, and implant components, and explain scientific rationale for dental implants.
- Explain the step by step clinical procedures related to dental implant therapy including diagnostic imaging, surgical guide fabrication, grafting and implant surgery, prosthesis restoration, and maintenance procedures.
- Understand anatomy and implant surgical procedures and identify the situation requiring grafting procedures and the indications for different implant placement and restoration techniques/protocols.
- Diagnose and treatment-plan a patient requiring restoration of the edentulous area using dental implants.
- Explain the options available for treating maxillary and/or mandibular edentulous and partially edentulous patients with dental implants.
- Define implant success criteria and present implant failure rates and recognize the common complications associated with implant dentistry including peri-implantitis and explain possible causes and intervention therapy of the complications.
- Understand biomechanics of dental implant therapy including bone biomechanics, screw mechanics and occlusion design.
- Understand the factors that are important when placing and restoring dental implants in the esthetic zone.
- Understand various macro and micro design features of the implants and recognize the advantages / disadvantages of different dental implant system.
- Understand the rationale and procedures to rehabilitate soft and hard tissue for dental implant therapy.
- Communicate with surgeons, general dentists, and lab technicians concerning the use of dental implants and explain lab procedures of prosthesis fabrication and post-treatment follow up and maintenance.

**Required Text and Readings**

- Course manual and videos
  - Provided by individual section directors.

  o You will be loaned a copy of this textbook by the program; however, you may purchase your own copy online if you wish.


**CREDITS**

PROS 7210 → 2.0 credit hours

**GRADING AND EVALUATION POLICIES**

**Weighting of factors:**

- 20% Complete Dentures**
- 20% Fixed Dental Prostheses**
- 20% Removable Dental Prostheses**
- 20% Occlusal Morphology**
- 20% Implant Prosthodontics**
**All individual sections of this course must be passed to pass the course. Failure in one of the five sections of this course will result in failure of the entire course.**

- See course rubric for grading criteria.
- Attendance: Attendance in this section / course is mandatory. One unexcused absence will result in failure of this section of the course.
- Readiness: Residents are expected complete all assigned readings and watch selected videos prior to each session.
- Participation: Each resident will be assigned to a patient requiring treatment with complete dentures. Active participation from the resident is expected during all phases of this course section and the patient’s treatment will be evaluated upon completion.
- Final exam: The final exam for any of the sections of this course may include an oral and/or written format with all residents participating.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥90%</td>
<td>A</td>
</tr>
<tr>
<td>80-89%</td>
<td>B</td>
</tr>
<tr>
<td>70-79%</td>
<td>C* (Probation at the discretion of the program director)</td>
</tr>
<tr>
<td>&lt;70%</td>
<td>F* (Remediation required with dismissal pending overall performance in program)</td>
</tr>
</tbody>
</table>

**Assessment Format PROS 7210:**
- It is your responsibility to check and be familiar with the Moodle site for this course. This is where you may find the schedule, syllabus, lecture notes, web links, quizzes, grades, and due dates.
- The course objectives can be answered by studying the course and laboratory manuals, videos, reading assignments, and information presented in the lectures.
- Quizzes will correspond with the lectures and will be posted on Moodle semi-weekly or weekly. The quizzes are designed to review key points or concepts presented in the lecture.
- Course quizzes and written examinations may use any identification format such as multiple choice, true/false, matching type, short answer, essay, and drawings.
- Professionalism and attendance are expected and required for all sessions.
- Participation is encouraged during the lecture.
- Final point accumulation is at the discretion of the course director.

**Schedule**
- Lecture topics and clinical procedures are listed in the course schedule.

**Additional Notes**
- The schedule is an attempt to provide a progressive sequence of educational material. To assure proper sequencing of the course material, the schedule may be amended at the discretion of the course director at any time during the semester.
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Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director.

**REMEDICATION POLICIES**
Residents with an overall course grade of ‘C’ for PROS 7210 will be placed on probation during the following term at the discretion of the resident’s program director. Residents with an overall course grade of ‘F’ for PROS 7210 must remediate during the following term to the satisfaction of the resident’s program director. Residents may also be considered for dismissal pending overall performance in the Advanced Education Program in Prosthodontics.

**MAKE-UP EXAM POLICIES**
Any scheduled examinations missed due a medical or family emergency can be made-up by making arrangements with the course director. Failure to be present for an examination without an excused absence will be handled at the discretion of the course director.

**ATTENDANCE**
Attendance is required for all seminars. If you are unable to attend class due to a medical or family emergency, please contact Jessica Andersen at 612.624.6644 or vaugh068@umn.edu. Failure to attend a seminar without an excused absence will be handled at the discretion of the course director.

**FEEDBACK**
Any feedback is welcome and should be forwarded to the course director by writing, emailing, or visiting the program director’s office.
**STUDENT INTEGRITY**
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

**COMMUNICATION**
All individual and full class communication will be through your University of Minnesota email account. Announcements intended for the whole class will be sent by email. It is a requirement of the course to check your email daily. While in class, please turn off all pagers and cellular phones.

**DISABILITIES**
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website [http://ds.umn.edu](http://ds.umn.edu).

**MENTAL HEALTH RESOURCES**
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via [www.mentalhealth.umn.edu](http://www.mentalhealth.umn.edu).

*Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006*

**WELLNESS PROGRAM FOR DENTAL STUDENTS**
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-
7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

**APPROPRIATE STUDENT USE OF CLASS NOTES**
Residents may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

**CHANGES MADE IN RESPONSE TO STUDENT FEEDBACK**
Constructive criticism is welcomed to improve this course for future residents.

**FACULTY INFORMATION**
Participating Faculty: Drs. Conrad, Adarve, Stendahl, Holtan, Seong (see page 1)
**COURSE TIMES, ROOMS, AND SEMINAR TITLES FOR EACH SESSION**

*Course Times:* 336 hours lecture/clinic/laboratory  
*Room:* Conference room 9-170 Moos Tower, Clinic 9 South Cubicles #33-40

**Schedule: Complete Dentures (Conrad)**

<table>
<thead>
<tr>
<th>#</th>
<th>Date</th>
<th>Seminar Topic</th>
<th>Reading Assignment</th>
<th>Clinic</th>
<th>Laboratory</th>
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| 1  | June 27 Friday 9am - noon | Introduction to complete dentures *(video slideshow)*  
  Complete denture anatomy  
  Clinical complete denture patient: Parts I and II *(video)* | Ch 1: p 1-27  
The Edentulous State  
Ch 3: p 35-41  
Aging  
Ch 8: p 161-70  
Anatomy | None | Watch assigned videos prior to every clinical session |
| 2  | June 30 Monday 8am – 4pm | Edentulous patient examination Preliminary impressions and casts *(video)*  
  Custom tray fabrication *(video)* | Ch 4: p 42-52  
Sequela  
Ch 5: p 53-76  
Exam  
Ch 8: p 171-173  
Prelim Impression | Edentulous patient examination  
Preliminary alginate impressions | Pour preliminary impressions  
Prepare preliminary casts  
Fabricate custom trays |
| 3  | July 7 Monday 8am – 4pm | Diagnostic classification of the edentulous patient  
Border molding *(video)*  
Final impressions *(video)*  
Boxing impressions *(video)*  
Master cast preparation  
Record base and wax occlusion rim fabrication *(video)* | Ch 5: p 77-92  
Improving Foundations  
Ch 8: p 173-176, 178-179  
Final Impressions | Maxillary:  
Border mold custom tray  
Final impression | Maxillary:  
Box and pour final impression  
Prepare master cast  
Fabricate record base & wax rim |
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<tr>
<th>Date</th>
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<th>Topic</th>
<th>Chapter(s)</th>
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<td>July 11</td>
<td>Friday 8am – 4pm</td>
<td>Oral pathology related to complete dentures</td>
<td>Ch 23: p 409-419 Socioeconomic &amp; Cultural Changes</td>
<td>Mandibular: Border mold custom tray Final impression</td>
<td>Mandibular: Box and pour final impression Prepare master cast Fabricate record base &amp; wax rim</td>
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<td>July 14</td>
<td>Monday 8am – 4pm</td>
<td>Maxillomandibular relations (video) Functional occlusion, articulators, facebow, mount maxillary cast (video)</td>
<td>Ch 9: p 180-198 Jaw Relations</td>
<td>Maxillary and mandibular relations – vertical dimension Facebow</td>
<td>Mount maxillary cast</td>
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<td>July 18</td>
<td>Friday 8am – 4pm</td>
<td>Anterior tooth selection Centric relation (video) Mount mandibular cast Anterior tooth arrangement (video)</td>
<td>Ch 9: p 198-203 Records Ch 10: p 204-215 Anterior Tooth Selection/Arrange</td>
<td>Centric relation record Select denture tooth mould/shade</td>
<td>Mount mandibular cast</td>
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<td>July 25</td>
<td>Friday 8am – 4pm</td>
<td>Posterior palatal seal Final wax contouring (video) Facebow remount jig Preparing lab prescriptions</td>
<td>Ch 8: p 176-178 PPS Ch 11: 249-254 PPS Ch 12: 255-257 Festooning</td>
<td>Posterior tooth try-in Posterior palatal seal</td>
<td>Final wax contouring Facebow remount jig</td>
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<tr>
<td>July 28</td>
<td>Monday am</td>
<td>No seminar</td>
<td>No clinic OR Appoint if needed</td>
<td>Complete final wax contouring</td>
<td>No clinic OR Appoint if needed</td>
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<td>Date</td>
<td>Day</td>
<td>Time</td>
<td>Schedule</td>
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| August 1   | Friday    | 8am – 4pm    | Complete denture processing *(video)*  
CD reline processing *(video)*  
Break out, laboratory remount | Ch 12: p 257-265  
Flaking Processing | No clinic | Flaking Processing  
Break out |
| August 4   | Monday    | 8am - noon   | Acrylic finishing & polishing *(video)*  
Delivery preparation  
Remount cast fabrication *(video)* | Ch 12: p 265-266  
Finish/Polish Remount Casts | No clinic | Acrylic finishing & polishing  
Remount casts  
Mount maxillary denture |
| August 8   | Friday    | 8am – 4pm    | Denture placement appointment | Ch 12: p 267-275  
Delivery | Adjust denture base  
Clinical remount | Complete laboratory procedures to prepare for delivery |
| August 11  | Monday    | 8am - noon   | Immediate complete dentures  
Part I  
Immediate complete dentures  
Part II  
Surgerize cast *(video)* | Ch 13: p 281-290,  
298-302  
Immediate Dentures  
Single Denture | Delivery  
Post-op instructions | Selective grinding |
| August 13  | Wednesday | 8am – 4pm    | Post-insertion trouble shooting | Ch 12: p 275-280  
Follow-Up | Post-insertion denture adjustment #1 | Maxillary immediate denture custom tray |
| August 18  | Monday    | 8am - noon   | Denture repairs *(2 videos)*  
Reline or rebase  
Tissue conditioning *(video)* | Ch 14: p 303-314  
Reline/Repair | Post-insertion denture adjustment #2 | Maxillary immediate denture record base and wax rim |
| August 20  | Wednesday | 10 – 11 am   | No seminar | Ch 7: p 121-160  
Dental Materials  
**Independent Reading** | Post-insertion denture adjustment #3 | Final Written Exam  *opens today until August 31st* |
Schedule: Fixed Dental Prostheses (Adarve)

Session 1: Thursday AM, July 3rd 9:00 am to noon
Lecture: -Biomechanical Principles of Tooth Preparation
Lab: -Primary Impression (Alginate) for Maxillary and Mandibular Arches
      -Prepare Tooth #19 FGC

Session 2: Thursday PM, July 3rd 1:00 to 4:00 pm
Lab: -Prepare Tooth 12 PFM
     -Prepare Tooth 9 All Ceramic

Session 3: Thursday AM, July 10th 9:00 am to noon
Lecture: -Fixed Partial Denture
Lab: -FPD 28-x-30

Session 4: Thursday PM, July 10th 1:00 to 4:00 pm
Lab: -FPD 6-x-8
     -FPD 13-x-15

Session 5: Thursday AM, July 17th 9:00 am to noon
Lecture: -Fabrication of Master Cast in Fixed Prosthodontics
Lab: -Final Impression
     -Facebow Record

Session 6: Thursday PM, July 17th 1:00 to 4:00 pm
Lab: -Boxing of Final Impression
     -Pouring of Final Impression

Session 7: Thursday AM, July 24th 9:00 am to noon
Lecture: -Fabrication of Master Cast in Fixed Prosthodontics
Lab: -Pindexing

Session 8: Thursday PM, July 24th 1:00 to 4:00 pm
Lab: -Pindexing
     -Mounting Master Casts in Articulator

Thursday, July 31st: No Class – Study Preparation Time for Anatomy

Session 9: Thursday AM, August 7th 9:00 am to noon
Lab: -PRACTICAL TEST 1
     -Single Crown Preparation
     -FPD Preparation
Session 10: Thursday PM, August 7th 1:00 to 4:00 pm  
  Lab:  
  -Die Trimming  
  -Spacer

Session 11: Thursday AM, August 14th 9:00 am to noon  
  Lab:  
  -Completion of Master Cast  
  -Full Contour Wax up on Tooth #9 and Tooth #30

Session 12: Thursday PM, August 14th 1:00 to 4:00 pm  
  Lecture:  
  -Provisional Restoration and Techniques  
  Lab:  
  -Single Crown Provisional #9 and FPD Provisional #19-x-21

Session 13: Thursday AM, August 21st 9:00 am to noon  
  Lab:  
  -Teeth Preparation for #6, 7, 8, 9, 10, 11 (provisional single crowns)

Session 14: Thursday PM, August 21st 1:00 to 4:00 pm  
  Lab:  
  -PRACTICAL TEST 2  
  -Single Crown Preparation and Provisional  
  -FPD Preparation and Provisional

Session 15: Thursday AM, August 28th 9:00 am to noon  
  Lab:  
  -Catch up on all required projects for submission  
  -Mounted Master Casts  
  -Prepared Teeth and Provisional

Session 16: Thursday PM, August 28th 1:00 to 4:00 pm  
  Lab:  
  -Evaluation and Feedback Session  
  -Regarding Practical Tests  
  -Regarding projects (master casts, prepared teeth and provisional)
Schedule: Removable Dental Prostheses (Stendahl)

Session 1 – Tuesday, July 1st
9:30-noon  General Concepts
Readings: McCracken’s text Ch. 1-4
RPD Syllabus Ch 3
1:00 – 4:00  Diagnosis; treatment planning; initial preparation
Readings: McCracken’s Text Ch 12-13
RPD Syllabus Ch 2

Session 2 – Tuesday, July 8th
9:30-noon  Components of a Removable Partial Denture and their Functions
Readings: McCracken’s Text Ch 5-9
RPD Syllabus Ch 1, 5, 6, & 7
1:00 – 4:00  Surveying and Design
Readings: McCracken’s Text Ch 10, 11
RPD Syllabus Ch 4, 8, 9, 10, 11, 12 & 13

Tuesday, July 15th
No Class Study Prep Time for Anatomy

Session 3 – Tuesday, July 22nd
9:30-noon  Mouth Preparation
Readings: McCracken’s Text Ch 14
RPD Syllabus Ch 16
1:00 – 4:00  Impression making
Readings: McCracken’s Text Ch 15, 16
RPD Syllabus Ch 17

Tuesday, July 29th
Dr. Stendahl out: No Class - study or lab work

Session 4 – Tuesday, August 5th
9:30-noon  Occlusal Relationships; Demonstration
Readings: McCracken’s Text Ch 17
RPD Syllabus Ch 14
1:00-4:00  Laboratory Procedures; Work Authorizations
Readings: McCracken’s Text Ch 18 & 19
RPD Syllabus Ch 15 & 18

Tuesday, August 12th
Dr. Stendahl out: No Class - study or lab work
Session 5 – Tuesday, August 19th
9:30-noon Tour of Lemke Dental Laboratory, RPD Section
1:00-4:00 Delivery; Remounting; Reline Procedures
Readings: McCracken’s Text Ch 20, 21
RPD Syllabus Ch 19 & 20

Session 6 - **Friday, August 22nd
9:30-noon Attachments; Removable Partial Overdentures; Interim Removable Partial Dentures; Use of Implants in Removable Partial Dentures
Readings: McCracken’s Text Ch 23, 25
RPD Syllabus Ch 22 & 23
1:00-4:00 Review

Session 7 – Tuesday, August 26th
9:30-noon Final Exam
Schedule: Occlusal Morphology (Holtan)

Session #1: Wednesday, July 2nd, 8 AM - 4 PM. Introduction to the section (slides, lecture on occlusion / occlusal concepts and discussion of the Hanau Model H-2 articulator). Mounting and equilibration of casts (to insure maxillary and mandibular canine contact with immediate posterior disclusion) on a Hanau H2 articulator.

Session #2: Wednesday, July 9th, 8 AM - 4 PM. Initial preparation of casts for the waxing of left posterior opposing quadrants (first premolar through second molar). Forming of mandibular and maxillary buccal cusps.

Session #3: Wednesday, July 16th, 8 AM - 4 PM. Forming of buccal ridges of mandibular and maxillary buccal cusps. Forming lingual triangular ridges of maxillary buccal cusps.

Session #4: Wednesday, July 23rd, 8 AM - 4 PM. Forming mesial and distal ridges of maxillary and mandibular buccal cusps. Placement of cones for maxillary lingual cusp tips.

Session #5: Wednesday, July 30th, 8 AM - 4 PM. Forming ridges of maxillary lingual cusps. Forming mesial and distal marginal ridges of maxillary teeth. Forming lingual triangular ridges for mandibular buccal cusps. Locate cones for mandibular lingual cusps. Complete ridges for each lingual cusp.

Session #6: Wednesday, August 6th, 8 AM - 4 PM. Placement of mesial and distal marginal ridges of mandibular teeth.

Wednesday, August 13th
No Class in Occlusal Morphology – will substitute with Complete Dentures

Session #7: Wednesday, August 20th, 8 AM - 4 PM. Finalize diagnostic wax-up.
**Schedule: Implant Prosthodontics (Seong)**

**Summer Orientation**

<table>
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<tr>
<th>#</th>
<th>Date</th>
<th>Time</th>
<th>Implant Company</th>
<th>Rep</th>
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<td>2</td>
<td>Monday, July 21</td>
<td>1:00–4:00 pm</td>
<td>Nobel Biocare</td>
<td>Jim Dennison</td>
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<td>Monday, July 28</td>
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<td>Dentsply (Astra Tech)</td>
<td>Mitch Nelson</td>
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<td>4</td>
<td>Monday, August 4</td>
<td>1:00–4:00 pm</td>
<td>BioHorizons</td>
<td>Daniel Boone</td>
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<td>5</td>
<td>Monday, August 11</td>
<td>1:00–4:00 pm</td>
<td>Straumann</td>
<td>Andy Pelleymounter</td>
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<td>6</td>
<td>Monday, August 18</td>
<td>1:00–4:00 pm</td>
<td>Whip Mix</td>
<td>Jason Radziewicz</td>
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**Fall Lecture Series**

**Session #1:** define osseointegration, understand osseointegration process in cellular level, the differences between natural teeth and dental implants, and implant components, and explain scientific rationale for dental implants.

**Date:** Thursday, September 4  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526

A. **Assigned readings:** Chapters 1, 2, 41. Carl E. Misch: Contemporary Implant Dentistry, 3rd Ed. Elsevier, 2008. Dr. JE Davies animations http://www.ecf.utoronto.ca/~bonehead/

**Session #2:** explain the step by step clinical procedures related to dental implant therapy including diagnostic imaging, surgical guide fabrication, grafting and implant surgery, prosthesis restoration, and maintenance procedures.

**Date:** Thursday, September 11  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526

Dr. Seong’s presentation will be given on quick preview of clinical procedures, reading CBCT, and surgical guide fabrications.

**Session #3:** understand anatomy and implant surgical procedures and identify the situation requiring grafting procedures and the indications for different implant placement and restoration techniques/protocols.

**Date:** Thursday, September 18  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526

**Session #4:** diagnose and treatment-plan a patient requiring restoration of the edentulous area using dental implants.

**Date:** Thursday, September 25  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526


**Session #5:** explain the options available for treating maxillary and/or mandibular edentulous and partially edentulous patients with dental implants.

**Date:** Thursday, October 2  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526


**Session #6:** define implant success criteria and present implant failure rates and recognize the common complications associated with implant dentistry including peri-implantitis and explain possible causes and intervention therapy of the complications.

**Date:** Thursday, October 9  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526

A. **Assigned readings:**
- Dr. Seong’s presentation will be given on implant success criteria, complications, and peri-implantitis prevalence and intervention.
Session #7: understand biomechanics of dental implant therapy including bone biomechanics, screw mechanics and occlusion design.

Date: Thursday, October 16  
Time: 8:00 – 10:00 AM  
Location: Seminar Room #9-170 and graduate laboratory room # 9-526


Session #8: understand the factors that are important when placing and restoring dental implants in the esthetic zone.

Date: Thursday, October 23  
Time: 8:00 – 10:00 AM  
Location: Seminar Room #9-170 and graduate laboratory room # 9-526

Dr. Seong’s presentation will be given on biotypes, Tarnow articles, and roads to esthetic restoration.

Session #9: understand various macro and micro design features of the implants and recognize the advantages / disadvantages of different dental implant system.

Date: Thursday, October 30  
Time: 8:00 – 10:00 AM  
Location: Seminar Room #9-170 and graduate laboratory room # 9-526

Dr. Seong’s presentation will be given on features of ideal dental implant.

No class November 6th: ACP

Session #10: understand the rationale and procedures to rehabilitate soft and hard tissue for dental implant therapy.

Date: Thursday, November 13  
Time: 8:00 – 10:00 AM  
Location: Seminar Room #9-170 and graduate laboratory room # 9-526

**Session #11:** communicate with surgeons, general dentists, and lab technicians concerning the use of dental implants and explain lab procedures of prosthesis fabrication and post-treatment follow up and maintenance.

**Date:** Thursday, November 20  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170 and graduate laboratory room # 9-526

Dr. Seong’s presentation will be given on communications among doctors and technicians and lab procedures.  
Q and A session will follow the seminar.

**Session #12: Final written exam**

**Date:** Thursday, December 4  
**Time:** 8:00 – 10:00 AM  
**Location:** Seminar Room #9-170.  
- Bring a laptop to write an answer in word document. Immediately after the exam you will email me the answers. Keep the exam questions confidential.
## Pros 7210  Advanced Technical Restorative Dentistry

### Resident Name

### Date

### Semester/Year  Summer Year 1  Probationary Period

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<td>Specialty level achievement or potential</td>
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<td>Mostly</td>
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### Grading Criteria 2

#### Removable Prosthodontics

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### Grading Criteria 2

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<td>Senior DDS level</td>
<td>Top 20% new DDS graduate or experienced dentist</td>
<td>Specialty level achievement or potential</td>
<td></td>
</tr>
<tr>
<td>Analysis and participation</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Grading Criteria 2

#### Implant Prosthodontics

<table>
<thead>
<tr>
<th>Grading Criteria</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Resident Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Written Exam*</td>
<td>&lt;70%</td>
<td>≥70%</td>
<td>≥80%</td>
<td>≥90%</td>
<td></td>
</tr>
<tr>
<td>Preparation for sessions</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>Analysis and participation</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Mostly</td>
<td>Always</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Grade will be accounted for in your PROS 7200 Fall Semester grade.

### Grade Table 1

<table>
<thead>
<tr>
<th>Grade</th>
<th>Total Points</th>
<th>Resident Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>62-68</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>55-61</td>
<td></td>
</tr>
<tr>
<td>C* (Probation)</td>
<td>48-54</td>
<td></td>
</tr>
<tr>
<td>F* (Dismissal)</td>
<td>≤47</td>
<td></td>
</tr>
</tbody>
</table>

Final point accumulation and grade is at the discretion of the course director. All individual sections of this course must be passed to pass the course.
<table>
<thead>
<tr>
<th><strong>Grading Criteria</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quizzes</td>
<td>Performance on all quizzes.</td>
</tr>
<tr>
<td>Final Written Exam</td>
<td>Performance on final written exam.</td>
</tr>
<tr>
<td>Laboratory Exercises</td>
<td>Demonstrates high skill level in completing assigned laboratory exercises. Willingness to receive and seek constructive criticism. Desire, drive, and potential to perform at a specialty level and become board certified. Motivation to improve skill set. Potential to work independently with faculty mentorship.</td>
</tr>
<tr>
<td>Clinical Exercises</td>
<td>Demonstrates high skill level in completing assigned clinical exercises. Willingness to receive and seek constructive criticism. Desire, drive, and potential to perform at a specialty level and become board certified. Motivation to improve skill set. Potential to work independently with faculty mentorship. Confidence in rapport/communication with patient.</td>
</tr>
<tr>
<td>Preparation for sessions</td>
<td>Reading assignments have been completed. Videos have been watched. Laboratory procedures are completed as planned. All sessions are attended and resident is punctual.</td>
</tr>
<tr>
<td>Analysis of reading assignments and participation in group discussion</td>
<td>Ability to understand and discuss reading assignments in a comprehensive, intellectual, and casual way without reading directly from the text. Participates in a meaningful open conversation about the current reading assignment while exchanging experiences and ideas.</td>
</tr>
</tbody>
</table>

**Feedback**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signatures**

**Program Director**

**Resident**
Anatomy of the Head and Neck (ANAT 7999) – 2014

Course Director: Mark S. Cook, PT, PhD
Department of Integrative Biology and Physiology
University of Minnesota
Cookx072@umn.edu

Lectures based on: Clinically Oriented Anatomy by Keith Moore and Arthur Dalley.

Course Description: A comprehensive review of the anatomy of the human head and neck with dissection.

Lecture: 6:00 – 7:00 pm  Room 2-137 Jackson Hall
Lab: 7:10 – 9:00 pm  5th floor Jackson Hall (room TBA)

Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/14</td>
<td>Introduction to the Neck</td>
</tr>
<tr>
<td>7/2/14</td>
<td>Anterior Neck</td>
</tr>
<tr>
<td>7/3/14</td>
<td>Posterior Neck</td>
</tr>
<tr>
<td>7/8/14</td>
<td>Posterior Triangle</td>
</tr>
<tr>
<td>7/9/14</td>
<td>Carotid Triangle</td>
</tr>
<tr>
<td>7/10/14</td>
<td>Face, Scalp and Parotid Gland</td>
</tr>
<tr>
<td>7/15/14</td>
<td><strong>Midterm Exam</strong></td>
</tr>
<tr>
<td>7/16/14</td>
<td>Muscles of Mastication and Infratemporal Fossa</td>
</tr>
<tr>
<td>7/17/14</td>
<td>Contents of Cranial Cavity</td>
</tr>
<tr>
<td>7/22/14</td>
<td>Orbit</td>
</tr>
<tr>
<td>7/23/14</td>
<td>Nasal Cavity, Nasopharynx</td>
</tr>
<tr>
<td>7/24/14</td>
<td>Oral Cavity and Oropharynx</td>
</tr>
<tr>
<td>7/29/14</td>
<td>Larynx and Laryngopharynx</td>
</tr>
<tr>
<td>7/30/14</td>
<td>Ear and Review</td>
</tr>
<tr>
<td>7/31/14</td>
<td><strong>Final Exam - cumulative</strong></td>
</tr>
</tbody>
</table>
Objectives:
1. Understand regional anatomy of the head and neck.
2. Demonstrate 3-dimensional relationships of structures in the head and neck.
3. Be able to correlate head and neck anatomy with common clinical procedures.
4. Be able to perform and interpret cranial nerve testing.

Exams: The examinations will be laboratory-based with lecture integration. There will be structures to identify on the specimens, with follow-up questions to integrate lecture material.

Grading: Midterm and final exams will each count equally (50% of your grade). There are no “make-up” exams for this course. If you miss an exam, it is recorded as a zero. Please notify Mark Cook if you anticipate a conflict with the exam dates.

90-100% = A
80-89% = B
70-79% = C
Below 70% = F

Anatomy Bequest Program Laboratory Rules
1) All students will be required to participate in the Anatomy Bequest Program orientation presentation either conducted in person by an Anatomy Bequest Program staff member or a video version prior to being allowed access to the donors.

2) No cell phones and/or cameras are allowed in the laboratory. Videotaping or photographing the human anatomical material is strictly prohibited without the prior consent of the University of Minnesota’s Anatomy Bequest Program Proposal Review Committee, including but not limited to any images which will published or distributed.

3) Students shall track all human anatomical material by keeping the donor’s acquisition number tag with the donor at all times. If the tag becomes disassociated from the donor, the course director should be contacted immediately. All tissue removed from the donor during dissection must be retained, identified with the donor’s acquisition number and tracked. Bins will be provided for appropriate storage of any removed tissues, and should stay with the donor at all times.

4) Anatomical material must not be removed from the dissecting laboratory.

5) Unauthorized access to the lab is not permitted – i.e. dissection and/or study of the donors without the permission of the instructor is forbidden. Additionally, individuals not enrolled in the course are not permitted to view the donors without permission by the instructor and fulfillment of all stated requirements.

6) Disrespectful language, improper handling, or any other behavior deemed inappropriate in regards to the donor or dissection process will not be allowed or tolerated. Both conversational and written language relating to the donor and donor dissection by human anatomy students lab must be respectful and discrete. Any information about the donor including the donor’s demographical, social or medical history is confidential and students are not allowed to disclose this information.

7) The use of the Internet in general, and social media sites in particular, including, but not limited to, Facebook, MySpace, Twitter, etc., by students as a venue for discussing any aspect of the donor or donor dissection is strictly prohibited.

8) Proper attire must be worn for all anatomical study. This includes long pants or floor length skirt, full coverage t-shirts (short or long sleeve), and closed-toed shoes.

9) The laboratory must remain clean. Laboratory tables and counters should be thoroughly washed after each lab, and the floors should be kept free of spills and wastes.

10) Non-compliance with the above policies may result in a student being immediately expelled from the course with a failing grade, the student being referred to further disciplinary actions such as a conduct review hearing, and/or criminal charges, if applicable.
Teaching and Evaluation in Dentistry

DENT 7033
Spring Semester, 2014

CONTACT INFORMATION FOR COURSE DIRECTOR:
Muriel J. Bebeau, Ph.D.
Professor, Department of Primary Dental Care
Room 15-136 Moos Tower
School of Dentistry
612-625-4633
651-210-5183 (Cell; urgent calls only)
bebea001@umn.edu

Office hours by appointment.

Room/Time: 15-254 Moos Tower
5:00 to 7:00 p.m., Thursdays

COURSE PURPOSES
To Introduce students to specific concepts and tools that will help them plan and implement dental education programs, to provide participants with practical teaching experiences, and to promote critical thinking about teaching and student assessment (and evaluation) in dentistry.

Through classroom activities, reflection and analysis, and course assignments, students will explore and develop teaching skills that promote learning in dental practice, in continuing education settings, and in the formal classroom.

COURSE OBJECTIVES
As a result of taking this course, participants will be able to:

Design a syllabus or alternative educational plan that incorporates principles of effective instruction. A well-developed plan demonstrates the relationship between instructional objectives and assessments, course content and methods, attends to learners’ developmental needs, assesses learning outcomes, and includes a plan for evaluating instructional effectiveness.

Develop and deliver a lecture that incorporates principles of effective instruction.

Develop a tool to assess student (or patient) learning.

Explain the rationale for applying a grading scheme to rate student performance.

Evaluate instructional effectiveness based on student performance and perceptions of learning, and offer data-based judgments for making revisions to enhance learning.
REQUIRED TEXT AND READINGS

There is no required text for this course. You will be directed to internet web sites and other readings and resources throughout the course. From time to time, handouts and readings relevant to the topics that emerge from discussions will be provided. As graduate students, you are expected to show initiative in researching topics of interest to you and relevant to the course.

One book which is well-suited to students in this course and which is available at used bookstores and at the University of Minnesota Bookstore is Wilbert J. McKeachie (2006), *Teaching Tips: Strategies, Research, and Theory for College and University Teachers*, Houghton Mifflin, Boston & New York. This book, in its twelfth edition, is intended for college teachers, and has short chapters on a range of topics of interest to anyone in the role of educator. Though not required, it is suggested as a supplement.

Students are expected to search the web and identify additional materials to assist in discussions and the presentation they will do during the semester. Students may also wish to look at used educational psychology textbooks, most of which will have sections on testing and evaluation; doing so would acquaint the learner with resources on such topics in the event the student takes on a more expanded educational role at some future point in professional life. A local resource you may want to review is the University of Minnesota Center for Teaching and Learning:
http://www1.umn.edu/ohr/teachlearn/index.html

Two very comprehensive and useful resources (Granted, the first is directed largely at K-12 teachers, but it’s still very useful, though many links aren’t functional):
http://www.mhhe.com/socscience/education/methods/resources.html#evaluation

The second is quite good:
http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/teachtip.htm

For information about graduate programs to enhance competence in teaching and learning in the professions:  http://chicago.medicine.uic.edu/departments___programs/departments/meded

CREDITS
Three graduate school credits are awarded for successful completion of this course.
GRADING AND REMEDIATION POLICIES
This course is graded on an "A-F" basis, without using the "+" or "-" options. There are 100 points available, distributed as follows:

- Group presentation: 25 points
- Classroom participation: 10 points
- Lecture presentation: 25 points
- Testing, grading, and course analysis assignment: 20 points
- Final Examination: 20 points

Total Points: 100 points

As a general rule for the course, the criteria for assigning course grades is based on attainment of a proportion of course points.

- A = 90%
- B = 80-89%
- C = 70-79%
- F = less than 70%

Should the course director find it necessary to modify this assignment, any change would work to the student’s advantage; that is to say, the cut-off points will not be raised, but could be lowered if, in the judgment of the course director, such a change is warranted. Any change is the prerogative of the course director and would be dictated only by instructional complications, significant class performance issues, or defects in assessment techniques. You should assume that the point allocation specified above will be used in grade determination.

Any student receiving a grade of “F” upon completion of the course will be given the opportunity to take a “make-up” exam which will cover material presented throughout the course. A score of 80% or higher on the make-up exam will be required to convert the “F” to a “C.” No grade higher than a “C” will be awarded to a student whose original performance resulted in the “F” grade. There are no other options for raising grades, and a make-up examination, if warranted, will be given on a date and at a time chosen by the instructor.

Attendance at the examination is required. Only excused absences are acceptable. You will only be able to retake a missed exam if you have a documented medical or family emergency.

STUDENT EXPECTATIONS
In addition to conducting themselves as professionals and in accordance with University policies, students are expected to come to class prepared, to attend all classes (or to make alternative arrangements with the instructor in advance), to be on time, to show respect for other students at all times, to participate actively and responsibly in classroom discussions and assigned group activities, and to discuss classroom concerns with the instructor, so that problems may be resolved.

GRADE DISPUTES
Grade disputes will follow University, Graduate School, and School of Dentistry policies. All grade disputes must first be addressed to the course director.
MAKE-UP EXAM POLICIES
If a student misses an exam or other assignment, the instructor has the prerogative to assign a failing grade or to assign alternative work or examination procedures.

ATTENDANCE
If you are unable to attend class due to a medical or family emergency, you should contact the instructor at 612-625-4633 or bebea001@umn.edu. The instructor's secretary, Ms. Chris Thompson, may be contacted at 612-625-9251.

FEEDBACK
Students will have the opportunity to complete an anonymous course evaluation at the end of the semester. Prior to that time, feedback is appreciated and can help provide mid-course adjustments and improvements. You may provide such feedback face-to-face, via e-mail, or through Chris Thompson, as identified above. Anonymous feedback can be sent to the instructor or her secretary's campus mail address, if desired. The Department Chair is Dr. Sheila Riggs and she can be contacted via phone at 612-626-5751 or e-mail at sriggs@umn.edu. Her office is located in Room 9-436 Moos Tower.

STUDENT INTEGRITY
Scholastic misconduct is broadly defined as “any act that violates the right of another student in academic work or that involves misrepresentation of your own work. Scholastic dishonesty includes, (but is not necessarily limited to), cheating on assignments or examinations; plagiarizing, which means misrepresenting as your own work any part of work done by another; submitting the same paper, or substantially similar papers, to meet the requirements of more than one course without the approval and consent of all instructors concerned; depriving another student of necessary course materials; or interfering with another student’s work.”

COMMUNICATION
University of Minnesota e-mail accounts will be used for all formal communications. Announcements intended for the whole class will be sent by e-mail. You should check your e-mail daily, if possible. While in class, as a courtesy to the speakers and fellow students, all pagers and cellular phones must be turned off or on silent/vibrate mode.

DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g., psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS Website http://ds.umn.edu.
MENTAL HEALTH RESOURCES
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu. Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006.

WELLNESS PROGRAM FOR DENTAL STUDENTS
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week, by calling 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

APPROPRIATE STUDENT USE OF CLASS NOTES
Students may not distribute, via internet or other means, instructor-provided lecture notes or other instructor-provided materials, except to other members of the same class, without the express consent of the instructor.

INDIVIDUAL CLASS SESSIONS
January
23  Introduction to the course  Bebeau  
    In this session, the instructor will provide an overview of the course and will elaborate on her expectations of students. Students will introduce themselves and engage in reflective activities to clarify their tacit understanding of the principles of effective instruction. Students will clarify their expectations, set learning goals for themselves, and participate with classmates in developing a list of educational problems the course could address. Students will be assigned to project groups and receive project assignments. Students will complete a pretest to assess initial competence.

30  Teaching and learning as scholarly activity  Bebeau  
    What is a teaching portfolio? What purposes does it serve? What are the elements of a teaching portfolio? How is a teaching portfolio evaluated? See Handout # http://medsci.indiana.edu/m620/sotl_08/teaching_portfolio_rubric.pdf

    Instructional objectives and course design  Bebeau

February
6   Lectures and use of presentation software (Powerpoint, Keynote, Breeze)  Group A
13  Theories of learning and human development  Group B
20  Clinical Instruction and Feedback  Group C
27  Problem-based learning and active learning strategies  Group D
March
6   Item analysis and grading systems . Group E
13  Item construction and test development . Group F
20  Spring Break – clinics closed
27  Instructional Design and Assessment of Instructional Effectiveness . Group G

April
  3   Individual presentations
  10  Individual presentations
  17  Individual presentations
  24  Individual presentations

May
  1   Individual presentations
  8   Individual presentations
  15  Final Exam

FINAL EXAM

The final exam will focus on material presented in the first seven weeks of the course. The remainder of the course involves application of the initial body of information. The exam will be a somewhat expanded version of the pretest.

STUDENT ASSIGNMENTS

In addition to the final exam, there are three core assignments which students are expected to complete during the semester. These include (1) participating in a small group presentation on an assigned topic, (2) preparation and delivery of a “mini-lecture” on any non-dental topic of your choice, and (3) development, administration, and analysis of a short test over your “mini-lecture,” together with a reflection on instructional effectiveness. Details of these assignments are included below:

Small Group Presentations

During the first class session, class members will organize themselves into seven teams. A team representative will draw a random topic assignment. Your team will then be responsible for conducting a class session on that topic. (An initial list of resources on each topic is included with this syllabus, but you are expected to investigate further and to provide the course director with a list of the additional resources you have used in preparing your session.) You are free to organize and conduct the class session as you wish, but you are expected to effectively organize a 20-30 minute discussion. This discussion should be based on your presentation and on one article on your topic that you’ve identified, AND DISTRIBUTED
IN ADVANCE, so that class members can be prepared. You are advised to meet with the course director who will serve as an instructional development consultant to assist you in preparing the session.

For assistance in planning your discussion, see Chapter 5 “Facilitating Discussion” from McKeachie’s (2006) *Teaching Tips* or “Organizing Effective Discussions” from McKeachie’s (1994) *Teaching Tips*. You may borrow a copy from the instructor.

Your grade will be based on the course director’s perception of (a) the appropriateness of the presentation to the material being presented, (b) the apparent contributions of each group member to the session (should be equitable), and (c) the extent to which the course session attends to principles of effective instruction, is clear, comprehensive, and engaging. **Note that all students are expected to participate in the discussion session.**

*Mini-lectures*

Beginning April 3rd, each student will be expected to deliver a short lesson on a non-dental topic of his/her choice. The lesson should be approximately 30 minutes in length, including opportunities for practice and feedback. Specific guidelines on the grading criteria for the lesson and related instructional activities are included with this syllabus. Again, the course director will serve as the student’s instructional development consultant.

*Testing and Grading Assignment*

Upon completion of the mini-lecture, each student will be expected to test the class members to see if their teaching objectives were accomplished. For the majority of topics, a written test will be appropriate, and at least one multiple-choice item should be included. A minimum of 5 test items is recommended. Each student will have approximately 10 minutes following their lecture to administer this test. Afterward, the course director will distribute a brief anonymous course evaluation, which she will have summarized and returned to the student. Once the results are in, students are expected to compile the results, to perform an item analysis on at least one multiple choice item, and to assign grades. The rationale for assigning grades should be provided. A copy of the test and paperwork including the raw scores, the item analysis, the grades, and the grading rationale, as well as an analysis of student performance and student perceptions of effectiveness, together with data-based recommendations for course revision should be presented as a mini course portfolio. The portfolio should be turned in two weeks after the lecture. Students presenting on May 8, must turn in their assignment by the 15th of May. Note: Specific directions and a rubric for scoring the mini portfolio will be provided during the lesson on *Assessing Instructional Effectiveness*. 

**SMALL GROUP PRESENTATION RESOURCES**

*Instructional objectives/course design*


[http://meded.ucsd.edu/faculty/writing_instructional_objectives.pdf](http://meded.ucsd.edu/faculty/writing_instructional_objectives.pdf)
Lectures and use of presentation software (Keynote/Powerpoint/Breeze)

A handout will be sent to you by e-mail with several short presentations to watch before coming to class.

The following resources provide guidelines for developing and assessing presentations:

General Guidelines for use of technology
http://www.tltgroup.org/flashlight/Handbook/Presentation/Ideas.htm

PowerPoint Presentation Tips:
http://www.cob.sjsu.edu/splane_m/presentationtips.htm

PowerPoint Presentation Rubric:
http://library.fayschool.org/Pages/powerpointrubric.pdf

Rubric for Peer Evaluation of Team Presentation
http://www.tltgroup.org/resources/Rubrics/Rubric-PeerEval-Presentation-LessonCritique.htm

Designing and evaluating rubrics
http://www.tltgroup.org/resources/Rubrics/A_Rubric_for_Rubrics.htm

Applying theories of learning and human development to the design of instruction

http://en.wikipedia.org/wiki/Learning_theory_(education) This reference describes the role theory can play in instructional design. Learning theory helps see the value of particular instructional strategies.
http://gsi.berkeley.edu/teachingguide/theories/overview.html
www.crlt.umich.edu/tstrategies/tslt
http://en.wikibooks.org/wiki/Contemporary_Educational_Psychology/Chapter_2:_The_Learning_Process

The following sites discuss theories specific to Motivation
http://allpsych.com/psychology101/motivation.html
http://www.apppsychology.com/Book/Motivation/motivationintro.htm
http://www.businessballs.com/davidmcclelland.htm
http://www.businessballs.com/erik_ekriksen_psychosocial_theory.htm

In addition to the sites listed, the instructor will distribute resources describing theories of human development appropriate for problems that professionals encounter when interacting with individuals at various levels of development associated with educational attainment or moral development.

Clinical teaching and feedback
http://cte.umdni.edu/clinical_education/index.cfm feedback
http://fod.msu.edu/OIR/TeachingMethods/clinical-teaching.asp Five micro skills of clinical teaching. This resource is particular useful for clinical faculty and specialists who interact with generalists

Problem-based learning and active learning (also seminars and discussion groups)
http://www.jdentaled.org/cgi/content/abstract/61/5/417
http://ldt.stanford.edu/~jeepark/jeepark+portfolio/PBL/theory.htm
Seminars and discussion groups
http://www.lc.unsw.edu.au/onlib/disc.html

Item analysis and grading systems
https://www.msu.edu/dept/soweb/itanhand.html  This is a good resource
http://www.statsoft.com/textbook/reliability-and-item-analysis/  This resource may be more than needed but is a more comprehensive resource.
http://pareonline.net/getvn.asp?v=4&n=10  This is a good resource

Item construction and test development
http://suen.educ.psu.edu/~hsuen/pubs/Taiwan.pdf  (This reading includes some interesting philosophy of test construction which would be good to review.
http://testing.byu.edu/info/handbooks/betteritems.pdf

Instructional Design
http://fog.ccsf.cc.ca.us/~mmalacho/OnLine/ADDIE.html
The instructor will assist with the presentation of directions for assessing effectiveness of the student’s mini course and will distribute a scoring rubric for assessing the mini portfolio

Item analysis and grading systems
https://www.msu.edu/dept/soweb/itanhand.html  This is a good resource

http://www.statsoft.com/textbook/reliability-and-item-analysis/  This resource may be more than needed but is a more comprehensive resource.

http://pareonline.net/getvn.asp?v=4&n=10  This is a good resource

Item construction and test development
http://suen.educ.psu.edu/~hsuen/pubs/Taiwan.pdf  (This reading includes some interesting philosophy of test construction which would be good to review.
http://testing.byu.edu/info/handbooks/betteritems.pdf
**Applying Principles of Effective Instruction**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Objective</strong></td>
<td>15</td>
</tr>
<tr>
<td>An outline is presented but the focus is on what the teacher will do (rather than what the learner will be able to do.)</td>
<td>0</td>
</tr>
<tr>
<td>Learning objective(s) are not explicit, but the purpose of the lesson can be inferred from what is presented.</td>
<td>1</td>
</tr>
<tr>
<td>Learning objective(s) are presented.</td>
<td>2</td>
</tr>
<tr>
<td>Well-written and worthwhile learning objectives are presented to indicate what the learner will be able to do following instruction.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Interest arousing activity</strong></td>
<td></td>
</tr>
<tr>
<td>Presenter uses visuals or activities that are unrelated to learning objective.</td>
<td>0</td>
</tr>
<tr>
<td>Presenter does not use an activity to arouse interest, but the presentation is interesting.</td>
<td>1</td>
</tr>
<tr>
<td>A short activity that captures interest.</td>
<td>2</td>
</tr>
<tr>
<td>A short activity that captures interest and motivates students to achieve the learning objective.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Instruction</strong></td>
<td></td>
</tr>
<tr>
<td>Presentation contains definitions, procedures, and/or demonstrations that contain inaccuracies or lack examples.</td>
<td>0</td>
</tr>
<tr>
<td>Presentation of definitions, procedures and/or demonstrations is difficult to understand and follow.</td>
<td>1</td>
</tr>
<tr>
<td>Definitions, procedures, and/or demonstrations are presented. Some examples are included.</td>
<td>2</td>
</tr>
<tr>
<td>Well-thought out definitions, procedures, and/or demonstrations that precede a range of positive and negative examples are presented.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Appropriate Practice with Feedback</strong></td>
<td></td>
</tr>
<tr>
<td>No opportunity for practice and feedback is provided, or practice is unrelated to the learning objective.</td>
<td>0</td>
</tr>
<tr>
<td>Some practice activities are provided, but feedback is not present or is not timely.</td>
<td>1</td>
</tr>
<tr>
<td>Practice activities present some opportunities to practice and receive feedback</td>
<td>2</td>
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<tr>
<td>Practice activities present appropriate and sufficient practice, with self-assessment and constructive feedback.</td>
<td>3</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>Test does not assess what was taught.</td>
<td>0</td>
</tr>
<tr>
<td>Test assesses some of what was taught. Test items are too easy, or include too many clues, or trick questions. Test directions are unclear.</td>
<td>1</td>
</tr>
<tr>
<td>Test assesses most of what was specified in the learning objectives. Test items include some clues that help eliminate distracters. Test directions could be clearer.</td>
<td>2</td>
</tr>
<tr>
<td>Test assesses what was taught, what was specified in the objectives, and does not present content or expect performance outside the range of what was taught. Test items are well-written (no trick questions, no clues in distracters).</td>
<td>3</td>
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**Total Comments:**
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
<table>
<thead>
<tr>
<th>Presentation Skills</th>
<th>Criteria</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization and Clarity</strong></td>
<td>Listener can follow presentation only with effort. Some arguments are unclear. Presentation is disorganized at times, or throughout.</td>
<td>0</td>
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<tr>
<td></td>
<td>Presentation is generally clear and well organized. A few minor problems caused confusion to the audience.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Presentation is clear, logical, and organized. Listener can follow line of reasoning.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Presentation Skills</strong></td>
<td>Presenter seems uncomfortable and can be heard only if listener is very attentive. Much of the information is read.</td>
<td>1</td>
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<tr>
<td></td>
<td>Pacing is sometimes too fast or too slow. Presenter seems occasionally uncomfortable, and the audience may have trouble hearing the presenter.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Presentation is a planned conversation, paced for audience understanding. Presenter seldom reads from slides. Speaker appears comfortable in front of the group and can easily be heard by all.</td>
<td>10</td>
</tr>
<tr>
<td><strong>Use of Communication Aids (slides, handouts, multimedia)</strong></td>
<td>Aids are inadequately prepared or used inappropriately. Font may be too small to be seen or too much info is included. Unimportant material may be highlighted.</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Aids contribute to the presentation but fall short of the skills and capabilities of the audience. Information may not stand out and reflects occasional errors in judgment (font size, color, etc).</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Aids enhance the presentation and are prepared in a professional manner. Font is large enough to be seen; Information is organized to maximize audience understanding; Main pts stand out.</td>
<td>2</td>
</tr>
<tr>
<td><strong>Verbal Interaction With Audience</strong></td>
<td>Responds to questions inadequately or lacks professionalism.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Generally responsive to audience comments, questions, and needs. Misses some opportunities for interaction</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Consistently clarifies, restates, and responds to questions. Summarizes when needed</td>
<td>1</td>
</tr>
<tr>
<td><strong>Length of Presentation</strong></td>
<td>More than 10 or minutes above allotted time.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Too short or too long; more than 5 minutes over the allotted 30 minutes; presentation 15 minutes or less.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Within the allotted time (20 min presentation; 5 min. test; 5 minutes for respondents to evaluate performance).</td>
<td>10</td>
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</tbody>
</table>

Total: 10

Comments:
## GRADUATE ORAL MEDICINE

### DENT 7051; Fall 2014

**Advanced Principles and Practice of Oral Medicine**

**See Moodle:** [https://ay13.moodle.umn.edu/course/view.php?id=1912#section-3](https://ay13.moodle.umn.edu/course/view.php?id=1912#section-3)

**DR. NELSON L. RHODUS, COURSE DIRECTOR**

**PROFESSOR & DIRECTOR, DIVISION OF ORAL MEDICINE & DIAGNOSIS**

**office:** 7-536 MOOS HST; 625-0693; rhodu001@umn.edu

<table>
<thead>
<tr>
<th>Session No.</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Lecturer</th>
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<tbody>
<tr>
<td></td>
<td>9-04-14</td>
<td>7:30-8:30</td>
<td>INTRODUCTION, Gen. Principles of Oral Medicine and Medical Mgmt</td>
<td>DR. RHODUS</td>
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<tr>
<td></td>
<td>9-09-14</td>
<td>7:30-8:30</td>
<td>Gen. Principles of Oral Medicine and Medical Mgmt</td>
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<tr>
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<td>9-11-14</td>
<td>7:30-8:30</td>
<td>CARDIOVASCULAR: Case Demo</td>
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<tr>
<td></td>
<td>9-16-14</td>
<td>7:30-8:30</td>
<td>*Controversies over antibiotic prophylaxis for dentistry</td>
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<tr>
<td></td>
<td>9-18-14</td>
<td>7:30-8:30</td>
<td>*Case 2A or 2B, AND *3: CARDIOVASCULAR</td>
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<td>9-23-14</td>
<td>7:30-8:30</td>
<td>*Case 4: CARDIOVASCULAR</td>
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<td>10-02-14</td>
<td>7:30-8:30</td>
<td>*Case 5: CARDIOVASCULAR</td>
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<td>10-07-14</td>
<td>7:30-8:30</td>
<td>*Case 6: CARDIOVASCULAR</td>
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<td>10-09-14</td>
<td>7:30-8:30</td>
<td>LIVER and RENAL</td>
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<td>10-21-14</td>
<td>7:30-8:30</td>
<td>*DIABETES</td>
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<td></td>
<td>10-23-14</td>
<td>7:30-8:30</td>
<td>BLEEDING</td>
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<td></td>
<td>10-30-14</td>
<td>7:30-8:30</td>
<td>*LEUKEMIA and TRANSPLANTS</td>
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<td>11-06-14</td>
<td>7:30-8:30</td>
<td>*VESICULOBULLOSUS and other COMMON ORAL LESIONS- pt 1</td>
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<td>11-11-14</td>
<td>7:30-8:30</td>
<td>VESICULOBULLOSUS and other COMMON ORAL LESIONS- pt 2</td>
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<tr>
<td></td>
<td>11-13-14</td>
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<td>*SALIVARY GLAND DYSFUNCTION</td>
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<td>7:30-8:30</td>
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<td></td>
<td>11-20-14</td>
<td>7:30-8:30</td>
<td>*LEUKOPLAKIA AND ORAL CANCER pt 2; room 7-580</td>
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<td></td>
<td>11-25-14</td>
<td>7:30-8:30</td>
<td>*BURNING MOUTH SYNDROME</td>
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<td>11-27-14</td>
<td>7:30-8:30</td>
<td>NO CLASS- THANKSGIVING</td>
<td></td>
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<tr>
<td></td>
<td>12-11-14</td>
<td>7:30-10:00</td>
<td>FINAL EXAMINATION **</td>
<td></td>
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</table>

**COURSE DESCRIPTION:**
This is a READING, LECTURE and CASE-BASED course designed to expand upon the graduate students understanding of medical-systemic problems as well as their oral manifestations/complications which are encountered in dental practice and to emphasize the principles of recognition and management of dental patients with medical problems. The foundation upon which the principles of medical management is based is thorough evaluation, and recognition of the medically compromised patient. The series of cases and lectures in this course will be dedicated to these objectives. A thorough understanding of the textbook is essential to accomplishing the specific objectives.

THE REQUIRED TEXT FOR THIS COURSE IS:

ESSENTIALLY THE STUDENT WILL BE RESPONSIBLE FOR A THOROUGH UNDERSTANDING OF THIS ENTIRE TEXT!

There will be current literature pertinent to the class which the student will be expected to read and provide a written summary as well as discuss if called upon in class.

ATTENDANCE WILL BE EXPECTED AT ALL COURSE ACTIVITIES. STUDENTS MAY BE CALLED ON DURING LECTURE TO DESCRIBE MATERIAL FROM THE READING ASSIGNMENT OR CASE EXERCISES!

THE LECTURES WILL BE DESIGNED TO SUPPLEMENT AND EXPAND UPON READING MATERIAL, NOT to cover all material for which students are accountable!. A GOOD DEAL OF THE COURSE OBJECTIVES MUST BE COMPLETED OUTSIDE OF CLASS, THERE WILL BE CASES WHICH MUST BE HANDED IN. THE LECTURES WILL NOT COVER ALL ASSIGNED MATERIAL!

There may be quizzes and/or one-minute papers at any class.
( ** all assignments due by the final exam)

COURSE EVALUATION:
PARTICIPATION (lecture, labs, exercises) :30%
FINAL COMPREHENSIVE EXAMINATION :70%

** completed assignments

GRADE BASE : (CURVED TO CLASS MAX.)
90-100=A
80-89 =B
70-79 =C
<69 =F

A STUDENT WITH A FAILING AVERAGE WILL BE GIVEN ONE COMPREHENSIVE RE-EXAMINATION ARRANGED BY THE COURSE DIRECTOR. ANY MAKE-UP EXAMINATIONS WILL HAVE TO BE ARRANGED INDIVIDUALLY by the student, WITHIN TWO WEEKS OF SCHEDULED EXAMINATION. MAKE-UPS WILL NOT BE THE SAME FORMAT NOR EVALUATED THE SAME AS THE ORIGINAL TEST.
THE TEST MAY CONSIST ENTIRELY OF AN ORAL EXAMINATION.
A. COURSE IDENTIFICATION

Name of course: Oral & Maxillofacial Radiologic Interpretation
Number: DENT 7052
Semester and year: Spring 2014
Credits: 2
Department: Diagnostic and Biological Sciences, Oral and Maxillofacial Radiology Program
Co-Course directors: Dr. Mansur Ahmad, and Dr. Mohammad Saiful Islam.
Office address and phones: 7-536 Moos Tower, 625-6147 (MA), 626-3399 (MSI)

B. COURSE GRADING

Two examinations and case write-ups will be given. The course score and letter grade equivalent are as follows:

<table>
<thead>
<tr>
<th>Examination</th>
<th>Percentage</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td># 1</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td># 2</td>
<td>50%</td>
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<tr>
<td>90-100</td>
<td>A</td>
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<td>80-89</td>
<td>B</td>
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<td>70-79</td>
<td>C</td>
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<td>00-69</td>
<td>F</td>
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</table>

C. COURSE DESCRIPTION

This course consists of a systematic study of intraoral and extraoral radiographs emphasizing radiographic, anatomy; radiologic interpretation of developmental and acquired anomalies of teeth, osseous structures, maxillary sinus and temporomandibular joints and manifestations of systemic diseases in jaws and associated structures.

D. COURSE PURPOSE

The purpose of this course is to assist students to recognize radiographic patterns of normal tissues and to detect and to evaluate radiographic evidence of deviations from normal so that they can make valid recommendations and judgments on the basis of radiographs alone or in conjunction with other procedures in arriving at a differential diagnosis, a tentative diagnosis, and the definitive or final diagnosis, treatment plan and prognosis. Emphasis is placed on developing the ability to use concepts already learned in oral and general pathology and basic biological science courses in understanding and evaluating the nature of the disease process.

E. COURSE OBJECTIVES

Upon completion of this course, students should be able to:

1. identify radiographic images of anatomic structures recorded in intraoral and extraoral radiographs, including CT and MRL
2. recognize radiographic evidence of deviations from normal in odontogenic structures, bone, maxillary sinus, temporomandibular joint and salivary glands.
3. identify and describe the nature of anomalies as recorded in radiographs.
4. list the anomalies which may have similar radiologic characteristics, i.e., process of making differential radiographic interpretation.
5. apply the concepts and specific criteria in isolating the disease process to a minimum number of possibilities.
6. correlate the radiographic evidence with other diagnostic procedures for the purpose of arriving at a tentative or final diagnosis.
7. describe the principles of digital radiography, nuclear medicine, ultrasound, computerized tomography and magnetic resonance imaging.
8. describe and identify radiologic manifestations of dento-maxillofacial trauma.
9. describe the principles of implant imaging.
10. Form a differential diagnosis based on various radiographic appearances of local and systemic diseases manifested in the maxillofacial region.
Unit 1: Principles of Radiographic Interpretation

Purpose: To assist students a step-by-step, analytical process to evaluate diagnostic images for interpretation.

Objectives:
1. To be able to describe the systematic radiographic interpretation protocols for both intraoral and extraoral images.
   a. Localize the abnormality
      i. Size
      ii. Number
   b. Periphery and shape
      i. Well-defined borders
      ii. Ill-defined borders
      iii. Shape
   c. Internal structures
      i. Soft tissues
      ii. Hard tissues
      iii. Air, fluid
      iv. Trabecular bone
   d. Adjacent structures
      i. Teeth
      ii. Lamina dura
      iii. PDL spaces
      iv. Bone
      v. Nerve canals
      vi. Sinus
      vii. Cortical bone
   e. Clinical information
   f. Radiographic interpretation
      i. Normal vs abnormal
      ii. Developmental vs acquired
      iii. Classification
      iv. Additional imaging, examination

Unit 2: Imaging of the paranasal sinuses

Purpose To assist students in understanding the radiographic anatomy of the paranasal sinuses and the radiographic manifestations of diseases of the paranasal sinuses.

Objectives: 1. To be able to describe the following diseases associated with paranasal sinuses as viewed with periapical, panoramic and CT images
   a. Sinusitis
   b. Retention pseudocysts
   c. Polyps
   d. Mucocele
   e. Benign and malignant neoplasms

Unit 3: Radiology of the Temporomandibular Joint

Purpose: To evaluate the general indications for use of diagnostic imaging as tool in the examination of the temporomandibular joint, and be able to describe and interpret various joint conditions.

Objectives:
1. To be able to describe the joint anatomy and the significance of the following
observed in the TMJ diagnostic images:
   a. Osteology of TMJ
   b. Soft tissues
   c. Shape of the condyle and fossa
   d. Condylar position
   e. Range and type of motion
   f. Joint space.

2. To be able to describe the indication, usefulness and limitations of each of the following TMJ imaging techniques:
   a. Plain films
   b. Panoramic imaging
   c. Computed tomography (CT)
   d. Magnetic Resonance Imaging (MRI)

3. Disturbances Affecting TMJ
   a. Developmental, Congenital
   b. Inflammatory
   c. Degenerative Joint Disease
   d. Tumors
   e. Trauma

Unit 4: Imaging for Implants

Purpose: To assist students in selecting proper imaging procedures for implant placement planning and evaluation.

Objectives: To be able to describe the indications, limitations and uses of radiographic examinations used for preoperative planning of implant placement.
   a. Periapical radiographs
   b. Panoramic radiographs
   c. Occlusal radiographs
   d. CT, cone beam CT

Unit 5: Circumscribed Radiolucencies

Purpose: To assist students in developing a differential diagnosis of localized circumscribed radiolucencies in intra-oral and extra-oral radiographs.

Objectives: To learn radiologic appearances of following structures
   a. Variations in trabecular patterns and bone marrow spaces
   b. Early stage tooth crypts
   c. Salivary gland depression (submandibular and sublingual)
   d. Post-extraction socket
   e. Hematopoietic bone marrow defects
   f. Fibrous healing defects
   g. Keratocystic odontogenic tumor
   h. Residual cyst
   i. Neural sheath tumors
   j. Traumatic neuroma
Progressive systemic sclerosis (Scleroderma)

Unit 6: Inter-radicular radiolucency

Purpose: To assist students in developing differential diagnosis of inter-radicular radiolucencies in intra-oral and extra-oral radiographs and advanced imaging including cone beam CT

Objectives: To be able to identify inter-radicular radiolucencies due to following conditions:
   a. Anterior median maxillary cleft
   b. Lateral periodontal cyst
   c. Lateral radicular cyst
   d. Incisive canal cyst
   e. Cyst of the incisive papilla
   f. Nasolabial cyst
   g. Traumatic bone cyst
   h. Buccal bifurcation cyst

Unit 7: Peri-coronal radiolucencies without opacities

Purpose: To assist students in developing a differential diagnosis of radiolucencies appear in the peri-coronal areas of a tooth.

Objectives: To be able to identify normal and pathologic conditions listed below:

   a) Peri-coronal radiolucencies without opacities:
      b) Normal follicular space
      c) Osteitis with peri-coronitis
      d) Dentigerous cyst
      e) Keratocystic odontogenic tumor
      f) Unicystic ameloblastoma
      g) Ameloblastic fibroma
      h) Melanotic neuroectodermal tumor of infancy

B. Peri-coronal radiolucencies with opacities
   1. Calcifying epithelial odontogenic cyst
   2. Calcifying epithelial odontogenic tumor
   3. Adenomatoid odontogenic tumor
   4. Ameloblastic fibro-odontoma
   5. Odontoma
   6. Ameloblastic odontoma

Unit 8: Multilocular radiolucencies

Purpose: To assist students in developing differential diagnosis of various multi-locular radiolucencies in radiographs

Objectives: To be able to identify the following pathological conditions that may present as multi-locular radiolucency:
   a. Basal cell nevus syndrome
   b. Keratocystic odontogenic tumor
   c. Ameloblastoma
d. Odontogenic myxoma
e. Central giant cells granuloma
f. Aneurysmal bone cyst
g. Central hemangioma
h. Arteriovenous malformation
i. Cherubism
j. Central odontogenic fibroma & osseous fibroma
k. Ossifying fibroma and non-ossifying fibroma

**Unit 9:** Poorly defined radiolucencies

Purpose: To assist students in developing differential diagnosis of poorly defined radiolucencies that may appear in radiographs

Objectives: Learn the radiologic appearances of following pathological conditions:
   a. Acute and chronic osteomyelitis
   b. Radiation and bisphosphonate induced osteonecrosis of the jaws
   c. Primary intraosseous carcinoma of the jaws
   d. Squamous cell carcinoma of the gingiva
   e. Central mucoepidermoid carcinoma
   f. Metastatic diseases of the jaws
   g. Fibrosarcoma of bone
   h. Ewing’s sarcoma
   i. Histiocytosis X
   j. Multiple myeloma
   k. Non-hodgkin’s lymphoma
   l. Burkitt’s lymphoma
   m. Hodgkin’s disease
   n. Leukemia

**Unit 10:** Generalized lack of densities

Purpose: Assist students to understand generalized radiolucent appearances of the jaws.

Objectives: To be able to describe radiologic features of conditions that may cause generalized bone loss in the jaws and the skeleton

Systemic conditions causing generalized radiolucencies:
   a. Hyperparathyroidism
   b. Hypoparathyroidism
   c. Familial hypophosphatemia
   d. Hypophosphatasia
   e. Osteoporosis
   f. Thalassemia (Cooley’s anemia)
   g. Sickle-cell anemia
   h. Chronic renal disease
   i. Rickets and osteomalacia

**Unit 11:** Generalized radiopacities
Purpose: To assist students learn about conditions causing generalized radiopacities in the jaw

Objectives: To be able to describe and formulate a differential diagnosis of generalized radiopaque appearances in the jaws

a. Gardner’s syndrome
b. Fibrous dysplasia
c. Florid cement-osseous dysplasia
d. Paget’s disease
e. Osteopetrosis
f. Sclerosteosis, endosteal hyperostosis, infantile cortical hyperostosis

Unit 12: Radiopacities in the soft tissues

Purpose: To assist students in understanding the radiographic manifestations of abnormalities of soft tissues.

Objectives: To be able to describe the general nature of abnormalities associated with soft tissues of head and neck listed below:

a. Sialolith
b. Phlebolith
c. Calcified arteries, carotid atheroma
d. Calcified carotid atheromas; differential diagnosis
e. Calcified lymph nodes
f. Myositis ossificans
g. Multiple miliary osteomas
h. Osteoma cutis, mucosae
i. Cysticercosis (larval stage of tapeworm)
j. Other calcified deposits
k. Calcified stylohyoid ligaments
l. Eagle’s syndrome

Unit 13: Developmental anomalies of jaws

Purpose: To assist students in making practical application of concepts and principles associated with the understanding of radiographic interpretation of developmental anomalies of jaws.

Objectives: 1. To be able to describe the general nature of developmental anomalies of jaws listed below:

a. Cleft palate and/or cleft of alveolar process
b. Developmental lingual mandibular salivary gland depression (static bone cavity; Stafne defect)
c. Fissural or developmental cysts
d. Crouzon syndrome
e. Hemifacial microsomia
f. Treacher Collins Syndrome
g. Cleidocranial dysplasia

Unit 14: Focal radiopacities
Purpose: To assist students in making practical application of concepts and principles associated with the understanding of radiographic interpretation of localized radiopacities as they manifest in the jaws

Objectives: 1. To be able to describe and form a differential diagnosis of localized radiopacities in the jaws as listed below:
   a. Chronic sclerosing osteitis and Garre’s osteomyelitis
   b. Idiopathic osteosclerosis, enostosis
   c. Root fragments
   d. Exostosis
   e. Mandibular and maxillary tori
   f. Osteoma
   g. Osteoid osteoma
   h. Benign osteoblastoma
   i. Chondroma and osteochondroma
   j. Benign chondroblastoma
   k. Osteosarcoma and chondrosarcoma

Unit 15: Periapical radiopacities

Purpose: To assist students understand radiopacities of normal and pathological conditions that may appear near the peri-apical area.

Objectives: To be able to describe and formulate a differential diagnosis of radiopacities in the periapical area to tooth/teeth
   a. Idiopathic osteosclerosis and sclerosing osteitis
   b. Hypercementosis
   c. Cemento-osseous dysplasia
   d. Periapical cemental dysplasia
   e. Benign cementoblastoma
   f. Ossifying fibroma and Juvenile ossifying fibroma

Unit 16: Systemic diseases manifested in the jaws

Purpose: To assist students in making practical application of concepts and principles associated with the understanding of radiographic interpretation of manifestations of systemic diseases in the jaws.

Objectives: To be able to describe the general nature of systemic diseases which may have radiographic manifestations in the jaws listed below
   a. Diabetes mellitus
   b. Osteogenesis imperfecta
   c. Cleidocranial dysplasia
   d. Hereditary ectodermal dysplasia

Unit 17: Principles of advanced imaging techniques

Purpose: To assist the students in understanding the basic principles of different advanced imaging techniques
Objectives: To be able to describe the principles, indications, usefulness and limitations of advanced diagnostic imaging systems

1. Digital radiography
   a. PSP
   b. CCD, CMOS
   c. Advantages, disadvantages

2. Nuclear Medicine
   a. Principles and instrumentation
   b. Radionuclide tracers
   c. Bone scintigraphy
   d. Salivary gland scintigraphy

3. Ultrasound
   a. Principles and instrumentation
   b. Dental applications
   c. Salivary gland masses

4. Computerized Tomography (CT) and Cone Beam CBCT
   a. Principles and instrumentations
   b. Anatomic Appearances

5. Magnetic Resonance Imaging (MRI)
   a. Principles and instrumentations
   b. Anatomic appearances

Unit 18: Radiologic manifestations of dentomaxillofacial trauma

Purpose: To assist the students in making practical applications of concepts and principles associated with the understanding of radiographic interpretations of traumatic injuries of dentomaxillofacial structures.

Objectives: 1. To be able to describe and identify the features of dental trauma as listed below:
   a. Presence of root fractures or injuries to periodontium
   b. Extent of extrusion or intrusion
   c. Presence of apical periodontitis
   d. Extent of root development
   e. Size of root development
   f. Presence of dental fragments or foreign bodies in soft tissue

2. To be able to describe the indications and usefulness of the following radiographic techniques in dental trauma:
   a. Periapical view
   b. Occlusal view
   c. Lateral anterior view
   d. Soft tissue view

3. To be able to describe and identify the features of traumatic injuries to mandible (including TMJ)
   a. Muscle action: favorable vs. unfavorable fractures, and occlusal discrepancies
b. Alveolar fractures  
c. Body fractures  
d. Ramus fractures  
e. TMJ fractures  
f. Imaging techniques  

4. To be able to describe and identify the features of traumatic injuries to the maxilla and associated bones  
   a. LeFort fractures  
   b. Tripod fractures  
   c. Naso-ethmoid fractures  
   d. Imaging techniques  
   e. Status of traumatized patient
<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/17</td>
<td>ULCERATIVE LESIONS AND VESICULOBULLOUS</td>
<td>WETZEL</td>
</tr>
<tr>
<td>9/24</td>
<td>SOFT TISSUE LESIONS</td>
<td>GOPALAKRISHNAN</td>
</tr>
<tr>
<td>10/3</td>
<td>BONE LESIONS</td>
<td>GOPALAKRISHNAN</td>
</tr>
<tr>
<td>10/8</td>
<td>ODONTOGENIC CYSTS AND TUMORS</td>
<td>WETZEL</td>
</tr>
<tr>
<td>10/15</td>
<td>NON-ODONTOGENIC CYSTS AND TUMORS</td>
<td>GOPALAKRISHNAN</td>
</tr>
<tr>
<td>10/22</td>
<td>CANCER</td>
<td>GOPALAKRISHNAN</td>
</tr>
<tr>
<td>10/29</td>
<td>HIV</td>
<td>WETZEL</td>
</tr>
<tr>
<td>11/5</td>
<td>SALIVARY GLAND</td>
<td>GOPALAKRISHNAN</td>
</tr>
<tr>
<td>11/12</td>
<td>TOOTH ABNORMALITIES</td>
<td>KOUTLAS</td>
</tr>
<tr>
<td>11/19</td>
<td>PEDIATRIC PATHOLOGY</td>
<td>WETZEL</td>
</tr>
<tr>
<td>11/26</td>
<td>THANKSGIVING</td>
<td>NO CLASS</td>
</tr>
<tr>
<td>12/3</td>
<td>DEVELOPMENTAL ABNORMALITIES</td>
<td>KOUTLAS</td>
</tr>
<tr>
<td>12/10</td>
<td>ORAL MANIFESTATIONS OF SYSTEMIC DISEASES</td>
<td>WETZEL</td>
</tr>
</tbody>
</table>
Syllabus

Dent 7062 Graduate Oral & Maxillofacial Pathology
Spring 2016

CONTACT INFORMATION FOR COURSE DIRECTOR:
Michael D. Rohrer, DDS, MS
16-206b Moos Tower; 4-2463; rohre008@umn.edu

COURSE PURPOSE
This is a course of advanced oral and maxillofacial pathology for residents/graduate students. The emphasis will be on clinical-pathologic correlation of diseases of the oral and maxillofacial region.

The course this semester will be a Clinical-Pathologic Conference (CPC) format. The plan was for the Fall 2015 class to be an overview of the main topics of oral pathology, which would be followed by the Spring 2016 class in a CPC format. The CPC discussion format will consist of case presentations with student descriptions of pathologic conditions from clinical and radiographic images, student descriptions of histopathology from biopsy material, and discussion of disease management. Historically this class grew out of the seminar for oral surgery residents to prepare them for their board examinations and the emphasis for histologic descriptions will be for the oral surgery residents. The class will focus on the understanding of clinical/pathologic correlations. Residents in all specialties will gain further knowledge and confidence in oral pathology that is expected of specialists.

COURSE OBJECTIVES
Following completion of the course the resident/graduate student will be able to:
• Describe pathologic changes in the hard and soft tissue of the oral and maxillofacial region
• Describe histologic features of the diseases discussed
• Discriminate among different diseases based on clinical signs and symptoms
• Discriminate among different diseases based on histological findings
• Correlate the cause and behavior of the diseases based on histological features
• Determine an appropriate course of action to treat the diseases based on histological features

REQUIRED TEXT AND READINGS
The textbook, Oral Pathology: Clinical Pathologic Correlations, 6e by Joseph A. Regezi DDS MS, James J. Sciubba DMD PhD and Richard C. K. Jordan DDS MSc PhD FRCD(C) FRCPATH (Dec 6, 2011) will be used as the basis for the course. All students should have access to this book either as a private copy or in their program’s library.
CREDITS
This is a credit course for graduate students who register with the university.

GRADING AND EVALUATION POLICIES
The class will be PASS/FAIL. Students will be evaluated by attendance at class and one written take-home examination.

STUDENT EXPECTATIONS
Students will be expected to attend all classes and to be on time and ready to begin at the starting time of the class (3:30 PM) and stay until the end (5:00 PM). If students will not be in attendance, such as for assignments at an outside hospital or other facility, or if there is a patient emergency, they should notify Professor Rohrer by email as far in advance of the class that will be missed as possible.

Students’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Students will be required to complete evaluations on line (using CourEval) before a grade will be given in this course.

GRADE DISPUTES
Grade disputes will follow University and SOD policies listed in the student handbook. All grade disputes must first be addressed to the course director.

REMEDIATION POLICIES
The class can be remediated by examination if agreed upon by the course director.

MAKE-UP EXAM POLICIES
If a student has an excused absence for missing an exam (illness, family emergency, etc.) the make up exam may be a different format such as essay or oral exam.

ATTENDANCE
Students who are absent are responsible for the material covered in the class session.

STUDENT INTEGRITY
Per the School of Dentistry Code of Conduct, "academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk." Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.

Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

COMMUNICATION
All individual and full class communication will be through your University of Minnesota e-mail account. Announcements intended for the whole class will be sent by e-mail. It is a requirement of the course to check your e-mail daily. While in class, please turn off all pagers and cellular phones.

DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.
MENTAL HEALTH RESOURCES
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006

WELLNESS PROGRAM FOR DENTAL STUDENTS:
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

COURSE TIMES, ROOMS AND LECTURE TITLES FOR EACH SESSION
The course will be conducted in room 16-104 (Gorlin Conference Room) from 3:30 to 5:00 pm.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic/Reading assignment</th>
<th>Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-Jan</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>14-Jan</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>21-Jan</td>
<td>NO CLASS</td>
<td></td>
</tr>
<tr>
<td>28-Jan</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Gopalakrishnan</td>
</tr>
<tr>
<td>4-Dec</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Wetzel</td>
</tr>
<tr>
<td>11-Feb</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>18-Feb</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>25-Feb</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Wetzel</td>
</tr>
<tr>
<td>3-Mar</td>
<td>NO CLASS</td>
<td></td>
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<tr>
<td>10-Mar</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>17-Mar</td>
<td>SPRING BREAK</td>
<td></td>
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<tr>
<td>24-Mar</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td>31-Mar</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Wetzel</td>
</tr>
<tr>
<td>7-Apr</td>
<td>NO CLASS</td>
<td></td>
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<tr>
<td>14-Apr</td>
<td>Clinical Pathologic Correlation Cases</td>
<td>Rohrer</td>
</tr>
<tr>
<td></td>
<td>EXAM Due Thursday April 21</td>
<td></td>
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</tbody>
</table>
DATE:  August 14, 2015
TO:    Heather Conrad DDS, Scott McClanahan DDS, Robert Jones DDS, Jeff Karp DMD, James Lipon DDS, Jane Miller PhD, Patrice Dahl R.N, James Gambucci DDS, Steve Shuman DDS,
FROM:  Dr. Jim Hinrichs

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject</th>
<th>Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 8, 2015</td>
<td>Principle of Sedation, Risk Assessment</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp. 8-62</td>
<td></td>
</tr>
<tr>
<td>Sept 15, 2015</td>
<td>Local Anesthetics/agents/techniques/complications</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Gow-Gates: <a href="https://www.youtube.com/watch?v=eCK6K0YrJEQ&amp;index=3&amp;list=PLFA211075A4F1F1F2">https://www.youtube.com/watch?v=eCK6K0YrJEQ&amp;index=3&amp;list=PLFA211075A4F1F1F2</a></td>
<td></td>
</tr>
<tr>
<td>Sept 22, 2015</td>
<td>Oral, Sublingual, Intranasal &amp; Intramuscular Sedation</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp. 95-118 &amp; 124-162</td>
<td></td>
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<tr>
<td>Sept 29, 2015</td>
<td>Nitrous Oxide / Oxygen Sedation</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp. 179-268</td>
<td></td>
</tr>
<tr>
<td>Oct 6, 2015</td>
<td>Anatomy &amp; Electrical Activity of the Heart</td>
<td>Patrice Dahl RN</td>
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<tr>
<td></td>
<td>ECG &amp; ACLS handouts</td>
<td>CCRN, ICU RN</td>
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<tr>
<td>Oct 13, 2015</td>
<td>ECG Interpretation</td>
<td>Patrice Dahl RN</td>
</tr>
<tr>
<td></td>
<td>ECG &amp; ACLS handouts</td>
<td>CCRN, ICU RN</td>
</tr>
<tr>
<td>Oct 20, 2015</td>
<td>Recognition &amp; Management of</td>
<td>Dr. Lipon</td>
</tr>
<tr>
<td></td>
<td>Dysrhythmias ECG &amp; handouts</td>
<td>Pedo/Dental Anesthesiologist</td>
</tr>
<tr>
<td>Oct 27, 2015</td>
<td>I.V Rationale, Pharmacology &amp; Techniques</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp.274-279, 316-375</td>
<td></td>
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<tr>
<td>Nov 3, 2015</td>
<td>Cardiovascular &amp; respiratory physiology of sedatives and narcotics – handouts</td>
<td>Dr. Lipon</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp.</td>
<td>Pedo/Dental Anesthesiologist</td>
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<tr>
<td>Nov 10, 2015</td>
<td>Monitors, I.V. Armamentarium, Venipuncture Malamed Sed pp. 63-86, 280-315</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td>Nov 17, 2015</td>
<td>Pediatric, Geriatric &amp; Medically Compromised</td>
<td>Dr. Rob Jones – Pediatric Dentistry</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed. Pp. 495-571</td>
<td>Dr. Steve Shuman – Geriatric Dentistry</td>
</tr>
<tr>
<td>Nov 14 - 17</td>
<td>Dr. Hinrichs out of town - AAP convention in Orlando</td>
<td></td>
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<tr>
<td>Nov 24, 2015</td>
<td>Complications &amp; I.V. Laboratory (lab @)</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed pp. 376-394</td>
<td></td>
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<tr>
<td>Dec 1, 2015</td>
<td>Medical Emergencies</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td></td>
<td>Malamed Sed. pp. 438-492</td>
<td></td>
</tr>
<tr>
<td>Dec 7 Mon.</td>
<td>Medical Emergencies/Laboratory</td>
<td>Jane Miller PhD</td>
</tr>
<tr>
<td>5:00-8:00</td>
<td>ACLS codes (SimMan® - B190 PWB)</td>
<td>Angie Mortenson M Ed</td>
</tr>
<tr>
<td>5:15-8:15</td>
<td>Airway management</td>
<td>Anne C Woll M Ed</td>
</tr>
<tr>
<td></td>
<td>Mock emergencies</td>
<td>&amp; Dr. Hinrichs</td>
</tr>
</tbody>
</table>
Class structure: This course will utilize a seminar-discussion format. Each participating individual will be expected to have read that day's assignment prior to class and be prepared to contribute to the discussion.

Course objectives: This course is designed to enhance the student's knowledge and ability to a) assess physical risk for dental patients, b) recognize and manage ECG dysrhythmias, c) administer local anesthetics and manage any associated complications, d) know the advantages, limitations and be able to manage possible complications associated with the administration of agents used to control anxiety during dental procedures [including the following routes of administration: oral, intramuscular, inhalation and intravenous] and e) prevent, recognize and manage medical emergencies which might arise within the dental setting.

Course grade: Course grades will be determined on the basis of the student's contribution to the discussions (15%) covering the assigned materials during the seminars, written case scenario on medical emergencies (10%), and score on the final examination (75%) given during the last class period.

Endodontic Residents '15
Scott McClanahan sent e-mail on July 29, 2015
Michael Regan Anderson and02657@umn.edu
Alex Brown brow4547@umn.edu
Kristine Knoll knoll059@umn.edu
Tyler Schuurmans schu004@umn.edu

Pediatric Dentistry Residents '14
Sacha Brueggemann sent e-mail on July 29, 2015
John Bakarich bakar007@umn.edu
Lindsay Bedeaux schue169@umn.edu
Teemar Carey carey247@umn.edu
Matthew Husman husma012@umn.edu
TaekHyun (Fran) Rhee rheex041@umn.edu
Emma Zimmerman zimme385@umn.edu

Periodontal Residents '14
Georgios Chatzopoulos chatz005@umn.edu
Janelle Hamilton hamil605@umn.edu
Caitlin Hemmerich hemm0089@umn.edu

Prosthodontic Residents '15
Jessica Anderson sent e-mail on July 29, 2015
Dane McMillan mcml222@umn.edu
James Lee leex8218@umn.edu
Joseph Lucero lucer023@umn.edu
Kale McMillan mcml221@umn.edu
Owen Trinh trin0072@umn.edu
Samuel Hickman hickm117@umn.edu

General Practice Residents '13
James Gambucci gambu001@umn.edu

Emily Reynaga e-mailed names on July 29, 2015
Nicholas Bussa bussa019@umn.edu
Michelle De Fazio defaz003@umn.edu
Jascha Marchuk march104@umn.edu
Chris Rivers river105@umn.edu
Zainah Shaker shake007@umn.edu

James Lipon, DDS
Cell # : 917-618-2515
Dentist Anesthesiologist
Pediatric Dental Resident
University of Minnesota
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• Sacha Brueggemann  
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Jeff Karp jmkarp@umn.edu  Phone: (612) 659-4910

• Emily Reynaga  
GPR Dental Res Coordinator — Developmental/Surgical Science  
ereynaga10@umphysicians.umn.edu  Phone: (612) 659-8691  
James Gambucci gambu001@umn.edu  Phone: (612) 625-7448
Mock emergencies

Type out a brief case scenario illustrating your below highlighted medical emergency in a dental setting. E-mail your case scenario to hinri001@umn.edu and ______ bring typed copy to B190 PWB to read aloud the review of medical history and clinical signs & symptoms. At that point you will pause for 5 seconds and ask your classmates to verbally list their differential diagnoses and describe their plan of action as well as the patient’s response.

Review of patient’s medical history:

Overview of clinical signs, patient’s symptoms and dental procedures being completed;

Assessment: differential diagnosis and identify top priority

Plan, methods and materials for management (ie. procedures, drugs, dose, etc.):

Evaluation of patient’s response (ie. improvement in vital signs or adverse reaction to drug administered):

**Emergencies listed in Malamed**

1. Immediate allergic reaction
2. Delayed allergic reaction
3. Asthmatic attack – bronchospasm
4. Hyperventilation
5. Epinephrine overdose
6. Foreign body obstruction/ emesis
7. Laryngospasm
8. Vasopressor syncope
9. Angina pectoris
10. Myocardial infarction
11. Severe hypotension with bradycardia
12. Hypertensive crisis
13. Stroke - cerebral vascular accident
14. Grand mal seizure
15. Local anesthetic overdose
16. Narcotic analgesic overdose with apnea
17. Benzodiazepine overdose with apnea
18. Hypoglycemia - insulin shock

**Required by MN Board of Dentistry**

Allergic reaction (Anaphylaxis)
Asthmatic attack (Bronchospasm)
Hyperventilation
Foreign body obstruction/ emesis
Laryngospasm
Syncope
Angina Pectoris (Chest pain)
Myocardial infarction (Heart attack)
Hypotensive crisis
Hypertensive crisis
Stroke
Seizures (convulsions)
Local anesthetic overdose
Narcotic overdose
Benzodiazepine overdose
Hypoglycemia
Apnea
Sudden cardiac arrest
Participants in Dent 7102 / Conscious Sedation:

PLEASE, keep the write-up on your assigned “Mock Emergency Scenario” brief and meaningful so you can subsequently utilizes them for training of your office staff.

Review of patient’s medical history: Approximately 45 seconds in duration when read aloud

Overview of clinical signs, patient’s symptoms and dental procedures being completed: Approximately 60 seconds in duration when read aloud

Assessment: differential diagnosis and identify top priority Approximately 30 seconds in duration when read aloud

Plan, methods and materials for management (ie. procedures, drugs, dose, etc.): Approximately 2 ½ minutes in duration when read aloud

Evaluation of patient’s response (ie. improvement in vital signs or adverse reaction to drug administered): Approximately 45 seconds in duration when read aloud

Please, e-mail a copy to myself hinri001@umn.edu for grading and a second copy to __________________ so he/she can pool all scenarios and redistribute a Master Copy to all course participants.

Respectfully,

Dr. Hinrichs
Oral Sedation Reference


<table>
<thead>
<tr>
<th>Oral Sedation Drugs</th>
<th>Drug category/sched</th>
<th>Treatment Time (single dose/adult)</th>
<th>Half-life (flumazenil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sonata/zalephn</td>
<td>imidazopyridine/IV</td>
<td>1 hour (5 to 10 mg) capsule</td>
<td>1 hour / yes</td>
</tr>
<tr>
<td>Ambien/zolpidem</td>
<td>imidazopyridine/IV</td>
<td>2-3 hours (5 to 10 mg)</td>
<td>1.4 to 4.5 hours / yes</td>
</tr>
<tr>
<td>Halicon/triazolam</td>
<td>benzodiazepine/IV</td>
<td>2-3 hours (0.25 to 0.5 mg) tablet</td>
<td>1.5 to 5.5 hours / yes</td>
</tr>
<tr>
<td>Dormicum/midazolam</td>
<td>benzodiazepine/IV</td>
<td>2-3 hours (~ 5 to 15 mg) liquid</td>
<td>1.2 to 12.3 hours / yes</td>
</tr>
<tr>
<td>Serax/oxazepam</td>
<td>benzodiazepine/IV</td>
<td>~4 hours (15 to 30 mg) capsule</td>
<td>5.7-10.9 hours / yes</td>
</tr>
<tr>
<td>Ativan/lorazepam</td>
<td>benzodiazepine/IV</td>
<td>~4 hours (2 to 4 mg) tablet</td>
<td>12 hours / yes</td>
</tr>
<tr>
<td>Xanax/alprazolam</td>
<td>benzodiazepine/IV</td>
<td>&gt;4 hours (0.5 to 1 mg) capsule</td>
<td>12-15 hours / yes</td>
</tr>
<tr>
<td>Valium/diazepam</td>
<td>benzodiazepine/IV</td>
<td>&gt;4 hours (5 to 10 mg) tablet</td>
<td>20-70 hours / yes</td>
</tr>
<tr>
<td>Dalmane/flurazepam</td>
<td>benzodiazepine/IV</td>
<td>&gt;6 hours (15 to 30 mg) tablet</td>
<td>*47-100 hours / yes</td>
</tr>
<tr>
<td>Nembutal/pentobarbital</td>
<td>barbiturate/II</td>
<td>3-6 hours (100 mg) capsule</td>
<td>21 to 42 hours / no</td>
</tr>
<tr>
<td>Seconal/secobarbital</td>
<td>barbiturate/II</td>
<td>3-6 hours (100 mg) capsule</td>
<td>20 to 28 hours / no</td>
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<tr>
<td>Chloral hydrate with</td>
<td>alcohol with</td>
<td>4-8 hours (500-1,500 mg) liquid</td>
<td>7 to 9.5 hours / no</td>
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<tr>
<td>Promethazine</td>
<td>phenothiazine deriv.</td>
<td>3-4 hours (12.5-25-50 mg) liquid</td>
<td>4 to 5 hours / no</td>
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</tbody>
</table>

* = plasma half-life of 2.3 hours but active metabolites with half-life of 47 to 100 hours

Some articles on oral sedation.
http://www.docseducation.com/upload_files/AnesthesiaAndPainControl[1].pdf
This article from the AGD General Dentistry Sept/Oct, 2007 on page 413 states: Event characteristics: Of the 7,740 cases submitted, 1,686 (21.8%) met the prospective criteria for an event (see Table 3). The majority (78.2%) of cases that were submitted had no events. The most frequent event was a decrease in diastolic BP of more than 25% from the baseline reading; this event occurred among 1,238 (16%) of cases examined. Approximately 4% (307) of cases reported oxygen saturation decreasing to below 90%. Of the cases identified as events, none were emergent.

http://www.docseducation.com/upload_files/AnesthesiaAndPainControl[1].pdf
The second article from the JADA 2006 page 509 states "A total of 613 dentists administering incremental triazolam reported 85 adverse reactions in 28,881 cases (0.3%)." None needed hospitalization, no deaths, 15 had SpO2 below 90% for more than 2 minutes, 18 with elevated systolic BP, 5 with hypotension below 75% of baseline, 10 with tachycardia or bradycardia, and 37 considered adverse due to the failure to maintain satisfactory levels of conscious sedation.

American Heart Association recommended blood pressure levels

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic (mm Hg)</th>
<th>Diastolic (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>less than 120</td>
<td>and less than 80</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120–139</td>
<td>or 80–89</td>
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<td>High</td>
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<td>Stage 1</td>
<td>140–159</td>
<td>or 90–99</td>
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<tr>
<td>Stage 2</td>
<td>160 or higher</td>
<td>or 100 or higher</td>
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</table>
Please evaluate the following statements on a scale of 1 to 7. A 7 indicates a very strong favorable response while a 1 implies a very negative response. N/A indicates the statement is not applicable.

1) The faculty and course content utilized basic science principles to aid the student in understanding methods of conscious sedation.  

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2) The faculty was knowledgeable and stimulated discussion about the subject.  

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<tr>
<th></th>
<th>Dr. James Hinrichs</th>
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<td>Ms. Patrice Dahl R.N.</td>
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<td>Dr. James Lipon</td>
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<td>Dr. Rob Jones</td>
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<td>Dr. Steve Shuman</td>
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3) I obtained a good understanding from lectures on each of the following subjects as it relates to conscious sedation.  

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<tr>
<th></th>
<th>Principles of sedation &amp; risk assess</th>
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<td>Pharmacology &amp; techniques of L.A.</td>
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<td>Pharmacology &amp; techniques of N₂O</td>
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<td>Cardiac anatomy &amp; ECG</td>
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<td>Recognition of dysrhythmias</td>
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<td>Cardiovascular &amp; respiratory phys.</td>
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<td>Oral &amp; I.M. sedation</td>
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<td>Medical emergencies</td>
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4) The laboratory exercises were very beneficial  

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<td>Medical emergencies @ AHC Sim Center</td>
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5) The final examination was fair and comprehensive.  

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6) I would highly recommend this course.  

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Additional comments:
From: James Hinrichs [mailto:hinri001@umn.edu]
Sent: Wednesday, November 25, 2009 12:00 PM
To: 'ashe0007@umn.edu'; 'harr1284@umn.edu'; 'phil8653@umn.edu'; 'wiswa004@umn.edu';
'Adam L Ridgeway'; 'Betty Huang'; 'Laura Kottemann'; 'Nancy Sandmann'; 'Sarah Welch';
'Timothy Richardson'; 'beck0610@umn.edu'; 'bird0066@umn.edu'; 'hsuxx182@umn.edu';
'issaxo08@umn.edu'; 'olow0001@umn.edu'; 'Krista Roquette'; 'port0194@umn.edu';
'moham281@umn.edu'; 'singl069@umn.edu'; 'abdel010@umn.edu'; 'evers109@umn.edu'; 'syang@umphysicians.umn.edu'; 'Larry Wolff';
'Scott McLanahan'; 'Soraya Beiraghi'; 'shuma001@umn.edu'; 'Mark Bierma'; 'djsslindy@aol.com'
Cc: 'moham281@umn.edu'; 'singl069@umn.edu'
Subject: Requirements to obtain MN Board of Dentistry approved "Sedation Permit"

Course participants in Dent 7102/ Conscious Sedation:

In order to obtain a “Conscious Sedation Permit” from the Minnesota Board of Dentistry you will need to:

1. Show proof of sixty hours of didactic training

<table>
<thead>
<tr>
<th>Course #</th>
<th>Description</th>
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<tbody>
<tr>
<td>A. OSur 5277</td>
<td>History &amp; Physical Diagnosis (risk assessment)</td>
<td>24</td>
</tr>
<tr>
<td>B. Dent 7102</td>
<td>Conscious Sedation</td>
<td>40 plus</td>
</tr>
<tr>
<td>C. Dent 7051</td>
<td>Oral Medicine (risk assessment)</td>
<td>22</td>
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<tr>
<td>D. Initial training course in ACLS</td>
<td>or ~ 16</td>
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<tr>
<td>D’. Re-certification course in ACLS</td>
<td>or ~ 8</td>
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Total structured hours provided via U of MN curriculum ~ 110

2. Time orientated monitoring sheet plus written pre-sedation & post-sedation instructions

3. Sedation consent form to be review with the patient and/or guardian before the sedation and signed/dated.

4. Minnesota currently requires at least ten documented intravenous cases for those anticipate using IV while many other states require 20 cases. Document all cases that you administered sedation
   a. Oral sedation
   b. nitrous oxide / oxygen sedation
   c. intravenous cases

5. Completed “Sedation Inspection Self-Evaluation Form” Sedation_Inspection_Self-evaluation_Form 10-08-08 final including:
   a. Proof of your current ACLS or PALS certification
   b. Board approved emergency kit including specific drugs and valid expiration dates not expired
      You may choose not to have one or more of the recommended drug(s) in your emergency kit but you must present a sound rationale for your exclusion.
   c. Positive pressure oxygen
   d. Auxiliary suction
   e. Auxiliary light source
   f. EKG unit
   g. Defibrillator
   h. Dentist and staff must be familiar with office protocol for recognition & management of medical emergencies.

6. Pass an in-office inspection as approved by the Minnesota Board of Dentistry.

I strongly suggest that you keep all of your sedation related course materials (syllabi for OSur 5277, Dent 7102, Dent 7051, ACLS/PALS certificate, time orientated monitoring sheets, mock emergency scenarios, etc.) organized in a 3-ring binder.

Respectfully,
James E. Hinrichs D.D.S., M.S.
Professor and Director of
Advanced Education Program in Periodontology
University of Minnesota
7-368 Moos Health Science Tower
515 Delaware Street SE
Minneapolis, MN 55455
E-mail: hinrl001@umn.edu
DENT 7123 - Temporomandibular Disorders and Orofacial Pain

Fall 2015
Room 2-690, Moos Tower

CONTACT INFORMATION FOR COURSE DIRECTOR:
Eric Schiffman, DDS, MS
6-320E Moos Tower
612-624-3130
schif001@umn.edu
Office hours by appointment

The purpose of this course is to provide students with the basic didactic information needed to recognize and manage patients with temporomandibular disorders. It will also give an overview of the scope and complexity of the clinical practice of TMD and Orofacial Pain management.

COURSE OBJECTIVES
At the conclusion of this course students will:
- delineate the scope of practice within the area of TMD & Orofacial Pain
- know the general differential diagnosis for pain presenting in the orofacial region
- understand how to provide patients with TMD self-care
- understand how to provide medical management for patients with acute TMD pain
- list the various treatment options available for TMD patient care
- list the various care providers, and their roles, typically involved in TMD patient care
- list the various types of pain disorder that may present in the orofacial region
- understand the role of dentists in diagnosing and treating of TMD and Orofacial Pain patients
- understand the role of dentists in diagnosing and treating sleep apnea patients

SCHOOL OF DENTISTRY COMPETENCIES ADDRESSED BY COURSE
The competencies addressed will be:
1. Selecting, obtaining, and interpreting patient data, information and radiographs to be able to use these findings to accurately assess and treat patients.
2. Formulate a comprehensive diagnosis and treatment and/or referral plan for the management of patients.
3. The prevention, assessment, and management of medical and dental emergencies.
4. Preventing and managing pain and anxiety in the dental patient.
5. Apply appropriate communication skills in providing patient-centered oral health care to a diverse population.
6. Applying appropriate ethical and legal standards in providing patient-centered oral health care within the individual’s scope of competence.

REQUIRED TEXT AND READINGS
There is no required textbook for this course. Suggested textbooks for supplemental learning are:


CREDITS
1.0

Version: 6/16/16
GRADING AND EVALUATION POLICIES.
The grade for this course will be derived from the final examination, which will comprise 100% of the mark for this course. The final exam will consist of multiple choice questions, with a credit of 1 mark given for each question answered correctly and 0 marks for those answered incorrectly. This course is graded via the A, B, C of F system with the following assignments:
A = 100% to 85%
B = 84% to 70%
C = 69% to 60%
F = 59% or less

STUDENT EXPECTATIONS
To receive a passing grade, students are expected to attend lectures and learn the didactic material. Students' evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Students will be required to complete evaluations on line before a grade will be given in this course.

GRADE DISPUTES
Grade disputes will follow University and SOD policies listed in the student handbook. All grade disputes must first be addressed to the course director.

REMEDIATION POLICIES
Graduate students who received failing grade in this course must remediate during the following term to the satisfaction of the course director and Director of the Graduate Prosthodontic program.

MAKE-UP EXAM POLICIES
If students miss the final exam due to an unexcused absence, they will receive a failing grade for the course. For students who miss the final exam due to an excused absence, a time will be arranged for them to take the exam.

ATTENDANCE
Attendance in lectures is mandatory.

FEEDBACK
Limited amount of time is available after lecture to address questions in the lecture component of this course. You may contact the lecturer via e-mail or follow up with the course director. Major concerns should be directed to the course director via the Director of the Graduate Prosthodontic Program.

STUDENT INTEGRITY
Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook. Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

COMMUNICATION

Version: 6/16/16
All individual and full class communication will be through your University of Minnesota e-mail account. Announcements intended for the whole class will be sent by e-mail. It is a requirement of the course to check your e-mail daily. While in class, please turn off all alerts and alarms on electronic devices.

**STUDENT ON-LINE PRIVACY AND SECURITY**

Online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.

**DISABILITIES**

The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website [http://ds.umn.edu](http://ds.umn.edu).

**MENTAL HEALTH RESOURCES**

As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via [www.mentalhealth.umn.edu](http://www.mentalhealth.umn.edu).

**WELLNESS PROGRAM FOR DENTAL STUDENTS**

The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

**APPROPRIATE STUDENT USE OF CLASS NOTES**

Students may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

**CHANGES MADE IN RESPONSE TO STUDENT FEEDBACK**

Added elective clinical exam. The clinical exam will be done outside lecture time, after normal clinic hours.
FACULTY INFORMATION

Course Director: Eric Schiffman, DDS, MS
Professor
Division of TMD & Orofacial Pain
schif001@umn.edu

Lecturers:
Jagdeep Bijwadia, MBBS
Pulmonary Medicine
HealthPartners
Jagdeep.S.Bijwadia@HealthPartners.com

Karen Decker, PT
Physical Therapist
Division of TMD & Orofacial Pain
decke005@umn.edu

Gary Anderson, DDS, MS
Associate Professor
Cleft Palate Program
ander018@umn.edu

Leesa Morrow, PhD, JD, LP
Clinical Assistant Professor
Division of TMD & Orofacial Pain
morro090@umn.edu

Mariona Mulet, DDS, MS
Clinical Assistant Professor
Division of TMD & Orofacial Pain
mulet001@umn.edu

Donald Nixdorf, DDS, MS
Associate Professor
Division of TMD & Orofacial Pain
nixdorf@umn.edu

James Swift, DDS
Professor
Division of Oral and Maxillofacial Surgery
swift001@umn.edu
COURSE TIMES, ROOMS AND LECTURE TITLES FOR EACH SESSION

DENT 7123
Temporomandibular Disorders and Orofacial Pain
Course Outline – Fall 2015

Room 2-690, Moos Tower

Classes start at either 7:30, 8:00 or 8:30 a.m.
(Dates in italics have longer hours or two sessions total; see below for details)

CLINIC SESSIONS
TMD, Orofacial Pain, and Dental Sleep Medicine Clinic
Room 6-440, Moos Tower
8:30 a.m. to 12:00 p.m. and 1:00 p.m. to 4 p.m.

Thurs. Sept 3 (7:30)  1. Orofacial Pain diagnoses
                   Introduction & Differential Diagnosis of Orofacial Pain – Eric Schiffman

Thurs. Sept 10 (7:30)  2. TMD Diagnosis
                      Clinical Assessment – Eric Schiffman

Thurs. Sept 17  No class

Thurs. Sept 24 (7:30)  3. TMD Diagnosis
                      Diagnosis of TMD, Part I – Eric Schiffman

Thurs. Oct 1 (7:30)  4. TMD Diagnosis
                     Diagnosis of TMD, Part II – Eric Schiffman

Thurs. Oct 8 (7:30)  5. TMD Treatment
                     Medical Management – Eric Schiffman

Thurs. Oct 15 (7:30)  6. TMD Treatment
                      Splint Therapy & Occlusal Adjustments – Gary Anderson

Thurs. Oct 22 (7:30)  7. TMD Treatment
                      Behavioral and Psychosocial Aspects – Leesa Morrow

Thurs. Oct 22 (8:30)  8. TMD Treatment
                      Role of Physical Therapy – Karen Decker

Thurs. Oct 29 (8:00-9:20)  9. TMD Treatment
                           Team Management – Eric Schiffman, Leesa Morrow and Karen Decker

Thurs. Nov 5 (8:00-9:20 a.m.)  10. Midterm Test

Thurs. Nov 12 (7:30)  11. TMD Treatment
                       TMJ Surgery – Jim Swift

Thurs. Nov 12 (8:30)  12. Orofacial Pain
                       Headache and Neurovascular Disorders – Donald Nixdorf

Version: 6/16/16
Thurs. Nov 19 (8:30) 13. Orofacial Pain
Neuropathic Pains seen by Dentists – Donald Nixdorf

Thurs. Nov 26  No class/ Holiday

Thurs. Dec 3 (7:30) 14. Orofacial Pain
Burning Mouth Syndrome – Mariona Mulet

Thurs. Dec 3 (8:30) 15. Sleep Apnea Essentials – Jagdeep Bijwadia

Thurs. Dec 10 (7:30) 16. Sleep Apnea – Management with oral appliances – Mariona Mulet

Thurs. Dec 10 (8:30) 17. Orofacial Pain
Non-odontogenic Tooth Pain – Don Nixdorf

Thurs. Dec 17 (8:00-9:00 a.m.) Final Examination

**Mandatory clinic rotation**

TMD, Orofacial Pain, and Dental Sleep Medicine Clinic
Room 6-440, Moos Tower
Monday through Thursdays
8:30 a.m. to 12:00 p.m. and 1:00 p.m. to 4:30 p.m.

Students need to arrange to observe at least 2 days in the clinic with the attending clinician.

**Mandatory review, demonstration and practice of the TMD clinical exam**

To be arranged during the course for 2 Wednesdays at 5:00 or 5:30 p.m.
Periodontal and Prosthodontic residents and faculty:

Below are the dates and videos we’ll review and discuss in Dent 7322 / Multidisciplinary Seminar on Wednesday evenings in Continuing Education Conference Room (6-410) from 6:00 pm - 7:45. The course objective is to enhance understanding of treatment planning objectives and collaborative care as provided among various dental specialties. Participants should register for this class as one credit hour on S/N grade basis. Grades will be based on student’s attending at least two-thirds or more of the classes (8/13) and contributing to the discussion for a satisfactory grade. Class will not be held on January 21st or March 11th & 18th since I’ll be out of town.

Respectfully,

James E. Hinrichs DDS, MS
Professor and Director of
Advanced Education Program in Periodontology

Nights for classes & selected video

1. January 14th = FCE05 Complex Decision-Making for Teeth and Implants in the Aesthetic Zone using the Interdisciplinary Team Hochman, Tarnow
2. January 21st = NO CLASS
3. January 28th = CE02 Sinus Therapy: Graft, Space or Biologic? Butler, Froum, Toffler, Wallace
5. February 11th = CE05 Impact of Osteoporosis on the Management of Periodontal and Implant Patients Armitage, Marriotti, McCauley
6. February 18th = FCE04 The Role of the Periodontist in the Treatment of the Pre-Diabetic and Diabetic Patient Geisinger, Mealey
7. February 25th = CE14 Comprehensive Understanding of Immediate Implants Kolinski, Wagenberg, Salama, Thomas
8. March 4th = GS02 Understanding and Managing Peri-implant Bone Loss Rosen, Albrektsson, Klinge, Schwarz
9. March 11th = NO CLASS
10. March 18th = NO CLASS
12. April 1st = FCE09 Guidelines for Decision-Making: When to Use Autogenous Tissue or Acellular Dermis Janakievski, Pasquinielli
13. April 8th = FCE13 Lasers and Periodontitis: Point/Counterpoint Teel, Cobb, Reynolds
14. April 15th = CE10 Social Media Doobrow, Holtzclaw, Zamora
15. April 22nd = GS03 Interactive Session - Managing the Unaesthetic Implant Faiella, Rosen, Bahat, Chu, Daftary, Mahallati, Tarnow
16. April 29th = CE06 Current State of Orthodontic Care Facilitated by Piezoelectric and Bone Regenerative Technologies Murphy, Dibart, Richman

OTHERS:

CE07 Options for Managing the Edentulous Arch Duello, Carpentieri, Ganeles
CE09 Out of the bottle: What’s the cost, and is it worth it? McAllister, Jovanovic, Levin, Neiva, Sculean
CE12 Treatment Decisions for Interdisciplinary Challenges in the Aesthetic Zone Okano, Apa, Chadroff
FCE01 Application of Microsurgical Principles in Plastic Periodontal and Implant Surgery - Scientific Data, Clinical Relevance and Future Perspectives Pearson, Zuhr
FCE03 New Perspectives on Vertical and Horizontal Ridge Augmentation Levine, Urban
FCE06 Adjacent Implants in the Esthetic Zone Conte, Staas
FCE11 Strategies to Reconstruct the Deformed Alveolus Langer, Langer
GS04 Soft Tissue Modeling and Remodeling after Implant Placement: The New Frontier Caplanis, Duello, Goldenberg, Velasquez
IP03 Innovations in Periodontics Session 3 Mandelaris, Abe, Mazor, Ohayon, Saffarpour
Periodontal Residents:
Micah Chan chanx199@umn.edu
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Wook-Jin Seong seong001@umn.edu
Jessica Anderson vaugh068@umn.edu
Gary Crowe gcrowe@umn.edu  Dental Continuing Education
COURSE DIRECTOR
Conrado Aparicio, PhD.
Associate Professor.
Department of Restorative Sciences.
School of Dentistry.
Office Hours: 8:00 a.m. to 10:00 a.m., Monday and Thursday; 16-250a Moos Tower
Telephone: 625-4467
Email: apari003@umn.edu

COURSE PURPOSE
Almost every course of dental treatment involves the use of biomaterials. This is particularly relevant in the field of prosthodontics. Use of the wrong material, or wrong usage of the correct material, can contribute significantly to failure of treatment. Thus the general course purpose is stated as: “the application of scientific principles to the selection and utilization of dental biomaterials in prosthodontics.” The emphasis will be in understanding (i) the structure-properties relationship and (ii) the role and performance of synthetic materials in a living environment.

COURSE OBJECTIVES
1. Understand the nature and general properties of polymers, metallic materials and ceramics.
2. Define the mechanical, physical and chemical properties of dental biomaterials used in prosthodontics.
3. State the general composition, structure and properties of all materials used in prosthodontics.
4. State the three mechanisms of adhesion, and their applicability to prosthodontics procedures.
5. State the principles of material reinforcement, with specific reference to composite materials and composite structures.
6. Understand the effect of mishandling of materials on properties, biocompatibility, durability and efficacy.
7. Systemically critique materials, noting their merits and limitations.
8. Employ critical skills in interpretation of the literature and utilize evidence-based principles in material selection.

Additionally, each lecture has specific objectives related to the lecture topic.

REQUIRED TEXT AND READINGS
1. Required reading
For each topic covered a list of 2-3 recently-published research papers dealing with relevant aspects of the topic will be provided for complementing the educational objectives and stimulate discussion in class.

2. Suggested reading

CREDITS
1.0 credits (15h, 1 h per lecture and student’s presentations).

GRADING AND EVALUATION POLICIES
1 test, 60% of the final grade
1 20-min oral presentation on one of the topics included in the required reading papers, 40 % of the final grade
**Grades**

<table>
<thead>
<tr>
<th>Total score (%)</th>
<th>Grade</th>
</tr>
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<tbody>
<tr>
<td>90-100</td>
<td>A</td>
</tr>
<tr>
<td>80-89</td>
<td>B</td>
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<tr>
<td>70-79</td>
<td>C</td>
</tr>
<tr>
<td>&lt;70</td>
<td>F</td>
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</table>

**STUDENT EXPECTATIONS**

Students are required to attend all 10 lectures, read the assigned literature for each topic, and present a 20-min. discussion topic. Students are expected to attend the lectures on time. Students’ evaluation of the course and the participating faculty are considered to be a mandatory requirement for the successful completion of this course and are used to help improve the course each year. Students will be required to complete evaluations on line (using CourseEval) before a grade will be given in this course.

**DISTANCE DELIVERY OF COURSE MATERIAL**

This course offers distance delivery components that may be required by the instructor for class facilitation, which may include use of Moodle, proctored examinations, Media Site video lectures, and/or other methods of course instruction that occur when students are separated from the instructor. Unless stated otherwise by the instructor, there is no additional cost for the use of distance education technologies.

**GRADE DISPUTES**

Grade disputes will follow University and SOD policies listed in the advanced education student handbook. All grade disputes must first be addressed to the course director

**REMEDICATION POLICIES**

Graduate students who received failing grade in this course must remediate during the following term to the satisfaction of the course director and Director of the Graduate Prosthodontic program.

**MAKE-UP EXAM POLICIES**

If students miss an exam please list the policy that applies for both an excused absence and unexcused absence, which will be of the same format as the missed examination.

**ATTENDANCE**

Attendance at classes is required. There is a new school attendance policy. Students who are absent from class for a reason other than an Excused Absence is responsible for making up any missed class content. The instructor will not offer make-up work if a student’s absence is not excused.

**FEEDBACK (Optional)**

The Course Director welcomes feedback on the classes. Clarification of the subject matter can be obtained by: (1) questions for clarification during lectures (2) email questions (3) office visits within office hours. If there are perceived to the problems with the course in general, it is preferable that these are communicated by the class officers to the Course Director in his office or after class. The Course Director might require optional feedback from students attending the class through an ad-hoc mid-term course evaluation.

**STUDENT INTEGRITY**

Per the School of Dentistry Code of Conduct, “academic misconduct is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk.” Additional information about acts considered infractions of the code can be found in the School of Dentistry Code of Conduct in the student handbook.
Academic misconduct is a violation of the School of Dentistry Code of Conduct and will be resolved following the procedures in the code.

COMMUNICATION
All individual and full class communication will be through your University of Minnesota e-mail account. Announcements intended for the whole class will be sent by e-mail (add in web site if appropriate). It is a requirement of the course to check your e-mail daily. While in class, please turn off all pagers and cellular phones.

STUDENT ON-LINE PRIVACY AND SECURITY
Online learning components of this course are password-protected with your U of M internet ID. Moodle technology will sometimes make students' names and U of M Internet IDs visible within the course website, but only to other students in the same class. Since we are using a secure, password-protected course website, this will not increase the risk of identity theft or spamming for anyone in the class. If you have concerns about the visibility of your Internet ID, please contact your instructor for further information.

DISABILITIES
The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or at ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

MENTAL HEALTH RESOURCES
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce your ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu.

Developed and endorsed by the Provost’s Committee on Student Mental Health, June 2006

WELLNESS PROGRAM FOR DENTAL STUDENTS
The Minnesota Dentist Wellness Program offers a consulting and counseling service to help Minnesota dentists, dental residents and dental student members with the many stressors that impact their lives and their practice of dentistry. Sand Creek is a service offered free of charge to dental students. Help is available by phone 24 hours a day, 7 days a week by call 1-800-632-7643. Face-to-face help is also offered through a counseling and consulting network with over 500 offices in Minnesota.

APPROPRIATE STUDENT USE OF CLASS NOTES
Students may not distribute, via internet or other means, instructor-provided lecture notes or other instructor provided materials except to other members of the same class without the express consent of instructor.

CHANGES MADE IN RESPONSE TO STUDENT FEEDBACK
Following student comments on previous courses, changes have been made in some details of the content and presentation of the course. Please provide feedback to the course director.
FACULTY INFORMATION
Dr C. Aparicio (Course Director)
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Dr. Alex Fok
Department of Restorative Sciences
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alexfok@umn.edu

COURSE TIMES, ROOMS AND LECTURE TITLES FOR EACH SESSION

Program for Summer 2014

SCHEDULE OF LECTURES (All lectures at 9-170 Moos Tower)

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Lecturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/29/2014</td>
<td>3-5 pm</td>
<td>Intro/Mechanical and flow properties</td>
<td>Aparicio</td>
</tr>
<tr>
<td>2</td>
<td>06/05/2014</td>
<td>3-5 pm</td>
<td>Alginate and elastomeric impression materials</td>
<td>Aparicio</td>
</tr>
<tr>
<td>3</td>
<td>06/12/2014</td>
<td>3-5 pm</td>
<td>Waxes</td>
<td>Aparicio</td>
</tr>
<tr>
<td>4</td>
<td>06/19/2014</td>
<td>3-5 pm</td>
<td>Gypsum and casting investment materials</td>
<td>Aparicio</td>
</tr>
<tr>
<td>5</td>
<td>07/10/2014</td>
<td>3-5 pm</td>
<td>Dental Cements</td>
<td>Aparicio</td>
</tr>
<tr>
<td>6</td>
<td>07/17/2014</td>
<td>3-5 pm</td>
<td>Metals and alloys in prosthodontics (PFM, partial denture, titanium)</td>
<td>Aparicio</td>
</tr>
<tr>
<td>7</td>
<td>07/24/2014</td>
<td>3-5 pm</td>
<td>Ceramics in prosthodontics (inc. all-ceramic restorations)</td>
<td>Aparicio/Fok</td>
</tr>
<tr>
<td>8</td>
<td>07/31/2014</td>
<td>3-5 pm</td>
<td>Acrylic and provisional materials</td>
<td>Aparicio</td>
</tr>
<tr>
<td>9</td>
<td>08/07/2014</td>
<td>3-5 pm</td>
<td>Composite materials, bonding, and shrinkage</td>
<td>Aparicio/Fok</td>
</tr>
<tr>
<td>10</td>
<td>08/14/2014</td>
<td>3-5 pm</td>
<td>Amalgam</td>
<td>Aparicio</td>
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<tr>
<td></td>
<td>08/21/2014</td>
<td>3-5 pm</td>
<td>Test</td>
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</tbody>
</table>

Lecture Objectives

Lecture 1 – Mechanical and Flow Properties

1. Describe the importance of the mechanical properties of dental biomaterials
2. List the objectives in measuring mechanical properties of materials
3. Define stress and list the five types of stress
4. Define and understand stress concentration
5. Define strain and distinguish between plastic and elastic strain
6. Understand the relevance of plastic and elastic deformation in impression taking
7. Draw and annotate a typical stress-strain graph
8. Define modulus of elasticity or Young’s modulus
9. Define proportional limit, elastic limit and yield point
10. Define and understand the difference between ultimate, and maximum strength
11. Define ductility and brittleness
12. Define modulus of resilience and toughness
13. Describe the measurement of impact strength
14. Define endurance limit (or fatigue limit)
15. Define hardness and list three standard methods of measuring hardness
16. Define abrasion
17. Define viscoelasticity, creep and stress relaxation
18. Define working time and setting time
19. List the factors on which the viscosity of a fluid depends

Lecture 2 - Alginate and elastomeric impression materials

1. List the requirements of impression materials.
2. Classify the available dental impression materials.
3. Distinguish between elastic and non-elastic materials.
4. Distinguish between hydrocolloids and non-aqueous elastomers.
5. Define the terms colloid and hydrocolloid.
6. Define sol and gel and distinguish between them.
7. Describe the two mechanisms of conversion of a sol into a gel.
8. Distinguish between reversible and irreversible sol to gel conversion reactions.
9. Describe the physical structure of a hydrocolloid.
10. Define syneresis and imbition.
11. Explain the significance of syneresis and imbibition in relation to dimensional stability.
12. List the main constituents of alginate impression materials.
13. Describe the setting reactions for alginate impression materials.
14. List the factors that are of importance in the correct manipulation of the material.
15. Critique alginate impression materials in relation to the ideal requirements for impression materials
16. List the principal types of elastomeric impression materials.
17. Discuss the property structure relationships of dental elastomers.
18. List recent developments in dental VPS impression materials, and critique currently available materials.
19. Discuss the properties of recently developed polyether impression materials.
20. Compare and contrast VPS and polyether impression materials.

Lecture 3 – Waxes

1. List the major types of waxes in terms of their composition
2. Recognize the main sources of waxes
3. Describe the general properties of waxes
4. Distinguish between the main properties of natural and synthetic waxes
5. Define the sol-sol transition temperature of waxes
6. Recognize the practical effects of thermal expansion and contraction of waxes
7. Recognize the practical effects of internal stresses during heating and cooling of waxes
8. Recognize the practical effects of the ability to burn of waxes
9. List and describe the dental applications of waxes

Lecture 4 – Gypsum and casting investment materials

1. List the desirable properties of cast and die materials.
2. Classify the hydrates of calcium sulfate.
3. Define gypsum.
4. Classify dental gypsum products (five types).
5. Describe the chemical setting reaction of calcium sulfate hemihydrate with water.
6. Describe the setting process of gypsum products.
7. Describe the mechanism of setting expansion of gypsum products
8. Distinguish between the two main forms of calcium sulfate hemihydrate in terms of (a) manufacture, (b) particle size and shape, (c) water/powder ratio, (d) structure of the set material, (e) mechanical properties and (f) dental applications.
9. Describe the effect of additives in terms of their effect on (a) setting rate, (b) setting expansion and (c) strength.
11. List the requirements for dental investment materials.
12. Classify investment materials according to the type of binder used.
13. Discuss the function of each major constituent of dental investment materials, and show how each contributes to mold expansion.
14. Describe the factors in the manipulation of dental investment materials and the methods for controlling overall expansion.
15. State why and when alternatives to gypsum bonding are required.
17. Describe the causes of faults in dental casting, including dimensional errors, rough surfaces and fins, porosity, contamination, and incomplete castings.

Lecture 5 – Dental Cements
1. List the types of setting reactions for directly placed dental restorative materials
2. Define cement as understood dentally
3. List the major dental applications of cements
4. List the available types of dental cement
5. List the three acids and two bases employed in dental acid-base reaction cements
6. List the four major types of acid-base cement in current dental use
7. Discuss the similarities between the acid-base reaction cements
8. State how the characteristic properties of each major component influences the properties and applications of a cement
9. Describe the mechanism of setting and fluoride release of glass-ionomer cements
10. Describe the mechanisms of setting of resin-modified glass-ionomer cements

Lecture 6 – Metals and Alloys in Prosthodontics
1. State the general limitations on selection of metallic materials for oral use
2. Discuss the requirements for alloys for cast partial dentures
3. Compare and contrast the properties of Type IV gold alloys and cobalt-chromium alloys
4. Discuss the composition and properties of investment materials for high temperature casting
5. Compare and contrast the properties of noble metal and base metal wrought alloys
6. Classify the alloys used for cast inlays, crowns and bridges
7. List the requirements for (1) alloys (2) ceramics for metal-ceramic restorations (MCR, or porcelain-fused-to-metal)
8. Describe the mechanism(s) of bonding between metal and ceramic
9. Discuss the most common applications of dental implants
10. Understand the wide choice of implant materials and designs
11. List the materials that are, or have been, used as dental implants
12. Discuss the relevant properties of titanium and its alloys

Lecture 7 – Ceramics in Prosthodontics
1. Compare and contrast the general properties of metallic and ceramic materials
2. Critique ceramic materials in terms of their general mechanical properties
3. Describe the mechanisms used to obtain high strength ceramics
4. List the dental applications of ceramic raw materials
5. Classify dental ceramics according to fabrication procedure
6. State the composition of conventional dental porcelain, distinguishing between this and household
7. Porcelain
8. State the role of alumina, leucite and zirconia when used as constituents of dental ceramics
9. Classify ceramics according to their principal constituent
10. Compare current ceramic materials in terms of mechanical properties
11. Critique the application of all-ceramic restorations

Lecture 8 – Acrylic and Provisional Materials
1. Describe the general composition of acrylic resin
2. Discuss the chemistry and structure of poly(methyl methacrylate)
3. List the three mechanisms of activation of free radical addition polymerization
4. State the dental applications for each mechanism of activation of polymerization
5. State the composition of the powder and liquid as supplied for both heat cured and self cure materials
6. Recognize the features of polymerization that require particular attention in the use of heat cured materials (a) polymerization shrinkage (b) reaction exotherm
7. List the dental applications of provisional materials
8. List the materials used for provisional materials
9. Discuss the available materials for temporary restorations
10. Give the reasons for using temporary c. and b. resins
11. List the requirements for temporary c. and b. materials
12. List the materials that have been, or are being used, as temporary c. and b. materials
13. Discuss the structure of cross-linked dimethacrylates
14. Discuss the effect of particulate ceramic fillers on the properties of polymers
15. State the composition of a typical filled dimethacrylate temporary c. and b. material
16. Critique available temporary c. and b. materials
17. Discuss temporary luting agents

Lecture 9 – Composite materials, bonding, and shrinkage
1. State the general similarities between current resin composite materials.
2. Understand the chemistry and properties of the available polymer systems.
3. Understand the role of inorganic fillers as constituents of resin composites.
4. Classify fillers in terms of their composition, particle size and content.
5. Describe and discuss the role of silane coupling agents.
6. Classify composites according to their viscosity/handling characteristics.
7. List and critique the different visible light curing systems
8. Discuss the consequences of polymerization shrinkage
9. Discuss the practical factors for minimizing the effects of polymerization shrinkage
10. Discuss the factors relating to the longevity of composite restorations
11. Describe the research attempts to develop materials with low or no polymerization shrinkage

Lecture 10 – Amalgam
1. Define amalgam.
2. List the practical stages in the preparation of an amalgam restoration.
3. Describe the intermetallic compound Ag₃Sn (γ-phase) and discuss its reaction with mercury.
4. Describe the structure of set material resulting from the reaction of Ag₃Sn (γ-phase) with mercury.
5. State the composition of ‘traditional,’ ‘low copper’ amalgams.
6. State the limitations of ‘low copper’ amalgams.
7. Discuss the effect of Cu in ‘high copper’ amalgams.
8. Classify contemporary ‘high copper’ amalgams.
9. Discuss the structure of contemporary ‘high copper’ amalgams.
10. Discuss the manipulative factors that influence the properties of amalgam.
11. Give a critique of amalgam restorations.
12. State the reasons why amalgam is usually used in combination with other materials in restoring teeth.
13. Discuss the choice of materials that can be used in conjunction with dental amalgam.
14. Discuss the environmental impact of mercury, and detail office procedures to minimize this concern.
DENT8100
Topics in Advanced Periodontology
“Bacteriology & Immunology of Periodontal Diseases”
Course Syllabus

Spring Semester 2014
Tuesday 9:15 - 11:00 a.m.
7-394 MT (Korn Library)

Participating Faculty:

Massimo Costalonga DMD, PhD    costa002@umn.edu
Paul J. Jardine PhD            jardine@umn.edu
Mark C. Herzberg DDS, PhD      mcherzb@umn.edu
James E. Hinrichs DDS, MS      hinri001@umn.edu
Karen F. Ross PhD              rossx007@umn.edu
Joel D. Rudney PhD             jrudney@umn.edu
Larry F. Wolff PhD, DDS        wolff001@umn.edu

Course Objectives: Discussion and/or lecture presentations addressing recent literature as related to the microbial etiology and pathogenesis of periodontal diseases. The course will be directed to graduate students in periodontology and other interested students in post-graduate programs in the School of Dentistry.
<table>
<thead>
<tr>
<th>Seminar #</th>
<th>Seminar Date</th>
<th>Title</th>
<th>Faculty Leader</th>
<th>Student Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1/06/14</td>
<td>Course introduction</td>
<td>Costalonga</td>
<td></td>
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<tr>
<td>1 X</td>
<td>1/13/14</td>
<td>The Oral Microbiome.</td>
<td>Costalonga</td>
<td>Dr. Michelle Gavino</td>
</tr>
<tr>
<td>2</td>
<td>1/20/14</td>
<td>OPEN DATE</td>
<td>Dr. Tom Nguyen</td>
<td></td>
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<tr>
<td>3 X</td>
<td>1/27/14</td>
<td>Bacteriology of Periodontal Disease I.</td>
<td>Costalonga</td>
<td>Dr. Elias Kersten</td>
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<tr>
<td>4</td>
<td>2/03/14</td>
<td>Bacteriology of Periodontal Disease II: Clinical studies.</td>
<td>Wolff</td>
<td>Dr. Vasiliki Koidou</td>
</tr>
<tr>
<td>5</td>
<td>2/10/14</td>
<td>Virulence Factors of Oral Bacteria.</td>
<td>Rudney</td>
<td>Dr. Tamir Shalev</td>
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<tr>
<td>6</td>
<td>2/17/14</td>
<td>Microbial Invasion of Oral Epithelial Cells and humoral innate defenses</td>
<td>Ross</td>
<td>Dr. Andreas Ioannou</td>
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<td>7 X</td>
<td>2/24/14</td>
<td>Innate Immunity/Antigen Presentation</td>
<td>Costalonga</td>
<td>Dr. Michelle Gavino</td>
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<td>8 X</td>
<td>3/03/14</td>
<td>Contribution of T cells</td>
<td>Costalonga</td>
<td>Dr. Tom Nguyen</td>
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<td>9 X</td>
<td>3/10/14</td>
<td>Contribution of B cells / Plasma cells</td>
<td>Costalonga</td>
<td>Dr. Elias Kersten</td>
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<td>10</td>
<td>3/17/14</td>
<td>Herpes viruses and Periodontitis</td>
<td>Jardine</td>
<td>Dr. Vasiliki Koidou</td>
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<td>11</td>
<td>3/24/14</td>
<td>Host Response: White blood cell function Neutrophil/Monocyte, Macrophages and Dendritic cells.</td>
<td>Herzberg</td>
<td>Dr. Tamir Shalev</td>
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<tr>
<td>12</td>
<td>3/31/14</td>
<td>Host Response: Chemical Mediators in Periodontal Disease (Cytokines, Prostaglandins, Interleukins, Kinins, etc.)</td>
<td>Herzberg</td>
<td>Dr. Andreas Ioannou</td>
</tr>
<tr>
<td>13</td>
<td>4/07/14</td>
<td>Humoral and Cellular Immune Response: Role of Immunopathological Mechanisms in Periodontal Disease</td>
<td>Costalonga</td>
<td>Dr. Michelle Gavino</td>
</tr>
<tr>
<td>14</td>
<td>4/14/14</td>
<td>Crevicular Fluid Components</td>
<td>Hinrichs</td>
<td>Dr. Tom Nguyen</td>
</tr>
<tr>
<td>15 X</td>
<td>4/21/14</td>
<td>Risk Markers for Periodontal Disease</td>
<td>Costalonga</td>
<td>Dr. Elias Kersten</td>
</tr>
<tr>
<td>4/28/14</td>
<td>OPEN DATE</td>
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</tbody>
</table>
Specific Course Information

A reading list for each topic will be supplied 10 days prior to the day of class. Each week each student will be responsible for writing a set of conclusions on the topic of the week. Hard copy of the conclusions is to be handed-in to the Faculty leader as well as to Dr. Costalonga at the beginning of each class.

**Students are expected to prepare abstract cards** on each required reading article and be familiar with that material in order to contribute to that day’s discussion.

The discussion of each article must contain SIX key sections:

1. Background (why the research is done, what is the gap in the scientific knowledge);
2. Hypothesis (when stated);
3. Aim or Objective;
4. Methods;
5. Results;
6. **Conclusions**.

1. Grading criteria
   All students will enroll on an A-F grading basis. Exceptions will require prior approval of Dr. Costalonga. In general, any student enrolling on an S/N basis will not be assigned any written literature reviews and will not be required to take the final examination. However, S/N registering students will be required to attend all classes and participate in class discussion. Grades will be based on the following criteria:

   - 50% Preparation and class discussion. **Students are expected read all required reading literature and be prepared to critically discuss it during class sessions.**

   - 25% Quality of 7 to 10 bullet-point conclusions. The students’ critical review of the literature will be an essential item in grading the conclusions provided to Dr. Costalonga or the Faculty leader at the beginning of each session. Students will be expected to form rational opinions based on documentation of the literature.

   - 25% Take home exam.

2. Late assignments and incompletes
   Make-up assignments will be provided according to University Senate Policy (complete policy in force 4/16/92 Senate minutes). Verified family illnesses, personal illnesses, family emergencies, and University-sponsored events will be valid reasons for missing class and/or examinations. Failure to complete any assigned “Conclusions” on time will result in a failing grade for that portion of the course (50% of grade) unless prior arrangements are made with Dr. Costalonga.

3. Grading will be based on evaluation of assigned papers, class discussion, class preparation and the conclusions as outlined in section 1 (above). Dr. Costalonga will be solely responsible for assigning grades. He will confer with other faculty teaching the course in assignment of grades.

4. Outside activities
   Attendance at continuing education courses will be allowed as per the class syllabus. Students are required to make prior arrangements with Dr. Costalonga if other outside activities are planned which interfere with class attendance, participation or preparation.

5. Course materials
   Course materials will be retained by Dr. Costalonga. Conclusions will be assembled into a syllabus and deposited in Dr. Costalonga’s office for future reference.
Specific questions about grading should be brought to the attention of Dr. Costalonga within 2 weeks after examinations are returned to the students. Dr. Costalonga will submit contested examination materials and grades to at least two other faculty for evaluation and arbitration. It should be understood that contested grades could be raised, remain the same, or be lowered as a result of this arbitration process. All examinations will be returned to Dr. Costalonga after the student is finished with them.

Grades results will be kept confidential.

6. Access to faculty
   All Faculty will be available for tutoring or help with the assigned coursework. Call Dr. Costalonga either at the University during the day or in the evening to arrange for tutoring or if there are specific questions regarding coursework. If it is not possible to complete assignments or attend the examination, students should contact Dr. Costalonga either at the University or at home prior to the date that the assignment or examination is to be taken. Dr. Costalonga University telephone number is 6-2466; home telephone number is 651-307-8599.

7. Student concerns
   Students are expected to bring any concerns to Dr. Costalonga regarding DENT8100 as soon as possible so that appropriate action may be taken to rectify any perceived problems and/or conflicts.

I, THE UNDERSIGNED STUDENT, HAVE READ THE ABOVE INFORMATION AND AM FAMILIAR WITH IT. I HAVE RECEIVED ANSWERS TO ANY QUESTIONS I HAVE ABOUT THIS INFORMATION.

________________________________________  __________________________________________
Student Signature                            Date                                      Date

Witness
Participants’ 2016 e-mail

Periodontal residents new 3rd & 2nd yr residents while new 1st yr only audit course.
Elias Kersten kersto49@umn.edu
Villy Koidou koido001@umn.edu
Tamir Shalev shale007@umn.edu
Georgios Chatzopoulos chatz005@umn.edu
Janelle Hamilton hamil605@umn.edu
Caitlin Hemmerich hemm0089@umn.edu
Dan Jabs jabsx008@umn.edu
David Paulson david.paulson@marquette.edu
Alon Shalev drshalev@gmail.com

Prosthodontic residents 3/3/16 asked Dr. Conrad for residents she plans to enroll
Samuel Hickman hickm117@umn.edu
James Lee leex8218@umn.edu
Joseph Lucero lucero23@umn.edu
Dane McMillan mcmil222@umn.edu
Kale McMillan mcmil221@umn.edu
Owen Trinh trin0072@umn.edu

DENT 8101 – Dental Implantology: A Multi-Disciplinary Approach

(All Sessions to be held in 7-594 & 7-580 Moos Tower 9-11 AM, UNLESS specified otherwise)

<table>
<thead>
<tr>
<th>SESSION #</th>
<th>DATE</th>
<th>SUBJECT</th>
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<tbody>
<tr>
<td>Session 1</td>
<td>Thursday May 19, 2016 - Dr. Hinrichs</td>
<td>Historical viewpoint, Criteria</td>
</tr>
<tr>
<td>(7-594 Moos T)</td>
<td>Costalonga out of town</td>
<td>for implant success, Tx Planning</td>
</tr>
</tbody>
</table>


Session 2  May 26, 2016 – Dr. Hinrichs  
Esthetics  
(7-594 Moos T)  
Costalonga out of town

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Journal/Volume/Year</th>
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</thead>
<tbody>
<tr>
<td>Kan</td>
<td>Gingival biotype assessment in the esthetic zone: visual verses direct measurement.</td>
<td>IJPRD 30: 236-243, 2010</td>
</tr>
<tr>
<td>Rodriguez-Ciurana</td>
<td>The effect of interimplant distance on the height of the interimplant bone crest when using platform-switched implants.</td>
<td>IJPRD 29: 141-151, 2009</td>
</tr>
</tbody>
</table>

Session 3  June 2, 2016 - Dr. Conrado Aparicio  
Implant biomaterials  
(7-594 Moos T)

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Journal/Volume/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aparicio</td>
<td>In vivo evaluation of micro-rough and bioactive titanium dental implants using histometry and pull-out tests.</td>
<td>JMBBM 4: 1672-1682, 2011</td>
</tr>
<tr>
<td>Brunski</td>
<td></td>
<td>JOMI 3: 85-97, 1988</td>
</tr>
<tr>
<td>Chiapasco</td>
<td></td>
<td>Clin Oral Implant Res 0: 1-6, 2011</td>
</tr>
<tr>
<td>Palmquist</td>
<td></td>
<td>J R Soc Interface 7: S515-527, 2010</td>
</tr>
</tbody>
</table>


Session 4  June 9, 2016 – Dr. Costalonga & Mr. Hari Prasad  Metal-soft/hard tissue interface Histology of implants & GBR

Costalonga
Marchetti  J Periodontol 73: 555-563, 2002


Prasad
Tatakis  J Periodontol Res 37: 93-100, 2002
Wikesjo  Clin Oral Impl Res. 15: 194-204, 2004
Froum  Int J Oral Maxillofac Implants 20: 54-60, 2005


Session 5       June 16, 2016 – Dr. Hinrichs Costalonga
Immediate Placement & Ridge Preservation, Loading Protocols


Session 6 June 23, 2016 - Dr. Hinrichs Costalonga
(7-594 Moos T)

Treatment options:
implant-supported crowns,
fixed-detachable,
“All-on-4” or 2 ball-O-rings

Brennan
IJOMI 25: 791-800, 2010
Canullo
IJOMI 27: 927-934, 2012
De Kok
IJOMI 26: 415-426, 2011
Han
Jensen
IJOMI 29: e30-e35, 2014
Jensen
Jensen
Keenan
Evid Based Dent 16:52-52, 2015
Lemos
J Dent 47:8-17, 2016
Malo
JADA 142: 310-320, 2011

Nisand

Schincagilia
Slot
Weinlander
IJOMI 25: 589-597, 2010

Jensen, O: angled dental implant placement into the vomer/nasal crest of atrophic maxillae for all-on-four immediate function: a 2-year clinical study in 100 consecutive patients. IJOMI 29: e30-e35, 2014.
Malo, P: A longitudinal study of the survival of all-on-4 implants in the mandible with up to 10 years follow-up. JADA 142: 310-320, 2011.

Slot, W: Maxillary overdentures supported by four or six implants in the anterior region; 1-year results from a randomized controlled trial. J Clin Periodontol 40: 303-310, 2013.

Session 7 June 30, 2016 - Dr. Seong
(7-594 Moos T)

Prosthodontic treatment plans
and restorative principals

Kim
Kois
Compendium 25: November, 2004
Misch
Dental Implant Prosthetics chapter 6 & 20

Session 8 July 7, 2016 - Dr. Seong
(8 South Clinic) PROSTHODONTIC LAB 8:00 – 11:15 AM
- Final impression technique
- Immediate provisional restorations
- Surgical guides
- Laboratory exercise:
  1. Implant placement + fabrication of cement retained immediate provisional restoration
  2. Final impression on # 5 implant: open and closed impression tray

Session 9 July 14, 2016 – Dr. Jeff Hodd 8:00-11:00
(Grad Pros Clinic 9th floor Moos T) Digital impressioning for construction crowns
1. Overview lecture on digital impressioning
2. Demonstration of chairside digital impression technique of implant abutment for fabrication of crown/bridge
3. Hands-on experience using intraoral digital impressioning (perio & pros residents paired-off as partners)

Session 10 July 21, 2016 - Dr. Hinrichs Costalonga
(7-394 Moos T) Advanced surgical techniques
9:00 – 11:00 AM
Carranza IJPRD 31: 45-50, 2011
Corinaldesi IJOMI 24: 1119-28, 2009
Peleg IJOMI 25: 153-162, 2010
Wallace IJPRD 27: 413-419, 2007
Wallace IJPRD 25: 551-559, 2005


First – option A: Repair of buccal deficiency in area #8 Initiate flared vertical releasing incisions at distal-buccal #7 and distal-buccal #9. Connect vertical releases via sulcular-crestal incision from mesial #7 to mesial #9. Reflect a full-thickness mucoperiosteal flap to expose eminences of teeth #7 & 9. Trim collagen membrane to extend > 3 mm onto eminences of #7 & 9 and palatal of crest. Use a small diameter bur to place numerous perforations in edentulous cortical bone. Place horizontal releasing incisions in base of labial flap to enhance coronal advancement for primary closure. Use horizontal mattress sutures to secure membrane beneath palatal flap. Restructure the alveolar ridge using rehydrated particulate bone. Reposition the membrane over the bone graft. Reassess the labial pedicle for adequate tension free closure. Initiate closure of the crestal incision by utilizing deep horizontal mattress sutures. Utilize continuous running interlocking suturing for superficial closure of edentulous area. Complete closure of vertical releasing incisions using routine interrupted suture.

First – option B: Repair of buccal deficiency in area #8 Initiate crestal incision from mesial #7 to mesial #9 for full-thickness mucoperiosteal flap with flared vertical releasing incisions, use periosteal elevator to tunnel beneath periosteum over eminences of teeth #7 & 9, trim collagen membrane to cover crest of ridge, buccal ridge deficiency and extend ≥ 3 mm onto the root eminences of teeth #7 & 9, securing collagen membrane beneath palatal flap with mattress suture, use a #2 or 4 round bur to make multiple perforations in the cortical plate, complete horizontal vestibular releasing incisions to help enhance coronal advancement for primary closure, restructuring ridge using rehydrated particulate bone,
represents the page content as text.
diameter bur to place numerous perforations in the area of the cortical bone to be augmented. Trim an aluminum foil template to cover the vertical ridge deficiency and ~3 to 5 mm beyond. Place two puncture holes in the buccal margin of aluminum template as guides for placement of fixation screws. Trim the collagen membrane to similar dimensions as aluminum template. Fill the curved collagen membrane with hydrated allogenic bone, invert over the defect, re-align the openings for fixation screw and secured the membrane via fixation screws. Initially close the flap by re-approximating the mesial vertical releasing incision at #21 followed by placement of at least three deep horizontal mattress sutures over the edentulous area of #19, 20 and 21. Subsequently, complete superficial crestal closure via continuous running interlocking suture followed by placement of routine interrupted sutures to close the vertical releasing incision. Consider 1st mixing 2 parts allogenic bone with 1 part calcium sulfate prior to placing into membrane to minimize risk for graft migrating into either buccal vestibule or to the mylohyoid muscle in floor of mouth and 2nd placement of crestal tenting screw.

Fifth - option B: **Reconstructing of vertical ridge deficiency in area #19, 20 & 21 employing titanium mesh stabilized with fixation screws and filled with allogenic.** Make a crestal-sulcular incision from distal area #18 to the mesial #21 and terminate as vertical releasing incision mesial to #21. Use North Carolina probe to measure the dimensions of the vertical deficiency and ~3 to 5 mm beyond. Use three prong orthodontic pliers to bend the titanium mesh and metal sheers to trim the mesh to desired dimensions. Drill three pilot holes thru openings in the mesh into the buccal cortical bone to subsequently secure the mesh to the ridge. Use #2 or 4 round bur to make multiple perforations through the cortical bone of the ridge deficiency to expose medullar blood supply. Cautiously make horizontal vestibular releasing incisions and blunt release of lingual flap to enhance coronal advancement for primary closure. Fill the titanium mesh with hydrated allogenic bone, invert over the defect, re-align fixation screw openings and secured the mesh and graft via the three fixation screws. Initially close the flap by re-approximating the mesial vertical releasing incision at #21 followed by placement of at least three deep horizontal mattresses sutures over the edentulous area of #19, 20 and 21. Superficial closure will be completed via continuous running interlocking suture.

Sixth: **Peri-implantitis at #29 treated via debridement and grafting with allogenic bone and calcium sulfate.**

*Dr. Kersten, Dr. Koidou and Dr. Shalev will use a 6 mm diameter trephine bur to a depth of ~4 mm in the area of #29. Use #4 round bur to clear area inside trephine opening. Place a 3.75 mm diameter X 13 length dummy Zimmer implant and retain the mounting head to simulate crown-implant with ~3-4 mm moat-like peri-implantitis defect. Red yarn mixed with boxing wax will be packed into the moat to simulate granulation tissue. They will use a 3 mm tissue punch to create gingival opening to permit implant-mounting head of #29 to penetrate gingiva.*

Place sulcular-crestal incision from mesial #28 to distal #31 and employ shallow vertical releasing incisions to enhance flap reflection. Reflect full-thickness mucoperiosteal flaps. Use curette (against bony walls of defect) and fine explore (between the threads of the implant) to simulate removal of granulation tissue (red yarn). Remove mounting head (simulates removal of abutment) and swab the internal aspect of the abutment opening with chlorhexidine followed by rinse with sterile saline. Utilize cotton pellet soaked in saline on an explorer to circumferentially clean each thread of the implant. Place a new non-contaminated cover screw to seal abutment opening. Rehydrate allogenic bone graft and fill the moat-like defect before covering the graft with either a calcium sulfate barrier or comparable product before suturing the flap in conjunction with procedure to remove oblique fractured implant.

Seventh: **Cervical fractured implant #30 treated via trephine removal and grafting of defect using allogenic bone covered by collagen membrane.**

This exercise will simulate the removal of an implant that has an oblique fracture at the level of the base of the abutment screw. Dr. Kersten, Dr. Koidou and Dr. Shalev will intentionally place 13 X 3.75 mm implants ~4 mm subcrestal to necessitate their removal via a trephine bur and Woodson elevator. Description of flap reflection was given in proceeding exercise.

View the pre-operative cone beam CT scan or periapical x-ray to determine the length of the implant and adjacent vital structures. Check incremental markings on trephine bur. Use a trephine bur with an internal diameter of 4-mm to 5-mm to cut around the implant to near its’ apex (caution for position of inferior alveolar nerve, artery and lingual plate). Employ a narrow elevator to luxate the implant and fracture the apical bone. Employ root tip picks or very narrow beaked forceps to remove mobile implant. Obtain a periapical x-ray to verify that the implant has been completely removed. Irrigate the defect and fill with rehydrated allogenic bone. Cover the graft and defect with a collagen membrane or calcium sulfate before
suturing. Initially re-approximating the vertical releasing incisions followed by the placement of at least three deep horizontal mattress sutures over the edentulous area of # 29 thru 30. Superficial closure will be completed via continuous running interlocking suture.

Session 12  Saturday July 30th ?8:15-1:30?? Dr. Kovacs & Dr. Kotsakis using Straumann Andy Pelleymounter Cellular 612-280-4209 laboratory exercise for “All-On-4” to be held in Korn Library

Session 13  August 4, 2016 - Dr. Hinrichs Costalonga Management of peri-implantitis and complications

AAP J Periodontol. 84: 436-443, 2013
Greenstein, G; The Clinical Significance of Keratinized Gingiva around Dental Implants. Compendium Contin Educ Dent.

Session 14    Thursday August 11, 2016  9:00-11:00 - Dr. Hinrichs  FINAL EXAM

Wednesday 10th    Perio Honors @ Vet School 8:00-4:15
### SCHEDULE

**OBio 5001: Methods in Research and Writing, 2 cr**  
Fall Semester 2014; 18-211 Moos Tower; Thursdays, 3:30-5:00 p.m.  
Co-directors: Joel Rudney (jrudney@umn.edu) and Bryan Michalowicz (micha002@umn.edu)  
Instructors: Nicole Theis-Mahon (theis025@umn.edu), Mike John (mjohn@umn.edu), and Ralph DeLong (delon002@umn.edu)

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Instructor</th>
</tr>
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<tbody>
<tr>
<td>9/4</td>
<td>Introduction, questions in search of answers, getting started</td>
<td>Rudney, Joel</td>
</tr>
<tr>
<td></td>
<td>Writing a proposal, making an oral presentation</td>
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<tr>
<td>9/11*</td>
<td>Information Sources for Searching the Literature</td>
<td>Theis-Mahon, Nicole</td>
</tr>
<tr>
<td>9/18</td>
<td>Principles of Research Design –I</td>
<td>Rudney, Joel</td>
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<tr>
<td>9/25</td>
<td>Principles of Research Design – II</td>
<td>Rudney, Joel</td>
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<tr>
<td>10/2</td>
<td>Student presentations – Background and Hypothesis</td>
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<tr>
<td>10/9</td>
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<td>10/16</td>
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<td></td>
<td>Make appointment for biostatistics consultation with BDAC</td>
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<tr>
<td>10/23</td>
<td>Principles in Epidemiology/Oral Health Quality of Life</td>
<td>John, Mike</td>
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<td>10/30</td>
<td>Measurement and Evidence-Based Dentistry</td>
<td>DeLong, Ralph</td>
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<td>11/6</td>
<td><strong>No class</strong> due to American College of Prosthodontists meeting</td>
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<td>11/13</td>
<td>Clinical Trials</td>
<td>Michalowicz, Bryan</td>
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<td>11/20</td>
<td>IRB: Use of Human Subjects in Research</td>
<td>Rudney, Joel</td>
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<tr>
<td>11/27</td>
<td>Thanksgiving — <strong>no class</strong></td>
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<td>12/4</td>
<td>Student Presentations – Full proposal</td>
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<td>12/11</td>
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<td><strong>Presenters e-mail updated presentations to Dr. Rudney and Dr. Michalowicz</strong></td>
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<td>12/18</td>
<td>Student presentations – Full proposal</td>
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<td><strong>Presenters e-mail updated presentations to Dr. Rudney and Dr. Michalowicz</strong></td>
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<tr>
<td>12/25</td>
<td><strong>Final written proposal due electronically to Dr. Rudney and Dr. Michalowicz</strong></td>
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*Students are to assemble at the Biomedical Library, 2nd floor, Reference Desk. There will be hands-on computer time for this one class.*
OBIO 5001: Methods in Research and Writing

Fall semester 2014
Thursdays, 3:30-5:00 pm
2 credits
18-211 Moos Tower

Drs. Joel Rudney and Bryan Michalowicz, Course directors
Diagnostic and Biological Sciences and Developmental and Surgical Sciences
Offices: 17-238 (Rudney) and 17-116 (Michalowicz) Moos Tower
Phones: x4-7199 (Rudney) and x5-6981 (Michalowicz)
Emails: jrudney@umn.edu and micha002@umn.edu

Formal course objectives:
To help you plan your graduate research project by following these steps:
1. Begin a critical review of the literature,
2. Identify a problem worthy of investigation,
3. Formulate a specific hypothesis,
4. Develop a study design, and
5. Give two oral presentations describing various components of your research proposal and prepare a written proposal.

How to get started:
1. Read the proposal examples we sent you right away. They are actual proposals by former students who did well in this course. It really helps to have a model that you can use to structure your own proposal.
2. Consult your faculty mentors early and often while developing your proposal for this course. They can’t (and won’t) write the proposal for you, but it’s part of their job to give you feedback on your ideas. One issue we have had in the past is that two students from the same program submit proposals that are virtually identical, except for a few details. Our expectation for this course is that every proposal must address a different topic.
3. We have structured this course to give you opportunities to get feedback on your proposal. That’s what the oral presentations and statistical consultations
are for. However, if you need clarification of that feedback, or extra input, make an appointment to consult one of the course directors.

Course Requirements, OBio 5001:

1. Attend and participate in all scheduled course sessions.

2. Give a PowerPoint presentation of the Background, Rationale, Hypothesis and Specific Aims for the proposal you are developing (no longer than 10 minutes). This will happen in October, and we will give you feedback on your presentation in class. The day on which you present will be determined by random selection, but you are expected to attend on the days when you are not presenting. After you present in class, your job is to make any changes suggested by Dr. Rudney, and then e-mail an updated copy of your slides to Dr. Rudney and Dr. Michalowicz.

3. From late October through November, you must make an appointment for a statistical consultation. We will give you contact information for the consultants at that time. The purpose of the consultation is to give you input on the study design you are developing. You will also get advice on how big a sample size you may need, and on the most appropriate way to analyze your data.

4. In December, you will give a PowerPoint presentation of your complete research proposal (no longer than 10 minutes) to include these content sections:
   - A critical review of the literature to identify the next important question to be answered.
   - The specific predictive hypothesis to be tested (which emerged from your review)
   - Specific aims of the project (list the three or four activities or experiments must be done to test your hypothesis)
   - Experimental design (explain the logic of your test of the hypothesis so that you will have a yes or no, or true or false answer)
   - Description of the methods (Describe exactly what will you do, including, where applicable, how you will recruit and consent subjects, subject
inclusion and exclusion criteria, laboratory methods, specimen collection protocols, clinical evaluation methods, statistical tests to be performed, etc.)
• Possible results (Describe alternative results for your study, based on whether your hypothesis is accepted or rejected).
• Discuss the clinical and/or biological significance of your study (how will it affect clinical practice, or change our understanding of oral biology).
The day on which you present will be determined by random selection, but you are expected to attend on the days when you are not presenting. After you present in class, your job is to make any changes suggested by Dr. Rudney, and then e-mail an updated copy of your slides to Dr. Rudney and Dr. Michalowicz.

5. You will submit a written research proposal to include the content of the oral presentation and references cited (not to exceed 10 double spaced manuscript pages of text). These should be e-mailed to Dr. Michalowicz and Dr. Rudney no later than December 25. We will review your proposals, but we may also seek the opinion of other faculty who are knowledgeable in your area.

Grades:
The attached rubric will be used to evaluate your two oral presentations, and your written research proposal. Criteria 1-6 will be used for the first presentation; all 12 criteria will be used for the second presentation and written proposal. The point totals from the rubrics will be weighted to determine your final grade. The weighting will be Background and Hypothesis presentation (20%), full proposal presentation (30%), and written proposal (50%). Because, of the extended deadline, your course grades won’t be entered until sometime in January.

Reminder:

During class, there is to be no cell phone or internet use, Googling, surfing, texting or tweeting. It’s a small classroom, the instructors can see you doing it, and it’s very distracting to us. Your cooperation and professionalism will be appreciated.
Rubric for evaluating OBio 5001 presentations and proposals

Student name:

<table>
<thead>
<tr>
<th>Review criteria</th>
<th>Not addressed properly, or at all</th>
<th>Addressed, but needs work</th>
<th>Clear and comprehensible</th>
</tr>
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<tbody>
<tr>
<td>1. There is a critical review of the literature</td>
<td>0 points</td>
<td>1 point</td>
<td>2 points</td>
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<tr>
<td>2. The research question is based on the literature review</td>
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<tr>
<td>3. States a reasonable and testable hypothesis or descriptive goal</td>
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<td>4. Independent and outcome variables are clearly defined</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. The population to be studied is clearly defined</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Two to four Specific Aims are listed, indicating distinct steps in the study</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. A research design is provided, and it addresses controls and confounders</td>
<td></td>
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<tr>
<td>8. The study methods are feasible, and clearly described</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. A power analysis has been done, and/or the sample size has been justified</td>
<td></td>
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<tr>
<td>10. Statistical methods are clearly described, and appropriate for the data</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. Possible results of the study are clearly described</td>
<td></td>
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</tr>
<tr>
<td>12. The clinical and/or biological significance of the study is discussed</td>
<td></td>
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</tr>
</tbody>
</table>

Point totals

Total points:
This course will present a series of lectures that explain the rationale for combined orthodontic and periodontal treatment for malocclusion cases that have experienced periodontal disease. The course objectives are to: 1) enhance the orthodontist's periodontal diagnostic and treatment planning skills of malocclusion cases with periodontitis. 2) enhance the periodontist's understanding of orthodontic treatment options for malocclusions and 3) illustrate how joint treatment efforts by an orthodontist and a periodontist can be combined to result in successful treatment of malocclusions for patients that have experienced periodontal disease. Residents are encouraged to provide collaborative care on cases following the course.

The course is offered as a Satisfactory / Non-satisfactory grade for 1-credit hour. The student’s grade will be based upon his/her attendance and contribution to discussion during class.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC/ASSIGNMENT</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 15, 2015</td>
<td>Periodontal diagnostic criteria, PSR and indications for referral to a periodontist.</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 22, 2015</td>
<td>Orthodontic considerations for mucogingival problems and hard tissue boundaries and pathological tooth migration</td>
<td>Dr. Larson / Dr. Langsjoen</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 29, 2015</td>
<td>Surgical exposure of impacted teeth and esthetic crown lengthening.</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 5, 2015</td>
<td>Overview of Soft Tissue Grafting Techniques and Periodontal Esthetics</td>
<td>Dr. Lareau</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 12, 2015</td>
<td>Periodontal regeneration in intrabony defects.</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 19, 2015</td>
<td>Treatment of aggressive periodontitis with S/RP + antibiotics, GTR, ridge augmentation and implant placement.</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 26, 2015</td>
<td>Periodontal Esthetics and Soft Tissue Grafting Techniques</td>
<td>Dr. Lareau</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:15-4:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 5, 2015</td>
<td>Periodontal complications associated with orthodontic therapy including root resorption.</td>
<td>Dr. Hinrichs</td>
</tr>
<tr>
<td><strong>Thursday</strong> 12:05-12:50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 12, 2015</td>
<td>Guided tissue regeneration, forced eruption and periodontal sequellae.</td>
<td>Dr. Larson / Dr. Langsjoen</td>
</tr>
</tbody>
</table>
March 19, 2015       NO CLASS

March 26, 2015
**Thursday** 12:05-12:50 Use of CT scans for surgical treatment planning examples of particulate and block graft for ridge reconstruction and implant placement. Dr. Hinrichs

April 2, 2015       Use of orthodontic extrusion to enhance periodontal therapy. Dr. Schmalz
**Thursday** 12:05-12:50

April 9, 2015       Periodontal Accelerated Osteogenic Orthodontics “PAOO - Wilkodontics”. Dr. Kotsakis
**Thursday** 12:05-12:50

April 16, 2015      Current concepts: Outcomes of Ortho/Perio Therapy. Dr. Larsen / Dr. Langsjoen
**Thursday** 12:05-12:50

April 23, 2015      NO CLASS / Minnesota State Dental Meeting – Star of the North Table Clinics afternoon of April 24th

April 30, 2015      Make-up if necessary

Orthodontics Email address:

<table>
<thead>
<tr>
<th>Orthodontics 1st Year Residents in 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newton, Brieanna Lise</td>
</tr>
<tr>
<td>Goergen, Matthew J</td>
</tr>
<tr>
<td>Kar, Farah A.</td>
</tr>
<tr>
<td>Lelich, Rosemary</td>
</tr>
<tr>
<td>Tai, Charlene</td>
</tr>
<tr>
<td>Weissend, Ariana</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Orthodontics 2nd Year Residents in 2015:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brownrigg, Danae C.</td>
</tr>
<tr>
<td>Gyllenhaal, Kelley A.</td>
</tr>
<tr>
<td>Hammer, Christine C.</td>
</tr>
<tr>
<td>Knudsen, Kyle W.</td>
</tr>
<tr>
<td>Larson, Chad E.</td>
</tr>
<tr>
<td>Schnitt, Rebecca A.</td>
</tr>
<tr>
<td>Periodontology 3rd Year Resident 2013</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td>Micah Chan  612-910-6203</td>
</tr>
<tr>
<td>George Kotsakis  651-395-9200</td>
</tr>
<tr>
<td>Alejandro Kovacs  612-817-8115</td>
</tr>
</tbody>
</table>

**Periodontology 2nd Year Residents:**

| Michelle Gavino McHale  612-396-8842 | gavi0040@umn.edu |
| Andreas Ioannou  612-666-5588        | joann005@umn.edu |
| Thomas Nguyen  612-402-1398          | nguy2292@umn.edu |

**Periodontology 1st Year Residents:**

| Elias Kersten  612-701-5211          | kerst049@umn.edu |
| Villy Koidou  612-701-8478           | koido001@umn.edu |
| Tamir Shalev  612-323-1399           | shale007@umn.edu |

**Prosthodontics Residents 2015:**

<table>
<thead>
<tr>
<th>2nd Year Residents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fouad Badr</td>
</tr>
<tr>
<td>Saad Bassas</td>
</tr>
<tr>
<td>Jason Kiangsootra (pronounced - king-sutra)</td>
</tr>
<tr>
<td>Sae-Eun Schlottke</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1st Year Residents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam Hickman</td>
</tr>
<tr>
<td>Joseph Lucero</td>
</tr>
</tbody>
</table>
Course Syllabus

PubH 6414 - 200, 320 - Online
Biostatistical Methods I
Summer 2014

Credits: 3
Meeting Days: online
Meeting Time: online
Meeting Place: online

Instructor: Laura Le, MA
Office Address: Mayo Building, A455
Minneapolis, MN 55414
E-mail: free0312@umn.edu
Office Phone: 612-624-1404
Office Hours: Via discussion board. Can set up an appointment via email to meet in person, skype, or have a phone call.

Teaching Assistant: Cami Terrill
E-mail: terri033@umn.edu
Office Hours: Via discussion board.

Teaching Assistant: Andrew St Martin
E-mail: stmar096@umn.edu
Office Hours: Via discussion board.

Teaching Assistant: Xiang Li
E-mail: lixx0897@umn.edu
Office Hours: Via discussion board.

Course Description
PubH 6414 Biostatistical Methods I is intended to convey the fundamentals, or basics, of a first course in biostatistics. Students who complete the course are expected to be able to interpret and understand the common statistical methods used in scientific journals as well as use basic statistical methods in their own research. The course consists of 12 online lessons, 12 homework assignments, 2 120-minute exams, and supplemental textbook readings.

This course is offered online via Moodle. Registered students will receive a welcome email with instructions about where and how to log on to the course.
Acknowledgements

This online course was originally developed in 2002 by Chap T. Le, PhD, Distinguished Professor of Biostatistics, University of Minnesota School of Public Health, and continuously improved by previous and current instructors of PubH 6414: Melanie M. Wall PhD, Judith Bebchuck PhD, Susan E. Telke MS, Cynthia S. Davey MS, Ann M. Brearley PhD MS, Jeremiah S. Menk MS, Robert E. Leduc PhD, and Laura Le MS. The R Commander lab modules were developed and recorded in 2011 by TA Sarah N. Verdoliva (now MS). The StatCrunch handouts were developed in 2013 by Laura Le.

Course Prerequisites

The course presupposes a basic knowledge of mathematics (including algebra). A Math Refresher website has been created by the University of Minnesota - School of Public Health to help you review these concepts: (http://www.sph.umn.edu/ce/tools/math/). It is entirely up to you whether you use the site. However, it's there to help you feel confident concerning the basic mathematical operations that may be referred to in the course.

Course Goals and Objectives

At the conclusion of the course, students will be able to:

- Recognize fundamentals of biostatistics in health-related fields.
- Calculate basic descriptive statistics.
- Use a statistical software tool (R Commander package or StatCrunch) to graphically display data.
- Have a basic understanding of probability models and how these relate to statistics.
- Estimate population parameters from sample data and calculate confidence intervals.
- Understand the principles of hypothesis testing and the correct interpretation of hypothesis test results.
- Generate regression analysis and ANOVA summaries and correctly interpret the results.
- Determine the appropriate test to use based on how the data were collected and on the outcome variable of interest.

Methods of Instruction and Work Expectations

Students should be aware that the expectations and requirements in this course are no different from the expectations and requirements in a typical lecture course. This is NOT a "work at your own pace" course. There are specific assignment deadlines. See the schedule below for details.

NOTE: PubH 6414 is in the process of being revised. The new PubH 6414 Biostatistical Literacy, which will be offered for the first time next year in Fall 2014, will be a stand-alone one-semester 3-credit course with the primary goal of developing student ability to read and interpret statistical results in the primary literature of their specific scientific field of interest. This course will involve minimal calculation and offer no formal training in any statistical programming software. Biostatistical Literacy will cover the fundamental concepts of study design, descriptive statistics, hypothesis testing, confidence intervals, odds ratios, relative risks, adjusted models in multiple linear, logistic and Poisson regression, and survival analysis. The focus will be when to use a given method and how to interpret the results, not the actual computation or computer programming to obtain results from raw data.

During the transition period from now through Summer 2014, PubH 6414 will contain some elements of both the old data analysis focus and the new literacy focus.

After the transition period, which begins in Fall 2014, PubH 6415, the second semester of the old sequence, will no longer be offered. Students who need PubH 6415 should plan to take it during the Summer term of 2014.
The course is organized by 12 sections or topics. For each section, there are

- online lecture slide sets,
- supplemental text readings,
- software lessons for learning how to use a statistical software tool (R Commander or StatCrunch), and
- homework assignments.

There are also two 120-minute exams in this course.

You have the opportunity to earn extra credit in this course by actively participating in a review session prior to each exam. You will need to sign up ahead of time for these review sessions so that we can set up small groups for these discussions. You will need to sign up no later than

- June 30 for the first review session
- July 28 for the second review session

Please see Guidelines for Review Group Discussion document (posted on Moodle) for more information about the requirements for earning extra credit during these review sessions.

**Course Communication**

*You must use your U of M email address!* All course communications will be sent to your University of Minnesota email account. If you have not yet initiated your U of M email account, you will need to do so at:

http://www.umn.edu/initiate.

Communications during this online course consist of **email** and **discussion forums** (a passive classroom). There will also be course announcements posted and emailed by the instructor. Homework files are turned in only via the course website.

**Forums** are the primary mechanism for interaction between students and the instructor and TAs, as well as among students. All of the students, the teaching assistants and the instructor can read all of the postings in the General Q&A Forums. Normally someone initiates a topic and others reply to the topic. The Forums grow and become a resource. If you have questions about homework assignments, post them in the appropriate Forum so all students can benefit from your question. The instructor and TAs will usually respond to posted questions within a day. Students may freely respond to other students’ questions or responses.

**Email** is best for one-on-one communications, such as specific questions about grading of assignments and exams. Email the instructor (free0312@umn.edu) or the TAs.

The weekly **announcements** from the instructor will include information about upcoming homework assignments, exams, and clarification of lesson material, if needed. Look for new announcement postings via email each week.

**Supplemental Course Text**


This book is available on paper through the University of Minnesota bookstore.

It is also available as an online resource through the University of Minnesota library, and is on reserve in the Biomedical Library. To access the online resource, go to [www.lib.umn.edu](http://www.lib.umn.edu) and make sure you are on the ‘Books’ tab. Type ‘Dawson Trapp Basic and Clinical Biostatistics’ in the book search box. Click on the ‘See the 2 editions & formats of this work’ link. When it shows you the books, click on the ‘View Online’ link.

**Supplemental Online Text:**

**Statistical Software**

In this course, you have **two** choices in terms of the statistical software tool you will use. One of these tools, R Commander package in the software R, is free. The other tool, StatCrunch, has a small fee associated with using it.

It will be up to you to go to the appropriate site to download or subscribe to the software package you choose. We hope that during the first week of the semester, you will have the time to explore your options and determine which package will best suit your need. An instruction module for downloading and installing R and R Commander on your computer or subscribing to StatCrunch will be presented during the first week of class.
<table>
<thead>
<tr>
<th>Weeks</th>
<th>Course Dates</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>June 16–21</td>
<td>Lesson 1: Getting Started With Biostatistics, Lesson 2: Descriptive Statistics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chapter 1 &amp; 2 (Optional Textbook Readings) Chpt. 4, pg. 49-90 (Sampling Distributions, through end of chapter)</td>
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<tr>
<td></td>
<td></td>
<td>Homework 1 &amp; 2 (DUE: SATURDAY, JUNE 21st by 11p)</td>
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<tr>
<td></td>
<td></td>
<td>Chpt 1 and 2, all pages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chpt. 4, pg. 49-90 (Random Variables and Probability Distributions)</td>
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<tr>
<td></td>
<td></td>
<td>Chapter 3 &amp; 4 (Optional Textbook Readings) Chpt. 4, pg. 72-80 (Random Variables and Probability Distributions)</td>
</tr>
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### Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Lesson</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 5</td>
<td></td>
<td>Review (July 3-6)</td>
</tr>
<tr>
<td>July 6</td>
<td></td>
<td>Exam 1</td>
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<tr>
<td>July 7-9</td>
<td></td>
<td>Exam 1</td>
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<tr>
<td>July 10-17</td>
<td></td>
<td>Homework 2</td>
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<tr>
<td>July 18-24</td>
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<td>Homework 3 &amp; 4</td>
</tr>
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</table>

### Assignments

- **Lesson 1:** Chpt 5.2, 5.4, 11.1-12.1
- **Lesson 2:** Chpt 5.4, 5.9, 11.4
- **Lesson 3:** Chpt 5.6, 6.1, 11.9-13.1
- **Lesson 4:** Chpt 5.8, 6.2, 11.11-13.2
- **Lesson 5:** Chpt 5.10, 6.3, 11.12-13.3
- **Lesson 6:** Chpt 5.12, 6.4, 11.13-13.4
- **Lesson 7:** Chpt 5.14, 6.5, 11.15-13.5
- **Lesson 8:** Chpt 5.16, 6.6, 11.16-13.6

**Homework:** DUE THURSDAY (July 11th)
<table>
<thead>
<tr>
<th>Date</th>
<th>Lesson</th>
<th>Homework</th>
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</thead>
<tbody>
<tr>
<td>July 25</td>
<td></td>
<td>Lesson 11: Inference for Means from Three or More Groups (One-way ANOVA)</td>
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<tr>
<td>Aug 1</td>
<td></td>
<td>Lesson 12: Inference for Relationships between Two Categorical Variables</td>
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<tr>
<td>Aug 2-8</td>
<td>8</td>
<td>Review (Aug 1-5)</td>
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<tr>
<td>Aug 9-15</td>
<td>6</td>
<td>Chpt. 7, pg. 11-175</td>
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<tr>
<td>Aug 16-22</td>
<td>5</td>
<td>Chpt. 6, pg. 200-201 (Confidence Interval for the Odds Ratio and the Relative Risk)</td>
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<tr>
<td>Aug 23-29</td>
<td>4</td>
<td>Chpt. 5, pg. 141-146</td>
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<tr>
<td>Aug 30</td>
<td>3</td>
<td>Chpt. 4, pg. 113</td>
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<td>Sep 6</td>
<td>2</td>
<td>Chpt. 3, pg. 84</td>
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<td>Sep 7-13</td>
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<td>Chpt. 2, pg. 64</td>
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<td>Sep 14-20</td>
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<td>Sep 21-27</td>
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<tr>
<td>Sep 28</td>
<td></td>
<td>Chpt. 1, pg. 30</td>
<td></td>
</tr>
</tbody>
</table>

**DUE:** Friday, August 8th at 11pm
Grading

PubH 6414 can only be taken A/F. The S/N option is not available for PubH 6414.

Grading is determined by:

- Twelve homework assignments (4% per assignment = 48%)
- Two 120-minute online exams, 26% each (52%)

All exams will be timed short-answer exams. Exams are to be completed independently.

You have the opportunity to earn extra credit (up to 4%, 2% per review session) in this course by actively participating in a review session prior to each exam. Please see Guidelines for Review Group Discussion document (posted on Moodle) for more information about the requirements for earning extra credit during these review sessions.

Late Policy:

Homework assignments are to be submitted by the due dates indicated in the course schedule. Homework assignments submitted 0-24 hours late will lose 10% of the grade (2 out of 20 points). Homework assignments submitted more than 24 hours late will not be accepted.

Exams are to be completed by the due dates indicated in the course schedule. Late exams will not be accepted. There are no provisions for make-up exams. Students with a legitimate need to reschedule an exam should contact the instructor as soon as possible.

A/F letter grade will be determined by total effort as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>≥93%</td>
<td>(4.0) Represents achievement that is outstanding relative to the level necessary to meet course requirements.</td>
</tr>
<tr>
<td>A-</td>
<td>≥90 &amp; &lt;93%</td>
<td></td>
</tr>
<tr>
<td>B+</td>
<td>≥85 &amp; &lt;90%</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>≥75 &amp; &lt;85%</td>
<td>(3.0) Represents achievement that is significantly above the level necessary to meet course requirements.</td>
</tr>
<tr>
<td>B-</td>
<td>≥70 &amp; &lt;75%</td>
<td></td>
</tr>
<tr>
<td>C+</td>
<td>≥65 &amp; &lt;69%</td>
<td>(2.0) Represents achievement that meets the minimum course requirements.</td>
</tr>
<tr>
<td>C</td>
<td>≥55 &amp; &lt;64%</td>
<td></td>
</tr>
<tr>
<td>C-</td>
<td>≥50 &amp; &lt;54%</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>&lt;50%</td>
<td>Represents failure (or no credit) and signifies that the work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed and there was no agreement between the instructor and the student that the student would be awarded an I.</td>
</tr>
</tbody>
</table>

Incomplete Contracts

A grade of incomplete “I” shall be assigned at the discretion of the instructor when, due to extraordinary circumstances (e.g., documented illness or hospitalization, death in family, etc.), the student was prevented from completing the work of the course on time. The assignment of an “I” requires that a contract be initiated and completed by the student before the last official day of class, and signed by both the student and instructor. If an incomplete is deemed appropriate by the instructor, the student in consultation with the instructor, will specify the time and manner in which the student will complete course requirements. Extension for completion of the work will not exceed one year (or earlier if designated by the student’s college). For more information and to initiate an incomplete contract, students should go to SPHGrades at: www.sph.umn.edu/grades.
University of Minnesota Uniform Grading and Transcript Policy: A link to the policy can be found at onestop.umn.edu.

Course Evaluation
Beginning in fall 2008, the SPH will collect student course evaluations electronically using a software system called CoursEval: www.sph.umn.edu/courseval. The system will send email notifications to students when they can access and complete their course evaluations. Students who complete their course evaluations promptly will be able to access their final grades just as soon as the faculty member renders the grade in SPHGrades: www.sph.umn.edu/grades. All students will have access to their final grades through OneStop two weeks after the last day of the semester regardless of whether they completed their course evaluation or not. Student feedback on course content and faculty teaching skills are an important means for improving our work. Please take the time to complete a course evaluation for each of the courses for which you are registered.

Other Course Information and Policies

Grade Option Change (if applicable)
For full-semester courses, students may change their grade option, if applicable, through the second week of the semester. Grade option change deadlines for other terms (i.e. summer and half-semester courses) can be found at onestop.umn.edu.

Course Withdrawal
Students should refer to the Refund and Drop/Add Deadlines for the particular term at onestop.umn.edu for information and deadlines for withdrawing from a course. As a courtesy, students should notify their instructors and, if applicable, advisor of their intent to withdraw.

Students wishing to withdraw from a course after the noted final deadline for a particular term must contact the School of Public Health Student Services Center at sph-ssc@umn.edu for further information.

Student Conduct, Scholastic Dishonesty and Sexual Harassment Policies
Students are responsible for knowing the University of Minnesota, Board of Regents’ policy on Student Conduct and Sexual Harassment found at www.umn.edu/regents/polindex.html.

Students are responsible for maintaining scholastic honesty in their work at all times. Students engaged in scholastic dishonesty will be penalized, and offenses will be reported to the SPH Associate Dean for Academic Affairs who may file a report with the University’s Academic Integrity Officer.

The University’s Student Conduct Code defines scholastic dishonesty as “plagiarizing; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; or altering, forging, or misusing a University academic record; or fabricating or falsifying of data, research procedures, or data analysis.”

Plagiarism is an important element of this policy. It is defined as the presentation of another's writing or ideas as your own. Serious, intentional plagiarism will result in a grade of "F" or "N" for the entire course. For more information on this policy and for a helpful discussion of preventing plagiarism, please consult University policies and procedures regarding academic integrity: http://writing.umn.edu/ww/plagiarism/.

Students are urged to be careful that they properly attribute and cite others’ work in their own writing. For guidelines for correctly citing sources, go to http://tutorial.lib.umn.edu/ and click on “Citing Sources”.

In addition, original work is expected in this course. Unless the instructors has specified otherwise, all assignments, papers, reports, etc. should be the work of the individual student. It is unacceptable to hand in assignments for this course for which you receive credit in another course unless by prior agreement with the instructor. Building on a line of work begun in another course or leading to a thesis, dissertation, or final project is acceptable.
Disability Statement
It is University policy to provide, on a flexible and individualized basis, reasonable accommodations to students who have a documented disability (e.g., physical, learning, psychiatric, vision, hearing, or systemic) that may affect their ability to participate in course activities or to meet course requirements. Students with disabilities are encouraged to contact Disability Services to have a confidential discussion of their individual needs for accommodations. Disability Services is located in Suite180 McNamara Alumni Center, 200 Oak Street. Staff can be reached by calling 612/626-1333 (voice or TTY).

Mental Health Services
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduce a student’s ability to participate in daily activities. University of Minnesota services are available to assist you with addressing these and other concerns you may be experiencing. You can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu
I. Course Description

PubH 6751, Principles of Management in Health Services Organizations, is a required course in the MPH curriculum. Students from other programs and from outside Public Health are welcome with the instructor’s permission; however, please note that the content is customized to public health settings (typically, not-for-profit or public organizations) and competencies. The course draws primarily from the fields of organizational theory and behavior to equip students with management and leadership competencies that enable them to make a positive difference in their work organizations and in the health of populations. In addition to facilitating more effective management and leadership, the competencies enable those who will not be in management positions to better understand managers and management and to more effectively contribute to their organizations.

II. Course Prerequisites

Public health MPH or certificate student; MHA student; dentistry MS student; environmental health MS or PhD major; or instructor’s consent.

III. Course Goals and Objectives

After completing the course, students will be better able to:

1) Describe key issues and competencies for the management of healthcare and public health organizations in the United States;
2) Understand their own strengths and weaknesses in management competencies;
3) Effectively contribute to organizational teams and teamwork;
4) Manage interpersonal conflict and differences in the workplace;
5) Apply quality and performance improvement concepts to address organizational performance issues;
6) Develop and communicate organizational vision, mission, goals, and objectives;
7) Manage change in organizations;
8) Use power and politics for personal and organizational effectiveness;
9) Communicate clearly and concisely in writing; and
10) Identify key learning resources for public health management.

IV. Methods of Instruction and Work Expectations
This course consists of seven one-week lessons, to be completed in sequence, beginning on the Monday of each week. Lessons generally consist of readings, an optional audio-supplemented PowerPoint slide presentation, a written assignment, and an online group discussion. There are approximately 100 pages of reading per week. Assignments are due by midnight of the final day (Sunday) of each one-week lesson period. Online group discussion forums require log-ins during the lesson week by times specified below in the Course Outline and on the course website. Please plan your participation accordingly. This is not a “work-at-your-own-pace” course. Assignments are released week-by-week, with one exception: the final assignment is visible from Day 1 so that students can cumulate materials for it. Students are welcome to prepare ahead by studying the required resources in advance.

For students interested in getting more than the minimum requirements out of this course, please consult the Optional Resources, and join the weekly Optional Forums. The Optional Forums allow you to raise questions or share resources customized to your own settings and career tracks and to go beyond the required material.

You can expect the instructor and teaching assistants to respond to emails and telephone messages within 24 hours and to grade written assignments and discussion group forum contributions within one week of the scheduled due dates. Teaching assistants will help facilitate group discussions and will assign preliminary grades to some written assignments. Final grading is the responsibility of the instructor. If you have questions about grades, please contact the instructor.

All course participants are expected to treat each other with respect and a positive spirit of inquiry.

V. Course Text and Readings
The textbook is available from the University of Minnesota Bookstore in Coffman Memorial Union and several other outlets, for purchase or rental. Four hard copies of the textbook are on reserve for this course at the Bio-Medical Library (at the front desk, for use in the Library only) at the University of Minnesota. Readings from sources other than the required textbook are linked or posted on the course website.

VI. Course Outline/Weekly Schedule
*Master Manager = Quinn, et al., Becoming a Master Manager*

Lesson 1, October 21 - 26: Orientation and Framework


“Competing Values Framework Introduction,” YouTube video, University of Michigan, June 29, 2012 (7 minutes, 5 seconds). [link on course website]


Assignment 1: Discussion Group Forum I [details posted on course website]

To allow for discussion, initial post required by 11:55 pm (Central time), Friday, October 24. Full assignment due by 11:55 pm (Central time), Sunday, October 26.

Lesson 2, October 27 - November 2: Creating and Sustaining Commitment and Cohesion

Required Resources: Master Manager, Module 1, “Creating and Sustaining Commitment and Cohesion,” pp. 35-107


“How to Resolve Workplace Conflict - In a Nutshell,” YouTube video, July 10, 2014 (2 minutes, 42 seconds). [link on course website]

“How to Do Effective Performance Appraisals,” YouTube video, July 10, 2008 (4 minutes, 21 seconds). [link on course website]

Optional Resources: Master Manager Module 1 Lecture (18 minutes slides with audio; pdf also posted)

“William Ury: The Walk from ‘No’ to ‘Yes,’” TED Talks video, October, 2010 (18 minutes, 45 seconds). [link on course website]

“Margaret Heffernan: Dare to Disagree,” TED Talks video, June, 2012 (12 minutes, 56 seconds). [link on course website]

Optional Forum

Assignment 2-1: Conflict Management Self-Assessment [details posted on course website]
Due by 11:55 pm (Central time), Sunday, November 2

Assignment 2-2: Discussion Group Forum II [details posted on course website]
To allow for discussion, initial post required by 11:55 pm (Central time), Friday, October 31. Full assignment due by 11:55 pm (Central time), Sunday, November 2.

Lesson 3, November 3 - 9: Establishing and Maintaining Stability and Continuity

Required Resources:  


Optional Resources:  
*Master Manager* Module 2 Lecture (11 minutes slides with audio; pdf also posted)


For those interested in more learning about quality improvement, explore the website of the Institute for Health Improvement Open School for Health Professions:  
[http://www.ihi.org/education/ihiopenschool/Pages/default.aspx](http://www.ihi.org/education/ihiopenschool/Pages/default.aspx) [link on course website]. The IHI Open School offers web courses on a variety of quality improvement topics. For an example of lean management used in public health settings, see “Lean in Public Health Department,” YouTube video, October 18, 2011 (9 minutes, 37 seconds) [link on course website].


Optional Forum

Assignment 3-1:  
Monitoring Performance [details posted on course website]  
**Due by 11:55 pm (Central time), Sunday, November 9**

Assignment 3-2:  
Discussion Group Forum III [details posted on course website]  
**To allow for discussion, initial post required by 11:55 pm (Central time), Friday, November 7. Full assignment due by 11:55 pm (Central time), Sunday, November 9.**

Lesson 4, November 10 - 16: Improving Productivity and Increasing Profitability I

Required Resources:  
*Master Manager*, Module 3 (partial), “Improving Productivity and Increasing Profitability,” pp. 178-220

Optional Resources: Optional Forum

Assignment 4: Job Design [details posted on course website]
Due by 11:55 pm (Central time), Sunday, November 16

Lesson 5, November 17 - 23: Improving Productivity and Increasing Profitability II

Required Resources: Master Manager, Module 3 (partial), pp. 220-253

Optional Resources: Master Manager Module 3 Lecture (10 minutes slides with audio; pdf also posted)
Optional Forum

Assignment 5-1: SWOT/Vision/Goals Analysis [details posted on course website]
Due by 11:55 pm (Central time), Sunday, November 23

Assignment 5-2: Discussion Group Forum IV [details posted on course website]
To allow for discussion, initial post required by 11:55 pm (Central time),
Friday, November 21. Full assignment due by 11:55 pm (Central time), Sunday, November 23.

Lesson 6, November 24 - 30: Promoting Change and Encouraging Adaptability

Required Resources: Master Manager, Module 4, “Promoting Change and Encouraging Adaptability,” pp. 254-328

“Where Good Ideas Come From,” YouTube video, September 17, 2010 (4 minutes, 7 seconds). [link on course website]

Optional Resources: Master Manager Module 4 Lecture (11 minutes slides with audio; pdf also posted)

“How to Give a Killer Presentation,” YouTube video, July 24, 2011 (14 minutes, 24 seconds). [link on course website]
Optional Forum

Assignment 6-1: Change Analysis [details posted on course website]
Due by 11:55 pm (Central time), Sunday, November 30

Assignment 6-2: Discussion Group Forum V [details posted on course website]
To allow for discussion, initial post required by 11:55 pm (Central time), Friday, November 28. Full assignment due by 11:55 pm (Central time), Sunday, November 30.

Lesson 7, December 1 - 7: Making a Difference

Required Resources:

- Master Manager, “Conclusion: Integration and the Road to Mastery,” pp. 329-349

Optional Resources:

- L. Spears, “Practicing Servant-Leadership,” Leader to Leader, 2004, Fall, 7-11. [pdf on course website]

Optional Forum

Assignment 7: Final Self-Reflection [details posted on course website] Due by 11:55 pm (Central time), Sunday, December 7

VII. Evaluation and Grading

Components of the final grade are as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion Group Forums I - V @ 5 points each (Assignments 1, 2-2, 3-2, 5-2, 6-2)</td>
<td>25 points</td>
</tr>
<tr>
<td>Written Assignments @ 12 points each (Assignments 2-1, 3-1, 4, 5-1, 6-1)</td>
<td>60 points</td>
</tr>
<tr>
<td>Final Self-Reflection (Assignment 7)</td>
<td>15 points</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100 points</td>
</tr>
</tbody>
</table>

Assignments completed late without prior permission are penalized as noted on the assignment. The final grade is the weighted average of the components. All students are evaluated on the basis of the same assignments – there is no “bonus” work or resubmissions to replace missed assignments or improve grades. The University utilizes plus and minus grading on a 4.000 cumulative grade point scale in accordance with the following:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>94.00 - 100.00%</td>
<td>(4.0) achievement that is outstanding relative to the level necessary to meet course requirements</td>
</tr>
<tr>
<td>A-</td>
<td>90.00 - 93.99%</td>
<td>(3.67)</td>
</tr>
<tr>
<td>B+</td>
<td>87.00 - 89.99%</td>
<td>(3.33)</td>
</tr>
<tr>
<td>B</td>
<td>84.00 - 86.99%</td>
<td>(3.00) achievement that is significantly above the level necessary to meet course requirements</td>
</tr>
<tr>
<td>B-</td>
<td>80.00 - 83.99%</td>
<td>(2.67)</td>
</tr>
<tr>
<td>C+</td>
<td>77.00 - 79.99%</td>
<td>(2.33)</td>
</tr>
<tr>
<td>C</td>
<td>74.00 - 76.99%</td>
<td>(2.00) achievement that meets the course requirements in every respect</td>
</tr>
<tr>
<td>C-</td>
<td>70.00 - 73.99%</td>
<td>(1.67)</td>
</tr>
<tr>
<td>D</td>
<td>60.00 - 69.99%</td>
<td>(1.00) achievement that is worthy of credit even though it fails to meet fully the course requirements</td>
</tr>
<tr>
<td>F</td>
<td>&lt; 60.00%</td>
<td>represents failure (or no credit) and signifies that the work was either (1) completed but at a level of achievement that is not worthy of credit or (2) was not completed</td>
</tr>
</tbody>
</table>
and there was no agreement between the instructor and the student that the student would be awarded an I.

S Represents achievement that is satisfactory, which is equivalent to a C- or better.

For additional information, please refer to: http://policy.umn.edu/Policies/Education/Education/GRADINGTRANSCRIPTS.html

Course Evaluation
Student course evaluations are collected electronically using a software system called CoursEval: www.sph.umn.edu/courseval. The system will send email notifications to students when they can access and complete their course evaluations. Students who complete their course evaluations promptly will be able to access their final grades just as soon as the faculty member renders the grade in SPHGrades: www.sph.umn.edu/grades. All students will have access to their final grades through OneStop two weeks after the last day of the semester regardless of whether they completed their course evaluation or not. Student feedback on course content and faculty teaching skills are an important means for improving our work. Please take the time to complete a course evaluation for each of the courses for which you are registered.

Incomplete Contracts
A grade of incomplete “I” shall be assigned at the discretion of the instructor when, due to extraordinary circumstances (e.g., documented illness or hospitalization, death in family, etc.), the student was prevented from completing the work of the course on time. The assignment of an “I” requires that a contract be initiated and completed by the student before the last official day of class, and signed by both the student and instructor. If an incomplete is deemed appropriate by the instructor, the student in consultation with the instructor, will specify the time and manner in which the student will complete course requirements. Extension for completion of the work will not exceed one year (or earlier if designated by the student’s college). For more information and to initiate an incomplete contract, students should go to SPHGrades at: www.sph.umn.edu/grades.

University of Minnesota Uniform Grading and Transcript Policy
A link to the policy can be found at onestop.umn.edu.

VIII. Other Course Information and Policies

Grade Option Change (if applicable)
For full-semester courses, students may change their grade option, if applicable, through the second week of the semester. Grade option change deadlines for other terms (i.e. summer and half-semester courses) can be found at onestop.umn.edu.

Course Withdrawal
Students should refer to the Refund and Drop/Add Deadlines for the particular term at onestop.umn.edu for information and deadlines for withdrawing from a course. As a courtesy, students should notify their instructor and, if applicable, advisor of their intent to withdraw.

Students wishing to withdraw from a course after the noted final deadline for a particular term must contact the School of Public Health Office of Admissions and Student Resources at sph-ssc@umn.edu for further information.

Student Conduct Code
The University seeks an environment that promotes academic achievement and integrity, that is protective of free inquiry, and that serves the educational mission of the University. Similarly, the University seeks a community that is free from violence, threats, and intimidation; that is respectful of the rights, opportunities, and welfare of students, faculty, staff, and guests of the University; and that does not threaten the physical or mental health or safety of members of the University community.

As a student at the University you are expected adhere to Board of Regents Policy: Student Conduct Code. To review the Student Conduct Code, please see: http://regents.umn.edu/sites/default/files/policies/Student_Conduct_Code.pdf.

Note that the conduct code specifically addresses disruptive classroom conduct, which means "engaging in behavior that substantially or repeatedly interrupts either the instructor's ability to teach or student learning. The classroom extends to any setting where a student is engaged in work toward academic credit or satisfaction of program-based requirements or related activities."
Use of Personal Electronic Devices in the Classroom
Using personal electronic devices in the classroom setting can hinder instruction and learning, not only for the student using the device but also for other students in the class. To this end, the University establishes the right of each faculty member to determine if and how personal electronic devices are allowed to be used in the classroom. For complete information, please reference: http://policy.umn.edu/Policies/Education/Education/STUDENTRESP.html.

Scholastic Dishonesty
You are expected to do your own academic work and cite sources as necessary. Failing to do so is scholastic dishonesty. Scholastic dishonesty means plagiarizing; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; altering, forging, or misusing a University academic record; or fabricating or falsifying data, research procedures, or data analysis. (Student Conduct Code: http://regents.umn.edu/sites/default/files/policies/Student_Conduct_Code.pdf) If it is determined that a student has cheated, he or she may be given an "F" or an "N" for the course, and may face additional sanctions from the University. For additional information, please see: http://policy.umn.edu/Policies/Education/Education/INSTRUCTORRESP.html.

The Office for Student Conduct and Academic Integrity has compiled a useful list of Frequently Asked Questions pertaining to scholastic dishonesty: http://www1.umn.edu/oscai/integrity/student/index.html. If you have additional questions, please clarify with your instructor for the course. Your instructor can respond to your specific questions regarding what would constitute scholastic dishonesty in the context of a particular class—e.g., whether collaboration on assignments is permitted, requirements and methods for citing sources, if electronic aids are permitted or prohibited during an exam.

Makeup Work for Legitimate Absences
Students will not be penalized for absence during the semester due to unavoidable or legitimate circumstances. Such circumstances include verified illness, participation in intercollegiate athletic events, subpoenas, jury duty, military service, bereavement, and religious observances. Such circumstances do not include voting in local, state, or national elections. For complete information, please see: http://policy.umn.edu/Policies/Education/Education/MAKEUPWORK.html.

Appropriate Student Use of Class Notes and Course Materials
Taking notes is a means of recording information but more importantly of personally absorbing and integrating the educational experience. However, broadly disseminating class notes beyond the classroom community or accepting compensation for taking and distributing classroom notes undermines instructor interests in their intellectual work product while not substantially furthering instructor and student interests in effective learning. Such actions violate shared norms and standards of the academic community. For additional information, please see: http://policy.umn.edu/Policies/Education/Education/STUDENTRESP.html.

Sexual Harassment
"Sexual harassment" means unwelcome sexual advances, requests for sexual favors, and/or other verbal or physical conduct of a sexual nature. Such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive working or academic environment in any University activity or program. Such behavior is not acceptable in the University setting. For additional information, please consult Board of Regents Policy: http://regents.umn.edu/sites/default/files/policies/SexHarassment.pdf

Equity, Diversity, Equal Opportunity, and Affirmative Action
The University will provide equal access to and opportunity in its programs and facilities, without regard to race, color, creed, religion, national origin, gender, age, marital status, disability, public assistance status, veteran status, sexual orientation, gender identity, or gender expression. For more information, please consult Board of Regents Policy: http://regents.umn.edu/sites/default/files/policies/Equity_Diversity_EO_AA.pdf.

Disability Accommodations
The University of Minnesota is committed to providing equitable access to learning opportunities for all students. Disability Services (DS) is the campus office that collaborates with students who have disabilities to provide and/or arrange reasonable accommodations.
If you have, or think you may have, a disability (e.g., mental health, attentional, learning, chronic health, sensory, or physical), please contact DS at 612-626-1333 or ds@umn.edu to arrange a confidential discussion regarding equitable access and reasonable accommodations.

If you are registered with DS and have a current letter requesting reasonable accommodations, please contact your instructor as early in the semester as possible to discuss how the accommodations will be applied in the course.

For more information, please see the DS website, https://diversity.umn.edu/disability/.

**Mental Health and Stress Management**
As a student you may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance and may reduce your ability to participate in daily activities. University of Minnesota services are available to assist you. You can learn more about the broad range of confidential mental health services available on campus via the Student Mental Health Website: http://www.mentalhealth.umn.edu.

**The Office of Student Affairs at the University of Minnesota**
The Office for Student Affairs provides services, programs, and facilities that advance student success, inspire students to make life-long positive contributions to society, promote an inclusive environment, and enrich the University of Minnesota community.

Units within the Office for Student Affairs include, the Aurora Center for Advocacy & Education, Boynton Health Service, Central Career Initiatives (CCE, CDes, CFANS), Leadership Education and Development – Undergraduate Programs (LEAD-UP), the Office for Fraternity and Sorority Life, the Office for Student Conduct and Academic Integrity, the Office for Student Engagement, the Parent Program, Recreational Sports, Student and Community Relations, the Student Conflict Resolution Center, the Student Parent HELP Center, Student Unions & Activities, University Counseling & Consulting Services, and University Student Legal Service.

For more information, please see the Office of Student Affairs at http://www.osa.umn.edu/index.html.

**Academic Freedom and Responsibility:** for courses that do not involve students in research
Academic freedom is a cornerstone of the University. Within the scope and content of the course as defined by the instructor, it includes the freedom to discuss relevant matters in the classroom. Along with this freedom comes responsibility. Students are encouraged to develop the capacity for critical judgment and to engage in a sustained and independent search for truth. Students are free to take reasoned exception to the views offered in any course of study and to reserve judgment about matters of opinion, but they are responsible for learning the content of any course of study for which they are enrolled.*

Reports of concerns about academic freedom are taken seriously, and there are individuals and offices available for help. Contact the instructor, the Department Chair, your adviser, the associate dean of the college, or the Vice Provost for Faculty and Academic Affairs in the Office of the Provost.

*Language adapted from the American Association of University Professors, "Joint Statement on Rights and Freedoms of Students."

Template update 6/2014
Graduate Program in Prosthodontics Clinical Requirements

Clinical Requirements

Complete dentures (including immediate dentures) – 30 units
Removable partial dentures – 10 units
Crowns – natural teeth – 80 units
Crowns – implants – 80 units
Implant dentures – 7 units
Implant placement – 20 units
Graduate Program in Prosthodontics Tuition, Fees, Professional Liability, Outside Activities, Vacation and Sick Leave

Please review the below listed summary of costs covered within your residency, which gives an approximate value for the tuition and medical insurance benefits you will receive, and the estimated tuition and fees for which you will be responsible.

Professional liability insurance is not required for students.

No activity outside of the program for purposes of earning an income is allowed.

Dental residents/fellows are allowed 10 days of personal time off (vacation or sick) per academic year (July 1 to June 30). Unused vacation or sick time cannot be rolled over into the next academic year without approval of the program director. In the event of illness, the affected dental resident/fellow is responsible for notifying the faculty member of the affected clinic(s) and the program director’s office as soon as the dental resident/fellow knows that the illness will cause an absence from clinical responsibilities. Personal time off for illness will be approved only for legitimate illnesses. A physician’s note may be requested to support the dental resident/fellow’s request for illness related personal time off.

The dental resident/fellow must give written notice of intent to use personal time off to their program director at least four weeks in advance, except for illness or unusual circumstances. Any time taken beyond the amount of personal time off available may require an extension of the program in order to fulfill program length requirements.

Each year we will assess the level of paid stipend, continued tuition and individual medical insurance benefits. Future terms and conditions of your residency appointment will be confirmed in writing each year of your advanced training program.

During the initial summer semester of the training program, you will not be enrolled in the graduate school. Once you arrive, we will work with you to submit your application to the University of Minnesota Graduate School in preparation for fall semester. Once enrolled in the graduate school your 25% appointment will qualify you for a non-resident tuition waiver and a 50% tuition benefit. You will be responsible for the remaining tuition.
## Graduate FY 2015 Projections

### Changes to student Account

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<thead>
<tr>
<th></th>
<th>Pros YR 1</th>
<th>Pros Yr2 &amp; Yr3</th>
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<tbody>
<tr>
<td><strong>Tuition</strong></td>
<td>$18,355.00</td>
<td>$22,963.00</td>
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<tr>
<td><strong>SOD FEES</strong></td>
<td></td>
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<tr>
<td>Dentistry's Equipment Collegiate Fee</td>
<td>$627.30</td>
<td>$627.30</td>
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<tr>
<td>Dentistry's Instrument-Usage Fee</td>
<td>$2,977.38</td>
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<tr>
<td><strong>University Fees Student fees</strong></td>
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<tr>
<td>Student service Fee</td>
<td>$1,269.62</td>
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<td>Graduate &amp; Prof Student Assembly</td>
<td>$35.31</td>
<td>$35.31</td>
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<tr>
<td>International student Fee ($445 charged if international)</td>
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<tr>
<td>International Student Aid fee ($42 charged if international)</td>
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</tr>
<tr>
<td>Transportation Fee</td>
<td>$61.20</td>
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<tr>
<td>Stadium Fee</td>
<td>$38.25</td>
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<tr>
<td><strong>Health insurance (single)</strong></td>
<td>$591.00</td>
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<tr>
<td><strong>Long Term Disability</strong></td>
<td>$124.50</td>
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<tr>
<td><strong>Total Projected Student Charges</strong></td>
<td>$24,079.56</td>
<td>$28,687.56</td>
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### Scholarship/Benefits

<table>
<thead>
<tr>
<th></th>
<th>Pros YR 1</th>
<th>Pros Yr2 &amp; Yr3</th>
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</thead>
<tbody>
<tr>
<td>Dental Fellow Tuition Benefit</td>
<td>($7,729.00)</td>
<td>($11,481.50)</td>
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<tr>
<td>Dental School Scholarship/credits</td>
<td>($2,897.00)</td>
<td>-</td>
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<tr>
<td><strong>Total Scholarship/Benefits</strong></td>
<td># ($10,626.00)</td>
<td>($11,481.50)</td>
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### Estimated Student Responsibility (student charges less scholarship/credits)

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<thead>
<tr>
<th></th>
<th>Pros YR 1</th>
<th>Pros Yr2 &amp; Yr3</th>
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<tbody>
<tr>
<td># ($13,453.56)</td>
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<td># ($17,206.06)</td>
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### Projected Graduate Student Support (from Dept)

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<thead>
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<th></th>
<th>Pros YR 1</th>
<th>Pros Yr2 &amp; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Stipend</td>
<td>$9,370.40</td>
<td>$9,370.40</td>
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<tr>
<td>Scholarships and Credits</td>
<td>$10,626.00</td>
<td>$11,481.50</td>
</tr>
<tr>
<td>Health Insurance Support</td>
<td>$3,204.00</td>
<td>$3,204.00</td>
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<tr>
<td>Estimated Student support</td>
<td># $23,200.40</td>
<td>$24,055.90</td>
</tr>
</tbody>
</table>

*If non resident of MN a waiver will be applied of approx $4100 to student account to bring them in line with resident rate.*
Graduate Program in Prosthodontics Resident Predoctoral Teaching Responsibilities

Every resident in the University of Minnesota School of Dentistry Advanced Education Program in Prosthodontics receives a 25% appointment as a “Dental Fellow Specialist” for the summer semester of the first year. Beginning with the fall semester of the first year, this designation changes to a “Dental Fellow” and this appointment carries with it a ½ day per week predoctoral teaching responsibility in prosthodontics (either clinical or pre-clinical). This appointment provides an annual stipend.
Graduate Program in Prosthodontics Required Equipment

The following equipment is required to be purchased by residents reporting to the University of Minnesota School of Dentistry Advanced Education Program in Prosthodontics. All other necessary equipment / supplies are provided by the School of Dentistry. Residents are welcome to bring or to purchase any other equipment they may personally prefer.

Required equipment includes:

- Laptop computer
- Intra-oral camera
- Denar D5A articulator
- Two semi-adjustable articulators (Hanau H-2 preferred)
Graduate Program in Prosthodontics Immunization Requirements

Requirements for Academic Health Center Students

According to Occupation Safety and Health Administration (OSHA) regulations, Centers for Disease Control and Prevention (CDC) guidelines, and Academic Health Center (AHC) policy, all students (including international students) enrolled in AHC colleges must meet immunization requirements as a condition of enrollment. **AHC students who do not complete these immunization requirements will not be able to register for classes.**

*Please note: AHC Student Immunization requirements do not apply to Veterinary Medicine students.*

Forms

The following information must be completed to register for classes in the AHC:

- [AHC Student Immunization Form](#) (PDF)
- [AHC Student Immunization Requirements and Process](#) (PDF)

Forms are held by Boynton Health Service; please make a copy of any forms you bring in for your records. Please read through any forms you need completed to make sure that you know what immunizations/titers you need and whether or not a health exam is also needed (this would be a separate appointment). This will allow the clinic to provide the services you need in a timely fashion.
This form must be completed and submitted with the proper signatures to Boynton Health Service. It will become part of your official medical record. It is the student’s responsibility to achieve compliance with AHC Immunization requirements.

Keep a copy of this form and any other documentation for your records. You may submit multiple copies of this form, each documenting different requirements. Please allow two business days for your immunization information to be updated and for hold to be removed. You may download a personalized version of this form by logging into www.myU.umn.edu with your University of Minnesota internet ID and clicking on the "Health and Wellness" tab. If you do not have a University internet ID, you may download a non-personalized PDF version of the form at http://www.ahc.umn.edu/immunizationform/

Required Immunization | Dates Immunizations Received OR | Antibody Titre Results | Provider Signature and Date
--- | --- | --- | ---
**Hepatitis B (Hep B)**
Report 3 doses or titre results | Dose 1 Date | Dose 2 Date | Dose 3 Date | + / - | / / MM DD YYYY

**Varicella (Chicken Pox)**
Report 2 doses or titre results | Dose 1 Date | Dose 2 Date | + / - | / / MM DD YYYY

**Measles (Rubeola)**
Report 2 doses after age 12 months or titre results | Dose 1 Date | Dose 2 Date | + / - | / / MM DD YYYY

**Mumps**
Report 2 doses after age 12 months or titre results | Dose 1 Date | Dose 2 Date | + / - | / / MM DD YYYY

**Rubella (German Measles)**
Report 2 doses after age 12 months or titre results | Dose 1 Date | Dose 2 Date | + / - | / / MM DD YYYY

**Tetanus/Diphtheria Pertussis (Tdap)**
Must be July 2005 or later | Dose Date Tdap | / / MM DD YYYY

**Required TST (Tuberculin Skin Test) (2-step Mantoux)**
Date | Induration | Date | Induration | Provider Signature and Date
--- | --- | --- | --- | ---
Report any TWO TST Tests applied more than one week apart and within one month (required once): | Step 1 Date | mm | Step 2 Date | mm | / /

Report most current TST test only if more recent than 2-step test (required if last TST test is more than 1 year old) | TST Date | mm | / / MM DD YYYY

For any POSITIVE TST test, provider must document steps taken (chest x-ray etc.): | / / MM DD YYYY

Medical Exemptions. Provider must document medical conditions that preclude that administration of a required vaccine or test.

Explanation of exemption: | Sign and Date
Academic Health Center
Immunization Policy

All students in the University of Minnesota Academic Health Center (AHC) schools and programs are required to have immunizations and/or tests as a condition of enrollment. Programs must meet this University of Minnesota Board of Regents requirement. Expectations for health professions students are consistent with those of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), and Minnesota state law for health care workers. First year students are expected to have this requirement completed prior to entering AHC programs. Information can be accessed at http://www.bhs.umn.edu/download/AHC_ImmunizationMemo-2.pdf

Required Documented Tests and Immunizations

1. **Hepatitis B.** Document three doses of the vaccine or antibody titre (blood test) results documenting immunity. Note: The Hepatitis B series takes four to six months to complete; therefore, if you have not had this series, you should begin this process as soon as possible to comply with this requirement.

2. **Varicella (Chicken Pox).** Document two doses of the vaccine or a self-reported history of the disease. If you are unsure whether or not you have had varicella, you may submit antibody titre results documenting immunity or proof of two immunizations.

3. **Measles (Rubeola).** Document two doses after age 12 months or antibody titre results documenting immunity.

4. **Mumps.** Document two doses after age 12 months or antibody titre results documenting immunity.

5. **Rubella (German Measles).** Document two doses after age 12 months or antibody titre results documenting immunity.

6. **Tetanus/Diptheria.** Document most current dose within the last ten years.

7. **A two-step tuberculin skin test (TST).** Documentation of the two-step TST
   
   a. This test involves placement of a purified protein derivative (PPD) to test for tuberculosis. It must be read 48-72 hours after placement, and the area of indurations recorded. The AHC
requires a second PPD test to be performed two weeks after the first test. This two-step TST needs to be done once.

b. Annual TST. Documentation of an annual TST. If you have had a two-step TST more than one year ago, you should have a standard TST. Annual TST’s are required each year you are in your program.

c. Documentation of a TB gold, quantiferon test will fulfill the requirement for a two-step TST and the annual TST.

8. Chest x-ray if you have had a positive TST. If you have had a positive TST, your documentation must include the results of your follow-up chest x-ray. Once this documentation is submitted, yearly TST testing is not required.

**Process required to obtain documentation**

Once students are admitted to an AHC school or program, they can find a personalized immunization form in the University myU Portal under the tab titled "Health and Wellness" at www.myu.umn.edu. Students may also download a non-personalized immunization form at: www.ahc.umn.edu/immunizationform.

Students should print and take this form to a health care provider to complete. A health care provider is defined as a physician (MD or DO), nurse practitioner, physician’s assistant, pharmacist, or registered nurse. Often the information may be required from multiple providers. In these cases, a separate Immunization Form for each provider is the preferred way to complete the documentation. It is highly recommended that students keep a copy of all documentation.

When the form or forms are completed, they must be turned in to Boynton Health Service (BHS) or faxed to 612-626-9768. When the BHS staff receives a student’s information, they will review the form and verify whether immunizations and documentation on the form meet the University standards. Immunization information will become part of a student’s confidential BHS medical record.

**Review and verification of immunizations and forms will take BHS staff approximately two to five days to process. Turning in the form does not confirm that students are in compliance with these requirements. The forms must be processed and verified by BHS**
before compliance is confirmed.

If students have not completed all requirements, a hold is placed on their records.

Contact Boynton Health Service at 612-626-5571 or immunizations@bhs.umn.edu with questions about immunizations.

Basic Life Support Training Requirements

The American Dental Association, Commission on Dental Accreditation requires that all of our students, clinical faculty, and appropriate support staff be certified to perform basic life support procedures, including cardiopulmonary resuscitation, and manage other medical emergencies.

Utilizing an American Heart Association accredited instructor, the SOD provides opportunities for faculty, staff, and students to participate in Basic Life Support Certification courses. All students are trained in CPR and Basic Life Support prior to the beginning of their clinical training and at appropriate intervals as needed to ensure continued certification.

The course teaches the following skills for all age groups: Cardio Pulmonary Resuscitation (CPR), ventilation techniques using a bag valve mask device, oxygen as well as other appropriate airway devices, use of an automated external defibrillator (AED), relief of a foreign-body airway obstructions (FBAO), risk factors for cardiovascular disease, signs and symptoms of a heart attack and stroke and actions to be taken for these emergencies, the chain of survival, and the importance of early access to the EMS system.

For more information related to CPR and Basic Life Support training, refer to the School of Dentistry Clinic Manual or the Dental Hygiene Clinic Manual, as appropriate. Questions related to documentation of CPR certification should be directed to: Debby Chapman, School of Dentistry, Clinical Systems, 612-626-4184.
Graduate Program in Prosthodontics Program Related Policies
Evaluation of Performance for Residents in the Graduate Program in Prosthodontics at the University of Minnesota School of Dentistry

1. The program director formally evaluates all residents in the Advanced Education Program in Prosthodontics at the University of Minnesota School of Dentistry at the end of each semester using the Advanced Clinical Prosthodontics Rubric (a copy of this form and other forms used for evaluation purposes is contained in each residents clinical manual). In addition, first year residents are evaluated at the end of the initial summer session (July through August) and if it should prove necessary, individually during the first fall semester. The initial summer session and fall semester of the first year is considered a probationary period for these residents.

The PROS 7200 Advanced Clinical Prosthodontics Rubric uses clinical production, progress, productivity, preparation, attendance, efficiency, quality, documentation, scheduling, financial, professionalism, and patient testimonials, as criteria for assessing a resident’s performance and progress. If a resident is deemed to fall below an acceptable level of performance by faculty, they are counseled, any necessary assistance for remediation is offered and a note describing the circumstance placed in their record. The individual in question will be given ample time to address any deficiencies noted and then re-evaluated by faculty at a pre-arranged time. In the unlikely event that the individual in question is unable to correct any identified deficiency or deficiencies, that individual will be discharged from the program. It must also be noted that the same scenario will apply at any time during the thirty-three month long program if deficiencies are noted for any particular resident and that person is either unwilling or unable to correct them.

2. Basic minimal expectations for residents in the Graduate Program in Prosthodontics at the University of Minnesota School of Dentistry:

a. All residents must maintain a 3.0 GPA overall and in each semester.
b. All residents must complete the clinical requirements described in their clinical manual prior to completion of the program in order to be granted a certificate.
c. All residents are expected to complete a research project. Preparation of a thesis (Plan A) and its successful defense or the preparation of three papers, one of which must be research based (Plan B) is required to be granted a Master of Science degree by the graduate school. It should be noted that Plan B also requires ten additional credit hours of course work.
d. All third year residents are expected to register for and take the American Board of Prosthodontics Section A Written Examination. All second year residents are expected to register for and take the Board Preparation Course hosted by the American College of Prosthodontists at the Annual Session.
e. When new patients are assigned to a resident, those individuals are to be contacted within three working days by the resident. Residents are expected to maintain contact with their patients on a regular basis during treatment.

f. All chart entries must be entered into the patient’s electronic health record in the SOAP format within 24 hours of the completion of the appointment. Chart entries must be typed thoroughly in each of the Subjective, Objective, Assessment, and Plan sections. Documenting patient encounters in the dental record is an integral part of continuity of care.

g. Under no circumstances, is a patient to be treated by a resident unless there is a treatment plan in the record approved by both the faculty and the patient.

h. Under no circumstances, is a completed prosthesis to be delivered to a patient unless the patient has paid in full. During the course of any treatment, it is the resident’s responsibility to insure that their patient is up to date with payments.

i. Under no circumstances is any prosthesis to be delivered to a patient without first having the approval of a faculty member. Radiographs must be taken of all final fixed dental prostheses and implants.

j. All prosthodontic laboratory prescriptions must be co-signed by a faculty member prior to submission for fabrication.

k. All residents must demonstrate acceptable time management skills. Residents are expected to be available during normal school working hours, i.e., 8 AM to 4PM. They are expected to be on time for scheduled program related events and seminars. For purposes of this program, on time means at least five minutes prior to the beginning of any event. Baring a legitimate emergency, any absence must be prior authorized or adequately explained by or to faculty. If a resident arrives late to a prosthodontic seminar, he/she will be dismissed from the seminar and his/her absence considered as unexcused. If a resident should have two unexcused absences from any particular seminar series, the letter grade for the seminar will be a “C”. If a resident should have three unexcused absences from the same seminar series, the letter grade for the seminar will be an “F” and the seminar course will have to be repeated the following year. The Graduate Program in Prosthodontics clinic is available for patient treatment from 9AM to 4 PM with an hour lunch break from 12AM to 1PM. Treatment for complex patients should be initiated at 9AM (whenever possible, any fixed prosthodontic procedures should be initiated in the morning). If a resident suspects that the treatment time for a patient will extend into or over the noon hour and a dental assistant’s support may be required, then that resident should notify the assistant the day prior to initiation of treatment. Complex patient treatment should not be initiated in the afternoon. Treatment for any patient must be completed by 4PM.

l. It is expected that all residents will spend the laboratory time necessary to assure that their patients are treated in a timely fashion. This time will often be after hours and/or on weekends. Whenever possible, laboratory work for any patient must be completed at least the day prior to initiation of treatment.

m. All residents must be prepared to participate in any scheduled seminar whenever called on by faculty (i.e., if the seminar in question is a literature based seminar, to have read all assigned articles prior to the beginning of the seminar in question and be able to discuss them when called on, or, if it is a treatment planning seminar requiring the resident to make a presentation, to be prepared to do so at least two days in advance of the scheduled
Interpersonal conversation during seminars is strongly discouraged and considered to be discourteous to other participants.

c. Cell phones must be turned off whenever a resident is in a classroom, laboratory or clinical setting.

d. Part of this program is attendance at two national meetings (ACP and AAFP) each year. While at these meetings, all residents are expected to attend all available program presentations. There are no exceptions.

e. A satisfactory professional appearance and personal/oral hygiene must be maintained at all times.

f. All residents are assigned individually on a rotational basis to clean the graduate prosthodontic laboratory. It is expected that the individual in question will complete this task at the end of each workday or prior to 8AM the following morning. Failure to clean the laboratory on a daily basis will result in an extension of your cleaning responsibilities.

g. All residents are expected to keep their personal office space clean, neat, and tidy. Written notice will be provided to the resident if their office space requires attention and the resident will be expected to clean the area prior to returning to clinic or seminars.

h. In addition to university holidays, residents are allowed 10 days of personal time off (vacation or sick) per academic year (July 1 to June 30). First year residents are not allowed to take vacation in their first two months of the program (July and August). Unused vacation or sick time cannot be rolled over into the next academic year without approval of the program director. In the event of illness, the affected dental resident/fellow is responsible for notifying the faculty member of the affected clinic(s) and the program director’s office as soon as the dental resident/fellow knows that the illness will cause an absence from clinical responsibilities. Personal time off for illness will be approved only for legitimate illnesses. A physician’s note may be requested to support the dental resident/fellow’s request for illness related personal time off. The dental resident/fellow must give written notice of intent to use personal time off to their program director at least four weeks in advance, except for illness or unusual circumstances. Any time taken beyond the amount of personal time off available may require an extension of the program in order to fulfill program length requirements.

I hereby attest that I have read and understand the contents of the above document and their significance for me as a resident in the Graduate Program in Prosthodontics at the University of Minnesota School of Dentistry.

Signature: 

Date: 
Lab Cleaning Protocol
Starts Tuesday and ends Monday

Residents will be assigned to clean the lab on a weekly-rotating schedule

During assigned week, resident will be expected to:
1. Make sure the lab is tidy at the end of each day. See Daily Checklist
2. Make sure that the lab is fully stocked at the beginning and at the end of the assigned week. See Weekly Checklist
3. Clean the assigned area of the lab for the week. See Weekly Rotating Area Assignments

### Daily Checklist
- All lab equipment is returned to its designated place
- All supplies are returned to designated shelf/cupboard
- Counters are free of debris
- Fresh paper is placed on counters
- Floor is swept
- Lathe bins are emptied and washed

### Weekly Checklist
- All items on Daily Checklist
- Sink is free of debris
- Lathe is completely clean – Rag wheels are packaged and taken to dispensing
- Plaster/stone/wax/debris are completely removed from the counter/walls/cabinets
- Supplies are stocked – gloves, stone, paper towels, soap, paper, etc.

### Weekly Rotating Area Assignments (See Pictures)

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<table>
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<tbody>
<tr>
<td>A.</td>
<td>Left side of the sink – Wipe down all items on counter. Clean out plaster container. Clean under the counter and around the sink.</td>
</tr>
<tr>
<td>B</td>
<td>Right side of the sink – Clean under and around the steamer; clean items within the wire basket</td>
</tr>
<tr>
<td>C.</td>
<td>Main shelves – Remove all items, discard waste, wipe off shelves, and replace items in their designated spots</td>
</tr>
<tr>
<td>D.</td>
<td>Cupboards under the main shelf – Wipe down, organize, and replenish all items in cupboard</td>
</tr>
<tr>
<td>E.</td>
<td>Lathe counter and under the counters – Clean counter; remove all contents, wipe them down and re-organize</td>
</tr>
<tr>
<td>F.</td>
<td>Shelves above the lathe – Remove all bins, clean shelves, and replace bins</td>
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</tbody>
</table>
**Goodkind|Holtan Resident Office**

Welcome residents to the newly renovated and renamed Goodkind|Holtan Resident Office!! This renovation was made possible by the generous donations of past alumni to honor the previous program directors, Drs. Goodkind and Holtan. Since a renovation like this may not happen again for another 40 years, we must respect this space to maintain it in excellent condition for future residents. The following rules will be applied to this space:

1. Stations will be assigned based on seniority in the program. You may move to a different station vacated by a graduating senior resident by submitting a request to the program director.
2. Personal items/books/papers may only be stored inside the overhead cabinet and inside the pedestal, with a modest amount on the desktop. There are to be no items stored on top of the overhead cabinet or under the desk on the floor. Items that do not fit in those spaces need to be taken home.
3. Desktops are to be free of clutter and organized.
4. Graffiti or other permanent stickers/adhesives/hooks are not permitted. Tackboards can be used for a modest amount of papers/photos.
5. You are responsible for the cleaning of your station and the floor around it. Monthly cleaning/dusting of your desk and floor is expected.
6. The fridge and microwave are provided for your comfort and convenience. These are shared appliances for the residents and it is expected that everyone will take ownership in cleaning up spills and disposing of food and drinks.
7. There are to be no garbage cans within the resident office. All waste should be disposed of in the garbage cans in the hallway.
8. Any resident in violation of these rules will be notified in writing.

Thank you for being considerate of this shared space and maintaining the best resident office in the dental school!!

Dr. Conrad
UNIVERSITY OF MINNESOTA
SCHOOL OF DENTISTRY
ADVANCED EDUCATION PROGRAM
RESIDENCY AGREEMENT

THIS IS AN AGREEMENT by and between the Regents of the University of Minnesota (“University”), a Minnesota constitutional corporation, and ______________________, hereinafter referred to as “resident.” The Agreement applies to Academic Year 2013-2014; actual dates of coverage are specified in Section 5 below.

THE PARTIES AGREE as follows:

1. Purpose. The primary purpose of the appointment of a resident is the successful completion of a graduate dental education training program. This Agreement and the provisions of the Advanced Education Resident Handbook referenced in this Agreement govern the relationship between the individual resident and the University.

2. Appointment Status. During the period in which the residents are undergoing graduate dental education training at the University, they have the status of students and are appointed as residents in the student/professional training classification (HR Codes 9552 and 9553) in the University appointment system.


3.1 The resident agrees to accept the duties, responsibilities, and rotations assigned by the program director or designee and to conduct himself or herself ethically and professionally in keeping with his or her position as a dentist, in the care of patients and in relationships with other hospital/clinic staff.

3.2 The resident agrees to participate fully in the educational and scholarly activities of the residency program and, as required, to assume responsibility for teaching and supervising other residents and dental students.

3.3 The resident agrees to provide safe, effective, and compassionate care of patients under faculty supervision, commensurate with the resident’s level of education and experience.

3.4 The resident agrees to abide by the bylaws, policies, rules, and regulations of the University of Minnesota School of Dentistry (the “School of Dentistry”), the University and the hospital and clinics to which assigned.

3.5 The resident agrees to meet state, federal, and University requirements for participating in a residency program prior to the start of and throughout the training program. These requirements include: a) credentials – submit proof of earning a D.D.S. or D.M.D. or equivalent degree, comply with state licensure requirements by obtaining a resident dentist
license from the Minnesota Board of Dentistry if not already fully licensed to practice dentistry in the State of Minnesota as required by the residency program; b) **health professional requirements** – submit proof of immunization; complete a background study request under Minnesota law; complete HIPAA training; c) **work authorization** -- obtain an appropriate visa, as agreed to by the program, if the resident is not a U.S. citizen or permanent resident; and d) **other** - complete a Human Resources Information Form (HRIF) upon appointment; and comply with any other requirements established by the individual residency program. The resident agrees that his/her immunization compliance status and background study results may be shared with clinical sites where the resident is assigned.

4. **Responsibilities of the University.**

4.1 The School of Dentistry shall be responsible for providing a graduate dental educational experience and training program through faculty planning, teaching, supervision, and evaluation of residents.

4.2 The University agrees to perform administrative functions for the benefit of the residents. These include arranging for the payment of stipends; maintaining certain resident records; administering the procedure related to the discipline of residents; and providing mechanisms for the coordination of programs among the affiliated hospitals and clinics, School of Dentistry and the various clinical services.

4.3 The University agrees to provide the following benefits to residents:

4.3.1 An annual stipend, payable on a bi-weekly basis.

4.3.2 Benefits as set forth in the Advanced Education Resident Handbook. All residents receive the following benefits regardless of appointment classification: professional liability insurance through University covering claims related to duties performed as part of the residency, whether such claims arise during or after the resident’s completion of the program; other insurance through the Office of Student Health Benefits specifically for dental residents that provides medical insurance and optional dependent coverage, long-term disability insurance, optional life insurance, and optional dental insurance at the resident’s cost; reasonable accommodations for residents with a documented disability; and counseling and psychological support services through the resident assistance program, including monitoring and assistance for impaired dentists consistent with professional and legal obligations. Residents also are eligible to participate in the University’s dependent and health care flexible spending accounts.

4.3.3 Leave of absence benefits, which include parental/family medical, professional/academic, personal, vacation, holiday, sick, bereavement, military and jury duty/witness leave. See the Advanced Education Resident Handbook for further details. The residency program is responsible for advising its residents on how a requested leave of absence may affect timely completion of the training program.

4.3.4 Other benefits as set forth in the Advanced Education Resident Handbook.
4.4 The School of Dentistry has established general policies on duty hours, on-call schedules, and the effect of absences on timely completion of the residency program. These matters are set forth in the Advanced Education Resident Handbook. Program policies will conform to any applicable requirements of the Commission on Dental Accreditation (CODA).

4.5 The School of Dentistry does not require residents to sign a noncompetitive guarantee.

5. Residency Term. Traditionally, the majority of residents successfully complete their training within the prescribed minimum period of 33 months. In keeping with University policy:

5.1 The term of the Agreement between the resident and the University is for the period starting June 24, 2013, and ending on March 31, 2016.

5.2 In unusual circumstances and at the discretion of the residency program, the Agreement may be extended beyond the term above to allow a resident to successfully complete the training program.


6.1 A periodic assessment of academic performance of each resident is the responsibility of the residency program director with input from program faculty. Academic performance of a resident must be evaluated by a careful and deliberate review, including documentation of the resident’s performance with respect to relevant exam scores, clinical diagnosis and judgment, dental knowledge, technical abilities, interpretation of data, patient management, communications skills, interactions with patients and other healthcare professionals, professional appearance and demeanor, and/or motivation and initiative. All recorded evaluations of a resident’s performance are accessible to the resident.

6.2 A resident can be disciplined and/or dismissed from the program for academic reasons. Before dismissing a resident for academic reasons, the program must give the resident notice of his/her performance deficiencies, an opportunity to remedy the deficiencies, and notice of the possibility of dismissal if the deficiencies are not corrected. See the Resident handbook for further details.

7. Grounds for Discipline and/or Dismissal of a Resident for Non-Academic Reasons.

Grounds for discipline and/or dismissal of a resident for non-academic reasons, as set forth in the Advanced Education Resident Handbook, include, but are not limited to, the following:

7.1 Failure to comply with the bylaws, policies, rules, or regulations of University, affiliated hospitals, medical staff, department, or with the terms and conditions of this document.

7.2 Commission by the resident of an offense under federal, state, or local laws or ordinances which impacts upon the resident’s abilities to appropriately perform his/her normal duties in the residency program.
7.3 Conduct which violates professional and/or ethical standards; disrupts the operations of University, its departments, or affiliated hospitals; or disregards the rights or welfare of patients, visitors, or hospital/clinical staff.

8. **Disciplinary and Grievance Procedures.**

8.1 Discipline and/or dismissal of a resident for academic reasons under Section 6 above may be grievable under the University policy "Addressing Student Academic Complaints" set forth in the Advanced Education Resident Handbook. Residents also may utilize this University complaint procedure for other complaints related to education and academic services to the extent covered by the complaint policy.

8.2 Residents who are disciplined and/or dismissed for non-academic reasons under Section 7 above are entitled to certain procedures as set forth in the Advanced Education Resident Handbook. These procedures are outlined in a section labeled “Codes of Conduct, Standards of Professional Conduct, Chemical Abuse and Dependency Policies.” They include notice of the disciplinary charges, an opportunity to respond to the allegations before discipline is imposed, and to appeal any discipline imposed for non-academic reasons.

8.3 Discipline imposed for either academic or non-academic reasons is implemented on the effective date determined by the program, regardless of whether the resident contests the discipline. The procedures referenced in paragraphs 8.1 and 8.2 above for contesting discipline are mutually exclusive; under no circumstances will a resident be afforded both the procedures outlined under University policy on Addressing Student Academic Complaints and the procedures set forth in the Advanced Education Resident Handbook under the provision entitled “Codes of Conduct, Standards of Professional Conduct, Chemical Abuse and Dependency Policies.”

8.4 The University is committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran’s status, or sexual orientation. Harassment based on sex, race or any other ground listed here is a form of discrimination prohibited under this policy. Residents who believe they have been subjected to discrimination or harassment on any of these grounds are urged to contact their program director or department chair. Complaints also may be pursued through the School of Dentistry Dean’s Office or the University of Minnesota Office of Equal Opportunity and Affirmative Action, as set forth in the Resident Institutional Policy Manual.

8.5 Residents who are disqualified from direct contact with patients under the criminal background study required by Minnesota law, Section 144.057, will be dismissed from the residency program or have their acceptance revoked if they have not started the program training yet. The resident may appeal this decision to a panel convened by the Dean of the School of Dentistry, under the terms of the “Academic Health Center Student Background Study Policy.”
9. **Residency Closure/Reduction.** If the University reduces the size of or closes the residency program, affected residents will be notified as soon as possible; and the University will make every effort within budgetary constraints to allow existing residents to complete their education. In the unlikely event that existing residents or those newly matched and under contract with the University are displaced by a program closure or reduction, the University will make every effort to assist the residents in locating another residency program where they can continue their education.

10. **Advanced Education Resident Handbook.** Upon signature of this Agreement, the resident acknowledges having access and agrees to adhere to the Advanced Education Resident Handbook. For further information on access, see the Program Director.

<table>
<thead>
<tr>
<th>Regents of the University of Minnesota</th>
<th>Resident</th>
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<tbody>
<tr>
<td>By: Leon A. Assael</td>
<td>By: ____________________________</td>
</tr>
<tr>
<td>Name: Dean, School of Dentistry University of Minnesota</td>
<td>Name:</td>
</tr>
<tr>
<td>Date: ____________________________</td>
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</tbody>
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**APPROVED BY RESIDENCY PROGRAM DIRECTOR**

| By: ____________________________ | |
| Name: Dr. Heather Conrad Program Director Department of Restorative Sciences Advanced Education Program in Prosthodontics | |
| Date: ____________________________ | |
Dental Resident/Fellow
Benefits Policies and Procedures

STIPENDS
Dental resident/fellow stipends are determined each year. The annual stipend amount will be sent out each year with the Program Residency Agreement. Dental residents/fellows on a sponsored scholarship through a government, military, or other group may not receive a stipend; see the program offer letter for details. Dental residents/fellows will receive a paycheck every other week, see payroll calendar for pay dates. The School of Dentistry receives the paychecks from payroll every other Wednesday. If they are not picked up by the end of Wednesday, then they will be mailed to the dental resident/s or fellow’s home address on file. The resident/fellow may also opt for direct deposit, which is highly encouraged because of the potential for lost/missing or misdirected mailings. The paycheck will be deposited into your account on the morning the paychecks are delivered to the Schools Human Resources Office.

Please be aware that taxes will be deducted from your base salary (annual stipend) as it is considered earned/worked income.

Any tuition, benefits, or University of Minnesota fees will be charged to the student accounts and Residents/Fellows are responsible for paying the balance of those charges by the due date.

For problems, questions, or concerns, please contact your program support person or the Human Resources office at 612-624-8161.

BENEFITS COVERAGE
Currently all dental resident/fellows benefit plans are provided through the Office of Student Health Benefits. Dental residents/fellows are instructed during their benefits orientation how to enroll or opt out of benefits coverage. Having benefits coverage is required in all programs, so proper timely enrollment or opt out procedures and forms must be completed within the first month of the program. All questions regarding benefits plans, options, and procedures should go directly through the Office of Student Health Benefits: 612-624-0627 or 1-800-232-9017, website: http://www.shb.umn.edu/ and email address: umshbo@umn.edu

VACATION/LEAVE
Dental residents/fellows are allowed 10 days of vacation leave per year. Each program may have a different calendar year used for vacation tracking; each program should communicate their vacation calendar to the dental resident/fellow at the start of their program. Each program will determine if they provide additional Professional/Educational leave days for their dental residents/fellows to be used for continuing education, conferences, or for Job interviews. Programs will communicate with their dental residents/fellows at the start of their program if they offer or allow additional Professional/Educational days. The amount of days for this may vary, but will most likely not exceed 3 days per year. Leave must be scheduled at least one month in advance and is on a first come, first served basis. To schedule leave, dental residents/fellows need to contact their program support person (or the program director) with the days they are requesting off. The request will be reviewed and approved/denied by the program director. Parental/medical leave is covered in the sections below.

Please note the following restrictions to leave:

- Because of the clinic/hospital/rotation coverage needed, it may not be possible for more than two dental residents/fellows to be gone at the same time. This includes all potential reasons for absence such as vacation, maternity/paternity leave, educational leave, interviews, and testing dates. Exceptions to this includes: Clinic closure dates, required conferences, or if more than two dental residents/fellows are gone for illness or medical leave.

- Dental residents/fellows may not request or will not be approved leave during certain rotations, exams or evaluation periods, or other specific time periods that are stated by the program. These specific times should be communicated by the program to the dental residents/fellows at the beginning of the academic year each year; exceptions may be made for illness or medical leave.

- The programs recognize the need for dental residents/fellows to schedule interviews for post-residency practice or academic positions. Interview time must be scheduled to create minimal disruption to the dental resident/fellows schedule. Each dental resident/fellow who needs to go for an interview must
make arrangements with their program support person and the residency program director to take time off to interview.

- Leave days do not roll over into the next academic year. The academic year will differ between programs but the first day of the ‘year’ should be the first day of the dental resident/fellow’s appointment. The calendar will use that as the start and end date of the academic year for each program.
- Total number of days off (e.g. vacation, meetings, courses, etc) must be within each Program’s guidelines.
- Any exceptions need approval by the residency program director.

**FAMILY MEDICAL LEAVE ACT (FMLA)**

Dental residents and fellows may be eligible for the Family Medical Leave Act (FMLA) depending on their program length and appointment percent. Dental residents/fellows must check with their program or the School of Dentistry Human Resources office to determine if they qualify. Leave shall not exceed 12 weeks in any 12-month period. The 12-month period is based on a fiscal year (07/01-06/30). The dental resident/fellow may qualify for Short Term and/or Long Term Disability benefits. Please refer to the Office of Student Health Benefits website for Dental Residents: http://www.shb.umn.edu/twincities/residents-fellows-interns/dentistry/index.htm for further information. Programs and the dental residents/fellows are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

**SICK LEAVE**

In the event of illness, the affected dental resident/fellow is personally responsible for notifying the faculty member of the affected clinic(s) and the program director’s office as soon as the dental resident/fellow knows that the illness will cause an absence from clinical responsibilities. Sick leave will be approved only for legitimate illnesses. A physician’s note may be requested to support the dental resident/fellow’s request for sick leave. If the above policy is not followed, the absence will be counted as vacation time. Sick days will be logged by the program director’s office and, if determined to be excessive, will result in loss of vacation days and/or the requirement to make up time at the end of residency training.

**Please note that it is the responsibility of the dental resident/fellow, if scheduled to give lectures, take call, or other duties, to arrange for coverage in the event of illness.**

**PARENTAL LEAVE**

*Policy*

The dental resident/fellow must give notice, in writing, of their intent to use parental leave and other leaves used in conjunction with parental leave to their program director at least four (4) weeks in advance, except under unusual circumstances.

*Birth mother:*

A birth mother shall be granted, upon request to the program director, up to six weeks parental (maternity) leave for the birth of a child. The maternity leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption.

Dental residents/fellows on maternity leave will receive the first two weeks of their leave as paid parental leave. This paid parental may be charged against the dental resident/fellow’s vacation, sick or PTO allocation.

Dental residents/fellows who have vacation available can use this time at the end of the paid two weeks for the child’s birth. Vacation time may also be used in conjunction with short-term disability (if applicable) during their maternity leave. Any time after the two weeks of leave and any vacation time that was approved, unpaid time up to the six weeks of leave may be granted. If more than six weeks is desired for maternity leave, this must be requested/approved/arranged with the program director and the School of Dentistry Human Resources office.

*Birth father:*

A birth father shall be granted, upon request to the program director, up to two weeks paid parental leave for the birth of a child. The leave may begin at the time requested by the dental resident/fellow, but no later
than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption. This paid parental leave may be charged against the dental resident/fellow’s vacation, sick or PTO allocation.

Registered same sex domestic partner:
Registered same sex domestic partner of someone giving birth shall be granted, upon request to the program director, up to two weeks paid parental leave. The leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption. This paid parental leave may be charged against the Residents’ vacation, sick or PTO allocation.

Adoption:
An adoptive parent shall be granted, upon request to the program director, up to two weeks paid parental leave for the adoption of a child. Dental residents/fellows who are registered same sex domestic partners of someone adopting a child shall be granted two weeks paid leave. The leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the adoption and no sooner than two weeks before the adoption. The leave must be consecutive and without interruption. This paid parental leave may be charged against the dental resident/fellow’s vacation, sick or PTO allocation.

Clarification
Holidays that occur during a leave of absence run concurrent with the leave and are not in addition to the leave.

Dental Resident/Fellow’s Next Steps*
*Work with your Program Directors office and the School of Dentistry Human Resources Resident contact

- what type of paperwork needs to be completed;
- if you qualify for Family Medical Leave Act (FMLA) and how it will be managed;
- how your pay will be impacted;
- how your benefits need to be coordinated; and
- if your leave will extend your time in the program.

Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

Programs must forward documentation to the School of Dentistry Human Resources office as well as the Associate Dean for Academic Affairs for leaves that extend the dental resident/fellow’s time in the program.

MEDICAL LEAVE
The dental resident/fellow must give notice, in writing, of intent to use medical leave to their program director at least four (4) weeks in advance, except under unusual circumstances. This leave would count against the dental resident/fellow’s vacation, sick or PTO allocation and any time taken for the leave beyond the amount of vacation/sick/PTO time available will be unpaid time.

A dental resident/fellow shall be granted, upon request to the program director, a leave of absence for their serious illness/injury that requires an absence of greater than 14 days.

Clarification
Holidays that occur during a leave of absence run concurrent with the leave and are not in addition to the leave.

Dental Resident/Fellow’s Next Steps*
*Work with your Program Directors office and the School of Dentistry Human Resources Resident contact

- what type of paperwork needs to be completed;
- if you qualify for Family Medical Leave Act (FMLA) and how it will be managed;
- how your pay will be impacted;
• how your benefits need to be coordinated; and
• if your leave will extend your time in the program.

Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that specialty board requirements are met prior to graduation from the program.

PERSONAL LEAVE
The dental resident/fellow must give notice, in writing, of intent to use personal leave to their program director at least four (4) weeks in advance, except under unusual circumstances. A dental resident/fellow may be granted, upon request to the program director, a personal leave of absence. This leave would count against the dental resident/fellow's vacation, sick or PTO allocation and any time taken for the leave beyond the amount of vacation/sick/PTO time available will be unpaid time.

Dental Resident/Fellow’s Next Steps*
* Partner with your program director support person and the School of Dentistry Human Resources office
  • what type of paperwork needs to be completed;
  • how your pay will be impacted;
  • how your benefits need to be coordinated; and
  • if your leave will extend your time in the program.

Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

COVERAGE OF RESPONSIBILITIES WHEN ABSENT
Although dental residents/fellows are assigned to one clinic/hospital site at a given time, in some programs dental residents/fellows may be pulled from one site to cover another when the necessity arises. In the event of prolonged absences (LOA, medical leave, etc.), the chief resident (if applicable), program director and program support person are responsible for rotations and should work out a coverage schedule between locations.

WORKERS COMPENSATION BENEFITS
When a dental resident/fellow is injured during the program, the dental resident/fellow MUST take immediate steps to report the injury to the University. If this process is not followed, workers compensation benefits could be denied or delayed. YOU MUST COMPLETE THE UNIVERSITY OF MINNESOTA WORKERS COMPENSATION EMPLOYEE INCIDENT REPORT; IT DOES NOT MATTER WHERE YOU WERE INJURED (OTHER SITES), THE U OF M FORM NEEDS TO BE COMPLETED! The policy and procedure on how to complete these forms is located: http://www.policy.umn.edu/Policies/hr/Benefits/WORKERSCOMP.html. The forms can now be completed online or can be printed out and completed. Please note and document the claim # in case an issue occurs. Please work with your program director or program support person to complete this process. If you receive a bill for the injury, please work with you program support person or the School of Dentistry HR department to help resolve the issue.

EFFECT OF LEAVE OF ABSENCE ON PROGRAM COMPLETION
In addition to the policy regarding Family and Medical Leave, the program must follow guidelines to meet required program standards and other requirements to ensure all aspects of the program are completed prior to graduation and obtaining the Certificate or Master’s Degree for program.

It is the responsibility of the department, program, and dental resident/fellow to be in compliance with the program Requirements concerning the effect of leaves of absence on satisfying the criteria for completion of the training program prior to granting leave.

The various Dental Board requirements should be reviewed by the program director and dental resident or fellow to assure that the dental resident/fellow is familiar with the possibility of having to make up time away from training. If an extended leave results in the requirement for additional training in order to satisfy program requirements, financial support for the additional training time must be determined when
arrangements are made for the leave and the makeup activity. Any leave that is more than 14 days in duration will most likely result in an extension of the program in order to fulfill all program requirements.
Policies printed in this handbook should be cross-referenced with the most current policies published on the School’s website. Any changes to policies will become effective immediately after they are sent to students’ University email accounts.
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MISSION STATEMENTS OF THE UNIVERSITY OF MINNESOTA AND THE SCHOOL OF DENTISTRY

UNIVERSITY MISSION STATEMENT

The University of Minnesota, founded in the belief that all people are enriched by understanding, is dedicated to the advancement of learning and the search for truth; to the sharing of this knowledge through education for a diverse community; and to the application of this knowledge to benefit the people of the state, the nation, and the world. The University's mission, carried out on multiple campuses and throughout the state, is threefold:

- **Research and Discovery**
  Generate and preserve knowledge, understanding, and creativity by conducting high-quality research, scholarship, and artistic activity that benefit students, scholars, and communities across the state, the nation, and the world.

- **Teaching and Learning**
  Share that knowledge, understanding, and creativity by providing a broad range of educational programs in a strong and diverse community of learners and teachers, and prepare graduate, professional, and undergraduate students, as well as non-degree seeking students interested in continuing education and lifelong learning, for active roles in a multiracial and multicultural world.

- **Outreach and Public Service**
  Extend, apply, and exchange knowledge between the University and society by applying scholarly expertise to community problems, by helping organizations and individuals respond to their changing environments, and by making the knowledge and resources created and preserved at the University accessible to the citizens of the state, the nation, and the world.

In all of its activities, the University strives to sustain an open exchange of ideas in an environment that embodies the values of academic freedom, responsibility, integrity, and cooperation; that provides an atmosphere of mutual respect, free from racism, sexism, and other forms of prejudice and intolerance; that assists individuals, institutions, and communities in responding to a continuously changing world; that is conscious of and responsive to the needs of the many communities it is committed to serving; that creates and supports partnerships within the university, with other educational systems and institutions, and with communities to achieve common goals; and that inspires, sets high expectations for, and empowers the individuals within its community.

http://www1.umn.edu/twincities/history-mission/index.html

SCHOOL OF DENTISTRY MISSION STATEMENT

The University of Minnesota, School of Dentistry improves oral and craniofacial health by educating clinicians and scientists who translate knowledge and experience into clinical practice.

The School is committed to:

- Graduating professionals who provide the highest quality care and service to the people of the state of Minnesota and the world;
- Discovering new knowledge through research, which will inspire innovation in the biomedical, behavioral and clinical sciences; and
- Providing oral health care to a diverse patient population in a variety of settings.

http://www.dentistry.umn.edu/about/our_leadership/mission/home.html
ADDITIONAL RESOURCES

Further direction within the profession, the School of Dentistry, and the University of Minnesota is provided in the most recent versions of these publications:

- ADA Principles of Ethics and Code of Professional Conduct
- Minnesota Dental Practice Act
- ADHA Code of Ethics
- University of Minnesota Board of Regents Student Conduct Code
- Academic Code of Conduct, University of Minnesota School of Dentistry
- Standards of Professional Conduct, University of Minnesota School of Dentistry

COMMISSION ON DENTAL ACCREDITATION

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling staff at 1-800-621-8099 extension 4653.

Updated 06/11

SCHOOL OF DENTISTRY CONTACTS

The School of Dentistry provides student support that enhances the success of its students. Student performance is monitored and additional academic assistance given through tutoring, seminars, and consultation for those in need.

For academic assistance and referral to support programs consult with:

Sara N. Johnson, MA  Bashar Bakdash, DDS, MPH, MSD
Director, Student Affairs  Interim Associate Dean for Academic Affairs
15-106 Moos Tower  15-238 Moos Tower
612-624-6960  612-626-5751
john6461@umn.edu  bakda001@umn.edu

Darryl Hamamoto, DDS, PhD  Jane Schwensohn
Associate Dean for Advanced and  Executive Administrative Specialist
Graduate Education  7-194 Moos Tower
15-116B Moos Tower  612-626-5453
612-624-3944  schwe008@umn.edu
hamam001@umn.edu

Updated 09/12
POLICY REGARDING EMAIL

Email is the University's and the School of Dentistry's official means of communication with students. Students are responsible for all information sent via their University email account. Students who forward their University email accounts to another email account are still responsible for all information, including attachments, sent to the account. Students are required to check their University email account daily. Communication from School of Dentistry’s officials cannot be sent to any email address other than the official University email address.

MENTAL HEALTH RESOURCES

Students may experience a range of issues that can cause barriers to learning, such as strained relationships, increased anxiety, alcohol/drug problems, feeling down, difficulty concentrating and/or lack of motivation. These mental health concerns or stressful events may lead to diminished academic performance or reduced ability to participate in daily activities. University of Minnesota services are available to assist with addressing these and other concerns. Students can learn more about the broad range of confidential mental health services available on campus via www.mentalhealth.umn.edu

Students in the School of Dentistry are also eligible for the Minnesota Dental Association sponsored Dentist Wellness Program, a professional and confidential problem-solving resource provided at no cost to the participant. The Dentist Wellness Program can be accessed by calling the Sand Creek Group, Ltd. at (800) 632-7643. In addition, students concerned about their relationship with alcohol or other drugs can contact Dentist Concerned for Dentists (DCD), a confidential support group made up of dentists from around the state who have experienced substance abuse/dependency problems in their own lives and who now serve others as confidential supporters and resources for recovery. DCD can be reached by calling (651) 275-0313.

PROFESSIONAL ATTIRE AND GUIDE FOR PERSONAL APPEARANCE

The personal appearance and demeanor of every person affects, either directly or indirectly, the care and management of patients. The image communicated to patients through personal attire and appearance, behaviors and interactions will influence their perceptions of the quality of care they will receive at the University of Minnesota, School of Dentistry and their confidence in the person providing that care. A presentation of professionalism is essential to uphold the standards of excellence set by the University of Minnesota, the School of Dentistry, and the dental profession.

Dentists, in their own practices, will decide for themselves what appearance promotes a demeanor of professionalism. Throughout the School of Dentistry this is best accomplished by a reasonable degree of conformity in attire and grooming.

All faculty, staff and students are responsible for maintaining a clean, neat and well-fitting wardrobe.
The policies in this section are currently under review for approval by appropriate bodies. Status of this approval can be determined by the online version of these policies. Students will be notified through email as soon as new policies are approved. Any changes to policies will become effective immediately after they are forwarded to students’ University email accounts. The most current policies are published on the School’s website.
UNIVERSITY OF MINNESOTA
BOARD OF REGENTS POLICY
STUDENT CONDUCT CODE

Adopted: July 10, 1970 Amended: December 13, 1974; March 11, 1994; June 13, 2003; December 8, 2006 Supersedes: (see end of policy)

STUDENT CONDUCT CODE

SECTION I. SCOPE.

This policy applies to all students and student organizations at the University of Minnesota (University).

SECTION II. JURISDICTION.

The Student Conduct Code (Code) shall apply to student conduct that occurs on University premises or at University-sponsored activities. At the discretion of the president or delegate, the Code also shall apply to off-campus student conduct when the conduct, as alleged, adversely affects a substantial University interest and either:

(a) constitutes a criminal offense as defined by state or federal law, regardless of the existence or outcome of any criminal proceeding; or

(b) indicates that the student may present a danger or threat to the health or safety of the student or others.

SECTION III. GUIDING PRINCIPLES.

(a) The University seeks an environment that promotes academic achievement and integrity, that is protective of free inquiry, and that serves the educational mission of the University.

(b) The University seeks a community that is free from violence, threats, and intimidation; that is respectful of the rights, opportunities, and welfare of students, faculty, staff, and guests of the University; and that does not threaten the physical or mental health or safety of members of the University community.

(c) The University is dedicated to responsible stewardship of its resources and to protecting its property and resources from theft, damage, destruction, or misuse.

(d) The University supports and is guided by state and federal law while also setting its own standards of conduct for its academic community.

(e) The University is dedicated to the rational and orderly resolution of conflict.
SECTION IV. THE RESPONSIBILITIES OF DUAL MEMBERSHIP.

Students are both members of the University community and citizens of the state. As citizens, students are responsible to the community of which they are a part, and, as students, they are responsible to the academic community of the University. By enforcing its Code, the University neither substitutes for nor interferes with other civil or criminal legal processes. When a student is charged in both jurisdictions, the University will decide on the basis of its interests, the interests of affected students, and the interests of the community whether to proceed with its disciplinary process or to defer action. Determinations made or sanctions imposed under the Code will not be subject to change because criminal charges arising out of the same facts were dismissed, reduced, or resolved in favor of the criminal law defendant.

SECTION V. DISCIPLINARY OFFENSES.

Any student or student organization found to have committed or to have attempted to commit the following misconduct is subject to appropriate disciplinary action under this policy:

Subd. 1. Scholastic Dishonesty. Scholastic dishonesty means plagiarizing; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; altering, forging, or misusing a University academic record; or fabricating or falsifying data, research procedures, or data analysis.

Subd. 2. Disruptive Classroom Conduct. Disruptive classroom conduct means engaging in behavior that substantially or repeatedly interrupts either the instructor's ability to teach or student learning. The classroom extends to any setting where a student is engaged in work toward academic credit or satisfaction of program-based requirements or related activities.

Subd. 3. Falsification. Falsification means willfully providing University offices or officials with false, misleading, or incomplete information; forging or altering without proper authorization official University records or documents or conspiring with or inducing others to forge or alter without proper authorization University records or documents; misusing, altering, forging, falsifying, or transferring to another person University-issued identification; or intentionally making a false report of a bomb, fire, natural disaster, or other emergency to a University official or an emergency service agency.

Subd. 4. Refusal to Identify and Comply. Refusal to identify and comply means willfully refusing to or falsely identifying one's self or willfully failing to comply with a proper order or summons when requested by an authorized University official.

Subd. 5. Attempts to Injure or Defraud. Attempts to injure or defraud means making, forging, printing, reproducing, copying, or altering any record, document, writing, or identification used or maintained by the University when done with intent to injure, defraud, or misinform.

Subd. 6. Threatening, Harassing, or Assaulitive Conduct. Threatening, harassing, or assaulitive conduct means engaging in conduct that endangers or threatens to endanger the health, safety, or welfare of another person, including, but not limited to, threatening, harassing, or assaulitive behavior.

Subd. 7. Disorderly Conduct. Disorderly conduct means engaging in conduct that incites or threatens to incite an assault or breach of the peace; breaching the peace; obstructing or disrupting teaching, research, administrative, or public service functions; or obstructing or disrupting disciplinary procedures or authorized University activities.

Subd. 8. Illegal or Unauthorized Possession or Use of Weapons. Illegal or unauthorized possession or
use of weapons means possessing or using weapons or articles or substances usable as weapons, including, but not limited to, firearms, incendiary devices, explosives, and dangerous biological or chemical agents, except in those instances when authorized by law and, where applicable, by proper University authority.

Subd. 9. Illegal or Unauthorized Possession or Use of Drugs or Alcohol. Illegal or unauthorized possession or use of drugs or alcohol means possessing or using drugs or alcohol illegally or, where applicable, without proper University authorization.

Subd. 10. Unauthorized Use of University Facilities and Services. Unauthorized use of University facilities and services means wrongfully using University properties or facilities; misusing, altering, or damaging fire-fighting equipment, safety devices, or other emergency equipment or interfering with the performance of those specifically charged to carry out emergency services; or acting to obtain fraudulently—through deceit, unauthorized procedures, bad checks, or misrepresentation—goods, quarters, services, or funds from University departments or student organizations or individuals acting in their behalf.

Subd. 11. Theft, Property Damage, and Vandalism. Theft, property damage, and vandalism include theft or embezzlement of, damage to, destruction of, unauthorized possession of, or wrongful sale or gift of property.

Subd. 12. Unauthorized Access. Unauthorized access means accessing without authorization University property, facilities, services, or information systems, or obtaining or providing to another person the means of such unauthorized access, including, but not limited to, using or providing without authorization keys, access cards, or access codes.

Subd. 13. Disruptive Behavior. Disruptive behavior means willfully disrupting University events; participating in a campus demonstration that disrupts the normal operations of the University and infringes on the rights of other individuals; leading or inciting others to disrupt scheduled or normal activities of the University; engaging in intentional obstruction that interferes with freedom of movement, either pedestrian or vehicular, on campus; using sound amplification equipment on campus without authorization; or making or causing noise, regardless of the means, that disturbs authorized University activities or functions.

Subd. 14. Hazing. Hazing means any act taken on University property or in connection with any University-related group or activity that endangers the mental or physical health or safety of an individual (including, without limitation, an act intended to cause personal degradation or humiliation), or that destroys or removes public or private property, for the purpose of initiation in, admission to, affiliation with, or as a condition for continued membership in a group or organization.

Subd. 15. Rioting. Rioting means engaging in, or inciting others to engage in, harmful or destructive behavior in the context of an assembly of persons disturbing the peace on campus, in areas proximate to campus, or in any location when the riot occurs in connection with, or in response to, a University-sponsored event. Rioting includes, but is not limited to, such conduct as using or threatening violence to others, damaging or destroying property, impeding or impairing fire or other emergency services, or refusing the direction of an authorized person.

Subd. 16. Violation of University Rules. Violation of University rules means engaging in conduct that violates University, collegiate, or departmental regulations that have been posted or publicized, including provisions contained in University contracts with students.

Subd. 17. Violation of Federal or State Laws. Violation of federal or state laws means engaging in conduct that violates a federal or state law, including, but not limited to, laws governing alcoholic beverages, drugs, gambling, sex offenses, indecent conduct, or arson.

Subd. 18. Persistent Violations. Persistent violations means engaging in repeated conduct or action in
violation of this Code.

SECTION VI. SANCTIONS.

The following sanctions may be imposed upon students or student organizations found to have violated the Code:

Subd. 1. Warning. A warning means the issuance of an oral or written warning or reprimand.

Subd. 2. Probation. Probation means special status with conditions imposed for a defined period of time and includes the probability of more severe disciplinary sanctions if the student is found to violate any institutional regulation during the probationary period.

Subd. 3. Required Compliance. Required compliance means satisfying University requirements, work assignments, community service, or other discretionary assignments.

Subd. 4. Confiscation. Confiscation means confiscation of goods used or possessed in violation of University regulations or confiscation of falsified identification or identification wrongly used.

Subd. 5. Restitution. Restitution means making compensation for loss, injury, or damage.

Subd. 6. Restriction of Privileges. Restriction of privileges means the denial or restriction of specified privileges, including, but not limited to, access to an official transcript for a defined period of time.

Subd. 7. University Housing Suspension. University housing suspension means separation of the student from University Housing for a defined period of time.

Subd. 8. University Housing Expulsion. University housing expulsion means permanent separation of the student from University housing.

Subd. 9. Suspension. Suspension means separation of the student from the University for a defined period of time, after which the student is eligible to return to the University. Suspension may include conditions for readmission.

Subd. 10. Expulsion. Expulsion means the permanent separation of the student from the University.

Subd. 11. Withholding of Diploma or Degree. Withholding of diploma or degree means the withholding of diploma or degree otherwise earned for a defined period of time or until the completion of assigned sanctions.

Subd. 12. Revocation of Admission or Degree. Revocation of admission or degree means revoking a student's admission to the University or revoking a degree already awarded by the University.
SECTION VII. INTERIM SUSPENSION.

The president or delegate may impose an immediate suspension on a student or student organization pending a hearing before the appropriate disciplinary committee (1) to ensure the safety and well-being of members of the University community or to preserve University property, (2) to ensure the student's own physical or emotional safety and well-being, or (3) if the student or student organization poses an ongoing threat of disrupting or interfering with the operations of the University. During the interim suspension, the student or student organization may be denied access to all University activities or privileges for which the student or student organization might otherwise be eligible, including access to University housing or property. The student or student organization has a right to a prompt hearing before the president or delegate on the questions of identification and whether the interim suspension should remain in effect until the full hearing is completed.

SECTION VIII. HEARING AND APPEALS OF STUDENT DISCIPLINE.

Any student or student organization charged with violation of the Code shall have the opportunity to receive a fair hearing and access to a campus-wide appeal. To safeguard the rights of students and student organizations, the president or delegate shall ensure that each campus has an appeals procedure to govern alleged violations of this policy. The appeals procedure shall provide both substantive and procedural fairness for the student or student organization alleged to have violated the Code and shall provide for resolution of cases within a reasonable period of time.

The appeals procedure must describe:

(a) grounds for an appeal;

(b) procedures for filing an appeal; and

(c) the nature of an appellate review.

SECTION IX. DELEGATION OF AUTHORITY.

The president or delegate shall implement this policy, including publishing and distributing the Code and the procedures governing the student disciplinary process at the University.


http://www1.umn.edu/regents/policies/academic/Student_Conduct_Code.html
SCHOOL OF DENTISTRY CODE OF CONDUCT

I. CODE OF CONDUCT

Students preparing for entry into the dental profession are expected to govern their conduct toward patients, other students, faculty, and other professionals with integrity, mutual respect, and honor. This Code of Conduct for the School of Dentistry is based on the following guidelines:

A. Students must treat patients with the realization that the health and welfare of the patients are paramount, and the students must respect the dignity and feelings of their patients in working with them.

B. It is axiomatic that students be honest in didactic and laboratory assignments, examinations, attendance sheets, use of equipment and supplies, entries in patient records and pre-clinical and clinical grade records, and in all aspects of treating patients.

C. Students must conduct themselves in a mature, courteous, and professional manner in lecture classes, clinics, and laboratories, and in other areas of the School of Dentistry and associated teaching environments.

D. Students must not display or participate in threatening, harassing or assaultive behavior or behavior that can reasonably be perceived by others as threatening, harassing or assaultive behavior. Threatening, harassing, or assaultive conduct means engaging in conduct that endangers or threatens to endanger the health, safety, or of physical or emotional welfare of another person or group.

II. INFRACTIONS OF THE CODE OF CONDUCT

Each student recognizes any academic misconduct is unacceptable behavior for students in a professional school and is a violation of the Code. “Academic misconduct” is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts, and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk. These acts may include but are not limited to:

A. Cheating, or assisting another student to cheat, on written examinations, assignments or practical examinations.

B. Plagiarism: presenting the scholarly work of another as one’s own.

C. Misrepresenting someone else’s project or clinical work as one’s own.

D. Falsifying or Forging or attempts to forge or falsify patient records and charts, classroom attendance, or student pre-clinical and clinical records.

1 “Students” in this document includes students enrolled in any program directed by the School of Dentistry. These include dental, dental hygiene, and dental therapy students as well as postgraduate certificate and advanced degree-granting programs.
E. **Abuse of Equipment** and wasting supplies, including the use of School of Dentistry equipment and supplies for non-school purposes.

F. **Disruptive Behavior** in lecture halls, clinics, or laboratories.

G. **Dishonesty** in any form including but not limited to the presentation of patient fees and collection of these fees.

H. **Patient Mismanagement or Misconduct** such as starting treatment without a starting check, working without supervision, verbal or sexual harassment, physical abuse, or abandonment.

(http://www1.umn.edu/regents/policies/academic/Student_Conduct_Code.html)

I. **Unethical Behavior** such as treating patients while under the influence of alcohol and/or illicit drugs and over-treatment of patients.

Additional non-academic disciplinary offenses actionable by the University and the procedures to be followed are stated in the University of Minnesota Student Conduct Code at http://www1.umn.edu/regents/policies/academic/Student_Conduct_Code.html

III. PROCEDURES FOR DISPOSITION OF ALLEGED VIOLATIONS OF CODE OF CONDUCT

A. Reporting of Alleged Violations

When a faculty member, course director, staff member or student has reason to believe that a violation of the Code of Conduct has been committed, that individual must provide written notification to the School of Dentistry’s Code of Conduct Officer. The Code of Conduct Officer reviews the allegation and determines if a resolution should be attempted without a hearing or if the alleged violation requires a hearing.

All records of allegations and investigation are retained in the Office of Academic Affairs.

B. Accused Student Rights

During the interview with the Code of Conduct Officer, the accused student(s) is informed in writing of the nature of the complaint against him/her and his/her rights. These accused student(s) rights include the following:

1. To be informed in writing during the meeting with the Code of Conduct Officer of the nature of the complaint against him/her and the specific provisions(s) of the Code of Conduct allegedly violated.

2. To work with an individual (faculty member, student, representative from the University Conflict Resolution Center, attorney, etc.) who can act as an advocate for the accused student(s) throughout the complaint process.

3. To be able to present his/her case personally or with the assistance of an advocate (refer to Section B, subtext 2).

4. To be able to hear and examine all evidence and testimony against him/her.

5. To have all information related to the complaint kept confidential by those bringing the complaint and by all parties involved in the hearing and disposition of the complaint.

6. To be notified in writing of the recommendation for the disposition of the complaint.
7. To have a written record of the case kept in the accused student(s’) file in the Office of Academic Affairs.

8. To appeal for sufficient cause his/her case to the University Provost’s Appeal Committee.

C. School of Dentistry’s Code of Conduct Officer

A regular faculty member, appointed by the Dean, and not in the administrative branch of the School of Dentistry, serves as the School’s Code of Conduct Officer for a minimum 3 year term and is eligible for reappointment. He/she

1. Receives the written report of an alleged violation.

2. Insures that the complainant(s) and the accused student(s) are made aware of the process and procedures that are followed in dealing with an alleged violation.

3. Insures that the accused is made aware of the allegations against him/her and informed of his/her rights in the hearing and appeals process.

4. May refer the accused student(s) and complainant(s) to resources for counsel and advice.

5. Attempts a resolution without a hearing following the procedures described in Section H, subtext 1 when the alleged violation does not require a hearing.

6. Refers the case to a Hearing Board when attempts to resolve the allegation in an informal manner are unsuccessful or the type of alleged violation requires a hearing. Procedures describing the formation of a Hearing Board are described in Section H, subtext 2.

7. May, in consultation with the Dean of the School of Dentistry, refer the case to the Office for Student Conduct and Academic Integrity for resolution within the University-wide disciplinary system instead of pursuing resolution within the School.

8. Does not participate in the proceedings of the Hearing Board.

9. Meets annually with faculty and each class to discuss the School’s Code of Conduct and the procedures followed to investigate an alleged violation.

10. Makes an annual report to the Dean, Associate/Assistant Deans, Department Directors and Division Directors summarizing activities related to violations of the School’s Code of Conduct.

If the Code of Conduct Officer is involved in an alleged violation, an interim Code of Conduct Officer is appointed by the Dean.

D. Director of Student Affairs

1. The Director may assist the accused student(s) in identifying resources related to resolution of the allegation; interpreting policy; and assessing additional need for resources.

2. The Director does NOT make judgments on the complaint nor act as an advocate for the accused student(s) during the complaint process.

E. Dental Therapy and Dental Hygiene Division Directors and Course Directors
1. All written reports of alleged violations are reviewed by the Code of Conduct Officer. The Officer consults the Dental Hygiene Division Director or Dental Therapy Division Director during an attempt to informally resolve an alleged violation when the alleged violation does not require a hearing and the accused is from one of these divisions. The Officer also consults the respective course director, if applicable, during an attempt to informally resolve an alleged violation when the alleged violation does not require a hearing.

2. The division director and the course director do not participate in the hearing unless called as a witness.

F. Advocate for Accused Student(s)

1. The advocate for the accused student(s) may act on behalf of the student(s) during the complaint process. The advocate may assist the accused student(s) in the informal resolution process if the Code of Conduct Officer determines informal resolution should be attempted. The advocate may represent the accused student(s) before the Hearing Board, including presenting witnesses and evidence on the accused student(s’) behalf and questioning the complainant(s) and complainant(s’) witnesses.

G. School Presenter

1. A member of the faculty or administrative staff of the School of Dentistry is appointed by the Dean to represent the school when the case is referred to a School of Dentistry Hearing Board. The Dean may appoint an individual for a specific case or may appoint this person for a specified time period (one year, etc.).

2. The School Presenter reviews the evidence against the accused student(s), interviews the complainant(s), determines the proposed witness list for the hearing in support of the complaint and acts as a resource and advocate for the complainant(s).

3. The School Presenter presents the evidence to the Hearing Board, calls approved witnesses and is allowed to question the accused student(s), all witnesses presented and the complainant(s) during the hearing.

4. If the accused is represented by an attorney during the hearing, the school presenter is replaced by an attorney from the Office of the General Counsel.

H. Resolution of Alleged Violations

Resolution of an alleged violation may occur through an informal person-to-person manner as described in the following Section H, subtext 1, or through a more formal Hearing Board as described in Section H, subtext 2.

There are some alleged violations that, because of their seriousness, automatically require a hearing if the Code of Conduct Officer determines that there is adequate supporting evidence. The informal person-to-person attempt at resolution described in subtext (1) below is not used for these alleged violations. These violations include cheating; plagiarism; misrepresenting someone else’s project or clinical work as one’s own; falsifying or forging records, charts or attendance, pre-clinical or clinical records; dishonesty; patient mismanagement; sexual harassment of patients, faculty, staff or other students; threatening or harassing conduct toward others; impairment while providing patient care.

1. Resolution without a hearing

   a. The Code of Conduct Officer meets separately with the complainant(s) and the accused student(s) to describe the policies and procedures to be followed in attempting to resolve the accusation. The accused is presented with a clear
b. The Code of Conduct Officer meets with the accused student(s), complainant(s), the course director and appropriate faculty, staff or students to investigate the issue and see if the meetings can result in an acceptable solution. These meetings are conducted separately or together, at the discretion of the Code of Conduct Officer.

c. Upon conclusion of the meetings, if there is adequate evidence to find the accused student(s) guilty of the allegation, the accused student(s) receive written notification of this finding and a proposed sanction. If the accused student(s) accepts the finding of guilt and the sanction, or fails to appeal, the sanction is enforced and a report of the violation filed in the accused student(s’) record. The Associate Dean of Academic Affairs and, if applicable, the course director are informed of the decision. If the accused student(s) wishes to challenge the guilty finding or sanction, she/he has ten working days to file a written appeal to the Code of Conduct Officer or the sanction is enforced.

d. If the Code of Conduct Officer is unable to resolve the dispute or the accused student(s) does not accept the proposed sanction, the case is referred to a Hearing Board following the procedures described in Section H, subtext 2.

2. Resolution with a Hearing

a. The Hearing Board evaluates evidence about the alleged violations of the code. The Hearing Board hears testimony from the parties and witnesses and receives written evidence. The Hearing Board endeavors to handle every alleged violation as justly and fairly as possible, to consider each case on its individual merits and to adjust each sanction to the nature and extent of the violation. After hearing all evidence and testimony, the Hearing Board votes to determine the outcome. If the Hearing Board finds a violation occurred, the board determines a sanction.

b. Membership and Officers of the Hearing Board

i. Hearing Board Officer

a. Hearing Board members elect one of the faculty members to serve as Chairperson. The Chairperson is a non-voting member of the Hearing Board except in the case of a tie at which time he/she may cast the tie-breaking vote.

ii. The Hearing Board has at least five members with 2 students enrolled in the doctor of dental surgery, dental hygiene or dental therapy programs and 3 or more faculty persons with faculty appointments in these programs.

a. Student members of the Hearing Board are selected from the School’s Student Affairs Committee with at least one being enrolled in the same program as the accused. If from the same program, student members are in a different year of the program than the accused whenever possible.

b. Faculty members of the Hearing Board are selected from the School’s Student Affairs Committee by its Committee Chair. Faculty members of the Hearing Board must not be party to or witness the alleged violation.
c. Either party to the complaint is given the right to challenge, with cause, seated members of the Hearing Board. The Chairperson rules on the merits of the challenge and decides whether or not the member(s) should be recused.

d. In the case of an accused advanced education or graduate student, an ad hoc committee composed of at least one advanced education or graduate student and two postgraduate faculty who serve as voting members. The Chair of the Advanced Education Committee selects these committee members.

e. The Associate Dean for Academic Affairs or his/her alternate as appointed by the Dean attends the hearing in a non-voting observer capacity and does not participate in the hearing unless called as a witness. The Associate Dean for Academic Affairs or his/her alternate does not make judgments on the complaint nor act as an advocate for the accused student(s) during the complaint process.

c. Meetings of the Hearing Board

i. The Chairperson gives written notification to the complainant(s) and the accused informing them of the following:

a. The charge filed and by whom it was filed.

b. The time, date and place of the hearing.

c. The hearing agenda.

d. Their right to be accompanied by an advocate. If the accused is represented by an attorney, an attorney provided by the School of Dentistry through the Office of the General Counsel presents the case against the accused. The accused must notify the Chairperson well in advance of the hearing if represented by an attorney.

e. Their right to call witnesses and the procedure used to call them.

f. The range of sanctions available to the Hearing Board.

g. The procedure for an appeal, if guilt is determined.

h. The right to challenge for cause seated members of the Hearing Board.

i. Any other information deemed relevant and necessary by the Hearing Board Chairperson.

ii. A preliminary plea of either “guilty” or “not guilty” is obtained by the Chairperson from the accused prior to the actual hearing. If the plea is guilty, the Hearing Board meets to receive this plea and decide the sanction. Witnesses may be called by either party to give testimony bearing upon the appropriate sanction.

iii. The Hearing Board Chairperson requires the parties to identify their witnesses and written evidence before the hearing and to provide this information to each other and the Hearing Board by a set date. The witness lists includes a brief explanation of the purpose of each
witness’ testimony. The Chair can limit the number of witnesses to avoid redundant testimony and can exclude written evidence deemed irrelevant or inappropriate.

iv. Meeting Procedures

a. The hearing to investigate an alleged violation of the School’s Code of Conduct is not a legal trial and not subject to all the formalities and processes followed in a court of law. The purpose of the hearing is to fairly and objectively determine if a violation occurred. All participants in the hearing are expected to keep the hearing procedures confidential and to treat each other with respect. Information regarding hearings, names of complainant(s), witnesses, and the accused, and the proceedings of the Hearing Board are strictly confidential.

b. Quorum and Voting Procedures

i. Five voting members of the Hearing Board constitutes a quorum. A quorum must be in the hearing room during the hearing.

ii. Questions are decided by a simple majority of the voting members present.

iii. The Chairperson of the Hearing Board casts the deciding vote if the initial vote by committee members results in a tie.

iv. All procedural decisions of the Chairperson may be changed by a majority vote of the Hearing Board members.

v. A formal record of the hearing is taken for appellate purposes by use of a tape recorder provided by the Hearing Board.

vi. A violation of the code occurs if a majority of the Hearing Board members find that the evidence and testimony meet the standard of “more likely than not” that a violation did occur.

vii. If the verdict is guilty, the Hearing Board determines the sanction according to the options identified in Section IV of this Code.

viii. After a decision has been reached, written notification is delivered to the accused and the Associate Dean for Academic Affairs promptly. This notification includes information on procedures for appeal. The course director is also be informed of the decision, if appropriate.

ix. The Associate Dean for Academic Affairs has the responsibility for carrying out the sanction determined by the Hearing Board. Except for grade changes, penalties are not imposed until after the appeal period expires or the appeal is concluded.

c. The Hearing Board conducts its meeting using the following agenda:
i. The charges are read by the Chairperson.

ii. The Chairperson asks for a plea from the accused.

iii. The accused enters his or her plea. If no plea is entered the proceedings continue as if a plea of “not guilty” had been entered.

iv. The Chairperson may recess the proceedings whenever deemed necessary or appropriate.

v. The complainant(s) may request a withdrawal of the charges at any time during the proceedings.

vi. The Chairperson calls the hearing to order and the hearing proceeds in the following order:
   a. The school presenter gives an opening statement and summarizes the evidence against the accused student(s).
   b. The accused student(s) or his/her advocate gives an opening statement summarizing the evidence in support of the accused.
   c. The school presenter calls his/her approved witnesses including the complainant(s).
   d. The accused or his/her advocate may question each of these witnesses and the complainant(s), followed by questions from the Hearing Board members.
   e. The accused or his/her advocate calls his/her approved witnesses. The advocate may also call the accused.
   f. The School Presenter may question each of these witnesses and the accused student(s), followed by questions from members of the Hearing Board.
   g. At the discretion of the Hearing Board, closing statements may be allowed. If so, the school presenter goes first with the accused student or his/her advocate giving the final closing statement.

The Hearing Board deliberates in closed session.

IV. POSSIBLE SANCTIONS FOR VIOLATIONS OF THE CODE OF CONDUCT

A. In arriving at the decision of what sanction to impose for a violation of the Academic Code of Conduct, each case shall be determined on its own individual merits, taking into consideration the nature of the infraction and the previous documented history of the student’s conduct in the School of Dentistry. After the appropriate consideration has been given to a case of violation of conduct, the following are possible sanctions that may be imposed. This list is intended as a guideline and does not preclude the imposition of other possible sanctions.

1. A verbal or written censure.
2. Assigning additional studies and/or reports for violations related to classroom or clinical work.
3. Lowering of a grade in a course in which a violation occurred.
4. Assigning an F grade for the course in which a violation occurred. If an F grade is given, the decision must be made whether the F grade can be resolved through additional studies and retaking a final examination, for example, or whether the course must be retaken the next time it is offered.
5. Disciplinary probation without the loss of class participation such as in lectures, laboratories, and clinics.
6. Disciplinary probation with the loss of class participation for a specified period of time, such as in lectures, laboratories, and clinics.
7. Suspension from the School of Dentistry for a specified period of time.
8. Deferring graduation and requiring an additional term or terms of attendance.
9. Expulsion from the School of Dentistry. This could be a permanent expulsion or expulsion for a period, such as a year, and could include certain rehabilitative functions mandated to take place in the interim.

V. APPEAL PROCESS

In the event the charged student is unwilling to accept the Hearing Board’s decision, the student may appeal to the Provost’s Appeal Committee as outlined in the Board of Regents Policy: Student Conduct Code. The written appeal must be filed within ten (10) week days of receipt of the decision by the charged student. The appeal should state the grounds on which the student believes the original hearing body clearly erred and offer preliminary arguments as to the support of the student’s claims according to the criteria specified below:

A. The decision was made without benefit of relevant evidence being available at the time of the initial hearing. If this ground is favorably reviewed, the case will be returned to the original body for presentation of new evidence.

B. The hearing was procedurally unfair, in that:
   1. The voting member(s) of the original body had bias or preformed judgment against the appealing party, an objection to which was not permitted at the original hearing or was permitted and was not honored by the hearing body.
   2. The original hearing deviated in a substantial way from its established hearing procedures.
   3. During the original hearing, an established student right under University policy was violated.

C. The decision was made contrary to the weight of the evidence.

D. The sanction was clearly inconsistent with the severity of the alleged violation of the Academic Code of Conduct.

02/11 Approved by the School of Dentistry Student Affairs Committee
SCHOOL OF DENTISTRY STANDARDS OF PROFESSIONAL CONDUCT

The University of Minnesota and the School of Dentistry are committed to the highest standards of professional conduct and integrity. The values we hold among ourselves to be essential to responsible professional behavior include honesty, trustworthiness, respect and fairness in dealing with other people, a sense of responsibility toward others and loyalty toward the ethical principles espoused by the University and the School of Dentistry. It is important that these values and the tradition of ethical behavior be consistently demonstrated and carefully maintained.

Members of the University community and the School of Dentistry have the obligation to respect and to be fair to faculty, staff, students, and patients, and to foster their intellectual and professional growth and well-being. Members must not engage in, nor permit, harassment, offensive behavior, or illegal discrimination. Members must not abuse the authority they have been given and care must be taken to ensure that any personal relationships do not result in situations that might interfere with objective judgment.

Workplace, patient care and educational experiences must impart ethical standards of professional conduct through example, instruction and clinical practice. Members of the University community and the School of Dentistry are expected to conscientiously fulfill their obligations in the performance of their duties and as part of the University community.

RESPECTFUL WORKPLACE

The School of Dentistry is proud of the respectful workplace we have developed for faculty, staff, students and patients. We believe our goal is to maintain an academic, work and patient care environment that is positive and respectful of others. Respect is provided to every person regardless of gender, race or color, religious or spiritual beliefs or creed, nationality, sexual preferences or affection, disability, credit or financial situation, public assistance, veteran status, or physical condition. We believe in providing a respectful and positive learning and working environment that maximizes the potential of all individuals.

With these values as the foundation for the School of Dentistry, we have established guidelines, based on University policy, for the behavior of our faculty, staff and students.

We will engage in legal and ethical conduct and will not tolerate offensive behavior. Offensive behavior is defined as action or conduct that has the purpose or effect of unreasonably interfering with an individual’s work, academic or professional performance or creating an intimidating or hostile work environment. Employment and academic experiences will be based on respect and performance.

Explicit or implicit harassment, unwelcome advances, requests for sexual favors, or unwelcome physical conduct of a sexual nature will be promptly addressed. In addition, a hostile workplace, including abusive language, discriminatory or offensive remarks or humor, offensive visual displays, pornography, or aggressive physical contact will be addressed.

EQUAL OPPORTUNITY, DIVERSITY AND AFFIRMATIVE ACTION

The University of Minnesota and the School of Dentistry are committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation. The University and the School of Dentistry shall seek to:

1. Provide equal access to its programs, facilities, including patient care clinics.
2. Advocate and practice affirmative action in employment including the use of recruiting and search processes to enhance participation of racial minorities, women, persons with a disability, and military veterans.
3. Establish and nurture an environment that actively acknowledges and values diversity and is
free from racism, sexism, and other forms of prejudice, intolerance or harassment, for all faculty, staff and students.

4. Provide equal educational access to members of under-represented groups, and develop affirmative action admission programs where appropriate to achieve this goal.

DISABILITY SERVICES

The Board of Regents of the University of Minnesota is committed to provide for the needs of faculty, staff and enrolled or admitted students with disabilities under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA). The School of Dentistry will make services available for any faculty member, staff, or student who, through a recent assessment, can document a disability. Disability Services, with support from the School of Dentistry, will provide appropriate services, including: (1) support, counseling, and information; (2) communications with medical provider; and (3) assistance with reasonable accommodations.

DRUG-FREE WORKPLACE

Having a respectful workplace also includes providing faculty, staff and students with a healthy and productive environment. We believe that drug and alcohol abuse affects the health, safety and well-being of all employees and students and restricts their ability to perform. This is particularly critical for those who work with and practice dentistry with patients. Therefore, the School of Dentistry supports and follows the University of Minnesota's Drug-Free Campus and Workplace policy. (http://www.policy.umn.edu/Policies/Operations/Safety/DRUGFREE.html ). This policy prohibits the unlawful possession, use, or distribution of alcohol and illicit drugs by employees. Furthermore, it prohibits the unlawful manufacture, distribution, dispensation, possession, or use of controlled substances in the workplace.

SEXUAL HARASSMENT

Sexual harassment by or toward faculty, staff, students, patients, or members of the University community is prohibited. Prompt and appropriate action will be taken when sexual harassment is discovered. Persons who suspect sexual harassment should report it to an appropriate authority, such as the Dental School’s EEO Officer; or Human Resources Director; or the University’s EEO Office. A violation of the sexual harassment policy may lead to disciplinary action, up to and including termination of employment or academic dismissal.

RECOUSE AND REPORTING

It is not necessary for any faculty, staff, or student who feels he or she is the subject of offensive, harassing or discriminatory behavior to handle the matter alone. We encourage you to directly object to any behavior you believe to be offensive. However, if you feel offended by faculty, staff, your boss, peers, or others whom you encounter in the course of your employment or academic studies and do not feel you are able to deal directly with the problem, go immediately to your supervisor, or, you may report the behavior to the School of Dentistry's Equal Opportunity Liaison, Dr. Carol Meyer (626-2332); the Interim Associate Dean for Academic Affairs, Dr. Shelia Riggs (626-5751) or the University of Minnesota's Office of Equal Opportunity and Affirmative Action (624-9547).

All allegations of offensive, discriminatory, or other inappropriate behavior will be responded to immediately. The facts shall determine the response to each complaint and each situation will be handled discreetly. Retaliation and intimidation directed toward anyone who makes a complaint is prohibited. This practice applies to each and every full- or part-time faculty, staff, student and patient in the School of Dentistry.
POLICY FOR DEALING WITH STUDENTS SUSPECTED OF CHEMICAL USE OR ABUSE

The University of Minnesota and the School of Dentistry strongly support a Drug-Free Campus Policy. For more information on this policy, go to http://www.policy.umn.edu/Policies/Operations/Safety/DRUGFREE.html

Within the School of Dentistry, violations of this policy will be dealt with as follows:

First Offense
1. If a student in the clinic is suspected of impairment or potential for impairment, he or she will be removed from the clinic and any appointed patients for the remainder of the day will be canceled or reassigned.
2. Faculty or staff involved in the incident will without delay file a professional behavior report form with the Office of Academic Affairs.

Subsequent Offense
1. Upon detection or suspicion of impairment, or potential for impairment, the student will be immediately dismissed from lab or clinic and a professional behavior report form will be filed with the Office of Academic Affairs.
2. The student will be escorted to Boynton for urinalysis/blood test and for assessment for chemical dependency.
3. If the student is determined to be chemically dependent, the Policy for Students with Chemical Dependency Problems will be enforced.
4. If the student is determined not to be chemically dependent, the matter will be referred to the appropriate committee for disposition.

POLICY FOR STUDENTS WITH CHEMICAL DEPENDENCY PROBLEMS

The University of Minnesota, School of Dentistry is supportive of the efforts of chemically dependent students to become free of their dependency problems. In dealing with chemically dependent students, the School's procedure involves intervention and requiring students to join treatment and rehabilitation programs. This procedure was established to insure the safety of patients that students may come in contact with and to protect the interests of the patients, students, faculty, and School.

The following steps will be followed as soon as a student has been identified as having chemical dependency problems:

1. The student will be granted a medical leave of absence from the educational program by the Council of Chairs. The request for a leave may be initiated by the student, the Director of Student Affairs, the student’s Program Director, or the student’s Director of Graduate Studies.
2. The Director of Student Affairs/Program Director/Director of Graduate Studies will arrange with the student a program for the treatment of chemical dependency. Usually, the student will be counseled to enroll in an inpatient chemical dependency treatment program and provide the Office of Academic Affairs, Program Director, or Director of Graduate Studies with evidence of successful completion of the program. However, the student may select a different treatment modality contingent on the approval of the Director of Student Affairs/Program Director/Director of Graduate Studies.
3. If a student and the Director of Student Affairs/Program Director/Director of Graduate Studies do not reach an agreement on a treatment and rehabilitation program, either may
request a hearing by the Council of Chairs.

4. The Director of Student Affairs/Program Director/Director of Graduate Studies will counsel the student to join a sobriety support group, e.g., Dentists Concerned for Dentists, after completion of the treatment program.

5. The student will be asked to give the Director of Student Affairs/Program Director/Director of Graduate Studies permission to solicit letters of reference from counselors, employers, or members of the sobriety support group to monitor the progress of the student's rehabilitation program.

6. The Director of Student Affairs/Program Director/Director of Graduate Studies will make recommendations to the Associate Dean for Academic Affairs to terminate the student's medical leave of absence and allow the student to resume the program after obtaining evidence with the student's consent that the student has completed the treatment program, is participating in a rehabilitation program, and is also being monitored for continued progress through the Health Professionals Service Program.

7. The Associate Dean for Academic Affairs will determine whether to permit the student to resume the program after obtaining evidence regarding the student’s progress in the rehabilitation and monitoring programs that show the student has been chemically free for at least ten weeks.

Draft 0/12
EDUCATIONAL PRIVACY:
POLICIES ON ACCESS TO STUDENT RECORDS

Introduction:
Federal law, state law, and regents' policy govern access to student records. University policy regulates sharing of information within the University. Below is a summary of the Regents Policy on Access to Student Records. This document may be viewed at http://www1.umn.edu/regents/policies/administrative/Student_Education_Records.pdf.

Directory Information: The following information is public information, unless the student has requested non-disclosure (suppression): Name, address, phone number, University assigned email address, dates of enrollment, enrollment status (full/part-time, not enrolled), college(s), major(s), adviser(s), class (freshman, sophomore, junior, senior), academic awards and honors, and degree(s) received.

Students have four options for directory suppression:
- Suppress address
- Suppress address and phone number
- Suppress address, phone number, and email
- Suppress all public information

Non-Public (Private) Information: Student education records other than publicly available directory information are private and shall not be disclosed except under certain prescribed conditions. Nonreleasable information includes:
- Grades
- Schedule
- Courses taken
- Educational services received

Students’ Rights: Students have the right to:
- Inspect and review nearly all the information the University maintains on them. The two specific exceptions to this are: letters of recommendation a student has waived the right to review and parents’ financial information (this usually is maintained in the financial aid office)
- Request an amendment to their record
- Consent to disclosure of personally identifiable information
- Know what an institution has designated as public/directory information and the right to limit the release—the University of Minnesota uses the term “suppress public information”—of that information
- Know school officials may access their records
- File complaints with: Family Policy Compliance Office US Department of Education 130 Coffey Hall, 400 Maryland Avenue, SW Washington, DC 20202-5920

General Guidelines: The following practices by University or School of Dentistry officials will help ensure compliance with the various laws and regulations.
- University officials have 30 days to respond to most legitimate requests
- Requests for information from the educational record must be referred to the appropriate education record custodian (e.g., registrar's office)
- Information will only be shared within the University and only with those who have a "legitimate educational interest". (Those with a "legitimate educational interest" are university employees who have a need to know to carry out their defined job functions.)
- Grades or graded materials will not be posted or distributed in such a way that one student can see or ascertain the grade of another
- Written permission must be obtained from the student before any nonpublic information can be released

For further information, contact Tina Falker, Office of the Registrar at 612-625-1064, view the FERPA tutorial at http://onestop.umn.edu/staff/ferpa_tutorial/index.html, or go to http://onestop.umn.edu/grades_and_transcripts/student_records_privacy.html

Updated 05/10
CONFIDENTIALITY OF STUDENT GRADES POLICY

Under provisions of federal and state legislation, examination scores, course grades, and similar indicators of student academic progress are not "public information." Accordingly, such information cannot be released or made public without written student permission, except for normal educational and administrative uses within the University.

Posting lists of examination scores or course grades, or returning test materials to students in ways which make it possible for students to obtain information about other students' scores or grades is inappropriate.

It is permissible to post grades or return graded materials using an identification number (not social security, student identification number, or clinic identification number) that cannot be associated with an individual student by others who view the materials. It is not permissible to leave graded examination materials with students' names on them in halls or other public places, or in mail folders (unless sealed in an envelope) for retrieval.

DISABILITY ACCOMMODATIONS STATEMENT AND PROCESS

The University of Minnesota is committed to providing all students equal access to learning opportunities. Disability Services is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations. Students registered with Disability Services, who have a letter requesting accommodations, are encouraged to contact the instructor early in the semester. Students who have, or think they may have, a disability (e.g. psychiatric, attentional, learning, vision, hearing, physical, or systemic), are invited to contact Disability Services for a confidential discussion at 612-626-1333 (V/TTY) or ds@umn.edu. Additional information is available at the DS website http://ds.umn.edu.

The Disability Services liaison to the School of Dentistry will assist eligible students with documentation of disability conditions, determination, and implementation of reasonable accommodations, information, referral, consultation, and training. All services are confidential. The School of Dentistry Liaison is located in 180 McNamara Alumni Center and can be reached by calling 626-1333 (voice or TTY). In order for the accommodation process to proceed smoothly, all parties need to understand their roles and responsibilities:

Students are responsible for:

- Providing Disability Services with documentation of the disability.
- Keeping the disability specialist informed and providing updated documentation if the disability changes.
- Requesting accommodations as far ahead of time as possible. Some accommodations cannot be effectively arranged if they are requested on short notice.
- Discussing accommodations with faculty and staff members as needed, especially when delivering accommodation letters from the disability specialist. If you have difficulty addressing their concerns or questions, direct them to the disability specialist for assistance.
- Notifying the disability specialist if there are any concerns or difficulties with receiving accommodations. The student and the disability specialist will then decide what the next steps should be.
**The Disability Specialist is responsible for:**

- Clarifying and obtaining what documentation is needed to determine eligibility for services.
- Maintaining student files in a confidential manner.
- Writing individualized letters to faculty or staff members, identifying reasonable accommodations and why they are needed. Letters will detail who is responsible for specific parts of providing accommodations and what to do if there are any concerns.
- Releasing disability-related information on a need-to-know basis to other University faculty and staff members.
- Discussing with the student how the disability impacts him/her at the University, and informing the student when additional documentation is needed.
- Helping the student to identify reasonable accommodations.

**Faculty and staff are responsible for:**

- Understanding accommodations recommended by DS, and contacting DS if they think additional accommodations are needed.
- Contacting DS or the student if there are concerns or questions about accommodations and how they will be provided.
- Knowing the essential elements of a course or program.
ACADEMIC DUE PROCESS POLICY

Informal Resolution
Resident and/or class complaints about course organization, procedures, or grades should be first brought to the course director for informal resolution. If the resident is not satisfied with the proposed resolution, then the resident may next appeal to the Division Director. If the complaint cannot be satisfactorily resolved with the Division Director, then the resident may next appeal to the Department Chairperson. If a mutually agreeable solution cannot be reached, the resident may appeal to the Associate Dean for Academic Affairs. This is however the final level for appeal using the informal resolution process. Grievances involving an instructor's judgment in assigning a grade based on academic performance may be resolved only through informal resolution.

Resident appeals, in writing, about adverse promotion decisions (such as suspension,repeat of a year or the dismissal from the School of Dentistry for academic reasons) shall be made to the Associate Dean for Academic Affairs. The resident has ten (10) working days in which to file an appeal. The Associate Dean for Academic Affairs shall inform the Advanced Education Committee, who shall then meet and begin its review of the resident appeal preferably within ten (10) working days from the time it was filed. The resident may request in writing that the appeal hearing be delayed in order for the resident to adequately prepare.

• Once the notice for the intent to appeal has been received by the Office of Academic Affairs, the resident may attend didactic courses with their originally assigned class. Participation in clinical patient care will be at the discretion of the Program Director.
• Once the date of the appeal hearing has been set, the resident will be notified at least three days in advance and they will confirm their attendance at least 24 hours in advance. If the resident cannot attend the appeal hearing, the Advanced Education Committee has the option to hold the meeting without the resident present.
• The resident should submit a written detailed alternate solution to the decision of the Advanced Education Program for which the resident is appealing to the Advanced Education Committee no later than 24 hours before the appeal hearing. The Office of Academic Affairs and/or the Office of Student Affairs can help with the formulation of this solution.
• The resident can bring a support person to the meeting with them such as the Director of Student Affairs, a parent, a faculty member, a fellow resident, etc. If the accused is represented by an attorney during the meeting, the School of Dentistry will be represented by an attorney from the Office of the General Counsel.
• The student will be advised as to the decision of the Advanced Education Committee within 10 (ten) working days.
• The decision of the Advanced Education Committee on the student’s appeal is final. Further review within the University is available only through the formal process of filing an academic grievance under the procedures of the Conflict Resolution Process for Student Academic Complaints (http://www.policy.umn.edu/Policies/Education/Student/STUDENTCOMPLAINTS_PROC01.html).

Formal Process
The student has a right to file an academic grievance either before or after complaints described earlier in this academic due process policy. Academic grievances are complaints brought by students regarding the provision of educational and academic services affecting their role as students. Academic grievances must be based on a claimed violation of a University rule, policy, or established practice. This policy does not limit the University's right to change rules, policies, or practices. Academic grievances are described by the Board of Regents; Conflict Resolution Process for Student Academic Complaints. A formal process of resolution is available for academic grievances. The student must submit a formal complaint in writing to the Academic Complaint Officer of the School, identifying the student grievant, the respondent individual(s) involved, the incident, the rule/policy/established practice claimed to be violated, and a brief statement of the redress sought. Additional steps of the formal process of academic grievance are described fully in the Board of Regents; Conflict Resolution Process for Student Academic Complaints (http://regents.umn.edu/sites/default/files/policies/Conflict_Res_Process_Students.pdf).

Approved by the Advanced Education Committee on 6/27/13
CLINIC POLICIES
AND TRAINING REQUIREMENTS
ACADEMIC HEALTH CENTER IMMUNIZATION POLICY

All students in the University of Minnesota Academic Health Center (AHC) schools and programs are required to have immunizations and/or tests as a condition of enrollment. Programs must meet this University of Minnesota Board of Regents requirement. Expectations for health professions students are consistent with those of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), and Minnesota state law for health care workers. Students are expected to have this requirement completed prior to entering AHC programs. Information can be accessed at www.ahc.umn.edu/immunizations.

Required Documented Tests and Immunizations

1. **Hepatitis B.** Document three doses of the vaccine or antibody titre (blood test) results documenting immunity. Note: The Hepatitis B series takes four to six months to complete; therefore, if you have not had this series, you should begin this process as soon as possible to comply with this requirement.

2. **Varicella (Chicken Pox).** Effective July 1, 2013, history of varicella can no longer be self-reported. Students must document two doses of the varicella vaccine, laboratory evidence of immunity or laboratory confirmation of disease, diagnosis or verification of a history of varicella disease by a licensed health-care provider, or diagnosis or verification of a history of herpes zoster by a licensed health-care provider. If acceptable documentation of immunity cannot be provided and a titre does not indicate immunity, the vaccine will need to be administered again.

3. **Measles (Rubeola).** Document two doses after age 12 months or antibody titre results documenting immunity.

4. **Mumps.** Document two doses after age 12 months or antibody titre results documenting immunity.

5. **Rubella (German Measles).** Document two doses after age 12 months or antibody titre results documenting immunity.

6. **Tetanus/Diptheria.** Document most current dose within the last ten years. Effective July 1, 2013, students who have not had a Td within the last 5 years must document a dose of Tdap.

7. Effective July 1, 2013 students must initially complete either (a) or (b) as follows:
   a. A two-step tuberculin skin test (TST) test. Documentation of the two-step TST. This test involves placement of a purified protein derivative (PPD) to test for tuberculosis. It must be read 48-72 hours after placement, and the area of indurations recorded. The AHC requires a **second PPD test to be performed two weeks after the first test.** This two-step TST needs to be done once.
   b. An Interferon Gamma Release Assay (IGRA) test (Quantiferon TB Gold (QFT-G), Quantiferon TB Gold in tube test (QFT-GIT); or T-Spot. TB Test (T-Spot). Annually complete either (a) or (b):
      a. Annual TST. Documentation of an annual TST. If you have had a two-step TST more than one year ago, you should have a standard TST. Annual TST’s are required each year you are in your program.
      b. Annual IGRA. Documentation of an annual IGRA.

8. **Chest x-ray if you have had a positive TST or IGRA.** If you have had a positive TST or a positive IGRA, your documentation must include the results of your follow-up chest x-ray. Once this documentation is submitted, yearly TST or IGRA is not required. Bacille Calmette-Guerin (BCG) vaccinated individuals who test positive by TST and negative by an IGRA are not required to have a follow-up chest x-ray.

We understand that many students have not had a two-step TST before. To understand this requirement for health care workers, you can refer to the immunization website (www.ahc.umn.edu/immunizations) and read the section “Why a Two-Step Tuberculin Skin Test?” Currently, 5% of AHC students are testing positive on the two-step TST and require health consultation.
Process required to obtain documentation

Once students are admitted to an AHC school or program, they can find a personalized immunization form in the University myU Portal under the tab titled "Health and Wellness" at www.myu.umn.edu. Students may also download a non-personalized immunization form at: www.ahc.umn.edu/immunizationform.

Students should print and take this form to a health care provider to complete. A health care provider is defined as a physician (MD or DO), nurse practitioner, physician’s assistant, pharmacist, or registered nurse. Often the information may be required from multiple providers. In these cases, a separate Immunization Form for each provider is the preferred way to complete the documentation. It is highly recommended that students keep a copy of all documentation.

When the form or forms are completed, they must be turned in to Boynton Health Service (BHS). When the BHS staff receives a student’s information, they will review the form and verify whether immunizations and documentation on the form meet the University standards. Immunization information will become part of a student’s confidential BHS medical record.

Review and verification of immunizations and forms will take BHS staff approximately two to five days to process. Turning in the form does not confirm that students are in compliance with these requirements. The forms must be processed and verified by BHS before compliance is confirmed.

If students have not completed all requirements, a hold is placed on their records and they will not be allowed to enroll in classes and rotations.

Contact Boynton Health Service at 612-626-5571 or immunizations@bhs.umn.edu with questions about immunizations.

BASIC LIFE SUPPORT TRAINING REQUIREMENTS

The American Dental Association, Commission on Dental Accreditation requires that all of our students, clinical faculty, and appropriate support staff be able to perform basic life support procedures, including cardiopulmonary resuscitation, and manage other medical emergencies.

Utilizing an American Heart Association accredited instructor, the SOD provides opportunities for faculty, staff, and students to participate in Basic Life Support Certification courses. Students are required to take the training course twice during their program and will be scheduled at appropriate intervals.

The course teaches the following skills for all age groups: Cardio Pulmonary Resuscitation (CPR), ventilation techniques using a bag valve mask device, oxygen as well as other appropriate airway devices, use of an automated external defibrillator (AED), relief of a foreign-body airway obstructions (FBAO), risk factors for cardiovascular disease, signs and symptoms of a heart attack and stroke and actions to be taken for these emergencies, the chain of survival, and the importance of early access to the EMS system.

All students are trained in CPR and Basic Life Support prior to the beginning of their clinical training and at appropriate intervals as needed to ensure continued certification. For further clinical requirements related to CPR and Basic Life Support training, refer to the School of Dentistry Clinic Manual or the Dental Hygiene Clinic Manual, as appropriate. Questions related to documentation of CPR certification should be directed to: Judi Vaughn, School of Dentistry, Clinical Systems, 626-5278.
RADIATION HYGIENE AND PROTECTION

Due to continuing concern about the use and potential harmful effects associated with exposure to ionizing radiation, the Policy for the Use and Control of Ionizing Radiation for Diagnostic Imaging at the School of Dentistry has been developed with an overall objective to implement those procedures that will assure the safe and effective use of ionizing radiation producing equipment and to minimize, as much as possible, any potential risks to patients, students, faculty and staff. Residents are required to comply with all relevant aspects of this policy. Control and use of radioactive materials for research purposes, i.e. radioactive isotopes and radiopharmaceuticals, is specifically excluded from the scope of this policy.

See Section O of the School of Dentistry Clinic Manual for further details of this policy
(https://intranet.ahc.umn.edu/SODintranet/prod/groups/sod/@pub/@sod/@intranet/documents/asset/sod_asset_131025.pdf)

BLOODBORNE PATHOGENS/INFECTIOUS DISEASES AND HAZARDOUS MATERIALS MANAGEMENT

In order for health care workers to be knowledgeable of the latest infection control techniques and hazardous materials management information, they must be continually trained. Through this training health care workers learn how to minimize or eliminate their exposure to bloodborne pathogens and how to safely handle and dispose of hazardous materials. The School of Dentistry provides training regarding bloodborne pathogens/infectious diseases and hazardous materials management for residents, faculty and staff.

Training for residents shall be provided as follows:
Before beginning provision of clinical care;
At least annually thereafter
Annual training for all residents shall be provided within one year of their previous training.
The School of Dentistry will provide additional training when changes, such as modification of tasks or procedures or institution of new tasks or procedures, affect the occupational exposure of health care workers. The additional training may be limited to addressing the new tasks or procedures.

See Section L of the School of Dentistry Clinic Manual for further details of this policy
(https://intranet.ahc.umn.edu/SODintranet/prod/groups/sod/@pub/@sod/@intranet/documents/asset/sod_asset_131025.pdf)
REQUIREMENTS FOR PARTICIPATION
IN CLINICAL ACTIVITIES

REQUIRED ANNUAL BACKGROUND STUDIES

Minnesota law requires that any person who provides services that involve direct contact with patients in health care facilities licensed by the Minnesota Department of Health has a background study conducted by the State. The background study covers a wide range of criminal offenses, and agency findings related to maltreatments of children or vulnerable adults. An individual who is disqualified from having direct patient contact as a result of the background study, and whose disqualification is not set aside by the Commissioner of Health, will not be permitted to participate in a clinical placement in licensed care facilities. Failure to participate in a clinical placement required by the academic program could result in ineligibility to qualify for a degree in School of Dentistry programs.

Background studies are required annually for all School of Dentistry students, graduate students, and residents.

REQUIRED TRAINING FOR COMPLIANCE
WITH HIPAA REGULATIONS

All students enrolled or participating in any of the University of Minnesota Academic Health Center programs are required to complete appropriate training associated with the Health Insurance Portability and Accountability Act. All training must be completed within the first 90 days of enrollment/participation. Training modules can be accessed at www.myu.umn.edu under the My Academics & Career tab. All students must complete the training modules. Students involved in research must also complete the following module:

• Privacy and Confidentiality in Research Training Module (55-70 minutes).

Failure to complete the necessary modules will result in an interruption in clinical or research activities. Please direct any questions or concerns to Ms. Gayle Waedekin at 624-9696 or eggen001@umn.edu.

Please direct any questions or concerns to Ms. Gayle Waedekin at 624-9696 or eggen001@umn.edu.
MOONLIGHTING

Purpose
The purpose of this policy is to provide advanced education students/residents/fellows (i.e., trainees) and their programs with information on managing moonlighting. If statements in this policy contradict that of immigration law or the Minnesota Board of Dentistry, their policies take precedence.

Advanced education programs in the School of Dentistry require full-time commitment to the program to provide students the best opportunity for academic and clinical success. Thus, students in these programs are strongly encouraged to devote their efforts to their programs. However, the School of Dentistry recognizes that some students may experience difficulties that could be ameliorated by working outside of the program (i.e., moonlighting). Thus, the School of Dentistry’s policy on advanced education students moonlighting is that directors of the student’s program determine whether the benefits of allowing the student to moonlight outweighs the costs to the student’s academic and clinical development. Residents/fellows in programs supported by Graduate Medical Education must follow the University of Minnesota Medical School, Graduate Medical Education Administration’s Moonlighting Policy (http://www.med.umn.edu/gme/instpolicymen/genpolprocmoonlighting/home.html). All advanced education residents/fellows must follow the CODA policy on Resident Duty Hours Restrictions.

American Dental Association, Commission on Dental Accreditation Evaluation & Operational Policies & Procedures

Y. POLICY ON RESIDENT DUTY HOURS RESTRICTIONS
The Commission on Dental Accreditation (CODA) acknowledges the revised resident duty-hours and supervision requirements of the Accreditation Council for Graduate Medical Education (ACGME). Recognized by the United States Department of Education, the Commission is the specialized programmatic accreditor for dental and dental-related programs. Institutions in which both graduate medical education residencies and advanced dental education programs reside may determine that CODA-accredited programs should comply with ACGME standards. It is the policy of the Commission that the institution should consider the accreditation standards of the Commission on Dental Accreditation for hospital-based dental residency programs and consider whether the ACGME requirements are in the best interests of patient safety, resident education and the CODA-accredited programs.

Adopted by CODA: 8/11

Policy
Trainees must not be required to engage in moonlighting activities. Moonlighting activities are not included as part of the educational program in the residency/fellowship programs. Moonlighting activities must not conflict with the scheduled and unscheduled time demands of the educational program and its faculty.

All moonlighting, regardless of where it occurs, must be approved by the program director before beginning the moonlighting activity and must be reported to the program director on a schedule determined by the program director.

Visas Requirements
Trainees on J-1 visas are not permitted to be employed outside the residency/fellowship program. Therefore they are not allowed to moonlight.

A trainee on an H-1B visa wishing to moonlight must obtain a separate H1-B visa for each facility where the trainee works outside the training program.

Trainee Responsibility
1. Trainees who wish to moonlight are required to obtain prospective permission from their program directors. Failure to provide this information is grounds for discipline under Sections 3.2 and 7.1 of the Residency/Fellowship Agreement.
2. Trainees must report all moonlighting hours to their program director on a regular basis determined by the program director.

**Program Responsibility**
1. Program directors determine the moonlighting policy for all trainees within their program.
2. Program directors will acknowledge in writing their awareness that a trainee is moonlighting and will include this information in the trainee’s file.
3. Program directors may withdraw permission to moonlight for any given trainee or group of trainees if those activities have been shown to interfere with their performance.

**Professional Liability**
Moonlighting activities and any activities that are not part of the formal education program are not covered under the University of Minnesota professional liability policy.

**Other Requirements**
Trainees engaged in moonlighting activities must be properly licensed and credentialed as determined by the organization where they moonlight.

Approved by the Advanced Education Committee on 5/6/13
RECOMMENDATIONS AND REFERENCES
FROM FACULTY AND STAFF

Students in advanced and graduate education programs often request that a faculty or staff member serve as a reference or provide a letter of recommendation to potential employers or other entities. The Family Educational Rights and Privacy Act (FERPA) grants students the right to consent to disclosure of his or her records (http://www.onestop.umn.edu/grades_and_transcripts/student_records_privacy.html). Thus, School of Dentistry faculty and staff must not disclose any information about the student without the student’s permission. Directory/public information, such as the student’s dates of enrollment, enrollment status, and degrees received, can be disclosed if the student has NOT chosen to suppress his or her public information. To determine whether a student (current or previously graduated) has suppressed his or her public information, search UM Reports/Student Information/Directory Information.

To disclose FERPA protected information, the student must submit a Reference Request and Student Authorization form signed by the student to the School of Dentistry. This form indicates what information can be released by whom, for what reasons, to whom, and for how long the authorization is valid.

At no point can any medical information can be released as all medical information is protected by the Health Insurance Portability and Accountability Act (HIPAA). Medical information may include reasons why a leave of absence was taken or any restrictions the student had or has during their program or beyond. If a faculty or staff member is asked about a leave that was taken during the program, he or she must not provide any specific information. If the student has authorized release of this information, the faculty or staff member can state that the leave was requested by the student and that it was approved by the program. If the student has not submitted an authorization form, refer the potential employer or program director to the student for more details.

Disciplinary information can only be shared if the student gives permission for this on the authorization form. This includes the information that there is no disciplinary information on the student. If the student does not indicate on the authorization form that disciplinary information on can be released, then the faculty or staff member should inform the potential employer or program director that the student must give permission for the School of Dentistry to release that information.

It is the responsibility of the faculty or staff member providing information about a student to be sure that the student has agreed in writing using the Reference Request and Student Authorization form for information to be disclosed. Upon receipt of a signed Reference Request and Student Authorization form from a student, a copy should be placed in the student’s program record and the original should be sent to the School of Dentistry’s Office of Human Resources.

For a quick and easy way to help understand these rules, review the FERPA tutorial at: http://onestop.umn.edu/staff/ferpa_tutorial/index.html

For additional information or resources on privacy information, review Balancing Student Privacy and School Safety: A Guide to the Family Educational Rights and Privacy Act for Colleges and Universities at http://www2.ed.gov/policy/gen/guid/fpco/brochures/postsec.html

Approved by the Advanced Education Committee on 5/6/13
Dental Resident/Fellow
Benefits Policies and Procedures

STIPENDS
Dental resident/fellow stipends are determined each year. The annual stipend amount will be sent out each year with the Program Residency Agreement. Dental residents/fellows on a sponsored scholarship through a government, military, or other group may not receive a stipend; see the program offer letter for details. Dental residents/fellows will receive a paycheck every other week, see payroll calendar for pay dates. The School of Dentistry receives the paychecks every other Wednesday. If they are not picked up by the end of Wednesday, then they will be mailed to the dental resident/s or fellow’s home address on file. The resident/fellow may also opt for direct deposit, which is highly encouraged because of the potential for lost/missing or misdirected mailings. The paycheck will be deposited into your account on the morning the paychecks are delivered to the dental school’s Human Resources Office.

Please be aware that taxes will be deducted from your base salary (annual stipend) as it is considered earned/worked income.

Any tuition, benefits, or University of Minnesota fees will be charged to the student accounts and Residents/fellows are responsible for paying the balance of those charges by the due date.

For problems, questions, or concerns, please contact your program support person or the Human Resources office at 612-624-8161.

BENEFITS COVERAGE
Currently all dental resident/fellows benefit plans are provided through the Office of Student Health Benefits. Dental residents/fellows are instructed during their benefits orientation how to enroll or opt out of benefits coverage. Having benefits coverage is required in all programs, so proper timely enrollment or opt out procedures and forms must be completed within the first month of the program. All questions regarding benefits plans, options, and procedures should go directly through the Office of Student Health Benefits: 612-624-0627 or 1-800-232-9017, website: http://www.shb.umn.edu/ and email address: umshbo@umn.edu

PERSONAL TIME OFF
Dental residents/fellows are allowed no more than 10 days of personal time off (sick or vacation) per year. The number of days allowed for personal time off is determined by the resident’s program. Each program may have a different calendar year used for tracking personal time off. Each program should communicate the number of days for personal time off and the program’s vacation calendar to the dental resident/fellow at the start of their program. In the event of illness, the affected dental resident/fellow is responsible for notifying the faculty member of the affected clinic(s) and the program director’s office as soon as the dental resident/fellow knows that the illness will cause an absence from clinical responsibilities. Personal time off for illness will be approved only for legitimate illnesses. A physician’s note may be requested to support the dental resident/fellow’s request for illness related personal time off.

The dental resident/fellow must give written notice of intent to use personal time off to their program director at least four (4) weeks in advance, except for illness or unusual circumstances. Any time taken beyond the amount of personal time off available will be unpaid time and may require an extension of the program in order to fulfill program length requirements.

Program Responsibility
Programs are responsible for tracking personal time off to insure that program requirements are met prior to graduation from the program.

FAMILY MEDICAL LEAVE ACT (FMLA)
Dental residents and fellows may be eligible for the Family Medical Leave Act (FMLA). Dental residents/fellows must check with their program and the School of Dentistry Human Resources Office to determine if they qualify. Leave shall not exceed 12 weeks in any 12-month period. The 12-month period is based on a fiscal year (07/01-06/30). The dental resident/fellow may qualify for Short Term and/or Long Term Disability benefits. Please refer to the Office of Student Health Benefits website for Dental
Residents: http://www.shb.umn.edu/twincities/residents-fellows-interns/dentistry/index.htm for further information. Programs and the dental residents/fellows are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

PARENTAL LEAVE

Policy

The dental resident/fellow must give notice, in writing, of their intent to use parental leave and other leaves used in conjunction with parental leave to their program director at least four (4) weeks in advance, except under unusual circumstances.

Birth mother:

A birth mother shall be granted, upon request to the program director, up to six weeks parental (maternity) leave for the birth of a child. The maternity leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption.

Dental residents/fellows on maternity leave will receive the first two weeks of their leave as paid parental leave. This paid parental may be charged against the dental resident/fellow’s personal time off allocation.

Dental residents/fellows who have personal time off available can use this time at the end of the paid two weeks for the child’s birth. personal time off may also be used in conjunction with short-term disability (if applicable) during their maternity leave. Any time after the two weeks of leave and any personal time off that was approved, unpaid time up to the six weeks of leave may be granted. If more than six weeks is desired for maternity leave, this must be requested/approved/arranged with the program director and the School of Dentistry Human Resources office.

Birth father:

A birth father shall be granted, upon request to the program director, up to two weeks paid parental leave for the birth of a child. The leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption. This paid parental leave may be charged against the dental resident/fellow’s personal time off allocation.

Registered same sex domestic partner:

Registered same sex domestic partner of someone giving birth shall be granted, upon request to the program director, up to two weeks paid parental leave. The leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the birth and no sooner than two weeks before the birth. The leave must be consecutive and without interruption. This paid parental leave may be charged against the residents’ personal time off allocation.

Adoption:

An adoptive parent shall be granted, upon request to the program director, up to two weeks paid parental leave for the adoption of a child. Dental residents/fellows who are registered same sex domestic partners of someone adopting a child shall be granted two weeks paid leave. The leave may begin at the time requested by the dental resident/fellow, but no later than six weeks after the adoption and no sooner than two weeks before the adoption. The leave must be consecutive and without interruption. This paid parental leave may be charged against the dental resident/fellow’s personal time off allocation.

Clarification

Holidays that occur during a leave of absence run concurrent with the leave and are not in addition to the leave.

Dental Resident/Fellow’s Next Steps*

*Work with your Program Directors office and the School of Dentistry Human Resources Resident contact

- what type of paperwork needs to be completed;
- if you qualify for Family Medical Leave Act (FMLA) and how it will be managed;
- how your pay will be impacted;
• how your benefits need to be coordinated; and
• if your leave will extend your time in the program.

Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

Programs must forward documentation to the School of Dentistry Human Resources office as well as the Associate Dean for Academic Affairs for leaves that extend the dental resident/fellow’s time in the program.

MEDICAL LEAVE
The dental resident/fellow must give notice, in writing, of intent to use medical leave to their program director at least four (4) weeks in advance, except under unusual circumstances. This leave would count against the dental resident/fellow’s personal time off allocation and any time taken for the leave beyond the amount of personal time off available will be unpaid time.

A dental resident/fellow shall be granted, upon request to the program director, a leave of absence for their serious illness/injury that requires an absence of greater than 14 days.

Clarification
Holidays that occur during a leave of absence run concurrent with the leave and are not in addition to the leave.

Dental Resident/Fellow’s Next Steps*
*Work with your Program Directors office and the School of Dentistry Human Resources Resident contact

• what type of paperwork needs to be completed;
• if you qualify for Family Medical Leave Act (FMLA) and how it will be managed;
• how your pay will be impacted;
• how your benefits need to be coordinated; and
• if your leave will extend your time in the program.

Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that specialty board requirements are met prior to graduation from the program.

PERSONAL LEAVE
The dental resident/fellow must give notice, in writing, of intent to use personal leave to their program director at least four (4) weeks in advance, except under unusual circumstances. A dental resident/fellow may be granted, upon request to the program director, a personal leave of absence. This leave would count against the dental resident/fellow’s personal time off allocation and any time taken for the leave beyond the amount of personal time off available will be unpaid time.

Dental Resident/Fellow’s Next Steps*
* Partner with your program director support person and the School of Dentistry Human Resources office

• what type of paperwork needs to be completed;
• how your pay will be impacted;
• how your benefits need to be coordinated; and
• if your leave will extend your time in the program.
Program Responsibility
Programs are responsible for tracking time off for all leaves to insure that program requirements are met prior to graduation from the program.

PROFESSIONAL/EDUCATIONAL LEAVE
Each program will determine if they provide additional Professional/Educational leave days for their dental residents/fellows to be used for continuing education, conferences, or for job interviews. Programs will communicate with their dental residents/fellows at the start of their program if they offer or allow additional Professional/Educational days. The amount of days may vary, but will most likely not exceed 3 days per year. Leave must be scheduled at least one month in advance and is on a first come, first served basis. To schedule leave, dental residents/fellows need to contact their program support person (or the program director) with the days off they are requesting. The request will be reviewed and approved/denied by the program director. Parental/medical leave is covered in the sections below.

RESTRICTIONS TO LEAVE AND PERSONAL TIME OFF
- Because of the clinic/hospital/rotation coverage needed, it may not be possible for more than two dental residents/fellows to be gone at the same time. This includes all potential reasons for absence such as personal time off, maternity/paternity leave, educational leave, interviews, and testing dates. Exceptions to this include: Clinic closure dates, required conferences, or if more than two dental residents/fellows are gone for illness or medical leave.
- Dental residents/fellows may not request or will not be approved leave during certain rotations, exams or evaluation periods, or other specific time periods that are stated by the program. These specific times should be communicated by the program to the dental residents/fellows at the beginning of the academic year each year; exceptions may be made for illness or medical leave.
- The programs recognize the need for dental residents/fellows to schedule interviews for post-residency practice or academic positions. Interview time must be scheduled to create minimal disruption to the dental resident/fellow’s schedule. Each dental resident/fellow who needs to go for an interview must make arrangements with their program support person and the residency program director to take time off to interview.
- Personal leave and personal time off do not roll over into the next academic year. The academic year will differ between programs but the first day of the ‘year’ should be the first day of the dental resident/fellow’s appointment.
- Total number of days off (e.g. vacation, meetings, courses, etc) must be within each Program’s guidelines.
- Any exceptions need approval by the residency program director.

COVERAGE OF RESPONSIBILITIES WHEN ABSENT
Although dental residents/fellows are assigned to one clinic/hospital site at a given time, in some programs dental residents/fellows may be pulled from one site to cover another when the necessity arises. In the event of prolonged absences (LOA, medical leave, etc.), the chief resident (if applicable), program director and program support person are responsible for rotations and should work out a coverage schedule between locations.

WORKERS COMPENSATION BENEFITS
When a dental resident/fellow is injured during the program, the dental resident/fellow MUST take immediate steps to report the injury to the University. If this process is not followed, workers compensation benefits could be denied or delayed. YOU MUST COMPLETE THE UNIVERSITY OF MINNESOTA WORKERS COMPENSATION EMPLOYEE INCIDENT REPORT; IT DOES NOT MATTER WHERE YOU WERE INJURED (OTHER SITES), THE U OF M FORM NEEDS TO BE COMPLETED! The policy and procedure on how to complete these forms is located: [http://www政策.umn.edu/Policies/hr/Benefits/WORKERSCOMP.html](http://www.policy.umn.edu/Policies/hr/Benefits/WORKERSCOMP.html). The forms can now be completed online or can be printed out and completed. Please note and document the claim # in case an issue occurs. Please work with your program director or program support person to complete this process. If you receive a bill for the injury, please work with you program support person or the School of Dentistry HR department to help resolve the issue.
EFFECT OF LEAVE OF ABSENCE ON PROGRAM COMPLETION
In addition to the policy regarding Family and Medical Leave, the program must follow guidelines to meet required program standards and other requirements to ensure all aspects of the program are completed prior to graduation and obtaining the Certificate or Master’s Degree for program.

It is the responsibility of the department, program, and dental resident/fellow to be in compliance with the program requirements concerning the effect of leaves of absence on satisfying the criteria for completion of the training program prior to granting leave.

The Specialty Board requirements should be reviewed by the program director and dental resident or fellow to assure that the dental resident/fellow understands that he/she may have to make up the time away from training. If an extended leave results in the requirement for additional training in order to satisfy program requirements, financial support for the additional training time must be determined when arrangements are made for the leave and the makeup activity. Any leave that is more than 14 days in duration will most likely result in an extension of the program in order to fulfill all program requirements.

Approved by the Advanced Education Committee on 5/6/13
Student Conduct Code

SECTION I. GUIDING PRINCIPLES.

(a) The University seeks an environment that promotes academic achievement and integrity, that is protective of free inquiry, and that serves the educational mission of the University.

(b) The University seeks a community that is free from violence, threats, and intimidation; that is respectful of the rights, opportunities, and welfare of students, faculty, staff, and guests of the University; and that does not threaten the physical or mental health or safety of members of the University community.

(c) The University is dedicated to responsible stewardship of its resources and to protecting its property and resources from theft, damage, destruction, or misuse.

(d) The University supports and is guided by state and federal law while also setting its own standards of conduct for its academic community.

(e) The University is dedicated to the rational and orderly resolution of conflict.

SECTION II. SCOPE.

This policy applies to all students and student organizations at the University of Minnesota (University), whether or not the University is in session.
SECTION III. DEFINITIONS.

Subd. 1. Academic Environment. Academic environment shall mean any setting where a student is engaged in work toward academic credit, satisfaction of program-based requirements, or related activities including but not limited to online courses, learning abroad, and field trips.

Subd. 2. Campus. Campus shall mean all University premises, including all land, buildings, facilities, and other property owned, possessed, leased, used, or controlled by the University, and adjacent streets and sidewalks.

Subd. 3. Plagiarism. Plagiarism shall mean representing the words, creative work, or ideas of another person as one’s own without providing proper documentation of source. Examples include, but are not limited to:

- Copying information word for word from a source without using quotation marks and giving proper acknowledgement by way of footnote, endnote, or in-text citation;
- Representing the words, ideas, or data of another person as one’s own without providing proper attribution to the author through quotation, reference, in-text citation, or footnote;
- Producing, without proper attribution, any form of work originated by another person such as a musical phrase, a proof, a speech, an image, experimental data, laboratory report, graphic design, or computer code;
- Paraphrasing, without sufficient acknowledgment, ideas taken from another person that the reader might reasonably mistake as the author’s; and
- Borrowing various words, ideas, phrases, or data from original sources and blending them with one’s own without acknowledging the sources.

It is the responsibility of all students to understand the standards and methods of proper attribution and to clarify with each instructor the standards, expectations, and reference techniques appropriate to the subject area and class requirements, including group work and internet use. Students are encouraged to seek out information about these methods from instructors and other resources and to apply this information in all submissions of academic work.¹
Subd. 4. Student. Student shall mean any person taking courses at the University or enrolled in a University program; any person participating as a student in University activities prior to the start of classes; any student who is not enrolled or registered for a particular term but has a continuing relationship with the University; any student who withdraws, transfers, or graduates after an alleged violation of the Student Conduct Code; and any already graduated student when the conduct at issue implicates the student’s University degree.

Subd. 5. Student Organization. Student organization shall mean any organization of students that is or has been registered as a University student organization under applicable University policies or procedures.

Subd. 6. University-Sponsored Activities. University-sponsored activities shall mean any program or event sponsored by the University, including but not limited to those sponsored by student organizations, or athletics.

SECTION IV. JURISDICTION.

Subd. 1. The Student Conduct Code shall apply to student conduct that occurs on campus or at University-sponsored activities.

Subd. 2. The Student Conduct Code shall apply to student conduct that directly relates to the University’s education, services, programs, or rules, including but not limited to scholastic dishonesty, hazing, violation of University rules, and falsification, whether the conduct occurs on campus or off campus.

Subd. 3. At the discretion of the president or delegate, the Student Conduct Code also shall apply to off-campus student conduct when the conduct, as alleged, adversely affects a substantial University interest and either:

(a) constitutes a criminal offense as defined by local, state, or federal law or ordinance, regardless of the existence or outcome of any criminal proceeding; or

(b) indicates that the student may present a danger or threat to the health or safety of the student or others.
SECTION V. THE RESPONSIBILITIES OF DUAL MEMBERSHIP.

Students are both members of the University community and of the state. Students are responsible to the community of which they are a part, and they are responsible to the academic community of the University. By enforcing its Code, the University neither substitutes for nor interferes with other civil or criminal legal processes. When a student is charged in both jurisdictions, the University will decide on the basis of its interests, the interests of affected students, and the interests of the community whether to proceed with its disciplinary process or to defer action. Determinations made or sanctions imposed under the Code will not be subject to change because criminal charges arising out of the same facts were dismissed, reduced, or resolved in favor of the criminal law defendant.

SECTION VI. DISCIPLINARY OFFENSES.

Any student or student organization found to have committed, attempted to commit, assisted or abetted another person or group to commit the following misconduct is subject to appropriate disciplinary action under this policy:

Subd. 1. Scholastic Dishonesty. Scholastic dishonesty means plagiarism; cheating on assignments or examinations; engaging in unauthorized collaboration on academic work; taking, acquiring, or using test materials without faculty permission; submitting false or incomplete records of academic achievement; acting alone or in cooperation with another to falsify records or to obtain dishonestly grades, honors, awards, or professional endorsement; altering, forging, misrepresenting, or misusing a University academic record; or fabricating or falsifying data, research procedures, or data analysis.

Subd. 2. Disruption of the Academic Environment. Disruption of the academic environment means engaging in behavior that substantially or repeatedly interrupts either the instructor’s ability to teach and/or a student’s ability to learn.

Subd. 3. Falsification. Falsification means willfully providing University offices or officials with false, misleading, or incomplete information; forging or altering without proper authorization official University records or documents or conspiring with or inducing others to forge or
alter without proper authorization University records or documents; misusing, altering, forging, falsifying, or transferring to another person University-issued identification; or intentionally making a false report of a bomb, fire, natural disaster, or other emergency to a University official or an emergency service agency.

Subd. 4. Refusal to Identify and Comply. Refusal to identify and comply means willfully refusing to or falsely identifying one’s self or willfully failing to comply with a proper order or summons when requested by an authorized University official, by law enforcement personnel, or by emergency medical staff responding to an emergency.

Subd. 5. Attempt to Injure or Defraud. Attempt to injure or defraud means making, forging, printing, reproducing, copying, or altering any record, document, writing, or identification used or maintained by the University when done with intent to injure, defraud, or misinform.

Subd. 6. Harm to Person. Harm to person means engaging in conduct that endangers or threatens to endanger the physical and/or mental health, safety, or welfare of another person, including, but not limited to, threatening, stalking, harassing, intimidating, or assaulting behavior.

Subd. 7. Bullying. Bullying means aggressive behavior directed at another person, either in person or through electronic means, that causes stress or harm and that is repeated over time, including but not limited to assaulting, defaming, terrorizing, making obscene gestures, or invading privacy.

Subd. 8. Sexual Assault. Sexual assault means actual, attempted or threatened sexual contact with another person without that person’s consent. Sexual assault is a criminal act that can be prosecuted under Minnesota state law, as well as under the Student Conduct Code and employee discipline procedures.

Subd. 9. Disorderly Conduct. Disorderly conduct means engaging in conduct that incites or threatens to incite an assault or breach of the peace; breaching the peace; obstructing or disrupting teaching, research, administrative, or public service functions; or obstructing or disrupting disciplinary procedures or authorized University activities.
Subd. 10. Illegal or Unauthorized Possession or Use of Weapons. Illegal or unauthorized possession or use of weapons means possessing or using weapons or articles or substances usable as weapons, including, but not limited to, firearms, incendiary devices, explosives, and dangerous biological or chemical agents, except in those instances when authorized by law and, where applicable, by proper University authority.

Subd. 11. Illegal or Unauthorized Possession or Use of Drugs or Alcohol. Illegal or unauthorized possession or use of drugs or alcohol means possessing or using drugs or alcohol illegally or, where applicable, without proper University authorization.

Subd. 12. Providing Alcohol to Minors. Providing alcohol to minors means directly or indirectly providing alcohol to anyone under the legal drinking age.

Subd. 13. Unauthorized Use of University Facilities or Services. Unauthorized use of University facilities or services means wrongfully using University properties or facilities; misusing, altering, or damaging fire-fighting equipment, safety devices, or other emergency equipment or interfering with the performance of those specifically charged to carry out emergency services; or acting to obtain fraudulently—through deceit, unauthorized procedures, bad checks, or misrepresentation—goods, quarters, services, or funds from University departments or student organizations or individuals acting on their behalf.

Subd. 14. Theft, Property Damage, or Vandalism. Theft, property damage, or vandalism means theft or embezzlement of, damage to, destruction of, unauthorized possession of, or wrongful sale or gift of property.

Subd. 15. Unauthorized Access. Unauthorized access means accessing without authorization University property, facilities, services, or information systems, or obtaining or providing to another person the means of such unauthorized access, including, but not limited to, using or providing without authorization keys, access cards, or access codes.

Subd. 16. Disruptive Behavior. Disruptive behavior means willfully disrupting University events; participating in a campus demonstration that disrupts the normal operations of the University and infringes on the rights of other individuals; leading or inciting others to disrupt scheduled or normal activities of the University; engaging in intentional
obstruction that interferes with freedom of movement, either pedestrian or vehicular, on campus; using sound amplification equipment on campus without authorization; or making or causing noise, regardless of the means, that disturbs authorized University activities or functions.

Subd. 17. Hazing. Hazing means any act taken on University property or in connection with any University-related group or activity that endangers the physical and/or mental health or safety of an individual (including, without limitation, an act intended to cause personal degradation or humiliation), or that destroys or removes public or private property, for the purpose of initiation in, admission to, affiliation with, or as a condition for continued membership in a group or organization.

Subd. 18. Rioting. Rioting means engaging in, or inciting others to engage in, harmful or destructive behavior in the context of an assembly of persons disturbing the peace on campus, in areas proximate to campus, or in any location when the riot occurs in connection with, or in response to, a University-sponsored event. Rioting includes, but is not limited to, such conduct as using or threatening violence to others, damaging or destroying property, impeding or impairing fire or other emergency services, or refusing the direction of an authorized person.

Subd. 19. Violation of University Rules. Violation of University rules means engaging in conduct that violates University, collegiate, or departmental regulations that have been posted or publicized, including provisions contained in University contracts with students.

Subd. 20. Violation of Local, State, or Federal Laws or Ordinances. Violation of local, state, or federal laws or ordinances means engaging in conduct that violates a local, state, or federal law, or ordinance, including, but not limited to, laws governing alcoholic beverages, drugs, gambling, sex offenses, indecent conduct, or arson.

Subd. 21. Persistent Violations. Persistent violations means engaging in repeated conduct or action in violation of this Code.
SECTION VII. SANCTIONS.

Student and student organizations found responsible for disciplinary offenses under the Student Conduct Code are subject to sanctions. Factors to consider in determining appropriate sanctions include: the nature of the offense, the severity of the offense, the culpability of the student or student organization, the impact on other students or members of the University community, and the opportunity for student development. Separation from the University through suspension or expulsion is a serious sanction that may be appropriate for: repeated violations of the Code, for serious scholastic dishonesty, and for misconduct that constitutes a threat to community safety or well-being (including, but not limited to harm to person and sexual assault), or significantly disrupts the rights of others or the operations of the University. The following sanctions may be imposed upon students or student organizations found to have violated the Code:

Subd. 1. Academic Sanction. An academic sanction means a sanction affecting the course or academic work of the student for violation of Section VI, Disciplinary Offenses, Subdivision 1, Scholastic Dishonesty.

Subd. 2. Warning. A warning means the issuance of an oral or written warning or reprimand.

Subd. 3. Probation. Probation means special status with conditions imposed for a defined period of time and includes the probability of more severe disciplinary sanctions if the student is found to violate any institutional regulation during the probationary period.

Subd. 4. Required Compliance. Required compliance means satisfying University requirements, work assignments, community service, or other discretionary assignments.

Subd. 5. Confiscation. Confiscation means confiscation of goods used or possessed in violation of University regulations or confiscation of falsified identification or identification wrongly used.

Subd. 6. Restitution. Restitution means making compensation for loss, injury, or damage.
Subd. 7. Restriction of Privileges. Restriction of privileges means the denial or restriction of specified privileges, including, but not limited to, access to an official transcript for a defined period of time.

Subd. 8. University Housing Suspension. University housing suspension means separation of the student from University Housing for a defined period of time.

Subd. 9. University Housing Expulsion. University housing expulsion means permanent separation of the student from University Housing.

Subd. 10. Suspension. Suspension means separation of the student from the University for a defined period of time, after which the student is eligible to return to the University. Suspension may include conditions for readmission.

Subd. 11. Expulsion. Expulsion means the permanent separation of the student from the University.

Subd. 12. Withholding of Diploma or Degree. Withholding of diploma or degree means the withholding of diploma or degree otherwise earned for a defined period of time or until the completion of assigned sanctions.

Subd. 13. Revocation of Admission or Degree. Revocation of admission or degree means revoking a student’s admission to the University or revoking a degree already awarded by the University.

SECTION. VIII. INTERIM SUSPENSION.

The president or delegate may impose an immediate suspension on a student or student organization pending a hearing before the appropriate disciplinary committee (1) to ensure the safety and well-being of members of the University community or to preserve University property, (2) to ensure the student’s own physical or emotional safety and well-being, or (3) if the student or student organization poses an ongoing threat of disrupting or interfering with the operations of the University. During the interim suspension, the student or student organization may be denied access to all University activities or privileges for which the student or student organization might otherwise be eligible, including
access to University housing or property. The student or student organization has a right to a prompt hearing before the president or delegate on the questions of identification and whether the interim suspension should remain in effect until the full hearing is completed.

SECTION IX.
HEARING AND APPEALS OF STUDENT DISCIPLINE.

Any student or student organization charged with violation of the Code shall have the opportunity to receive a fair hearing and access to a campus-wide appeal. To safeguard the rights of students and student organizations, the president or delegate shall ensure that each campus has an appeals procedure to govern alleged violations of this policy. The appeals procedure shall provide both substantive and procedural fairness for the student or student organization alleged to have violated the Code and shall provide for resolution of cases within a reasonable period of time.

The appeals procedure must describe:

(a) grounds for an appeal;

(b) procedures for filing an appeal; and

(c) the nature of an appellate review.

SECTION X. DELEGATION OF AUTHORITY.

The president or delegate shall implement this policy, including publishing and distributing the Code and the procedures governing the student disciplinary process at the University.

1 Portions used with permission from New York Institute of Technology and University of Texas, San Antonio. SUPERSEDES: EXISTING DISCIPLINARY APPEALS POLICIES IN CONTRADICTION AND SPECIFICALLY REPEALS THE APPEALS POLICIES DATED FEBRUARY 9, 1979.

http://www1.umn.edu/regents/policies/academic/Student_Conduct_Code.html
ACADEMIC DUE PROCESS POLICY

Informal Resolution
Resident and/or class complaints about course organization, procedures, or grades should be first brought to the course director for informal resolution. If the resident is not satisfied with the proposed resolution, then the resident may next appeal to the Division Director. If the complaint cannot be satisfactorily resolved with the Division Director, then the resident may next appeal to the Department Chairperson. If a mutually agreeable solution cannot be reached, the resident may appeal to the Associate Dean for Academic Affairs. This is however the final level for appeal using the informal resolution process. Grievances involving an instructor's judgment in assigning a grade based on academic performance may be resolved only through informal resolution.

Resident appeals, in writing, about adverse promotion decisions (such as suspension, repeat of a year or the dismissal from the School of Dentistry for academic reasons) shall be made to the Associate Dean for Academic Affairs. The resident has ten (10) working days in which to file an appeal. The Associate Dean for Academic Affairs shall inform the Advanced Education Committee, who shall then meet and begin its review of the resident appeal preferably within ten (10) working days from the time it was filed. The resident may request in writing that the appeal hearing be delayed in order for the resident to adequately prepare.

- Once the notice for the intent to appeal has been received by the Office of Academic Affairs, the resident may attend didactic courses with their originally assigned class. Participation in clinical patient care will be at the discretion of the Program Director.
- Once the date of the appeal hearing has been set, the resident will be notified at least three days in advance and they will confirm their attendance at least 24 hours in advance. If the resident cannot attend the appeal hearing, the Advanced Education Committee has the option to hold the meeting without the resident present.
- The resident should submit a written detailed alternate solution to the decision of the Advanced Education Program for which the resident is appealing to the Advanced Education Committee no later than 24 hours before the appeal hearing. The Office of Academic Affairs and/or the Office of Student Affairs can help with the formulation of this solution.
- The resident can bring a support person to the meeting with them such as the Director of Student Affairs, a parent, a faculty member, a fellow resident, etc. If the accused is represented by an attorney during the meeting, the School of Dentistry will be represented by an attorney from the Office of the General Counsel.
- The student will be advised as to the decision of the Advanced Education Committee within 10 (ten) working days.
- The decision of the Advanced Education Committee on the student’s appeal is final. Further review within the University is available only through the formal process of filing an academic grievance under the procedures of the Conflict Resolution Process for Student Academic Complaints (http://www.policy.umn.edu/Policies/Education/Student/STUDENTCOMPLAINTS_PROC01.html).

Formal Process
The student has a right to file an academic grievance either before or after complaints described earlier in this academic due process policy. Academic grievances are complaints brought by students regarding the provision of educational and academic services affecting their role as students. Academic grievances must be based on a claimed violation of a University rule, policy, or established practice. This policy does not limit the University's right to change rules, policies, or practices. Academic grievances are described by the Board of Regents; Conflict Resolution Process for Student Academic Complaints. A formal process of
resolution is available for academic grievances. The student must submit a formal complaint in writing to the Academic Complaint Officer of the School, identifying the student grievant, the respondent individual(s) involved, the incident, the rule/policy/established practice claimed to be violated, and a brief statement of the redress sought. Additional steps of the formal process of academic grievance are described fully in the Board of Regents; Conflict Resolution Process for Student Academic Complaints (http://regents.umn.edu/sites/default/files/policies/Conflict_Res_Process_Students.pdf).
School of Dentistry Code of Conduct

I. CODE OF CONDUCT

Students preparing for entry into the dental profession are expected to govern their conduct toward patients, other students, faculty, and other professionals with integrity, mutual respect, and honor. This Code of Conduct for the School of Dentistry is based on the following guidelines:

A. Students must treat patients with the realization that the health and welfare of the patients are paramount, and the students must respect the dignity and feelings of their patients in working with them.

B. It is axiomatic that students be honest in didactic and laboratory assignments, examinations, attendance sheets, use of equipment and supplies, entries in patient records and pre-clinical and clinical grade records, and in all aspects of treating patients.

C. Students must conduct themselves in a mature, courteous, and professional manner in lecture classes, clinics, and laboratories, and in other areas of the School of Dentistry and associated teaching environments.

D. Students must not display or participate in threatening, harassing or assaultive behavior or behavior that can reasonably be perceived by others as threatening, harassing or assaultive behavior. Threatening, harassing, or assaultive conduct means engaging in conduct that endangers or threatens to endanger the health, safety, or of physical or emotional welfare of another person or group.

1 “Students” in this document includes students enrolled in any program directed by the School of Dentistry. These include dental, dental hygiene, and dental therapy students as well as postgraduate certificate and advanced degree-granting programs.

II. INFRACTIONS OF THE CODE OF CONDUCT

Each student recognizes any academic misconduct is unacceptable behavior for students in a professional school and is a violation of the Code. “Academic misconduct” is any unauthorized act that may (1) give a student an unfair advantage over other students, (2) interfere with the educational pursuits of others, (3) jeopardize the good name and reputation of the School of Dentistry, (4) involve attempts to mislead, misrepresent, and/or falsify documents, papers, charts,
and/or any information given to faculty or administrative officials or (5) place patients under unnecessary risk. These acts may include but are not limited to:

A. **Cheating**, or assisting another student to cheat, on written examinations, assignments or practical examinations.

B. **Plagiarism**: presenting the scholarly work of another as one’s own.

C. **Misrepresenting** someone else’s project or clinical work as one’s own.

D. **Falsifying or Forging** or attempts to forge or falsify patient records and charts, classroom attendance, or student pre-clinical and clinical records.

E. **Abuse of Equipment** and wasting supplies, including the use of School of Dentistry equipment and supplies for non-school purposes.

F. **Disruptive Behavior** in lecture halls, clinics, or laboratories.

G. **Dishonesty** in any form including but not limited to the presentation of patient fees and collection of these fees.

H. **Patient Mismanagement or Misconduct** such as starting treatment without a starting check, working without supervision, verbal or sexual harassment, physical abuse, or abandonment.

I. **Unethical Behavior** such as treating patients while under the influence of alcohol and/or illicit drugs and over-treatment of patients.

Additional disciplinary offenses actionable by the School or University are stated in the University of Minnesota Student Conduct Code at http://www1.umn.edu/regents/policies/academic/Student_Conduct_Code.html.
III. PROCEDURES FOR DISPOSITION OF ALLEGED VIOLATIONS OF CODE OF CONDUCT

A. Reporting of Alleged Violations

When a faculty member, course director, staff member or student has reason to believe that a violation of the Code of Conduct has been committed, that individual must provide written notification to the School of Dentistry’s Code of Conduct Officer. The Code of Conduct Officer reviews the allegation and determines if a resolution should be attempted without a hearing or if the alleged violation requires a hearing.

All records of allegations and investigation are retained in the Office of Academic Affairs.

B. Accused Student Rights

During the interview with the Code of Conduct Officer, the accused student(s) is informed in writing of the nature of the complaint against him/her and his/her rights. These accused student(s) rights include the following:

1. To be informed in writing during the meeting with the Code of Conduct Officer of the nature of the complaint against him/her and the specific provisions(s) of the Code of Conduct allegedly violated.

2. To work with an individual (faculty member, student, representative from the University Conflict Resolution Center, attorney, etc.) who can act as an advocate for the accused student(s) throughout the complaint process.

3. To be able to present his/her case personally or with the assistance of an advocate (refer to Section B, subtext 2).

4. To be able to hear and examine all evidence and testimony against him/her.

5. To have all information related to the complaint kept confidential by those bringing the complaint and by all parties involved in the hearing and disposition of the complaint.
6. To be notified in writing of the recommendation for the disposition of the complaint.

7. To have a written record of the case kept in the accused student(s’) file in the Office of Academic Affairs.

8. To appeal for sufficient cause his/her case to the University Provost’s Appeal Committee.

C. School of Dentistry’s Code of Conduct Officer

A regular faculty member, appointed by the Dean, and not in the administrative branch of the School of Dentistry, serves as the School’s Code of Conduct Officer for a minimum 3 year term and is eligible for reappointment. He/she

1. Receives the written report of an alleged violation.

2. Insures that the complainant(s) and the accused student(s) are made aware of the process and procedures that are followed in dealing with an alleged violation.

3. Insures that the accused is made aware of the allegations against him/her and informed of his/her rights in the hearing and appeals process.

4. May refer the accused student(s) and complainant(s) to resources for counsel and advice.

5. Attempts a resolution without a hearing following the procedures described in Section H, subtext 1 when the alleged violation does not require a hearing.

6. Refers the case to a Hearing Board when attempts to resolve the allegation in an informal manner are unsuccessful or the type of alleged violation requires a hearing. Procedures describing the formation of a Hearing Board are described in Section H, subtext 2.
7. May, in consultation with the Dean of the School of Dentistry, refer the case to the Office for Student Conduct and Academic Integrity for resolution within the University-wide disciplinary system instead of pursuing resolution within the School.

8. Does not participate in the proceedings of the Hearing Board.

9. Meets annually with faculty and each class to discuss the School’s Code of Conduct and the procedures followed to investigate an alleged violation.

10. Makes an annual report to the Dean, Associate/Assistant Deans, Department Directors and Division Directors summarizing activities related to violations of the School’s Code of Conduct.

If the Code of Conduct Officer is involved in an alleged violation, an interim Code of Conduct Officer is appointed by the Dean.

D. Director of Student Affairs

1. The Director may assist the accused student(s) in identifying resources related to resolution of the allegation; interpreting policy; and assessing additional need for resources.

2. The Director does NOT make judgments on the complaint nor act as an advocate for the accused student(s) during the complaint process.

E. Dental Therapy and Dental Hygiene Division Directors and Course Directors

1. All written reports of alleged violations are reviewed by the Code of Conduct Officer. The Officer consults the Dental Hygiene Division Director or Dental Therapy Division Director during an attempt to informally resolve an alleged violation when the alleged violation does not require a hearing and the accused is from one of these divisions. The Officer also consults the respective course director, if applicable, during an attempt to informally resolve an alleged violation when the alleged violation does not require a hearing.
2. The division director and the course director do not participate in the hearing unless called as a witness.

**F. Advocate for Accused Student(s)**

1. The advocate for the accused student(s) may act on behalf of the student(s) during the complaint process. The advocate may assist the accused student(s) in the informal resolution process if the Code of Conduct Officer determines informal resolution should be attempted. The advocate may represent the accused student(s) before the Hearing Board, including presenting witnesses and evidence on the accused student(s’) behalf and questioning the complainant(s) and complainant(s’) witnesses.

**G. School Presenter**

1. A member of the faculty or administrative staff of the School of Dentistry is appointed by the Dean to represent the school when the case is referred to a School of Dentistry Hearing Board. The Dean may appoint an individual for a specific case or may appoint this person for a specified time period (one year, etc.).

2. The School Presenter reviews the evidence against the accused student(s), interviews the complainant(s), determines the proposed witness list for the hearing in support of the complaint and acts as a resource and advocate for the complainant(s).

3. The School Presenter presents the evidence to the Hearing Board, calls approved witnesses and is allowed to question the accused student(s), all witnesses presented and the complainant(s) during the hearing.

4. If the accused is represented by an attorney during the hearing, the school presenter is replaced by an attorney from the Office of the General Counsel.

**H. Resolution of Alleged Violations**

Resolution of an alleged violation may occur through an informal person-to-person manner as described in the following Section H, subtext 1, or through a more formal Hearing Board as described in Section H, subtext 2.
There are some alleged violations that, because of their seriousness, automatically require a hearing if the Code of Conduct Officer determines that there is adequate supporting evidence. The informal person-to-person attempt at resolution described in subtext (1) below is not used for these alleged violations. These violations include cheating; plagiarism; misrepresenting someone else’s project or clinical work as one’s own; falsifying or forging records, charts or attendance, pre-clinical or clinical records; dishonesty; patient mismanagement; sexual harassment of patients, faculty, staff or other students; threatening or harassing conduct toward others; impairment while providing patient care.

1. Resolution without a hearing

a. The Code of Conduct Officer meets separately with the complainant(s) and the accused student(s) to describe the policies and procedures to be followed in attempting to resolve the accusation. The accused is presented with a clear statement in writing describing the alleged violation. The Code of Conduct Officer assists both parties in identifying resources related to resolution of the allegation, interpreting policy, and assessing additional need for support.

b. The Code of Conduct Officer meets with the accused student(s), complainant(s), the course director and appropriate faculty, staff or students to investigate the issue and see if the meetings can result in an acceptable solution. These meetings are conducted separately or together, at the discretion of the Code of Conduct Officer.

c. Upon conclusion of the meetings, if there is adequate evidence to find the accused student(s) guilty of the allegation, the accused student(s) receive written notification of this finding and a proposed sanction. If the accused student(s) accepts the finding of guilt and the sanction, or fails to appeal, the sanction is enforced and a report of the violation filed in the accused student(s’) record. The Associate Dean of Academic Affairs and, if applicable, the course director are informed of the decision. If the accused student(s) wishes to challenge the guilty finding or sanction,
she/he has ten working days to file a written appeal to the Code of Conduct Officer or the sanction is enforced.

d. If the Code of Conduct Officer is unable to resolve the dispute or the accused student(s) does not accept the proposed sanction, the case is referred to a Hearing Board following the procedures described in Section H, subtext 2.

2. Resolution with a Hearing

a. The Hearing Board evaluates evidence about the alleged violations of the code. The Hearing Board hears testimony from the parties and witnesses and receives written evidence. The Hearing Board endeavors to handle every alleged violation as justly and fairly as possible, to consider each case on its individual merits and to adjust each sanction to the nature and extent of the violation. After hearing all evidence and testimony, the Hearing Board votes to determine the outcome. If the Hearing Board finds a violation occurred, the board determines a sanction.

b. Membership and Officers of the Hearing Board

i. Hearing Board Officer

   a. Hearing Board members elect one of the faculty members to serve as Chairperson. The Chairperson is a non-voting member of the Hearing Board except in the case of a tie at which time he/she may cast the tie-breaking vote.

   ii. The Hearing Board has at least five members with 2 students enrolled in the doctor of dental surgery, dental hygiene or dental therapy programs and 3 or more faculty persons with faculty appointments in these programs.

      a. Student members of the Hearing Board are selected from the School’s Student Affairs Committee with at least one being enrolled in the same program as the accused. If from the same program, student
members are in a different year of the program than the accused whenever possible.

b. Faculty members of the Hearing board are selected from the School’s Student Affairs Committee by its Committee Chair. Faculty members of the Hearing Board must not be party to or witness the alleged violation.

c. Either party to the complaint is given the right to challenge, with cause, seated members of the Hearing Board. The Chairperson rules on the merits of the challenge and decides whether or not the member(s) should be recused.

d. In the case of an accused advanced education or graduate student, an ad hoc committee composed of at least one advanced education or graduate student and two postgraduate faculty who serve as voting members. The Chair of the Advanced Education Committee selects these committee members.

e. The Associate Dean for Academic Affairs or his/her alternate as appointed by the Dean attends the hearing in a non-voting observer capacity and does not participate in the hearing unless called as a witness. The Associate Dean for Academic Affairs or his/her alternate does not make judgments on the complaint nor act as an advocate for the accused student(s) during the complaint process.

c. Meetings of the Hearing Board

i. The Chairperson gives written notification to the complainant(s) and the accused informing them of the following:

a. The charge filed and by whom it was filed.

b. The time, date and place of the hearing.
c. The hearing agenda.

d. Their right to be accompanied by an advocate. If the accused is represented by an attorney, an attorney provided by the School of Dentistry through the Office of the General Counsel presents the case against the accused. The accused must notify the Chairperson well in advance of the hearing if represented by an attorney.

e. Their right to call witnesses and the procedure used to call them.

f. The range of sanctions available to the Hearing Board.

g. The procedure for an appeal, if guilt is determined.

h. The right to challenge for cause seated members of the Hearing Board.

i. Any other information deemed relevant and necessary by the Hearing Board Chairperson.

ii. A preliminary plea of either “guilty” or “not guilty” is obtained by the Chairperson from the accused prior to the actual hearing. If the plea is guilty, the Hearing Board meets to receive this plea and decide the sanction. Witnesses may be called by either party to give testimony bearing upon the appropriate sanction.

iii. The Hearing Board Chairperson requires the parties to identify their witnesses and written evidence before the hearing and to provide this information to each other and the Hearing Board by a set date. The witness lists includes a brief explanation of the purpose of each witness’ testimony. The Chair can limit the number of witnesses to avoid redundant testimony and can exclude written evidence deemed irrelevant or inappropriate.
iv. Meeting Procedures

a. The hearing to investigate an alleged violation of the School’s Code of Conduct is not a legal trial and not subject to all the formalities and processes followed in a court of law. The purpose of the hearing is to fairly and objectively determine if a violation occurred. All participants in the hearing are expected to keep the hearing procedures confidential and to treat each other with respect. Information regarding hearings, names of complainant(s), witnesses, and the accused, and the proceedings of the Hearing Board are strictly confidential.

b. Quorum and Voting Procedures

i. Five voting members of the Hearing Board constitutes a quorum. A quorum must be in the hearing room during the hearing.

ii. Questions are decided by a simple majority of the voting members present.

iii. The Chairperson of the Hearing Board casts the deciding vote if the initial vote by committee members results in a tie.

iv. All procedural decisions of the Chairperson may be changed by a majority vote of the Hearing Board members.

v. A formal record of the hearing is taken for appellate purposes by use of a tape recorder provided by the Hearing Board.

vi. A violation of the code occurs if a majority of the Hearing Board members find that the evidence and testimony meet the standard of “more likely than not” that a violation did occur.

vii. If the verdict is guilty, the Hearing Board determines the sanction according to the options identified in Section IV of this Code.
viii. After a decision has been reached, written notification is delivered to the accused and the Associate Dean for Academic Affairs promptly. This notification includes information on procedures for appeal. The course director is also be informed of the decision, if appropriate.

ix. The Associate Dean for Academic Affairs has the responsibility for carrying out the sanction determined by the Hearing Board. Except for grade changes, penalties are not imposed until after the appeal period expires or the appeal is concluded.

c. The Hearing Board conducts its meeting using the following agenda:

i. The charges are read by the Chairperson.

ii. The Chairperson asks for a plea from the accused.

iii. The accused enters his or her plea. If no plea is entered the proceedings continue as if a plea of “not guilty” had been entered.

iv. The Chairperson may recess the proceedings whenever deemed necessary or appropriate.

v. The complainant(s) may request a withdrawal of the charges at any time during the proceedings.

vi. The Chairperson calls the hearing to order and the hearing proceeds in the following order:

a. The school presenter gives an opening statement and summarizes the evidence against the accused student(s).

b. The accused student(s) or his/her advocate gives an opening statement summarizing the evidence in support of the accused.

c. The school presenter calls his/her approved witnesses including the complainant(s).
d. The accused or his/her advocate may question each of these witnesses and the complainant(s), followed by questions from the Hearing Board members.

e. The accused or his/her advocate calls his/her approved witnesses. The advocate may also call the accused.

f. The School Presenter may question each of these witnesses and the accused student(s), followed by questions from members of the Hearing Board.

g. At the discretion of the Hearing Board, closing statements may be allowed. If so, the school presenter goes first with the accused student or his/her advocate giving the final closing statement.

The Hearing Board deliberates in closed session.

IV. POSSIBLE SANCTIONS FOR VIOLATIONS OF THE CODE OF CONDUCT

A. In arriving at the decision of what sanction to impose for a violation of the Code of Conduct, each case shall be determined on its own individual merits, taking into consideration the nature of the infraction and the previous documented history of the student’s conduct in the School of Dentistry. After the appropriate consideration has been given to a case of violation of conduct, the following are possible sanctions that may be imposed. This list is intended as a guideline and does not preclude the imposition of other possible sanctions.

1. A verbal or written censure.
2. Assigning additional studies and/or reports for violations related to classroom or clinical work.
3. Lowering of a grade in a course in which a violation occurred.
4. Assigning an F grade for the course in which a violation occurred. If an F grade is given, the decision must be made whether the F grade can be resolved through additional studies
and retaking a final examination, for example, or whether the course must be retaken the next time it is offered.

5. Disciplinary probation without the loss of class participation such as in lectures, laboratories, and clinics.

6. Disciplinary probation with the loss of class participation for a specified period of time, such as in lectures, laboratories, and clinics.

7. Suspension from the School of Dentistry for a specified period of time.

8. Deferring graduation and requiring an additional term or terms of attendance.

9. Expulsion from the School of Dentistry. This could be a permanent expulsion or expulsion for a period, such as a year, and could include certain rehabilitative functions mandated to take place in the interim.

V. APPEAL PROCESS

In the event the charged student is unwilling to accept the Hearing Board’s decision, the student may appeal to the Provost, as outlined in the Student Conduct Code Procedure: Twin Cities
http://policy.umn.edu/Policies/Education/Student/STUDENTCONDUCTCODE_PROC01.html

To appeal a disciplinary decision, a student must submit a written appeal to the Provost’s Appeal Secretary within five (5) weekdays of the student’s receipt of the original disciplinary decision. The appeal must include a written statement setting forth the ground(s) for the appeal, specifically identifying the ground(s) and explaining why the ground(s) for appeal are met.

02/11 Approved by the School of Dentistry Student Affairs Committee
12/12 Updated per change in University appeal procedure
School of Dentistry
Standards of Professional Conduct

The University of Minnesota and the School of Dentistry are committed to the highest standards of professional conduct and integrity. The values we hold among ourselves to be essential to responsible professional behavior include honesty, trustworthiness, respect and fairness in dealing with other people, a sense of responsibility toward others and loyalty toward the ethical principles espoused by the University and the School of Dentistry. It is important that these values and the tradition of ethical behavior be consistently demonstrated and carefully maintained.

Members of the University community and the School of Dentistry have the obligation to respect and to be fair to faculty, staff, students, and patients, and to foster their intellectual and professional growth and well-being. Members must not engage in, nor permit, harassment, offensive behavior, or illegal discrimination. Members must not abuse the authority they have been given and care must be taken to ensure that any personal relationships do not result in situations that might interfere with objective judgment.

Workplace, patient care and educational experiences must impart ethical standards of professional conduct through example, instruction and clinical practice. Members of the University community and the School of Dentistry are expected to conscientiously fulfill their obligations in the performance of their duties and as part of the University community.

RESPECTFUL WORKPLACE

The School of Dentistry is proud of the respectful workplace we have developed for faculty, staff, students and patients. We believe our goal is to maintain an academic, work and patient care environment that is positive and respectful of others. Respect is provided to every person regardless of gender, race or color, religious or spiritual beliefs or creed, nationality, sexual preferences or affection, disability, credit or financial situation, public assistance, veteran status, or physical condition. We believe in providing a respectful and positive learning and working environment that maximizes the potential of all individuals.
With these values as the foundation for the School of Dentistry, we have established guidelines, based on University policy, for the behavior of our faculty, staff and students.

We will engage in legal and ethical conduct and will not tolerate offensive behavior. Offensive behavior is defined as action or conduct that has the purpose or effect of unreasonably interfering with an individual’s work, academic or professional performance or creating an intimidating or hostile work environment. Employment and academic experiences will be based on respect and performance.

Explicit or implicit harassment, unwelcome advances, requests for sexual favors, or unwelcome physical conduct of a sexual nature will be promptly addressed. In addition, a hostile workplace, including abusive language, discriminatory or offensive remarks or humor, offensive visual displays, pornography, or aggressive physical contact will be addressed.

EQUAL OPPORTUNITY, DIVERSITY AND AFFIRMATIVE ACTION

The University of Minnesota and the School of Dentistry are committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation. The University and the School of Dentistry shall seek to:

1. Provide equal access to its programs, facilities, including patient care clinics.
2. Advocate and practice affirmative action in employment including the use of recruiting and search processes to enhance participation of racial minorities, women, persons with a disability, and military veterans.
3. Establish and nurture an environment that actively acknowledges and values diversity and is free from racism, sexism, and other forms of prejudice, intolerance or harassment, for all faculty, staff and students.
4. Provide equal educational access to members of under-represented groups, and develop affirmative action admission programs where appropriate to achieve this goal.
DISABILITY SERVICES

The Board of Regents of the University of Minnesota is committed to provide for the needs of faculty, staff and enrolled or admitted students with disabilities under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA). The School of Dentistry will make services available for any faculty member, staff, or student who, through a recent assessment, can document a disability. Disability Services, with support from the School of Dentistry, will provide appropriate services, including: (1) support, counseling, and information; (2) communications with medical provider; and (3) assistance with reasonable accommodations.

DRUG-FREE WORKPLACE

Having a respectful workplace also includes providing faculty, staff and students with a healthy and productive environment. We believe that drug and alcohol abuse affects the health, safety and wellbeing of all employees and students and restricts their ability to perform. This is particularly critical for those who work with and practice dentistry with patients. Therefore, the School of Dentistry supports and follows the University of Minnesota's Drug-Free Campus and Workplace policy. (http://www.policy.umn.edu/Policies/Operations/Safety/DRUGFREE.html). This policy prohibits the unlawful possession, use, or distribution of alcohol and illicit drugs by employees. Furthermore, it prohibits the unlawful manufacture, distribution, dispensation, possession, or use of controlled substances in the workplace.

SEXUAL HARASSMENT

Sexual harassment by or toward faculty, staff, students, patients, or members of the University community is prohibited. Prompt and appropriate action will be taken when sexual harassment is discovered. Persons who suspect sexual harassment should report it to an appropriate authority, such as the Dental School’s EEO Officer; or Human Resources Director; or the University’s EEO Office. A violation of the sexual harassment policy may lead to disciplinary action, up to and including termination of employment or academic dismissal.
RECOUSE AND REPORTING

It is not necessary for any faculty, staff, or student who feels he or she is the subject of offensive, harassing or discriminatory behavior to handle the matter alone. We encourage you to directly object to any behavior you believe to be offensive. However, if you feel offended by faculty, staff, your boss, peers, or others whom you encounter in the course of your employment or academic studies and do not feel you are able to deal directly with the problem, go immediately to your supervisor, or, you may report the behavior to the School of Dentistry's Equal Opportunity Liaison, Dr. Carol Meyer (626-2332); the Director of Student Affairs, Ms. Sara Johnson (624-6960) or the University of Minnesota's Office of Equal Opportunity and Affirmative Action (624-9547).

All allegations of offensive, discriminatory, or other inappropriate behavior will be responded to immediately. The facts shall determine the response to each complaint and each situation will be handled discreetly. Retaliation and intimidation directed toward anyone who makes a complaint is prohibited. This practice applies to each and every full- or part-time faculty, staff, student and patient in the School of Dentistry.
Wellness Program, a professional and confidential problem-solving resource provided at no cost to the participant. The Dentist Wellness Program can be accessed by calling the Sand Creek Group, Ltd. at (800) 632-7643, 24 hours a day, seven days a week. Sand Creek Group also offers a comprehensive web-based information resource that provides dentists and their families with interactive tools and current information about child care, adoption, education, eldercare, wellness and everyday life issues. This information is accessible through the members section of the MDA website.

In addition, DDS, Graduate and Advanced Education students concerned about their relationship with alcohol or other drugs can contact Dentist Concerned for Dentists (DCD), a confidential support group made up of dentists from around the state who have experienced substance abuse/dependency problems in their own lives and who now serve others as confidential supporters and resources for recovery. DCD can be reached by calling (651) 275-0313.

Professional Attire and Guide for Personal Appearance

The personal appearance and demeanor of every person affects, either directly or indirectly, the care and management of patients. The image communicated to patients through personal attire and appearance, behaviors and interactions will influence their perceptions of the quality of care they will receive at the University of Minnesota School of Dentistry and their confidence in the person providing that care. A presentation of professionalism is essential to uphold the standards of excellence set by the University of Minnesota, the School of Dentistry, and the dental profession.

Dentists, in their own practices, will decide for themselves what appearance promotes a demeanor of professionalism. Throughout the School of Dentistry this is best accomplished by a reasonable degree of conformity in attire and grooming. All faculty, staff and students are responsible for maintaining a clean, neat and well fitting wardrobe.

The following guidelines apply for all DDS, DH and DT students:
Personal hygiene and grooming habits are essential components of professional appearance and presentation.
Hair: (including beards and mustaches) should be clean, neatly trimmed, and well maintained. Those who shave must be clean-shaven. Long hair should be pinned or held back so that it does not interfere with the field of vision or require handling during treatment procedures.

Makeup and perfume/after-shave: Strong perfumes and cologne may be offensive to others or may cause allergic reactions; therefore avoid excessive use. Heavy application of make-up should also be avoided.

Personal hygiene: Body hygiene is required so that offensive body odor is avoided. Fingernails should be trimmed, clean and well groomed. Artificial nails are not allowed as they may harbor microorganisms.

Jewelry: Rings that may compromise clinical protective barriers should not be worn in clinics. All watches, necklaces, etc. must be covered by protective barriers such as the blue clinic gown. No facial piercing should be evident during the school/clinic day (i.e. no rings or studs may be worn on the face or in the mouth). Tattoos must be covered in clinic.

All students will wear the School of Dentistry matching scrub shirt, pants, and/or skirt in the color designated for their program (navy blue for DDS students, burgundy for DH students, black for DT students). Scrub pants and skirts should not touch or drag the ground when standing or seated. Scrubs must be maintained in a clean, neat, and professional manner. Any head coverings such as hijabs, yamakas, etc. and/or face veils must be changed or washed daily. In addition, clean, predominately white, black or color matching shoes (closed-toed and fluid resistant) and white socks (crew length or longer) are required. We suggest these shoes be worn only in Moos Tower so they remain clean and professional in their appearance. Skirts must be at or below the knee. Legs must be cover with nude, black, or color matching hoses, tights, or scrub pants. Students may wear white, black, or color matching tee shirts underneath their scrub tops, if desired. Nametags must be visible.

Attendance Policy

Please see the School of Dentistry Current Students website (http://www.dentistry.umn.edu/current-students/absences/index.htm) for DDS, DT and DH attendance policies and procedures.

Updated 6/12
Policy for Students with Chemical Dependency Problems

The University of Minnesota School of Dentistry is supportive of the efforts of chemically dependent students to become free of their dependency problems. In dealing with chemically dependent students, the School’s procedure involves intervention and requiring students to join treatment and rehabilitation programs. This procedure was established to insure the safety of patients that students may come in contact with and to protect the interests of the patients, students, faculty, and School.

The following steps will be followed as soon as a student has been identified as having chemical dependency problems:

1. The student will be granted a medical leave of absence from the educational program by the Council of Chairs. The request for a leave may be initiated by the student or the Director of Student Affairs/Director of the Division of Dental Hygiene/Director of the Dental Therapy.

2. The Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy will arrange with the student a program for the treatment of chemical dependency. Usually, the student will be counseled to enroll in an inpatient chemical dependency treatment program and provide the Office of Academic Affairs/Division of Dental Hygiene/Division of Dental Therapy with evidence of successful completion of the program. However, the student may select a different treatment modality contingent on the approval of the Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy.

3. If a student and the Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy do not reach an agreement on a treatment and rehabilitation program, either may request a hearing by the Council of Chairs.

4. The Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy will counsel the student to join a sobriety support group, e.g., Dentists
Concerned for Dentists, after completion of the treatment program.

5. The student will be asked to give the Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy permission to solicit letters of reference from counselors, employers, or members of the sobriety support group to monitor the progress of the student's rehabilitation program.

6. The Director of Student Affairs/Director of the Division of Dental Hygiene/Director of Dental Therapy will make recommendations to the Associate Dean for Academic Affairs to terminate the student's medical leave of absence and allow the student to resume the program after obtaining evidence with the student's consent that the student has completed the treatment program, is participating in a rehabilitation program, and is also being monitored for continued progress through the Health Professionals Service Program.

7. The Associate Dean for Academic Affairs will determine whether to permit the student to resume the program after obtaining evidence regarding the student's progress in the rehabilitation and monitoring programs that show the student has been chemically free for at least ten weeks.

Updated 07/09
DH Make-Up Exam Policy for Missed Exams Due to Extramural Clinical Experiences

Students at clinical outreach sites in the Metro area or in Hibbing or Wilmar must take the exam on or one day after the examination date. The student must notify the course director that he/she will miss an exam due to a SOD clinical rotation. The time and place of the make-up exam must be coordinated with the course director and/or Tina Jalivay in the dental hygiene office. This policy applies to students who study abroad.

DDS, DH and DT Remediation Exams Policy

The Scholastic Standing Committee will decide the availability of re-examinations for failed courses after reviewing the student’s academic record. If a student fails a course, the maximum grade attainable after successful re-examination is a C. If the student does not successfully complete re-examination, the Scholastic Standing Committee will determine the student’s options.

2/3/86 Approved EPC 6/1/98 Amended by the EPC 8/25/04 Amended by the EPC 8/1/05 Amended by the EPC

Academic Due Process Policy

Informal Resolution

Student and/or class complaints about course organization, procedures, or grades should be first brought to the course director for informal resolution. If the student is not satisfied with the proposed resolution, then the student may next appeal to the Division Director. If the complaint cannot be satisfactorily resolved with the Division Director, then the student may next appeal to the Department Chairperson. If a mutually agreeable solution cannot be reached, the student may appeal to the Associate Dean for Academic Affairs. This is however the final level for appeal. Grievances involving an instructor’s judgment in assigning a grade based on academic performance may be resolved only through the informal resolution described above.
Student appeals, in writing, about adverse promotion decisions (such as suspension, repeat of a year or the dismissal from the School of Dentistry for academic reasons) shall be made to the Core Student Scholastic Standing Committee. The student has ten (10) working days in which to file an appeal. The Core Student Scholastic Standing Committee shall then meet and begin its review of the student appeal preferably within ten (10) working days from the time it was filed. The student may request in writing that the appeal hearing be delayed in order for the student to adequately prepare. Please see “Specific Procedures for Appealing Adverse Decisions” section later in this handbook.

Formal Process

The student has a right to file an academic grievance either before or after complaints described earlier in this academic due process policy. Academic grievances are complaints brought by students regarding the provision of educational and academic services affecting their role as students. Academic grievances must be based on a claimed violation of a University rule, policy, or established practice. This policy does not limit the University's right to change rules, policies, or practices. Academic grievances are described by the Board of Regents; Conflict Resolution Process for Student Academic Complaints.

A formal process of resolution is available for academic grievances. The student must submit a formal complaint in writing to the Academic Complaint Officer of the School, identifying the student grievant, the respondent individual(s) involved, the incident, the rule/policy/established practice claimed to be violated, and a brief statement of the redress sought. Additional steps of the formal process of academic grievance are described fully in the Board of Regents; Conflict Resolution Process for Student Academic Complaints.

11/12/90 Approved EPC, 7/19/93 Amended EPC 10/02/95 Amended EPC 6/1/98 Amended by the EPC 8/1/05 Amended by the EPC Updated 07/09
Disputes in the classroom, workplace or elsewhere on campus may arise in any number of ways. The University of Minnesota is committed to preventing disputes where possible, and to quickly and fairly resolving disputes when they do arise.

Take this opportunity to acquaint yourself with the resources available to address faculty, staff, and student needs. Check with your college or administrative unit for additional resources.

Learn More Inside...
Frequently Asked Questions

If I have a problem with a co-worker, do I have to file a formal complaint? No. Most of the dispute resolution offices offer consulting services that do not require lodging a formal complaint. The Office for Conflict Resolution can help you evaluate informal options for resolving an employment concern.

I have a problem with my professor, but what can I do without jeopardizing my grade? Talk to the Student Conflict Resolution Center. They respect a student's wishes regarding confidentiality and can help with a wide range of student issues.

I want the dirty jokes in my unit to stop, but I don't want to get anybody in trouble. Where can I go? Talk to the Office of Equal Opportunity and Affirmative Action. The EOAA office will work with you to find non-punitive strategies to get the conduct to stop.

What can I do to prevent conflicts among the researchers on this big research project? Look at Resource for Researchers at www.umn.edu/~sos. It is a short checklist of items that, if discussed and decided early, can help prevent common research disputes.

I do not agree with my supervisor's interpretation of the sick leave policy. Where should I go? Contact the Human Resources Director in your unit or a Human Resources Consultant in the central Office of Human Resources. If you do not reach agreement, the Office for Conflict Resolution is a resource for you.

We have a long-standing conflict in our department. What can I do? The Employee Assistance Program is knowledgeable about educational programs and organization development initiatives. Your consultation with them will be kept confidential.

What if I don't want to be labeled a troublemaker? The University encourages students, staff, and faculty to come forward with concerns. By doing so, you create the opportunity to help your co-workers, the unit, and the University. The University wants to send the message that raising concerns is not “causing trouble.”

Department of Audits
Investigates allegations of financial, operational, technical or regulatory misconduct
www1.umn.edu/audit/
hotline – 612-626-0227
office – 612-625-1368

Aurora Center for Advocacy and Education
Counsels victims of stalking, harassment, sexual assault, and relationship abuse
www1.umn.edu/aurora
crisis line – 612-626-9111
office – 612-626-2929

Council of Academic Professionals and Administrators
Advises U administration on policies impacting P&As and advocates for P&As in U governance
www1.umn.edu/ohr/capa

Civil Service Committee
Advocates for civil service employees
www1.umn.edu/csc
csc@tc.umn.edu

Collective Bargaining Units
Represents bargaining unit employees in employment disputes
Union steward or business agent

Disability Services
Offers services to support students and employees with disabilities
ds.umn.edu/Employee
612-624-3316

Employee Assistance Program
Faculty & Academic Staff Assistance Program
Offers confidential counseling and dispute resolution services for employees and faculty
www1.umn.edu/ohr/eap
CS and BU 612-626-0253
Faculty and P&A 612-625-4073

Equal Opportunity and Affirmative Action
Provides consultation, problem solving, education, and training; investigates harassment and discrimination complaints
www.eoaffact.umn.edu
612-624-9547

General Counsel
Conducts investigations and gives legal advice to University administrators
www.ogc.umn.edu
612-624-4100

Human Resources
Provides guidance about HR policies for all employees
www.umn.edu/ohr
Central HR - 612-625-2000
Unit HR office
Acad Hlth Ctr HR – 612-624-7957

Office for Conflict Resolution
Administers processes to resolve employment disputes for non-bargaining unit employees
www.umn.edu/conflictresolution
612-624-1030

Senate Judicial Committee
Hears complaints by faculty on tenure and academic freedom disputes
www1.umn.edu/usenate/committees/judicial.html
612-625-9369

Student Conflict Resolution Center
Provides ombuds and advocacy assistance for students in disputes
www.umn.edu/~sos
612-624-7272

Student Judicial Affairs
Hears complaints regarding student conduct on campus
www.sja.umn.edu
612-624-6073

University Counseling and Consulting Services
Offers short-term counseling services to students
www.ucs.umn.edu
612-624-3323

University Student Legal Services
Represents students in non-University legal matters
www1.umn.edu/usls/
612-624-1001

If I have a problem with a co-worker, do I have to file a formal complaint? No. Most of the dispute resolution offices offer consulting services that do not require lodging a formal complaint. The Office for Conflict Resolution can help you evaluate informal options for resolving an employment concern.

I have a problem with my professor, but what can I do without jeopardizing my grade? Talk to the Student Conflict Resolution Center. They respect a student’s wishes regarding confidentiality and can help with a wide range of student issues.

I want the dirty jokes in my unit to stop, but I don’t want to get anybody in trouble. Where can I go? Talk to the Office of Equal Opportunity and Affirmative Action. The EOAA office will work with you to find non-punitive strategies to get the conduct to stop.

What can I do to prevent conflicts among the researchers on this big research project? Look at Resource for Researchers at www.umn.edu/~sos. It is a short checklist of items that, if discussed and decided early, can help prevent common research disputes.

I do not agree with my supervisor’s interpretation of the sick leave policy. Where should I go? Contact the Human Resources Director in your unit or a Human Resources Consultant in the central Office of Human Resources. If you do not reach agreement, the Office for Conflict Resolution is a resource for you.

We have a long-standing conflict in our department. What can I do? The Employee Assistance Program is knowledgeable about educational programs and organization development initiatives. Your consultation with them will be kept confidential.

What if I don’t want to be labeled a troublemaker? The University encourages students, staff, and faculty to come forward with concerns. By doing so, you create the opportunity to help your co-workers, the unit, and the University. The University wants to send the message that raising concerns is not “causing trouble.”
UNIVERSITY OF MINNESOTA
School of Dentistry
Clinic Manual

Revised May 2013
SCHOOL OF DENTISTRY

Clinic Manual

The intent of this manual is to provide the University of Minnesota School of Dentistry Students, Faculty, and Staff with a resource regarding clinical policies and procedures. The manual is available to all students, faculty, and staff in electronic format through the School of Dentistry Intranet. Alternate formats are available upon request.
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General Clinic Information

Welcome to the University of Minnesota Dental Clinics! Approximately 450 patients visit the clinics daily. In addition, there are nearly 200 students, over 200 faculty and 200 staff members involved in clinic operations. In order to provide the best education opportunities to students and the best dental care to patients, it is important that all individuals involved in the clinics utilize this manual as the resource for policies and protocols.

Clinic Directory

As just mentioned over 400 faculty and staff are a part of the clinic operations. Some staff members, such as the Patient Care Coordinators, Dental Assistants, Stores Clerks, Laboratory Technicians, and Treatment Planning Coordinators are individuals students may interact with on a daily basis, while others, such as Medical Records, and Insurance personnel will often work with patients or behind the scenes supporting patients, students, faculty, and other staff.

The following is a list of the clinic areas that students will work in throughout their academic experience:

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<tr>
<th>CLINIC</th>
<th>LOCATION</th>
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<tr>
<td>Silver (Dr. Stefani)</td>
<td>9th floor</td>
<td>612-625-2198</td>
</tr>
<tr>
<td>Red (Dr. Watkin)</td>
<td>9th floor</td>
<td>612-625-5489</td>
</tr>
<tr>
<td>Purple (Dr. Mills)</td>
<td>9th floor</td>
<td>612-625-5999</td>
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<tr>
<td>Green (Dr. Nadeau)</td>
<td>9th floor</td>
<td>612-625-8987</td>
</tr>
<tr>
<td>Yellow (Dr. Owen)</td>
<td>9th floor</td>
<td>612-626-4192</td>
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<tr>
<td>Blue (Dr. Meyer)</td>
<td>8th floor</td>
<td>612-625-0324</td>
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<tr>
<td>Orange (Dr. Real)</td>
<td>8th floor</td>
<td>612-624-4191</td>
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<td>Maroon (Dr. Gambucci)</td>
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<td>612-624-2481</td>
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<tr>
<td>Dental Implants</td>
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<td>612-625-3649</td>
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<tr>
<td>Endodontics</td>
<td>8th floor</td>
<td>612-624-2661</td>
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<tr>
<td>Urgent Care</td>
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<td>612-625-4908</td>
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<tr>
<td>Oral Radiology</td>
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<td>612-625-6444</td>
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<td>612-625-7171</td>
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<tr>
<td>Periodontology (Grad/Undergrad)</td>
<td>7th floor</td>
<td>612-625-6177</td>
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<td>Prosthodontics</td>
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<td>612-625-5441</td>
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The following is a more detailed directory of School of Dentistry Clinics and Departments.
# School of Dentistry Telephone Directory

## Administration and Central Services

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<tr>
<td>Dean</td>
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<tr>
<td>Chief Administrative Officer</td>
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<td>6-1711</td>
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## Academic Affairs

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<td>Chris Thompson</td>
<td>5-9224</td>
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<td>Bruce Eidel</td>
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<td>Allison Smith</td>
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## Continuing Dental Education

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<td>Preng Rasmussen</td>
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<td>Ruo Fei</td>
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<td>Andrew McLean</td>
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## Development/Alumni Relations

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<td>Emily Best</td>
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<td>Laura Ried</td>
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## Academic Computing Lab

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<td>Tessa Ludwick</td>
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<td>Jennifer Armstrong</td>
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## CLINICAL AFFAIRS

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## Instrument Management Systems

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<td>Jan Tilley</td>
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## DENTAL CLINICS

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<td>9th Floor</td>
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<tr>
<td>TMD and Orofacial Pain</td>
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## EMERGENCY TELEPHONE NUMBERS

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<tr>
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### DEVELOPMENTAL and SURGICAL SCIENCES

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<tr>
<td>Larry Wolff</td>
<td>Intern Chair</td>
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<td>17-253</td>
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<tr>
<td>Denise Thoroan</td>
<td>Executive Assistant</td>
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<td>7-194</td>
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<td>Nina Tran</td>
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<td>Gery Anderson</td>
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<td>Anna Thomas</td>
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<td>Nina Tran</td>
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### Diagnostic and Biological Sciences

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Donald Simone</td>
<td>Intern Chair</td>
<td>5-4664</td>
<td>17-253</td>
</tr>
<tr>
<td>Doug Nagay</td>
<td>Executive Assistant</td>
<td>4-9123</td>
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<tr>
<td>Nina Tran</td>
<td>Financial Administrator</td>
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<tr>
<td>Institute for Molecular Virology Program</td>
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<tr>
<td>Louis Mardery</td>
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<td>6-5525</td>
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</tr>
<tr>
<td>Ian Jackson</td>
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<tr>
<td>Ann Hogan</td>
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<tr>
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<tr>
<td>Nabil Rhodner</td>
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<tr>
<td>Iman Ahmad</td>
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<tr>
<td>Joyce Wallace</td>
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<td>Fritz Rader</td>
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<tr>
<td>Jan Jackson</td>
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<tr>
<td>Eric Schimmel</td>
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<td>5-3146</td>
<td>6-235D</td>
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<tr>
<td>Don Vardaroff</td>
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<tr>
<td>Thomas Schimmel</td>
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<tr>
<td>Barbara Bults</td>
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<td>5-3684</td>
<td>7-368</td>
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<tr>
<td>James Hruschka</td>
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<td>6-6807</td>
<td>7-368</td>
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<tr>
<td>Barb Schmidt</td>
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<td>7-508</td>
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<tr>
<td>Lisa Dukart</td>
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<td>6-7083</td>
<td>7-304</td>
</tr>
<tr>
<td>Nina Nolos</td>
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### Primary Dental Care

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<tr>
<td>Sheila Ragg</td>
<td>Chair</td>
<td>6-7515</td>
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<tr>
<td>Giza Dugan</td>
<td>Executive Assistant</td>
<td>5-2691</td>
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<tr>
<td>Sade Ayees-Opadre</td>
<td>Financial Administrator</td>
<td>4-3490</td>
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<tr>
<td>Comprehensive Care Division</td>
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<tr>
<td>Kevin Quick</td>
<td>Intern Division Director</td>
<td>5-4448</td>
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<tr>
<td>Mark Weigner</td>
<td>Administrative Support</td>
<td>4-7934</td>
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<tr>
<td>Dental Hygiene Division</td>
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<tr>
<td>Christine Blue</td>
<td>Division Director</td>
<td>5-5994</td>
<td>9-372</td>
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<tr>
<td>Tara Michael</td>
<td>Student Personnel Coordinator</td>
<td>5-8021</td>
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<tr>
<td>Community Oral Health Division</td>
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<tr>
<td>Peter Berwald</td>
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<td>6-5400</td>
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<tr>
<td>Chris Thompson</td>
<td>Executive Assistant</td>
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<tr>
<td>Oral Health Services for Older Adults Program</td>
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<tr>
<td>Stephen Shoemus</td>
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<tr>
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<tr>
<td>Paul Schultz</td>
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<td>4-5331</td>
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<tr>
<td>Megan Reed</td>
<td>Community Program Specialist</td>
<td>5-1417</td>
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<tr>
<td>Jerry Pederson</td>
<td>Director, Epping Clinic</td>
<td>218-263-9188</td>
<td>9-426</td>
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<tr>
<td>Debra Vos Alman</td>
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<td>218-263-9187</td>
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<tr>
<td>Dental Therapeutics Division</td>
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<tr>
<td>Karl Seif</td>
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<tr>
<td>Annabel Nagay</td>
<td>Program Coordinator</td>
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### General Practice Residency

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<tbody>
<tr>
<td>Mark Roetting</td>
<td>Clinic Director</td>
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<td>8-260</td>
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<tr>
<td>James Gamberculi</td>
<td>GPR Program Director</td>
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</tr>
<tr>
<td>Debby Weens</td>
<td>Dental Clinic Manager</td>
<td>6-6989</td>
<td>R</td>
</tr>
<tr>
<td>Emily Laffegg</td>
<td>Residency Coordinator</td>
<td>6-6989</td>
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</tr>
<tr>
<td>GPR Clinic</td>
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### RESTORATIVE SCIENCES

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<tbody>
<tr>
<td>Ralph DeLong</td>
<td>Intern Chair</td>
<td>5-4149</td>
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<tr>
<td>Denise Thoroan</td>
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<td>Nina Nolos</td>
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<td>Biomaterial Research Center Program</td>
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<tr>
<td>Alex Fok</td>
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<td>5-4906</td>
<td>16-212</td>
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<tr>
<td>Marilyn Vinoy</td>
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<td>5-9950</td>
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<tr>
<td>Scott McIninden</td>
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<td>5-4474</td>
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<tr>
<td>Scott McIninden</td>
<td>Director, Advanced Training Program</td>
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<tr>
<td>Mike Baidran</td>
<td>Director, DDS Program</td>
<td>6-1313</td>
<td>8-166</td>
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<tr>
<td>Walter Bowles</td>
<td>Director, Pre-Clinic Research</td>
<td>5-6635</td>
<td>8-166</td>
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<tr>
<td>Jane Schiller</td>
<td>Administrative Support</td>
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<td>Operative Dentistry Division</td>
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<tr>
<td>Gary Bihlbeard</td>
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<tr>
<td>Jason Bolds</td>
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<td>Craig Bothman</td>
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<td>Erin Novak</td>
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<tr>
<td>Gary Cook</td>
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<tr>
<td>Carol Smeds</td>
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<tr>
<td>Brother Susana</td>
<td>Director, Advanced Training Program</td>
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<td>Margar Johnson</td>
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### Misc.

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<tr>
<td>LDRCCR Alex Folk</td>
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<tr>
<td>PASS Program</td>
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<td>15-121</td>
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</tbody>
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Page | 6
Clinic Hours

The U of M Dental Clinic schedules provide patients with a variety of appointment options. Students must check their clinic schedules to be certain that they will be available when discussing appointment options with patients. State law prohibits students treating patients without a faculty member being in attendance; this applies to before, during, or after the clinic session. The Comprehensive Dental Clinics, including Undergraduate Endodontics and Undergraduate Periodontics, operate on the following schedule during the academic year:

<table>
<thead>
<tr>
<th>A.M.</th>
<th>P.M.</th>
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</thead>
<tbody>
<tr>
<td>9:00</td>
<td>Students and Faculty in Clinic 1:00</td>
</tr>
<tr>
<td>9:15</td>
<td>Patients Seated 1:15</td>
</tr>
<tr>
<td>12:00</td>
<td>Patient Dismissal 4:00</td>
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</table>

Double Clinics 1 day semester five, all clinic sessions semester six according to the following schedule:

<table>
<thead>
<tr>
<th>A.M.</th>
<th>P.M.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Students and Faculty in Clinic 1:00</td>
</tr>
<tr>
<td>8:15</td>
<td>Patient #1 Seated 1:15</td>
</tr>
<tr>
<td>9:30 – 10:00</td>
<td>Final Evaluation patient #1 2:15-2:45</td>
</tr>
<tr>
<td>10:15</td>
<td>Patient #2 Seated 3:00</td>
</tr>
<tr>
<td>11:30 – 12:00</td>
<td>Final Evaluations patient #2 4:00-4:30</td>
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</table>

**Dental Hygiene Clinic Hours**

**DDS & DT Clinic Hours**

<table>
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<tr>
<th>A.M.</th>
<th>Set-Up</th>
<th>Treatment</th>
<th>Clean up</th>
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<tbody>
<tr>
<td>Fourth Year</td>
<td>8:45-9:45</td>
<td>9:00-12:00</td>
<td>12:00-12:15</td>
</tr>
<tr>
<td>Third Year</td>
<td>9:30-9:45</td>
<td>9:45-12:00</td>
<td>12:00-12:15</td>
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</table>

<table>
<thead>
<tr>
<th>P.M.</th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Fourth Year</td>
<td>1:00-1:15</td>
<td>1:15-4:00</td>
<td>4:00-4:15</td>
</tr>
<tr>
<td>Third Year</td>
<td>1:00-1:15</td>
<td>1:15-4:00</td>
<td>4:00-4:15</td>
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</table>

Summer session AM start times depend upon the didactic schedule. Clinic set-up times begin after the end of the didactic session.

Dispensary hours are:

<table>
<thead>
<tr>
<th>North (clean instruments)</th>
<th>South (used instruments)</th>
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</thead>
<tbody>
<tr>
<td>7:45 am – 12:00 pm</td>
<td>9:00 am – 1:30 pm</td>
</tr>
<tr>
<td>12:15 – 4:30 pm</td>
<td>1:45 – 5:45 pm</td>
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</table>
Mission of the School of Dentistry

The University of Minnesota School of Dentistry improves oral and craniofacial health by educating clinicians and scientists who translate knowledge and experience into clinical practice. The School is committed to:

- graduating professionals who provide the highest quality care and service to the people of the State of Minnesota and the world
- discovering new knowledge through research, which will inspire innovation in the biomedical, behavioral and clinical sciences; and
- providing oral health care to a diverse patient population in a variety of clinical settings

Patient Brochure

The Patient Brochure (http://www.dentistry.umn.edu/prod/groups/sod/@pub/@sod/documents/content/sod_content_404668.pdf) has been developed to outline Patient Rights and Responsibilities for individuals interested in becoming a patient at the University of Minnesota School of Dentistry. These individuals will be provided with a copy of the brochure prior to their Initial Faculty Consultation appointment and will be asked to sign a form stating that they have read the brochure and understand their rights and responsibilities as a patient. Students, faculty, and staff should be familiar with the material in the brochure and refer patients to the document for answers to questions.
General Clinic Policies

Medical Emergencies

Basic Life Support Training
Students, staff, and faculty members who attend to patients in the UM Dental Clinics are required to maintain current Basic Life Support for Healthcare Providers certification. Regularly scheduled trainings for School of Dentistry students, staff, and faculty are provided in-house by a licensed paramedic. All instructors are American Heart Association certified trainers. Student dentists are certified twice: during the summer after their first year in the program and during the summer of their senior year. For additional information, contact Clinical Systems Office (Room 8-440).

Medical Emergency Protocol Provided in Dental Clinics Only (Floors 6-9, 8AM - 4:30PM)
If a dental patient is having signs or symptoms of an actual or impending medical emergency including:

• Shortness of breath
• Seizure
• Blotches on skin
• Diminished consciousness
• Aspiration of Foreign Body
• Malaise or fatigue
• Wheezing, unable to get breath
• Chest pain
• Loss of awareness
• Asthma attack

1. Stay with patient
2. Alert faculty and clinic staff; obtain clinic emergency kit and oxygen tank
3. Continuous assessment – ABCs of BLS, blood pressure, pulse, symptoms
4. Treat emergency
5. Discharge patient
6. Record event by filling out medical emergency form within 24 hours.

Turn into 8-440b Moos Tower (Associate Dean, Clinic Administration and Patient Care)

If emergency situation worsens or is severe and there is need for additional support:

If emergency situation worsens or is severe and there is need for additional support:

1. Send person to call 1 2 3 4 5 (Fairview Southdale Emergency Operator) and request ONE of the following:

   a. No pulse or breathing – CODE BLUE TEAM, specifying ADULT or PEDIATRIC (if patient is under 18 years, regardless of size)
b. Breathing with pulse – DENTAL RESPONSE TEAM (for more severe medical emergencies where patient is not recovering normally).

2. Caller must state the following information:
   a. “School of Dentistry”
   b. “Moos Tower”
   c. “Floor” the emergency is on
   d. “Call Back Number”

3. Caller must then proceed to South Elevators of Moos Tower to meet code team and take them to site of code. Return to South Elevators as code/response team may arrive individually.

4. Student and Faculty must stay with patient until code/response team leave the scene.

5. Record event by filling out medical emergency form within 24 hours. Turn into 8-440 Moos Tower (Associate Dean for Clinical Affairs office).

**Universal Treatment of Emergencies**

Categorizing an emergency is unnecessary in most cases until the acute situation has improved. It is more important to respond quickly to the symptoms of the emergency. There are a few “universal modes of treatment” common to nearly all emergencies.

a. Place the patient in a supine position with the torso parallel to the floor and feet elevated slightly. **EXCEPTION:** Respiratory problems and chest pain should be handled in a semi-supine position (20 degrees from horizontal).

b. Establish and maintain open airway and administer oxygen. **EXCEPTION:** Hyperventilation

c. Establish respiration.

d. Establish pulse.

e. Check blood pressure.

   Be prepared to perform cardiopulmonary resuscitation (CPR).

f. If medical assistance is required, call 1 2 3 4 5, following protocol listed above.

**Medical Emergency Equipment**

The following emergency equipment and supplies are available from the clinical dispensing stations:

- Oxygen delivery systems (oxygen tank, bag, and mask)
- Portable suction system and throat suction tip
- Basic emergency kit containing:
- Blood pressure cuff and stethoscope
- Aspirin
- Benedryl
• Nitrolingual spray (200 meter dose)
• Epinephrine “Bee Sting Kit”
• Beta 2 Agonist Inhaler
• Pocket masks
• Semiliquid sugar source
• Alcohol wipes
• Sterile 4 x4’s

Emergency Equipment and Supplies in the Clinic

Clinic supervisors are responsible for checking and documenting the emergency equipment and supplies every month and reporting this to the Medical Emergency Program Coordinator.

Indoor Directions from Dental School to University of Minnesota Medical Center, Fairview

Emergency Room

- Take any elevator to second floor Moos Tower
- Exit to the south and proceed to main concourse into Phillip-Wangensteen Building
- Follow tunnel signs marked “University of Minnesota Medical Center, Fairview” until you reach the...
glass enclosed ramp (hairpin turn on ramp)

- Proceed upward through the ramp and enter the doorway marked “University of Minnesota Medical Center, Fairview”
- Follow directional signs on walls through the Hospital to the Emergency Room

**Protocols for Referring People for Outside Medical Treatment after an Accident**
The following information applies to Patients; Dental, Dental Therapy and dental hygiene students; Graduate students and residents; Auxiliary education trainees; Faculty and Staff; a chart outlining these protocols can be found at the end of this section.

**NEEDLE STICKS AND OTHER EXPOSURE TO BLOOD OR BODY FLUIDS**
Between the hours of 8:00 AM and 4:30 PM for injuries involving exposure to blood, the injured person and the source patient should report to Boynton Health Center within two hours of the incident. After 4:30 PM the injured person and source patient must call Boynton Health Service’s 24-Hour Triage Nurse at (612) 625-7900 to have the risk assessed and be directed as to where to seek treatment. If assessments indicate a high risk of infectious disease, seek prophylactic medication treatment within two hours of needlestick. The Boynton Heath Services Triage Nurse will suggest a site for initial treatment. Whatever the risk assessment, every student with a needle stick must complete a follow-up exam at Boynton Health Service within 72 hours of exposure. Prophylactic and follow-up treatments will be covered at Boynton Health Services by student fees. Additional online information can be found at www.ahceducation.umn.edu and by clicking on “For Students”. Patients may decline treatment. When patients consent to testing, charges will be paid by the U of M Dental Clinics.

All other injuries are handled as follows:

**PATIENT INJURIES AND MEDICAL EMERGENCIES**
Patients requiring further evaluation and/or treatment are to be escorted to the University of Minnesota Medical Center, Fairview Emergency Room.

When patients are taken to the Emergency Room, the patients will not be billed for accidents arising as a direct result of dental treatment. Inform the Emergency Room nurse that billing should be directed to the Clinical Systems Office, Room 8-440 Moos Tower.

**DENTAL AND DENTAL HYGIENE STUDENTS, DENTAL THERAPY STUDENTS, GRADUATE STUDENTS AND RESIDENTS**
All students must report to Boynton Health Service if medical treatment is required following personal injury. Student charges at Boynton Health Service and related referrals may be covered by health service fees. University policy stipulates that all students carrying more than six (6) credits must pay the health service fee. The health service fee does not cover hospitalization or surgery expenses and Regents policy stipulates that all students must carry supplemental hospitalization coverage. This additional coverage may be purchased from the University; proof of coverage with an employer-based, non-university plan is required by the university through the Student Health Benefit waiver process.

Students who self-refer to the University Hospital Emergency Room between the hours of 8 AM
4:30 PM or go to the outpatient clinics in Phillips-Wangensteen will incur expenses for which they, not the University of Minnesota, will be responsible.

**AUXILIARY EDUCATION TRAINEES**
Dental assistant trainees are referred to Boynton Health Service for emergency medical treatment. Payment for Health Service treatment is the responsibility of the student or his/her training program. The on site dental assistant coordinator should be informed and accompany the trainee to Boynton Health Service.

**FACULTY AND STAFF**
Faculty and staff may report to Boynton Health Services, their own clinic/doctor, or Health Partners Occupational Clinic in cases of work related injury. If the condition is life threatening, individuals are to go to the Fairview University Hospital Emergency Room.

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### University of Minnesota Dental Clinics
Accidental Injuries Requiring Treatment Outside of the UofM Dental Clinics

**Accidental Injuries (EXCEPT NEEDLESTICKS see below)**

<table>
<thead>
<tr>
<th>Patients</th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fairview University Hospital Emergency Room</td>
<td>Fairview University Hospital Emergency Room</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Systems Office, 8-434 Moos Tower</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Students</th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predoctoral,</td>
<td>Boynton Health Service</td>
<td>Fairview University Hospital Emergency Room</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Systems Office, 8-434 Moos Tower</td>
</tr>
<tr>
<td>Graduate,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainees</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty and Staff</th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Boynton Health Service, Employee choice or Occupational Medicine Clinic Health Partners 2220 Riverside Avenue So Minneapolis, MN 55454 952-883-6999 Critical Care Injuries* Hospital Emergency Room</td>
<td>Fairview University Hospital Emergency Room</td>
<td>U of M Employee Incident Report</td>
<td>Supervisor for forwarding to Workman's Compensation Department</td>
</tr>
</tbody>
</table>
### NEEDLESTICKS and other Exposures to Blood or Body Fluids

<table>
<thead>
<tr>
<th></th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients,</strong></td>
<td>Boynton Health Service within two hours of the incident</td>
<td>Contact Boynton health Center (612)625-7900 for step-by-step directions within two hours of the incident</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Affairs Office, 8-434 Moos Tower</td>
</tr>
<tr>
<td><strong>Students</strong></td>
<td>Boynton Health Service within two hours of the incident</td>
<td>Contact Boynton Health Center (612)625-7900 for step-by-step directions within two hours of the incident</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Affairs Office, 8-434 Moos Tower</td>
</tr>
<tr>
<td><strong>Staff and Faculty</strong></td>
<td>Boynton Health Service within two hours of the incident</td>
<td>Fairview University Hospital Emergency Room within two hours of the incident</td>
<td>U of M Employee Incident Form and First Report of Injury (UM1536)</td>
<td>Supervisor for forwarding to Workman’s Compensation Department</td>
</tr>
</tbody>
</table>

*Critical Care Injuries are defined as those injuries which prohibit travel and demand immediate active medical attention but are not so severe as requiring 911 service. Examples are chemical burns or eye injuries. Sprains, strains, and contusions are not considered Critical Care Injuries. All required forms are available at the clinic reception desks.*

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### Dental Emergencies

Managing dental emergencies is an important part of any dental practice. Because we have so many patients and multiple programs in the U of M Dental Clinics, how we manage dental emergencies requires knowledge of the patient's status as a U of M Dental Clinics patient. This section describes how patients receive emergency care based on their student assignment, active or inactive status, and even the time of day that they seek care.

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### MANAGEMENT OF PATIENTS WITH DENTAL EMERGENCIES

Patients with dental emergencies are managed through the Comprehensive Care Group Clinics and treated either in these clinics or in specialty clinics, most commonly the Endodontics Clinic or Oral Surgery Clinic, as indicated. During semester breaks and patients of record may be treated in the Urgent Care clinic by volunteer students.

Undergraduate students complete an Emergency Clinic rotation in the Urgent Care Clinic. Students whose
schedules are open or who have patient cancellations or failures are expected to be available to provide care to emergency patients both in their color groups as well as the Urgent care clinic.

Emergency patients who are new to the School of Dentistry will be assigned to any Comprehensive Care Group based on availability of students and chairs. Patients of record will be assigned to their group clinic for emergency care. Students should check in with their PCC at the beginning of each session if they are open or have a patient cancellation, at which time they will be assigned an emergency patient.

Faculty support, instruction and evaluation are provided by the Urgent Care Clinic faculty for patients new to the school. Comprehensive Care Clinic faculty will supervise patient care in the color groups. Group leaders may provide oversight for any emergency patients at their discretion or as circumstances dictate.

*Students must complete a Competency Exam in Management of Dental Emergencies prior to graduation. Oversight for this exam is provided by the Emergency Clinic faculty or by the Comprehensive Care Clinic Group Leader.

**FEES**

Emergency patients are registered in Urgent care or at each color group reception window. Patients’ medical history and registration information is currently completed on paper. The medical history is transferred to the electronic health record in the axiUm system where all patient information including digital radiograph taken will be located. We currently still use a paper chart for storage of past radiographs taken on each patient as well as past chart information prior to axiUm. A basic evaluation fee is charged to all emergency patients. Since these patients may not be current patients under care with an existing treatment plan, a fee for service will be charged for care provided. Patients who repeatedly seek emergency services or who have unpaid balances from previous visits may be denied further care.

Patients Assigned to a Particular Student

**DENTAL EMERGENCIES**

When one of your patients contacts you with an emergency or an immediate need, you should attempt to rearrange your schedule to assist your patient. This may involve shortening a previously arranged appointment with another patient or scheduling your patient during an open appointment time or at the end of the clinic session. Please schedule your patient in your Color group Clinic with your Patient Care Coordinator for evaluation and treatment of the patient’s chief complaint. All students are required to care for their own assigned patient's emergency needs. Patients on outreach will be seen by another color group student.

Urgent Care Clinic

Patients that are not a patient of record will be seen in the UCC clinic. During semester breaks all patients of record will also be seen for dental emergencies in the UCC clinic. Phones are answered Monday thru Friday from 8:15-12:00 and from 1:00-4:00. Appointments are scheduled the same day and next day for emergency service and temporary treatment of dental pain. The cost of an Urgent Care appointment is usually between $75 and $200. Payment is due at the time of the visit unless patients have dental insurance. Patients are expected to spend up to 3 1/2 hours for the visit. Patients may have to wait to be seen.
**ENDODONTIC EMERGENCIES**

You may refer your patient to the Endo Emergency Clinic (612-624-2661) for treatment of endodontic post-operative pain. Endo Emergency appointments are scheduled on the eighth floor with the Endodontic clinic patient care coordinator. Endo Emergency appointments are scheduled Monday-Friday from 8:30-4:30. Evening/Weekend Endo Emergencies are covered by the resident on call at 651-321-4946 pager or the hospital 612-273-2700.

**Dental Emergencies after Clinic Hours**

If patients call the Urgent care clinic with a dental emergency that requires immediate attention they are asked to contact Fairview University Medical Center at 612-273-3000 and ask for the resident on call. Patients may also contact their local hospital emergency department. **Finals Week and Semester Breaks**

The Urgent Care Clinic is open during all finals weeks and semester breaks to treat dental emergencies for assigned, unassigned, and new patients with dental emergencies. During these times, student volunteers are staffing the Urgent Care Clinic. Students are not required to be in the clinic during break times. There are, however, various times throughout the year when the clinic is closed. At these times, patients are provided directions for obtaining care when they call the clinic phone lines.

**Emergency Procedures**

Emergencies that may require evacuation include

1. Fire alarms
2. Severe weather warnings
3. Chemical spills
4. Other threats to health & safety

**Fire Alarms**

Anyone discovering a fire or seeing smoke should take the following actions in the order indicated:

1. Remove or alert anyone in immediate danger.
2. Confine the fire by closing the doors around it.
3. Report the fire by pulling the nearest alarm box. (Located next to all exit doors)

If the alarm is sounded on the clinic floor all students, staff and faculty should move out of the clinic area to an adjacent building or down the closest stairwell. Elevators are not to be used.

4. Have someone meet the fire department at the ground level main entrance.

5. Secure the area by shutting all doors as you leave the area.

Extinguish a fire only if:

- You are familiar with the proper use of a fire extinguisher
- The fire is small
- Several people are available to assist

**Severe Weather Warnings**

Tornado Warnings and Severe Thunderstorm Warnings may require curtailment of activities. Evacuate all perimeter rooms with windows. Move to inner rooms and/or lower floors of the building. Avoid large areas with poorly supported roofs, glass areas, and temporary buildings. Evacuate the top floor. **CAUTION:** Close
doors when leaving rooms. This will limit wind effects if the windows are blown out.

**Chemical Spills**

**Evacuate**
- Leave the spill area, alert others in the area and direct/assist them in leaving the area.
- Without endangering yourself: remove victims to fresh air, remove contaminated clothing and flush contaminated skin and eyes with water for 15 minutes. If anyone has been injured or exposed to toxic chemicals or chemical vapors, call 911 and seek medical attention immediately.

**Confine**
- Close doors and isolate the area. Prevent people from entering spill area.

**Report**
- From a safe place, call the Department of Environmental Health and Safety (EHS) (612) 626-6002 during working hours, 911 after hours (Twin Cities Campus 911 operators will contact on-call EHS personnel).
- Report that “this is an emergency” and give your name, phone and location; location of the spill; the name and amount of material spilled; extent of injuries; and safest route to the spill.
- Stay by that phone, EHS will advise you as soon as possible.
- EHS or the Fire Department will clean up or stabilize spills, which are considered high hazard. In the case of a small spill and low hazard situation, EHS will advise you on what precautions and protective equipment to use.

Contact the Health and Safety officer for the School of Dentistry to report the incident at 612-625-5116.

**Secure**
- Until emergency response personnel arrive: block off the areas leading to the spill, lock doors, post signs and warning tape, and alert others of the spill.
- Post staff by commonly used entrances to the area to direct people to use other routes.

*In case of injury to staff, the supervisor(s) must complete and fax in the workers' compensation reporting forms within 24 hours. A School of Dentistry Incident Report Form should be completed after any incident.*

**Other Threats to Health & Safety**

The procedures listed below are intended as a resource for you in preparing for emergencies before they happen.

• Bomb Threat
• Fire Safety
• Medical emergencies
• Personal safety
• Severe summer weather
• Shelter information
• Utility outages
• Warning systems/sirens
Notification:

UNIVERSITY WARNING SYSTEMS:

1. Outdoor Warning System - The Siren
   a) Alert Signal (often called the "tornado siren") The alert signal is a five-minute steady tone sounded over our outdoor siren system. Most often used in severe weather, it is not only a tornado alert; this siren simply means that you should turn on your radio or television for information and recommended action. This system is tested on the first Wednesday of every month at 1:00 p.m.

   b) Attack Warning (This is often called the "air raid siren") The attack warning is a five-minute wavering tone. This signal means that an attack against the country has been detected and that personal protective action should be taken. Turn your radio to an Emergency Alert Station (E.A.S.) for more information.

2. Internal Warning System - Phone System
   The University of Minnesota employs a system utilizing its existing telephone capabilities. This system is referred to as the "group alert." It allows the University Police Department and the Department of Emergency Management to record an emergency message and disseminate it to designated offices and buildings throughout the Twin Cities Campus. It is activated whenever an emergency, tornado, severe storm, hazardous material release, or major fire threatens the campus and its occupants. This system is tested monthly on the first Wednesday following the test of the outdoor warning at 1:05 p.m.

3. Tone Alert Radio
   The Tone Alert Radio or "TAR," is a one-way radio receiver. The University of Minnesota Police Department will activate the radio anytime there is urgent information regarding a situation affecting the Twin Cities campus. For example:
   1. Severe weather (tornado, thunderstorm) watches or warnings
   2. Street/building closures due to fire, gas leak, chemical spill, etc.
   3. "All-clear" messages after any of the following
   The Tone Alert Radios are located at each 6th, 7th, 8th and 9th floor front desk as well as other locations in the School of Dentistry.

SCHOOL OF DENTISTRY ADDITIONAL WARNING SYSTEMS:

Primary Method: Tone Alert Radio - 2 per floor
The School of Dentistry’s Health & Safety Office, in conjunction with the University’s Department of Emergency Management, has placed Emergency Tone Alert Radios (TARs) throughout the School of Dentistry. TARs are provided so that emergency information can be communicated throughout the School. IF AN ALERT IS ISSUED, the radio will sound a loud alarm and the police dispatcher will broadcast a verbal message with information and instructions. The TAR has a six-hour battery backup. In cases requiring mass evacuations the radio should be unplugged and taken to the predetermined central meeting locations. Staff can then receive any additional directions issued by the University police.
In the School of Dentistry, we'll have a minimum of two radios per floor and individuals monitoring the radios will respond to all alerts by notifying colleagues in their respective areas. The Police Department will test the system at 1:05 p.m. on the first Wednesday of each month.

**Secondary Method: Phone Group System**

There is an emergency notification phone list that is activated through the School of Dentistry’s Health & Safety Office. It includes all department and division offices plus other areas. In addition, the clinic floors (6-9) have a PA system for announcements. There is a NOAA weather radio in the Health & Safety Office that sounds an alert in the event of severe weather or national emergency/disaster.

**Emergency Evacuations**

Preparedness is necessary to avoid confusion in an emergency; inform yourself about the actions you will take in an emergency requiring evacuation of the clinics. Examples of emergencies which require evacuation of clinics include fire alarms, storm warnings, chemical spills, and other threats to the health and safety of building occupants.

You, and your patient, must leave clinical areas when an alarm sounds or you are instructed to leave by faculty or staff.

**CAUTION:** Elevators must not be used during fire alarms or severe weather warnings.

- Leave the area when the alarms sound or you are instructed to leave by faculty or staff
- Use the most direct way to exit Moos Tower without creating crowding

**Floors 4, 6, 7, 8, and 9:**

- North Clinics: Exit through the north stairwell to descend, or through the north stairwell to enter the Weaver-Densford building
- Central Clinics: Exit through the east stairwell to descend, or through the north stairwell to enter the Weaver-Densford building
- South Clinics: Exit through the south stairwell to descend, or through the south skyway to enter the Phillips-Wangensteen building
- Reception Areas: Ask occupants of lobby to follow you. Exit through the west stairwell to descend, or through the south skyway to enter the Phillips-Wangensteen building
- Laboratories: Exit through the east stairwell to descend
- Special Considerations: Assist individuals with mobility or other limitations. Connect parents or guardian with minor children, and then exit the area. Note: In situations of imminent danger, minors should be escorted by a School of Dentistry employee or student to a safe place and then reunited with their parents or guardian as soon as possible.
• Guidelines for anesthetized dental patients: The decision to not evacuate a patient is the responsibility of the treatment provider and must be based on the safety risk assessment that immediate evacuation would be harmful to the patient, not on convenience.

1. An observer must be assigned to watch the corridor area
2. Stabilize patient as soon as possible
3. Evacuate immediately if:
   • Ordered to by the Fire Department
   • Observer becomes aware of danger, e.g., smoke is seen or smelled etc.

Floors 15, 16, 17, and 18:
• Exit through the west or south stairwells to street level exits, or move laterally into other buildings where or when possible

• The Phillips-Wangensteen building is accessible starting on the 14th floor, at the southwest corner of Moos Tower. Floors 14 to 7 are accessible from Moos Tower.

• The Weaver-Densford building is accessible starting on the 9th floor, at the northeast corner of Moos Tower. Floors 9 to 4 are accessible from Moos Tower.

• Special Consideration: Assist individuals with mobility or other limitations

Mass Emergency Evacuation of Moos Tower - Predetermined Central Meeting Locations:

<table>
<thead>
<tr>
<th>Location #1</th>
<th>Location #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th floor</td>
<td>PWB 3rd floor escalator lobby</td>
</tr>
<tr>
<td>6th floor</td>
<td>PWB 2nd floor escalator lobby</td>
</tr>
<tr>
<td>7th floor</td>
<td>PWB 2nd floor escalator lobby</td>
</tr>
<tr>
<td>8th floor</td>
<td>PWB 2nd floor by Outside</td>
</tr>
<tr>
<td>9th floor</td>
<td>PWB 2nd floor by Outside</td>
</tr>
<tr>
<td>15th floor</td>
<td>PWB 14th floor elevator lobby</td>
</tr>
<tr>
<td>16th floor</td>
<td>PWB 14th floor elevator lobby</td>
</tr>
<tr>
<td>17th floor</td>
<td>PWB 14th floor elevator lobby</td>
</tr>
<tr>
<td>18th floor</td>
<td>PWB 14th floor elevator lobby</td>
</tr>
</tbody>
</table>

*If location #1 is not accessible, please move to location #2.*

If neither location is accessible, everyone should meet at the Radisson Hotel on the 2nd floor ballroom.
University Closure Due to Severe Weather or Emergencies
As a general practice, the University of Minnesota does not close unless the health, safety, and security of University personnel and students are seriously brought into question. When this does happen, either because of severe weather conditions or other emergencies, the Executive Vice President and Provost is responsible for initiating closing procedures for the campus.

Official Announcements
If the decision to close the Twin Cities campus is made, University Relations is responsible for notifying the University community and the public. The University attempts to have closure decisions announced before 6:00 AM. All official University announcements will be made exclusively through University Relations. Announcements of an emergency closing will, to the extent possible, specify the starting and ending times of the closing, and whether the closing includes specific University services, events, and evening or Saturday classes and programs.

The radio is the primary source of information on University closings. The University community is expected to listen to radio announcements for closing information. Calling University offices will not guarantee that the latest or most accurate information is provided to the caller.

University Relations phone: 612-624-6868 will contact the wire services and the following media outlets:

- Radio K-AM 770
- KSTP-AM
- WMNN-AM 1330
- KMSP-TV 9
- Star Tribune
- WCCO-AM 830
- 1500 MPR 91.1/99.5
- WCCO-TV 4
- KARE-TV 11
- Pioneer Press
- KFAN-AM 1130
- KEEY-FM 102.1
- KSTP-TV 5
- Minnesota Daily

Information will also be posted on the University home page: www.umn.edu

TXT-U is the University’s emergency notification text messaging system to provide students, faculty, and staff with critical campus safety information. The University will enroll all students, faculty and staff, all personnel have the option to opt out of using this safety tool.
Quality Assurance Program

U of M School of Dentistry’s Vision and Goal
The University of Minnesota, School of Dentistry is a leader in the Midwest and the nation in research, teaching and patient service-oriented care in dentistry. Our vision is strategically focused and totally committed to continuous improvements and quality initiatives. Commitment to quality requires involvement of faculty, administrators, staff, students, patients, alumni, product suppliers and equipment manufacturers. The goals of quality assurance (QA) are:

i) To ensure that patients receive the best care possible
ii) To proactively prevent problems before they arise
iii) To effectively deal with problems in a timely and appropriate manner should they arise
iv) To enhance the level of satisfaction for all parties involved in patient care settings

U of M School of Dentistry’s Quality Assurance Process
Quality Assurance (QA) is a continuous ongoing process that is responsive to the dynamics of a constantly evolving patient environment. It involves the definition and prioritization of a problem or a process that is believed to have a significant adverse impact on the quality of learning, patient care and/or the appropriateness of services rendered. This is followed by a thorough diagnostic and interactive analysis by all pertinent constituents to identify the possible root causes of the problem and evaluate concomitant solutions to the quality issue. Quantifiable outcome/criteria based upon predefined standards of care are periodically measured to provide meaningful recommendations for quality improvement. If approved, adopted and implemented, the solution is then reevaluated as part of a continuing ongoing process that will involve:

a) Routine performance checks
b) Review of a representative sample of patients and patient records
c) Evaluation of a timely/appropriate response when there is a significant difference between anticipated versus actual outcomes.

Quality Assurance Organizational Structure
The Dean of the UMNSOD has appointed a QA Coordinator who is cognizant of and proficient in the quality arena. This QA Coordinator reports directly to the Associate Dean of Clinical Affairs who is responsible to the Dean for all UMN SOD quality issues/concerns in the patient care arena.
Additional SOD committees that support the QA structure are:

- Clinical Affairs committee
- Infection Control and Safety committee
- axiUm Change Management Committee

**UMN SOD Quality Assurance Mechanism**

The QA coordinator in conjunction with each Clinical Division will conduct formal ongoing assessments of the quality of their patient care program. Patient-Centered general standards of care and standards of care for each clinical discipline are developed and are:

1. Focused on comprehensive patient treatment.
2. Written in a clearly defined and simplified format.
3. Based on a small number of objective measurable quantifiable indicators for each clinical discipline.

**General Standards of Quality Care**

**Patient Care Guidelines:**

1. Patients seeking treatment at the University of Minnesota, School of Dentistry will NOT be denied admission to any of its clinics or provisions of care based on race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veterans status, or sexual orientation.

2. Each prospective patient will be offered the earliest possible screening appointment at which time the patient will complete the application process and have an initial oral examination accomplished.

3. Assignment of comprehensive care patients will occur within 3 weeks of the initial oral examination. If patients choose not to wait, they will be advised to seek alternate care.

4. Patients will be accepted into the predoctoral clinics for treatment when the patients’ dental needs are within the scope of the SOD’s predoctoral program to assure that the delivery of care is within the appropriate degree of expertise of the SOD students and their supervising clinical faculty. Patients not accepted under this criteria will be informed at the time of their screening examination/consultation and will have it documented as such in the patient’s chart. Patients not appropriate for the predoctoral program may be referred to the SOD specialty clinics or area private dentists.

5. Patients will be treated with dignity, courtesy and respect at all times.

6. Patients will be notified of their personal responsibilities and all applicable SOD policies and procedures prior to the initiation of comprehensive elective treatment. Each patient will receive a copy of the Patient’s Rights and Responsibilities have an opportunity to discuss them or ask questions and will be provided understandable answers in layperson terms and/or in a common level of communication.

7. SOD patients (or their parent or legal guardian) will have reasonable and informed participation in decisions concerning their dental health. They will be informed of reasonable treatment alternatives, the benefits and risks inherent there-in, including the risk of no treatment and prognosis in common understandable terms. A summary of the primary and/or alternative treatment plans will be documented in the Patient’s Electronic Health Record (EHR).

8. Patient care will be provided under the supervision of licensed faculty members.
9. Each comprehensive care patient will receive a Completion of Care Examination at completion of treatment that will include assessment of:
   
a. The treatment provided to ensure that applicable SOD's Standards of Care have been met.
b. The patient’s current level of comfort and satisfaction with the treatment.
c. The patient’s record for provider compliance with record keeping standards.
d. The patient’s current oral health status.
e. The patient’s interest in and appropriate interval for a recall examination date.
f. The patient’s commitment to continue treatment at the SOD or the indication for referral, or discontinuation of care.

10. The SOD will provide emergency dental services for active patients of record during normal clinic hours initially via his/her assigned provider. After this time and/or when the SOD is normally closed, the patient is instructed to contact the Fairview Hospital Emergency Room where dentists from the school’s General Practice Residency are available to respond to emergency dental needs. In the emergency is life threatening, the patient is instructed to seek care at the nearest hospital emergency room.

11. Authorized faculty in consultation with the Associate Dean of Clinical Affairs, may elect not to accept patients for treatment or to discontinue the care of patients who request care that is not in accordance with the SOD’s Standards of Care, who are non-compliant, and/or whose behavior poses a threat to the SOD and/or the well being of a SOD student, faculty or employee.

12. Patients whose dental treatment is discontinued in accordance with SOD guidelines will be advised of it in writing. The SOD will ensure that the patient’s dental status is stable, will provide emergency service for a period of 30 days and will suggest in writing that the patient seek an alternate provider of dental care for continuance and/or completion of care.
Patients' Dental Records

1 An Electronic Health Record will be established and maintained for all registered comprehensive care patients that documents all diagnostic and therapeutic actions as well as all communication related to that patient's care.

2 The SOD Patient Dental Records are confidential documents and must be managed in accordance with state and federal laws.

Management of Medical Emergencies

1 Medical emergencies that occur in the SOD will be brought to the immediate attention of the nearest attending faculty member where that emergency occurs (minor emergencies will be handled by that attending faculty member).

2 The attending faculty member will further evaluate the patient's medical status concerning his/her Airway, Breathing, and Circulation (ABC's) and determine if additional expertise and/or equipment is required due to a potentially life-threatening medical emergency situation.

3 If additional expertise or equipment is needed, the faculty member will activate the emergency protocol given in the Clinic Manual and posted on all clinic telephones.

Infection and Biohazard Management/Control

1 All SOD patients will receive treatment that is in accordance with the policies and procedures delineated in the SOD's Infection and Exposure Control Management Plan. This plan will be in accordance with the current guidelines of the ADA, the CDC, OSHA, NIOSH and the laws of the State of Minnesota.

2 Current universal precaution infection control standards will be utilized for all patient treatment rendered in the SOD and affiliated clinics.

3 A documented on-going compliance assessment program will be maintained to assure that the standards for infection and biohazard control are met, that discrepancies are noted, and that mechanisms are in place for timely corrective actions and for systematic follow-up reevaluation.
Anesthesiology Best Practices

1. The patient's medical history, current treatment plan, and signed informed consent form will be reviewed and updated as necessary by the student and attending faculty member prior to any administration of anesthesia and/or medication.
2. The type, dosage (cartridges, milliliters, cc's, milligrams etc.), and injection location of local anesthesia will be recorded in the patient's chart.
3. Medications must be justified based upon the patient's current medical condition/needs. They will be prescribed only by a clinical faculty member and legibly documented in the patient's dental record indicating the following: name of medication; dosage of medication; amount/number requested; regimen; and number of refills if any.

Anesthesiology Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Progress note entries will contain an update/review of patient’s medical history.</td>
<td>Date of initial or updated medical history will be within six months of treatment date.</td>
</tr>
</tbody>
</table>
| 2. Patients treated using local anesthesia had type, dosage, and location of local anesthetic appropriately documented in the dated treatment record progress note. | 1. Add type, dosage, amount and location of local anesthesia used to SOAP progress note template.  
2. Develop report to show compliance with template use |
| 3. Patient exhibits prolonged sedation or general anesthesia effects. | Report administration of Narcan (naloxone). |
**Comprehensive Care Best Practices**

Comprehensive care is defined as an integrated patient centered approach to address the total oral health needs of our patients.

1. Patients at the SOD will receive a thorough examination including but not limited to extra and intra oral exams, radiographic exam and occlusal analysis.
2. Comprehensive treatment plans will be developed and explained to the patient in language that he/she can understand. Alternative plans will be developed to meet the health, cultural and economic needs of the patient.
3. The patient will be given accurate estimates as to the time and financial resources necessary to complete the proposed treatment plan.
4. The dental student assigned to a patient will manage his/her treatment utilizing all members of the dental team in an efficient and effective manner.
5. At the completion of treatment, the patient will be enrolled in an ongoing recall program specific to his/her dental needs.

### Comprehensive Care Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comprehensive care patients had their treatment effectively managed by the originally assigned dental student.</td>
</tr>
<tr>
<td>2. The School of Dentistry will track the percentage of patients seen each month who are comprehensive care versus episodic care patients.</td>
</tr>
<tr>
<td>3. Comprehensive care patients received and signed an appropriate treatment plan.</td>
</tr>
<tr>
<td>4. Urgent Care patients had their “Chief Complaint” addressed and documented at their first visit.</td>
</tr>
<tr>
<td>5. Patients seen in UCC were informed of their next treatment need.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assigned student performed both the treatment plan and the QA evaluation of treatment examination. (axiUm report)</td>
</tr>
<tr>
<td>Current axiUm report.</td>
</tr>
<tr>
<td>axiUm report shows % of treated patients with an active treatment plan.</td>
</tr>
</tbody>
</table>
| 1. Develop Urgent Care progress note template.  
2. Include Diagnosis Code box with drop down list.  
Monitor compliance with diagnosis recording (axiUm report) |
| 1. Develop Urgent Care progress note template.  
2. Include “Next Treatment Needed” check box.  
3. Monitor compliance with diagnosis recording (axiUm report) |
Dental Hygiene Best Practices: Quality Indicators

Standards:

1. Dental hygiene care is evidenced-based.

2. Each patient's medical/dental history is reviewed and updated at every dental hygiene appointment.

3. A Medical Management Plan is completed to address medical/patient issues affecting dental treatment.

4. The dental hygiene care plan is patient-centered and based upon the medical history, recognized assessment (diagnostic) information that includes vital signs, extra/intra-oral examination, gingival observations, hard tissue examination, periodontal examination, current radiographs and dental examination by the attending dentist.

5. The dental hygiene care plan for periodontal therapy is patient-centered and based on an assessment of risk factors and present disease as determined by gingival observations, periodontal probing measurements, attachment level measurements, mobility, furcations, mucogingival involvement, occlusion and restorations in need of margination.

6. The dental hygiene care plan for caries prevention and control is patient-centered and based on an assessment of risk factors and present disease as determined by the patient’s restorative treatment plan, findings from the attending dentist's hard tissue examination and clinical findings recorded by the student hygienist.

7. A recall interval appropriate for the degree of caries risk and extent of periodontal disease is documented.

8. An attending dentist will authorize all non-routine dental hygiene care.

9. Radiographic frequency and type is based on risk and authorized by an attending dentist. A dental examination is performed by an attending dentist when radiographs are exposed and as needed. Exposed radiographs will meet the standards of quality set by the School of Dentistry.
10. The dental hygiene care plan documents the informed consent of the patient. The dental hygiene care plan is integrated into the patient’s written progress notes to include treatment risks, benefits, alternatives, and goals.

11. Dental hygiene treatment outcomes for periodontal therapy will be determined through evaluation of those factors listed in #5 of this document and/or change in periodontal classification. A documented consultation with an attending dentist will confirm treatment success and/or need for additional therapy options or referral.

12. Dental hygiene treatment outcomes for caries preventive therapy will be determined through evaluation of those factors listed in #6 of this document and/or change in caries classification. A documented consultation with an attending dentist will confirm treatment success and/or need for additional therapy.

13. The self-care discussion is documented in the patients record.

14. Documentation is thorough and has been approved by faculty.

* Benchmark for all standards is 80% CB 08/2012
Endodontic Best Practices

1. Diagnosis will be based upon evaluation of a documented current patient history and history of the dental problem.
2. Endodontic treatment plans will be based upon recognized diagnostic information that includes a current well-centered periapical radiograph showing the root tip(s) of the affected tooth.
3. Endodontic treatment plans will include a documented evaluation of tooth restorability that includes tooth mobility, periodontal pocket depths and occlusion.
4. Endodontic treatment documentation will verify aseptic technique by use of dental dam.
5. Access preparation will conserve hard tissue but will facilitate adequate instrumentation. Canal preparation will conserve hard tissue but will facilitate proper obturation based upon the materials being used.
6. The obturation will properly seal the root canal to optimize further continued function.
7. A dated post operative radiograph will be taken and retained in the patient’s chart at completion of the obturation to help verify the quality of the endodontic procedure.
8. If further restorative care is needed at the completion of endodontic therapy, the patient will be informed. The patient will also be informed of the risks of not proceeding with required restorative care.
9. Routine endodontic therapy (i.e. diagnosis, instrumentation, and obturation) should normally be completed within three clinical appointments.

Endodontic Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Endodontic treatment was based on documented diagnostic criteria</td>
<td>Measure compliance with predoctoral endodontic progress note template.</td>
</tr>
<tr>
<td>2. Endodontic procedures were accomplished using a dental dam.</td>
<td>“Dental dam isolation with oraseal” incorporated into predoctoral endodontic progress note template. Make it a check box?</td>
</tr>
<tr>
<td>3. Endodontic procedures were completed within 3 clinical appointments.</td>
<td>axiUm report showing initial, treatment in progress and completion endodontic codes.</td>
</tr>
</tbody>
</table>
| 4. Patients were informed of future treatment needs at the time of obturation. Patients were also informed of the risk of not appropriately restoring the endodontically treated tooth. | 1. Add text box to predoctoral endodontic progress note template to include recommended future treatment.  
2. Add statement of risk of no treatment to progress note template |
| 5. SOD will track endodontically treated teeth needing retreatment or extraction within 12 months following initial endodontic therapy. | axiUm report showing number of endodontic retreats or extractions of endodontically treated teeth over preceding 12 months. |
| 6. Endodontically treated teeth did not have any complications (i.e perforation, broken instrument, over- or under-filling). | Add complications text box to progress note template to capture instances of perforation, broken instrument, over or under filling. |
Patients accepted for treatment will receive a comprehensive clinical examination to include but may not be limited to the following: a thorough medical, dental and social history and assessment of risk factors for oral and related regional disease, a complete extra-oral head, neck and intra-oral exam including periodontal and dental screening to detect the presence of disease.

For all patients, information pertaining to the severity and level of control of medical conditions that may adversely affect the patient’s ability to safely undergo dental procedures should be obtained by interviewing and examining the patient. If this information cannot be obtained from the interview and examination, it should be obtained through consultation with the appropriate health care provider, usually a physician.

Appropriate diagnostic aids will be used during initial patient evaluations that include but may not be limited to the following: radiographs, diagnostic casts, periodontal probing, pulpal vitality testing, percussion, palpation, medical laboratory tests, or biopsy.

Patients with a history and/or clinical findings that suggest the need for medical, psychological or other professional evaluation will be informed in terms he/she can commonly understand. Patients must be informed of the reason for the medical consultation and a release of medical information form must be signed by the patient or his/her guardian.

All diagnostic radiographic exposures must be authorized by a clinical faculty member after a clinical examination of the patient. The exposures will be in accordance with the general guidelines of the general Standards of Care and the SOD's Clinic Manual. A dated legible entry will be made in the patient’s treatment record progress notes and countersigned by a clinical faculty member.

The selection criteria for prescribing radiographs will be based upon but not limited to the following: current FDA guidelines for radiographic exposure, new or recall patient status, the availability of radiographs from other sources, the patient's chronological age, the patient’s prior medical/radiological history, the risk assessment of caries, periodontal disease, periapical pathosis, or other pertinent criteria.

Intra-oral radiographs will be mounted and labeled with the patient’s name and chart number and the date of exposure. Only duplicate radiographs should be placed in an envelope that is labeled and dated.

Elective radiographs will not be taken on females in their first trimester of pregnancy; however, emergency radiographs are permitted with proper lead apron protection.

All patient exposures will be recorded on the radiology form contained in the patient’s chart. The date, type and number of radiographs will be recorded.

All exposures of patients will be performed using leaded aprons. Whenever possible, leaded thyroid shields will be used on patients up to 18 years old.

The University Radiation Safety Office will calibrate and inspect at least biannually all x-ray generating equipment within the SOD to assure compliance with federal and state laws.

A radiation film badge will be placed outside of every operatory that has an x-ray machine.

A patient's rejection of recommended radiographs may potentially compromise the quality of diagnosis and/or future dental treatment and may be justification for non-selection of patient or the discontinuance of comprehensive dental treatment at the SOD. If this is the case, an entry must be made in the patient's progress notes which are also signed by the patient, the student and the attending clinical faculty.

A patient’s treatment plan (emergency or final) will reflect an appropriate sequence of
treatment, the approximate number of appointments for each sequence and the approximate costs.
15 The patient will be advised of appropriate alternative treatment modalities and their inherent risks.
16 A signed/dated informed consent must be obtained from the patient or parent/legal guardian prior to initiating any treatment.
17 All appropriate General Standards of Care will apply.
### Oral Diagnosis, Medicine, Radiology Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th></th>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
</table>
| 1 | SOD comprehensive care patients requiring a written medical consultation had it appropriately evaluated and documented prior to initiation of their definitive dental treatment. | 1. Add check box in medical history form for patients needing medical consultation.  
2. Develop electronic axiUm consultation form.  
3. axiUm report showing date out and date in of consultation form. |
| 2 | Patients needing antibiotic pre-medication had their pre-medication appropriately documented as part of the progress note. | 1. Add “Needs Premedication” check box to axiUm Medical Management Plan form.  
2. Review prescription history in axiUm to see if appropriate antibiotics were prescribed. |
| 3 | SOD comprehensive care patients had vital signs recorded at their first clinical visit for registration or re-registration purposes. | axiUm report showing vital signs recorded at initial examination and at subsequent recall appointments. |
| 4 | Patients had their medical/health history accomplished at their first clinical visit to the SOD and appropriately recorded in the patient’s chart. | axiUm report. |
Oral Maxillofacial Surgery Best Practices

1. Diagnosis will be based upon evaluation/documentation of, but not limited to, the following: a current patient medical/health history, the patient’s chief complaint, clinical/visual examination of the patient and appropriate pertinent diagnostic aids.

2. Appropriate written informed consent will be obtained prior to the initiation of definitive treatment; the patient must be aware of the benefits and risks of treatment including the risk of no treatment at all, the factors which may affect the known risks and complications, and the realistic alternative treatment option.

3. Indications for dento-alveolar surgery may include, but are not limited to the following: the removal of diseased, non-restorable and/or nonfunctional teeth, the management of acute odontogenic and/or periodontal infection, the optimization of prosthetic reconstruction, the prevention and/or elimination of pathology, the improvement of oral hygiene, the facilitation of orthodontic and/or restorative treatment, the control and/or elimination of chronic or acute pain and/or infection, the repair of traumatic injuries, and/or the improvement of esthetic, cosmetic, or functional limitations and/or deficiencies.

4. Detailed, written postoperative/post-surgical instructions will be given to the patient; these will include information pertinent to the timely access to emergency dental care and/or the need for follow-up visit.

5. All anesthetics/medications used and/or prescribed for the patient will be appropriately annotated in the patient’s chart.

6. The attending clinical faculty member will determine and document the need for submission of the excised tissue for microscopic examination, the resulting reports will likewise be evaluated and appropriately documented in the patient’s treatment record.

Oral Maxillofacial Surgery Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patients had appropriate informed consent obtained and documented prior to the</td>
<td>axiUm report showing compliance with consent form usage.</td>
</tr>
<tr>
<td>surgical procedure.</td>
<td></td>
</tr>
<tr>
<td>2 Patients had appropriate documentation of drugs/medications used during the</td>
<td>Oral Surgery progress note template.</td>
</tr>
<tr>
<td>procedure</td>
<td></td>
</tr>
<tr>
<td>3 Patients had appropriate documentation of discharge drugs/medications prescribed</td>
<td>axiUm report of medications prescribed in OMFS.</td>
</tr>
<tr>
<td>or recommended as a result of the procedure.</td>
<td></td>
</tr>
<tr>
<td>4 Patients had biopsy results appropriately requested, evaluated and results/follow-</td>
<td>Track date out and in of electronic biopsy form.</td>
</tr>
<tr>
<td>up annotated in the patient treatment record.</td>
<td></td>
</tr>
<tr>
<td>5 Orthodontic extraction patients had a written copy of his/her orthodontic</td>
<td>Electronic form?</td>
</tr>
<tr>
<td>extraction request specifically identifying by number the teeth treatment planned</td>
<td></td>
</tr>
<tr>
<td>for elective extraction.</td>
<td></td>
</tr>
<tr>
<td>6 Patients were free from post operative complications (dry socket, pain, infection</td>
<td>Return visit progress note template including diagnosis code check box.</td>
</tr>
<tr>
<td>and or bleeding).</td>
<td></td>
</tr>
<tr>
<td>7 Wrong tooth extracted</td>
<td>OMFS incident report.</td>
</tr>
<tr>
<td>8 Postoperative hospital admission.</td>
<td>OMFS incident report.</td>
</tr>
<tr>
<td>9 Damage to adjacent tooth or teeth during extraction.</td>
<td>OMFS incident report.</td>
</tr>
</tbody>
</table>
Orthodontic Best Practices

1 All comprehensive orthodontic patients will have a comprehensive examination and appropriate diagnostics records as suggested by the American Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics. This provides a baseline for diagnostic assessment and for documentation of growth and treatment changes.

2 All comprehensive orthodontic patients will have a documented problem list including dental, facial, skeletal, functional, and/or psychosocial problems, and a faculty-approved treatment plan designed to best address these problems.

3 All comprehensive care patients will be seen on a regular basis throughout active treatment in order to facilitate efficient completion of care.

4 All comprehensive care patients will undergo a formal evaluation of treatment progress in mid-treatment and receive appropriate adjustments to the treatment plan if needed.

5 The decision to conclude treatment will be approved by the appropriate faculty and communicated to the patient/family.

6 All comprehensive orthodontic patients will have post-treatment records as suggested by the Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics. This provides a basis to review treatment outcome, inform the patient/family of future treatment needs and to assess any post-treatment change that may occur.

Orthodontic Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Comprehensive orthodontic patients have documentation of appropriate examination and diagnostic records.</td>
<td>% of comprehensive orthodontic patients with documentation of records and examination.</td>
</tr>
<tr>
<td>2 Comprehensive orthodontic patients have a signed treatment plan that summarizes the problem list and treatment approach.</td>
<td>% of comprehensive orthodontic patients with signed treatment plan in the electronic orthodontic record.</td>
</tr>
<tr>
<td>3 Orthodontic patients in active treatment will be seen at least every 2 months.</td>
<td>Report of Active patients with no kept appointment in the last 2 months.</td>
</tr>
<tr>
<td>4 Comprehensive orthodontic patients have a documented mid-treatment review.</td>
<td>% of comprehensive orthodontic patients with documentation of mid-treatment review.</td>
</tr>
<tr>
<td>5 Orthodontic patients have a signed completion of treatment form.</td>
<td>% of comprehensive orthodontic patients with documentation of signed debanding form.</td>
</tr>
<tr>
<td>6 Post-treatment records are available.</td>
<td>% of comprehensive orthodontic patients with documentation of post-treatment records.</td>
</tr>
</tbody>
</table>
Pediatric Dentistry Best Practices

1. Pediatric dentistry at the SOD is accomplished in accordance with the quality criteria established by the American Academy of Pediatric Dentistry.
2. Pediatric diagnosis and treatment planning is based on the prevention and/or elimination of dental pathology.
3. An appropriately signed “Informed Consent” form and a current patient health history form is signed and dated by parent/legal guardian before treatment is initiated.
4. Diagnosis will be based upon, but may not be limited to, the following: the patient history, a complete intra- and extra-oral examination and radiographs appropriate to the patient’s caries pattern, spacing and developmental stage of dentition.
5. The patient’s health history will be updated at 6 month intervals but the patient’s current health status will be evaluated and documented on each dated patient treatment entry.
6. The pediatric treatment plan will fully consider the patient’s needs, the parent concerns and objectives, and the patient’s chief complaint. The specific clinical aspects will also include an appropriate preventive program specific to the individual needs and risk factors of each pediatric patient.
7. Appropriate behavior modification techniques may be employed to manage the pediatric patient which includes, but may not be limited to, the following:
   a. Communicative management.
   b. Nitrous oxide-oxygen sedation supervised by an instructor licensed to administer it.
   c. Prescription pre-medications appropriate to the patient’s age and weight.
   d. Local anesthesia appropriate to the patient’s age and weight.
   e. Other methods that may positively affect the dentist-patient relationship as approved in writing in the patient treatment chart after informed consent with the parent/legal guardian.
      i. Physical restraint would be used only in emergency situations and/or for very limited procedures such as during the administration of local anesthesia.
8. SOD pediatric patients with behavior modification problems beyond control utilizing the above modalities will be referred to a pediatric dentist for sedation and/or general anesthesia.
9. Appropriate preventive therapy will be individualized for each patient and may include, but may not be limited to, the following:
   a. Instruction regarding the etiology of dental disease in simple terms that both the patient and parent/legal guardian can readily understand.
   b. Basic oral hygiene instruction, demonstration, simulation and/or participation.
   c. Appropriate fluoride therapies.
   d. Sealants, appropriate resin and/or glass ionomer restorations.
   e. Diet assessment and/or counseling.
10. Management of developing occlusion may include, but may not be limited to, the following:
    a. Diagnostic case evaluation
    b. Deleterious habit pattern modification
    c. Space maintenance therapy
    d. Space regaining
    e. Cross-bite correction
    f. Comprehensive orthodontic evaluation for those 10-14 years of age.
11. Pediatric patients requiring pulp therapy for primary and/or permanent teeth will be
accomplished in accordance with AAPD guidelines.

## Pediatric Dentistry Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pediatric patients had a current health history form signed by his/her parent or legal guardian prior to the start of treatment.</td>
<td>Medical history at initial appointment.</td>
</tr>
</tbody>
</table>
| 2. Pediatric patients who had a complex medical history had appropriate documentation (alerts) in the patient record prior to the start of treatment. | 1. Add “Medical Management Plan” check box to Pediatric medical/dental history  
2. Check to see if “Medical Management Plan” entered or updated in axiUm. |
| 3. Pediatric patients had his/her treatment plan appropriately signed by his/her parent or legal guardian prior to the start of treatment. | % of pediatric patients seen with active treatment plan. (axiUm report) |
| 4. Moderate and high caries risk patients had sealants placed on their 1st molars within 4 years of eruption | % of moderate, high or extreme caries risk patients (Cambra) 6 to 10 years of age who have at least one unrestored or unsealed 1st molar. |
| 5. Pediatric patients had an appropriate topical fluoride treatment done in conjunction with his/her oral prophylaxis. | Continue? |
| 6. Pediatric patients had an occlusal examination documented in the dental chart at their previous routine examination | Electronic clinical exam form? |
| 7. Pediatric patients had an appropriate recall prophy date established based upon his/her caries index documented in the progress notes | Cambra risk category and assigned recall interval (axiUm report). |
Periodontic Best Practices

7 All SOD comprehensive care patients (dentate and/or with dental implants) will receive a periodontal examination in conjunction with his/her comprehensive treatment plan. This periodontal examination will be based on patient history and the use of appropriate diagnostic aids which include, by may not be limited to, the following: current radiographs, pocket probing, furcation evaluation, keratinized tissue assessment, gingival recession and tooth mobility. Oral hygiene homecare will also be evaluated in order to facilitate the development of appropriate individualize patient-specific oral hygiene instruction.

8 All comprehensive care patients will receive a periodontal diagnosis and treatment plan coordinated within the patient’s comprehensive treatment plan.

9 All comprehensive care patients will receive a thorough debridement consistent with his/her periodontal classification.

10 Periodontal therapy will be performed in a properly sequenced and timely manner as an integral component of the overall SOD interdisciplinary written treatment plan.

11 Comprehensive treatment will be aimed at eliminating and/or controlling etiologic factors and creating an oral environment that is conducive to optimal periodontal health and stable clinical attachment levels.

12 A program of supportive periodontal therapy will be recommended for all SOD comprehensive care patients and he/she will be placed on an appropriate patient-specific maintenance and/or recall schedule.

Periodontic Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SOD adult comprehensive care patients had a periodontal evaluation and charting as part of his/her initial/revised treatment plan.</td>
<td>% of comprehensive care patients who had periodontal examination at initial appointment.</td>
</tr>
<tr>
<td>2 SOD adult comprehensive care patients with periodontal pockets &gt; 5 mm received appropriate documented treatment prior to initiation of permanent prosthetic treatment (if indicated).</td>
<td>% of prosthodontics patients with pocket depths &gt; 5mm (excluding 3rd molars) who received periodontal consult prior to permanent prosthetics</td>
</tr>
<tr>
<td>3 SOD comprehensive care patients with early onset periodontal disease, unresolved inflammation, pocket depths greater than 5 mm, vertical bone defects, radiographic evidence of progressive bone loss, progressive tooth mobility, progressive attachment loss, exposed root surfaces, and/or a deteriorating risk profile received a periodontal consultation.</td>
<td>1. Develop periodontal consult form or progress note template.  2. % of patients with pocket depths &gt; 5mm who received a periodontal consultation.</td>
</tr>
<tr>
<td>4 SOD comprehensive care patients had a periodontal recall date appropriately established, documented, and scheduled.</td>
<td>% of scaling and root planning patients with an active recall date.</td>
</tr>
<tr>
<td>5 SOD patients received initial periodontal therapy as indicated in the comprehensive treatment plan.</td>
<td>% of treatment planned periodontal procedures completed within 12 months.</td>
</tr>
</tbody>
</table>
Preventive Services Best Practices

1. All comprehensive care patients will have an individualized treatment plan directed towards maintenance of function and prevention of disease.
2. All comprehensive care patients will have preventive services explained in understandable terms and integrated into his/her written sequenced treatment plan. These services include, but may not be limited to, the following: plaque control, mechanical debridment, oral health counseling, caries control, appropriate use of fluorides, sealants, diet counseling and athletic mouth guards.
3. Comprehensive care patients will have an oral prophylaxis and/or recall examination date established at an interval level appropriate for his/her risk of developing further oral disease. This recall date will be legibly written/ documented by a dated entry in the patient’s treatment record progress notes and signed by both the attending clinical faculty and student provider.

Preventive Services Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 SOD comprehensive care patients had their risk for caries and periodontal</td>
<td>Cambra for adults?</td>
</tr>
<tr>
<td>disease documented.</td>
<td></td>
</tr>
<tr>
<td>2 SOD comprehensive care patients had an appropriate maintenance oral prophylaxis</td>
<td></td>
</tr>
<tr>
<td>date and/or recall examination date enetred into axiUm.</td>
<td>% of patients seen who have active recall date in axiUm.</td>
</tr>
<tr>
<td>3 SOD adult comprehensive care patients who are caries active had an appropriate</td>
<td>High or Extreme Risk for caries (Cambra) received fluoride therapy</td>
</tr>
<tr>
<td>topical fluoride intervention.</td>
<td>or fluoride prescription. (axiUm report)</td>
</tr>
<tr>
<td>4 SOD comprehensive care patients received oral hygiene maintenance within 60</td>
<td>axiUm report for overdue patients.</td>
</tr>
<tr>
<td>days of his/her designated/documemted recall date.</td>
<td></td>
</tr>
</tbody>
</table>
Restorative Best Practices

1. The restorative interdisciplinary standards of care involve operative dentistry, materials science, both fixed and removable prosthodontics, implant supported restorations and preventive dentistry services. Comprehensive treatment plans will be developed that provide optimal function, esthetics, and length of service and offer reasonable alternatives when appropriate. Active disease of hard and soft tissues will be controlled prior to initiating definitive restorative care. Preparation design will follow accepted biomechanical principles.

2. Comprehensive diagnosis, treatment planning and subsequent treatment will take into consideration the biological principles of periodontal and pulpal health and occlusal function when evaluating and/or selecting the restorative materials and/or techniques appropriate for the individualized needs of the patient. When appropriate, written referrals will be made based upon the diagnosis of pathology and/or to accommodate the patient’s “Chief Complaint”.

3. Treatment plans will be preceded by appropriate documented review, update and evaluation of the patient’s health history and signed informed consent. The comprehensive treatment plan will be sequenced, written in a format that the patient can understand and be within the scope of the predoctoral program. Prior to commencement of comprehensive treatment, the patient will be made aware of his/her financial responsibilities, the approximate total treatment time and visit intervals of the plan, and the appropriate follow-up in the event of a dental emergency. The comprehensive treatment plan will be signed and dated by the patient, the attending faculty member and the student provider prior to its initiation.

4. Comprehensive treatment will be completed as expeditiously as possible taking into account, but not limited to the following: the abilities of the student provider, prolonged tissue healing times, financial constraints and/or scheduling conflicts on the part of the patient. All patient procedures will be accomplished utilizing standard universal precautions to prevent microbial contamination/cross contamination. Whenever possible, intra-coronal tooth restorations and cementations will be accomplished using isolation from surrounding soft tissue, saliva, and other causes of intra-oral moisture using the dental dam. When the dental dam cannot be placed, as in the cementation of a fixed prosthesis, appropriate absorbents and intra-oral evacuators will be used.

5. All patient visits and/or restorative procedures will be documented in appropriate sequence via dated legible entries in the patient’s treatment record progress notes that will include but not be limited to the following: review/update of patient’s health status; procedure accomplished, brand name and amount of materials used; technique of anesthesia (block vs infiltration) plus brand name, amount and concentration of solution used, any adverse side effects/misadventures encountered during treatment including follow-up; purpose and projected date/time required for next treatment visit; signature of attending faculty member and the student provider.

6. The decision to replace missing teeth is based upon clinical findings, occlusal considerations, the ability of the patient to maintain the prosthesis, the prognosis for drift and/or super eruptions, teeth position and patient preference. All missing teeth do not necessarily need to be replaced. A pre-prosthetic evaluation will precede initiation of any fixed and/or removable prosthodontic treatment which will include documentation of the control of active disease of hard tissue and soft tissue, the treatment/management of any periodontal pockets >5mm deep, a thorough occlusal analysis, accurately mounted diagnostic casts, occlusal adjustments, diagnostic wax-ups, assessment of TMD/parafunctional habits and vitality testing of abutment teeth.

Patients requiring complete dentures will have an initial evaluation that includes but may not be limited to the following: a current health history; an appropriately signed Informed Consent, adequate appropriate radiographs; and possibly articulated diagnostic casts in situations
where pre-prosthetic surgery is being considered. The diagnosis and case history/treatment plan will be reviewed and approved by an attending faculty member prior to commencement of the case. Overdentures, immediate dentures and/or implants may be considered for the partially edentulous patient for whom the remaining teeth are no longer able to support a removable partial denture. Existing dentures will be evaluated for correction such as reline, rebase, occlusal adjustment, etc.

7 Patients undergoing prosthetic replacement therapy must agree in writing that he/she is satisfied with the aesthetics and function of the case prior to its processed completion.

8 A written post treatment review will be accomplished at the patient’s final completion visit of the comprehensive restorative care by the assigned predoctoral student provider and his/her attending faculty to accomplish the following: ascertain the satisfaction level of the patient concerning treatment rendered at the SOD; verify that no further dental treatment needs to be done at that time on the patient; establish a recall examination appointment date appropriate for the patients needs relative to their level of risk for developing further dental pathology. The treatment review and recall date will be appropriately documented with a legible dated entry in the patient’s treatment record and will be signed by both the attending faculty and the student provider.

### Restorative Dentistry Quality Indicators and Description of Measurement

<table>
<thead>
<tr>
<th>QUALITY INDICATOR</th>
<th>MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Comprehensive care patients had an exam to initiate the comprehensive treatment planning process no later than 1 month after his/her initial clinical visit in the admissions clinic.</td>
<td>axiUm report</td>
</tr>
<tr>
<td>2 Comprehensive care patients started definitive treatment within 3 weeks of signing approval of his/her sequence comprehensive treatment plan.</td>
<td>axiUm report</td>
</tr>
<tr>
<td>3 Comprehensive care patients who received treatment for a single unit crown had it completed/cemented within 4 clinical appointments (including crown preparation) and within 2 months of initial crown preparation.</td>
<td>axiUm report showing initial, treatment in progress and completion restorative codes.</td>
</tr>
<tr>
<td>4 Comprehensive care patients receiving prosthodontic treatment for a 3 to 5 unit fixed bridge had it completed/cemented within 5 clinical appointments and within 3 months of initial tooth preparation.</td>
<td>axiUm report showing initial, treatment in progress and completion fixed prosthodontics codes.</td>
</tr>
<tr>
<td>5 Comprehensive care patients receiving removable prosthodontic treatment had his/her partial denture completed /delivered within 5 clinical appointments and within 3 months of initial preliminary impressions.</td>
<td>axiUm report showing initial, treatment in progress and completion fixed prosthodontics codes.</td>
</tr>
<tr>
<td>6 Comprehensive care patients receiving removable prosthodontic treatment had his/her complete dentures delivered within 7 clinical appointments and within 3 months of the initial preliminary impression.</td>
<td>axiUm report showing initial, treatment in progress and completion fixed prosthodontics codes.</td>
</tr>
<tr>
<td>7 Comprehensive care patients who had operative procedures done at the SOD did not require re-treatment of the same procedure for at least 12 months after its completion.</td>
<td>axiUm report</td>
</tr>
</tbody>
</table>

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**Urgent Care Best Practices**

4. The patient's medical history, vital signs and chief complaint will be recorded and reviewed for each new patient.
5. Each patient will receive a diagnosis and appropriate treatment options relative to their chief complaint.
6. Patients will be informed of their next treatment need and given an opportunity to make another appointment at the School of Dentistry.

**Urgent Care Quality Indicators and Description of Measurement**

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>1. Medical history and vital signs recorded for new UCC patients</td>
<td>AxiUm report</td>
</tr>
<tr>
<td>2. Chief complaint noted in progress note</td>
<td>AxiUm report. (Need to develop template progress note for UCC)</td>
</tr>
<tr>
<td>3. Patient informed of next treatment need</td>
<td>AxiUm report. (Template progress note)</td>
</tr>
<tr>
<td>% of new UCC patients seen in other Sod clinic within 30 days following initial UCC appointment.</td>
<td>AxiUm report</td>
</tr>
</tbody>
</table>
Standards of Professional Conduct

The University of Minnesota and the School of Dentistry are committed to the highest standards of professional conduct. Therefore, all members of the University community and the School of Dentistry are expected to adhere to the highest ethical standards of professional conduct and integrity. The values we hold among ourselves to be essential to responsible professional behavior include honesty, trustworthiness, respect and fairness in dealing with other people, a sense of responsibility toward others and loyalty toward the ethical principles espoused by the institution and the School of Dentistry. It is important that these values and the tradition of ethical behavior be consistently demonstrated and carefully maintained.

Members of the University community and the School of Dentistry have the obligation to respect and to be fair to faculty, staff, students, and patients, and to foster their intellectual and professional growth and well-being. Members must not engage in, nor permit, harassment and illegal discrimination. Members must not abuse the authority they have been given and care must be taken to ensure that any personal relationships do not result in situations that might interfere with objective judgment.

Workplace, patient care and educational experiences must impart ethical standards of professional conduct through example, instruction and clinical practice. Members of the University community and the School of Dentistry are expected to conscientiously fulfill their obligations in the performance of their duties and as part of the University community.

Respectful Workplace
The School of Dentistry is proud of the respectful workplace that we have developed for faculty, staff, students and patients. We believe that our goal is to maintain an academic, work and patient care environment that is positive and respectful of others. Respect is provided to every person regardless of gender, race or color, religious or spiritual beliefs or creed, nationality, sexual preferences or affection, disability, credit or financial situation, public assistance, veteran status, or physical condition. We believe in providing a respectful and positive learning and working environment that maximizes the potential of all individuals.

With these values as the foundation for the School of Dentistry, we have established guidelines, based on University policy, for the behavior of our faculty, staff and students.
We will engage in legal and ethical conduct and will not tolerate offensive behavior. Offensive behavior is defined as action or conduct that has the purpose or effect of unreasonably interfering with an individual's work, academic or professional performance or creating an intimidating or hostile work environment. Employment and academic experiences will be based on respect and performance.

Explicit or implicit harassment, unwelcome advances, requests for sexual favors, or unwelcome physical conduct of a sexual nature will be promptly addressed. In addition, a hostile workplace, including abusive language, discriminatory or offensive remarks or humor, offensive visual displays, pornography, or aggressive physical contact will be addressed.

**Equal Opportunity, Diversity, and Affirmative Action**

The University of Minnesota and the School of Dentistry are committed to the policy that all persons shall have equal access to its programs, facilities, and employment without regard to race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation. The University and the School of Dentistry shall seek to:

1. Provide equal access to its programs, facilities, including patient care clinics.
2. Advocate and practice affirmative action in employment including the use of recruiting and search processes to enhance participation of racial minorities, women, persons with a disability, and veterans;
3. Establish and nurture an environment that actively acknowledges and values diversity and is free from racism, sexism, and other forms of prejudice, intolerance or harassment, for all faculty, staff and students.
4. Provide equal educational access to members of under-represented groups, and develop affirmative action admission programs where appropriate to achieve this goal.

4. The School of Dentistry currently has a Diversity Committee with representation from faculty, staff and students.

**Disability Services**

The Board of Regents of the University of Minnesota is committed to provide for the needs of faculty, staff and enrolled or admitted students with disabilities under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (ADA). The School of Dentistry shall make services available for any faculty member, staff, or student who, through a recent assessment, can document a disability. Disability Services, with support from the School of Dentistry, will provide appropriate services, including:

(1) support, counseling, and information; (2) communications with medical provider; and (3) assistance with reasonable accommodations.

**Drug-Free Workplace**

Having a respectful workplace also includes having a workplace where faculty, staff and students can work and learn in a healthy and productive environment. We believe that drug and alcohol abuse affects the health, safety and well-being of all employees and students and restricts their ability to perform. This is particularly critical for those who work with and practice dentistry with patients. Therefore, the School of Dentistry supports and follows the University of Minnesota's Drug-Free Campus and Workplace policy. This policy prohibits the unlawful possession, use, or distribution of alcohol and illicit drugs by employees and students. Furthermore, it prohibits the unlawful manufacture, distribution, dispensation, possession, or use of controlled substances in the school. For more information on this policy, go to
Students Suspected of Chemical Use or Abuse
The University of Minnesota and the School of Dentistry strongly support a Drug Free University. For more information on this policy, go to http://www.policy.umn.edu/Policies/Operations/Safety/DRUGFREE.html

Within the School of Dentistry, student violations of this policy will be dealt with as follows:

**FIRST OFFENSE:**
- Immediately upon detection or suspicion of impairment, or potential for impairment, the student will be dismissed from class or lab. If a student in the clinic is suspected of impairment or potential for impairment, he or she will be removed from the clinic and any appointed patients for the remainder of the day will be canceled or reassigned.
- Faculty or staff involved in the incident will immediately file a professional behavior report form with the Office of Academic Affairs. This report will be passed on to the Ethics Committee for disposition.

**SUBSEQUENT OFFENSE:**
- Immediately upon detection or suspicion of impairment, or potential for impairment, the student will be dismissed from class, lab, or clinic and a professional behavior report form will be filed with the Office of Academic Affairs.
- The student will be escorted to Boynton for urinalysis/blood test and for assessment for chemical dependency.
- If the student is determined to be chemically dependent, the Policy for Dealing with Student with Chemical Dependency Problems will be enforced.
- If the student is determined not to be chemically dependent, the matter will be referred to the Ethics Committee for disposition.

**Sexual Harassment**
Sexual harassment by or toward faculty, staff, students, patients, or members of the University community is prohibited. Prompt and appropriate action will be taken when sexual harassment is discovered. Persons who suspect sexual harassment should report it to an appropriate authority, such as the Dental School's EEO Officer or Human Resources Department; or the University's EEO Office. A violation of the sexual harassment policy may lead to disciplinary action, up to and including termination of employment or academic dismissal.

**Recourse and Reporting**
It is not necessary for any faculty, staff, or student who feels that he or she is the subject of offensive, harassing or discriminatory behavior to handle the matter alone. We encourage you to directly object to any behavior you believe to be offensive. However, if you feel offended by faculty, staff, your Supervisor, peers, or others whom you encounter in the course of your employment or academic studies and do not feel you are able to deal directly with the problem, go immediately to your supervisor, or, you may report the behavior to the School of
Dentistry's Equal Opportunity Officer, Dr. Carol Meyer (626-2332 Human Resources Department 612-626-4172 or the University of Minnesota's Office of Equal Opportunity and Affirmative Action (624-9547).
All allegations of offensive behavior will be responded to appropriately. The facts shall determine the response to each complaint and each situation will be handled discreetly. Retaliation and intimidation directed toward anyone who makes a complaint is prohibited. This practice applies to each and every full-or part-time faculty, staff and student in the School of Dentistry.

**Student Appearance**

The personal appearance and demeanor of every person affects, either directly or indirectly, the care and management of patients. The image communicated to patients through personal attire and appearance, behaviors and interactions will influence their perceptions of the quality of care they will receive at the University of Minnesota School of Dentistry and their confidence in the person providing that care. A presentation of professionalism is essential to uphold the standards of excellence set by the University of Minnesota, the School of Dentistry, and the dental profession.

Dentists, in their own practices, will decide for themselves what appearance promotes a demeanor of professionalism. Throughout the School of Dentistry this is best accomplished by a reasonable degree of conformity in attire and grooming.

All faculty, staff and students are responsible for maintaining a clean, neat and well-fitting wardrobe.

**The following guidelines apply for all DDS, DT, DH, and students:**

Personal hygiene and grooming habits are essential components of professional appearance and presentation.

- **Hair** (including beards and mustaches): should be clean, neatly trimmed, and well maintained. Those who shave must be clean-shaven. Long hair should be pinned or held back so that it does not interfere with the field of vision or require handling during treatment procedures.

- **Makeup and perfume/after-shave:** Strong perfumes and cologne may be offensive to others, therefore avoid excessive use; heavy application of make-up should also be avoided.

- **Personal hygiene:** Body hygiene is required so that offensive body odor is avoided. Fingernails should be trimmed, clean and well groomed.

- **Jewelry:** Rings that may compromise clinical protective barriers should not be worn in clinics. No facial piercing should be evident during the school/clinic day (i.e. no rings or studs may be worn on the face or in the mouth.)

All students will wear the School of Dentistry matching scrub shirt, pants, and/or skirt in the color designated for their program (navy blue for DDS students, burgundy for DH students, black for DT students). Scrub pants and skirts should not touch or drag the ground when standing or seated. Scrubs must be maintained in a clean, neat, and professional manner. Any head coverings such as hijabs, yarmulkas, etc. and/or face veils must be changed or washed daily. In addition, clean, predominately white, black or color matching shoes (closed toed and fluid resistant) and white socks (crew length or longer) are required. We suggest these shoes be worn only in Moos Tower so they remain clean and professional in their appearance. Skirts must be at or below the knee. Legs must be covered with nude, black or color matching hose, tights or scrub pants. Students may wear white, black or color matching tee shirts underneath their scrub tops if desired. Nametags must be visible.
The following guidelines apply to all DDS, DT and DH classes:
All students will wear matching scrub shirt and pants in the color designated for their program (navy blue for DDS students, burgundy for DH students). In addition, clean, predominately white shoes (close toed) and white socks, (crew length or longer) are required. We suggest these shoes be worn only in Moos Tower so they remain clean and professional in their appearance. Students may wear white tee shirts underneath their scrub tops, if desired. Nametags must be visible.

Dress Code Violations or Complaints

It is the duty of the attending faculty member or staff supervisor, either because of personal observation or by report from others, to inform a student in violation of the above guidelines.

The notification process will be conducted in a polite, courteous, professional manner but may include instruction to leave the clinical area until professional appearance is attained.

Repeated violations of the Clinical Dress and Grooming Guidelines by a student will be reported to the Associate Dean,Clinic Administration and Patient Careoffice for further action.
Student Assignments

General Information

Patients will be assigned to students in accordance with protocols determined by various divisions and Clinical Systems. Included in the assignment process is a review of current patients assigned to student and availability within the student's schedule to ensure that the patient will be seen in a timely manner. Total experience needed per division will depend upon the quality and overall distribution of patient treatment to which the student has been assigned, and which he/she has completed.

Students should plan their work so that patients are dismissed promptly at the end of a clinic session.

A student's whereabouts must be known to the School should the latter need to communicate with him/her. This availability is part of the responsibility of a professional. In the event of illness or emergency, the Coordinator of Academic Services (Office of Academic Affairs) and the student’s Patient Care Coordinator (PCC) should be notified immediately. The PCC will take responsibility for notifying scheduled patients of the student’s absence.

Each division determines its own policy regarding absences from its clinics. In general, reasons for excused absences include illness, accident, personal crisis, religious observances, and participation in various School of Dentistry programs, such as summer research or representing the school at professional conferences. Students must complete a “Planned Absences Request” form for all planned absences. The only way that a planned absence will be considered excused is by formally having the absence approved by using the request form. Further information about the “Planned Absences Request” process can be obtained from the Office of Student Services (15-106 Moos Tower).

Use of Personal Sessions

Students are given seven days, or fourteen clinic sessions, per year for personal/sick days. Any additional time out of the clinic must be made up in a manner agreed upon between the student and the Group Leader.

Attendance Information – DDS, DT and DH Students

2012 – 2013

The School of Dentistry has the responsibility of preparing its students both academically and clinically for the practice of dentistry. Successful skill and knowledge based development requires continuous attendance in all classes, instructional sessions and participation in clinical assignments as designated by curriculum/clinical schedules.

School of Dentistry students are expected to demonstrate professional behavior in keeping with this attendance policy by attending all classes and/or clinics as indicated on their schedules.

Excused Absence Policy
Student absences from class or clinic may be excused for the following reasons:
1. Illness of the student or his or her dependent*
2. Subpoenas
3. Jury duty
4. Military service
5. Recognized religious holidays
6. Family emergency
7. Death in the family
8. Participation in School of Dentistry student groups, as approved by a faculty advisor
9. Official school business

If a student is absent due to circumstances identified above, the instructor may not penalize the student and must provide reasonable and timely accommodation or opportunity to make up exams or other course requirements that have an impact on the course grade (Regents Policy: Makeup Work for Legitimate Absences).

Students who plan to be absent due to circumstances identified above must submit a planned absence request, if possible, to the Office of Student Affairs. Students must submit requests and notify instructors as far in advance as possible so that instructors have adequate time to make alternative arrangements.

*In the case of illness, students are required to submit a physician’s note if they are absent on the day of any graded course component to the Director of Academic Services & Registrar (Lucy Hartel). Students must also follow the same day absence notification process for illness. Clinical faculty and administration also reserve the right to request a doctor’s note for any clinical session absence due to illness.

A student with multiple absences due to illness may be scheduled to meet with the Associate Dean for Academic Affairs to discuss the situation, the impact on the student’s education and potential strategies for moving forward to ensure the student’s long-term success.

**Additional Information regarding Clinic Absences**
Students are expected to be in school every day and readily accessible even when a patient is not scheduled as there may be need for them to assist with an emergency in clinic or other patient care. Students absent from clinic must report all absences, both personal and excused to ensure consistency in patient care.

Personal sessions must be submitted to Clinical Systems (Kathy Hughes) at least two weeks in advance. Requests submitted after two weeks may not be approved.

Excused absences must be submitted to Clinical Systems (Kathy Hughes) at least two weeks in advance whenever possible.

**Students who are in both class and clinic must submit a planned absence request to the Office of Student Affairs and Kathy Hughes for all excused absences. Instructors**
will not offer make-up work (e.g., exams quizzes, practicals, etc.) if a student’s absence is not excused.

Other Attendance Information
Records of submitted absence requests will be maintained by the Office of Academic Affairs. This information will be reported to Scholastic Standing Committees as needed. Scholastic Standing Committees may review multiple absences of any student to determine whether the integrity and continuity of the student’s education has been compromised and make recommendations regarding remediation.

Comprehensive Care Clinic
Students will provide Operative and some Prosthodontic procedures within their group clinic, while Periodontic and Predoctoral Prosthodontic procedures will take place in the 7N and 9N clinics respectively. Students are expected to be in the comprehensive care clinic at all times, except when scheduled into a specialty clinic rotation or with appointments in the Endodontic, Periodontic, and advanced Restorative clinics. Students are expected to complete all necessary treatment on each patient assigned for comprehensive dental care. In the event of graduation or if student needs cause the treatment to be interrupted, the Group Leader is responsible to oversee the transfer of the patient to another student in his/her group to complete the treatment.

Specialty Clinic Rotations
Rotations to specialty clinics are assigned to students throughout the entire clinical experience. Students are to report to rotation clinics when scheduled. No patients are to be scheduled by students for treatment in any other clinic during these assignments. In order to maintain the proper functioning of the specialty clinics, all students must report to their assignments.

Dental Therapy students rotate through Oral Surgery, Perio, Endodontics as well as the Comprehensive Care Clinics beginning in their fifth semester.
DH students enter into the Comprehensive Care clinics in the second semester of their first year. DH rotates through IFC in their third semester.
Fourth year students rotate through Admissions, Urgent Care Clinic, Oral Surgery, Pediatric Dentistry and Outreach. Third year students rotate through Admissions, Urgent Care, Pediatric Dentistry, Graduate Periodontology Assisting, Endodontic Recall, Undergrad Perio Assist, Orthodontics and Oral Surgery Assisting.
Second year students enter the Comprehensive clinic Spring semester treating Perio recall patients.
A student who must leave any clinic must notify an instructor in the clinic of his/her destination and the period of time he/she plans to be absent. Unannounced departures will be considered patient abandonment.
When a student cannot attend a rotation for reasons other than illness, he/she must secure an alternate student from his/her own class to take the assignment. In order for the change to be official, the students must complete a “Clinic Block Schedule Change Request” form and submit to the Coordinator of Scheduling Services (8-440), ensuring that change is made in the clinic computer system, as well as notify the rotation clinic of the change. Switching of assignments among students is strongly discouraged.
Summer Session

The start of summer session marks the starting point for the next academic year. Therefore, on the first day of classes/clinic for summer, the most senior group of students enters their fourth year. During the summer, the fourth year students will be scheduled into clinic full time and will provide a majority of the treatment in the clinics during the session. The new third year class will also be in clinic during the summer months, however, their schedule allows for clinical experiences only in the afternoons.
Patient Routing Procedures

Patient Admissions
Adult persons (18 years of age or older) wishing to become patients at the UM Dental Clinics make an initial evaluation appointment by calling 612-625-2495, or in person at any of the reception desks on the 8th or 9th floors of Moos Tower.

Patients seeking care at the U of M Dental Clinics are seen in the Comprehensive clinic color groups for the Admissions appointment (previously called Initial Faculty Consultation; IFC). Two dental students from each group, along with a Dental Therapy Student and/or a Dental Hygiene Student (if available) are blocked for the Admissions rotation each morning and afternoon session Monday through Thursdays. Patients check in at the color group they are assigned to.

Translation Services
Foreign language and hearing impaired interpreter services are available.

Referring Friends and Relatives
Students who have a friend or family member they would like to have assigned as one of their patients should schedule a reverse admissions appointment for the individual with their Patient Care Coordinator.

Radiographic Appointments
Most patients have radiographs exposed as part of their Admissions appointment. Appointments may be scheduled at a later date at the discretion of the patient or when radiographs have been requested from an outside dentist.

Students will not be permitted to make an appointment for diagnosis and treatment planning unless the patient has an appropriate set of interpreted radiographs.

Patient Parking
Preferential parking for patients is reserved at the Washington Avenue Parking Ramp, 501 Washington Avenue SE, Minneapolis MN 55455 across the street from Moos Tower. Patients may enter the ramp by using the center lane and telling the attendant that they are a dental patient. Even if the signs say the ramp is full, patients are to use the center lane and talk with the attendant.

Patients must bring the parking ticket with them to their appointment, as the only way to qualify for reduced rates patients is to request validation of their parking ticket when they check in at any of the clinic reception desks at the end of their appointment.

Handicapped parking space is available immediately next to the elevator on each level of the Washington
Avenue ramp.

University of Minnesota direction information is available at 612-625-5000
Patient Management

New Patient Assignment

Typically, the student who completes the Admissions appointment is assigned to the patient. All patients must have a Patient Assignment form completed documenting the student assignment signed by the supervising faculty.

Patient information gathered at this appointment is forwarded to the Patient Management Office (PMO). If the patient is not assigned to the student, the PMO staff will work with the students group director to match the patient with a student dentist, considering factors including, but not limited to:

- Student clinical experiences
- Patient’s dental needs
- Student clinical schedules
- Patient’s schedules

The patient is then contacted for further appointments.

The Student-Patient Listing (SPL)

Format of SPL

The Student-Patient Listing (SPL) is a computer printout which contains the names, chart numbers, and treatment needs of the adult patients you treat during your clinical program.

The following is a brief description of the format of the SPL.

HEADING: your name, group clinic and the date of the SPL appear on the first line.

BODY: the body of the SPL contains a listing of patient names, treatment information and status codes.
SUBTOTAL: this line is a running tally of all the treatment needs of your assigned patients for which you are responsible.

TOTAL: this line contains the total number of assigned units or surfaces for each clinical division.

The assigned student is responsible for total care of patients appearing on his/her SPL.

**Changing Information on the SPL**
The Student-Patient Listing (SPL) is the document through which the student and the School of Dentistry "communicate" about his/her clinical requirements and the patients' ongoing dental needs. If the information of the SPL is inaccurate, it is the student's responsibility to change it: he/she is responsible for keeping his/her SPL current and accurate.

Treatment planning is completed in the AxiUm system. Information is printed for each patient. All students must see a Treatment Planning Coordinator to review the information with the patient and student. Financial responsibility and insurance information will be discussed and patients will sign and approve proposed treatment. Patient Management staff will review all Treatment Plans and update students SPL.

**Avoiding Patient Abandonment**
The doctor-patient relationship is the central focus of any dental practice and as professional a medical professional, you are trusted to make decisions and take actions that benefit your patient's health. This relationship can end for many reasons. Whatever the reason, termination of care can adversely affect the patient. The law protects the patient in this situation, even when the patient terminates the relationship. The doctor-patient relationship simply doesn't end when the patient leaves your office or care. It continues until either party properly ends it. Unless the relationship is legally terminated, the courts may consider it to exist even years after the patient and dentist last communicated.

**LEGAL RESPONSIBILITY**
Our courts hold you responsible for properly ending or handling the patient's termination of the relationship. Once a doctor-patient relationship has been established, the doctor has a legal duty to treat a patient until the relationship is terminated. Some of the typical ways this relationship might end include:

- the patient changes dentists
- the patient moves
- the dentist initiates termination due to the patient's failure to follow
- treatment failure to pay for services, or failure to show up for appointments
Avoiding the charge of abandonment

How you handle the termination of the relationship will depend upon who initiates termination. Be sure to document any letter and/or any subsequent correspondence or conversations in the patient’s dental record/AxiUm record. Also, keep the certified mail receipt as part of the file.

- In order to avoid a charge of patient abandonment the following must be done:
  - Advise the patient of cost and process of obtaining dental record and x-rays
  - Provide a list of unmet dental needs and associated risks
  - Give patient adequate time to find another dentist before terminating relationship
  - Be able to prove that you have made a "reasonable effort" to get the above information to the patient (certified mail).

Dealing with patient problems

The following is a list of situations that should be discussed with your Group Director and the Patient Management Office Staff.

- Difficulty scheduling patient appointments
- Chronically late patient for scheduled appointments
- Chronic failure to appear for scheduled appointments
- Patient requesting treatment or lack of treatment which falls outside accepted standards of care
- Behavioral problems
- Patient moves from area
- Patient chooses to seek future care outside the School of Dentistry
- Unable to contact patient or they do not respond to telephone call messages, etc. after they have been treatment planned or treatment has commenced
- Patient who does not want to come back for final Quality Assurance exam appointment.
- Patient who defers treatment more than 4-6 months

For a patient who has not returned for completion of a specific procedure (ex: RCT, cement a crown) use the appropriate letter and address the associated risk using the Unresolved Dental Problem/Associated Potential Risk form.
Protocol for Advisory Letters to Patients

Letters
There are of several types of advisory letters for patients, each customized to the particulars of the situation. The letters are available on disk in the Dental Learning Resource Material Center (DLMRC) and must be typed by students in the DLRMC. Three copies of the letter must be prepared, with one copy (the patient’s) on U of M School of Dentistry letterhead. Two copies of the letter must be signed by the student dentist and the group leader. After the letters are signed they are to be brought to the Patient Management Coordinators by the student.

Once the Patient Management Office receives the copies of the letter, the staff will mail the original, place the second copy in the patient's record and make notation in the progress notes, Letters are documented in the AxiUm progress notes when letters are sent to the patients.

Documentation needed for dismissal
It is extremely important that all records are properly maintained. When patients are dismissed from our clinical program for whatever reason, it is absolutely necessary that the record be appropriate and properly documented. Important information to record includes:

- All late, failed, and canceled appointments must be listed in the progress notes and signed by students and faculty
- All canceled/rescheduled appointments done at the initiative of the student dentist must also be recorded.
- Category I: Important to record the incident and give details but do not make any judgments--ex: the patient is psychotic (you are not qualified to make this judgment).
- Keep a list in your personal notebook of dates and times of telephone calls, etc. then enter these at a later time in the record. Example: 061015 called patient and left message on answering machine (or with friend) the following times/dates. Patient has not responded. If this patient is eventually dismissed, then the notes or a photocopy of the page from your personal notebook must become a part of the patient's record. This type of documentation is mandatory as the student/school must prove that we have made a "reasonable" effort to contact the patient, i.e., we have not "abandoned" the patient.
Completing Patient Treatment

As a portion of quality assurance of patient care, when the patient’s final or agreed on treatment plan has been complete, it is the student’s responsibility to:

- Assure the completion of the patient’s care as agreed on

- Assure the patient’s current condition is updated to account for any changes in the patient’s problems or needs since the original data base collection.

Document Completion of Patient Treatment

This may be accomplished with any faculty member, most logically the faculty supervising the patient's last procedure or group leader.

- The Quality Assurance – Patient’s Treatment Complete form is completed when all criteria are met - including signature, Quality Assurance is completed in the AxiUm record.
  - If any item is not "up to date" these changes should be made or accomplished prior to signifying completion.

- If postoperative radiographs are indicated, they may be taken at this time, or the patient may be referred to radiology for a full mouth series. These radiographs will be charged to the patient, in the same manner as for a "recall appointment."
  - Record the taking of all radiographs in the AxiUm progress notes.

- If new problems are identified, update the master Problem List and/or revise the existing uncompleted treatment plan or create a new plan, whichever is most appropriate.
Patient Records

All people receiving treatment in the UM Dental Clinics must be registered and a record of their treatment kept on file. Patient records are legal documents which outline the care the patient receives at the UM Dental Clinics. These records are the sole means the School of Dentistry has for documenting patient treatment. It is essential that these records be available at all times, and that no treatment be provided without the patient record.

To insure availability of the records, the School of Dentistry maintains a central records system. At all times, records must either be in the system or checked out to an individual in an approved area. **At no time should the original record be taken out of the dental school building.** This enables records personnel to retrieve a patient record in the event of emergency treatment. The School of Dentistry clinics are currently using the Dental School paper chart which store all past documentation and dental films. The students document all patient treatment in the AxiUm chart. The School of Dentistry transitioned to digital radiographs on October 1, 2012.

Using the Patient Record

For every clinical period in which your patient has been appointed, his/her paper record will be available at the front desk in time of the appointment.

You must make an entry for daily treatment in your patient's AxiUm record. Entries must be completed and signed by your instructor before your instructor leaves the clinic the day of treatment.

At the end of each clinical session you are required to return patient records to the PCC on floors 6-9. Patient records should never be taken home. In addition, locked drop boxes for returning charts are located in the 8th and 9th floor lobbies. These boxes are to be used only after the front desks are closed for the day.

Even if you are seeing the patient the following day, return his/her record. A record request is automatically generated each time you make an appointment and the record must be accounted for. The patient, in the meantime, may come in for emergency care, or, oftentimes, the record is needed for non-patient care activities such as insurance or accounting.

A HOLD of any kind (Accounting, etc.) on a dental record requires an approval from the appropriate office placing the hold prior to treating the patient.
If the Patient Management Office, Patient Accounts Office, or other approved area require a review of a patient record with you, and a two-day lead time is not possible, a staff member from the area must request the record and assume responsibility for it.

Confidentiality of Patient Records

The information included in dental records is of significant legal importance. The dental record is a patient's file containing treatment-related information. The dentist is legally obligated to send copies of the record to whomever the patient desires. A doctor's failure to safeguard or provide copies to the patient may result in a legal action against the doctor. Also, the doctor may face a breach of confidentiality charge if the record is forwarded anywhere without the patient's consent.

A dental record, or any part of a dental record, cannot be forwarded without the patient's consent. Furthermore, the patient's approval should be expressed in writing with a records-release consent form. This form should specify to whom the record is to be sent. It should also be signed and dated by the patient. Release forms are available from central records. When sending a dental record to anyone, it is important that a copy of the record is sent; the original record is to remain within the School of Dentistry. A fee will be charged for duplication.

Patient records are confidential documents and may not be released for use outside of the UM Dental Clinics without written patient consent except as provided by law.

It is important for students, faculty, and staff to restrict conversation about a patient's histories except where it is relevant to their care.

HIPPA Standards

University Of Minnesota HIPAA Notice of Privacy Practices
Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact the Privacy Office at (612) 624-7447.

Who Will Follow This Notice

- The University of Minnesota provides a wide variety of health care services through various separate, but related units. This notice describes the privacy practices of the University of Minnesota, including:
  - Any health care professional authorized to enter information into your medical record.
  - All health care departments, clinics and units such as Boynton Health Services, the Community University Health Care Center (CUHCC), the School of Dentistry or a student health service.
  - Any member of a volunteer group we allow to help you while you are a patient.
  - All University health care employees, staff and other personnel, and students.
• Separate notices describe the practices of the University of Minnesota UPlan. In order to help the University provide quality health care, all of the above entities, sites and locations may share health information with each other for treatment, payment or operations purposes described in this notice.

OUR COMMITMENT REGARDING HEALTH INFORMATION
We understand that health information about you and your health is personal. We are committed to protecting health information about you by complying with all applicable federal and state privacy and confidentiality requirements. Accordingly, we have developed policies, enhanced the controls over our computers and other systems which access and store health data, and educated our workforce about protecting your health information.

This health facility is part of the University of Minnesota. The University of Minnesota provides a variety of health care services to the community. In doing so, the various parts of the system obtain health information about and from their patients. As we obtain this information, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the University of Minnesota. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to make sure that health information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to health information about you; and follow the terms of the notice that is currently in effect.

The University of Minnesota strives to protect the privacy and security of your health information during your treatment and after your treatment has ended. The University uses electronic record systems and believes they are an important part of improving the quality and safety of the care we provide. Physicians, authorized practitioners, and authorized members of our workforce are given access to these systems so that they can access your information when needed. The University of Minnesota has policies, procedures and technical safeguards in place to protect your information from being accessed by anyone other than those authorized.

While our internal information systems are reasonably secure from access by unauthorized parties, e-mail communication between you and the University of Minnesota is not secure because it is transmitted through public communication lines (the Internet). There is a possibility that e-mail transmitted using the Internet could be intercepted or received by an unauthorized person. Physicians and staff will not communicate with you using e-mail unless you have authorized us to do so.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and give examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We will provide medical information about you to doctors, nurses, technicians, medical students, residents, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may
need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different units of the University also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may use and disclose medical information about you in order to communicate with you about available treatment— for example, to send you appointment or prescription refill reminders, or to offer wellness and other educational programs, or to tell you about or recommend possible treatment options or alternatives that may be of interest to you. With your agreement, we also may disclose information about you to others outside the University involved in your care. These may include specialists who are consulted about your treatment or care, home health agencies or medical equipment suppliers who provide services that are related to your care, and your regular physician on record so that they have appropriate information for providing care to you.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, the responsible party (guarantor) on your account, Medicare or other governmental programs, an insurance company or another third party. When you become a patient, we will ask for your agreement to disclose information outside the University as necessary to obtain payment for your health care. For example, we may need to give your health plan information about care you received so your health plan will pay us or reimburse you for the care. We may also tell your health plan about a treatment you are going to receive, to obtain prior approval or to determine whether your plan will cover the rest of the treatment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the health care units of the University and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the University should offer, what services are not needed, and whether certain new treatments are effective. We may also provide information to doctors, nurses, technicians, medical and nursing or other students and other personnel and trainees for review and learning purposes. With your agreement we may also combine the medical information we have with medical information from other health care centers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information, so that others may use it to study health care and health care delivery without learning who you are. If we do so, we only provide them with health information when it is necessary and only after they have signed a written agreement agreeing to protect the privacy of the information.

**Business Associates.** Sometimes it is necessary for us to hire outside parties (business associates) to help us carry out certain health care operations or services. These services are provided in our organization through contracts with the business associates. Examples include computer maintenance by outside companies, consultants and transcription of medical records by outside medical records services. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we’ve asked them to do. Similarly, there are departments of the University that provide services to us, and may need access to your health information to do their jobs. We require business associates and other University of Minnesota departments to appropriately safeguard your information.

**Appointment Reminders.** We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or health care.
Treatment Alternatives. We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits or Services. We may use and disclose health information to tell you about health related benefits or services that may be of interest to you.

Fundraising Activities. We may use certain information to contact you in an effort to encourage donations for the University. We may disclose contact information to a foundation related to the University so that the foundation may contact you to encourage donations. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the University. When, and if, the University of Minnesota or a related foundation contacts you to encourage a donation, you can choose to opt out of any future contacts. If you do not want the University or foundation to contact you for fundraising efforts, address your request in writing to the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may communicate medical information about you to a family member or friend who is involved in your medical care or payment for your medical care. If your condition prevents you from being able to state your wishes about such communications, we will use our professional judgment to determine with whom we should communicate. In addition, in the event of a natural disaster or other disaster, we may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Other Care Providers. With your agreement, we may disclose medical information to health care professionals who have cared or currently are caring for you, such as, a referring hospital and its physicians, rescue squads or a nursing home medical director, for them to use in treating you, seeking payment for treatment, and certain health care operations, such as evaluating the quality of their care and the performance of their staff, providing training, and licensing and accreditation reviews.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. By performing research, we learn new and better ways to diagnose and treat illnesses. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. We also may retain samples from tissue or blood and other similar fluids normally discarded after a medical procedure for later use in research projects. All these research projects, however, are subject to a special review and approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. In some cases, your authorization would be required. In other cases it may not, where the review process determines that the project creates no more than a minimal risk to privacy, obtaining your authorization would not be practical and the researchers show they have a plan to protect the information from any improper use or disclosure. We may also disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the University. And if a research project can be done using medical data from which all the information that identifies you (such as your name, social security number and medical record number) has been removed, we may use or release the data without special approval. We also may use or release data for research with a few identifiers retained—dates of birth, admission and treatment, and general information about the area where you
live (not your address), without special approval. However, in this case we will have those who receive the data sign an agreement to appropriately protect it. In the event that you participate in a research project that involves treatment, your right to access health information related to that treatment may be denied during the research project so that the integrity of the research can be preserved. Your right to access the information will be reinstated upon completion of the research project.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent an immediate, serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ or tissue procurement or to an organ donation bank, to further organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers’ Compensation.** We may release medical information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report endangering disabilities of drivers and pilots;
- to report abuse or neglect of children and vulnerable adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you
in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if you have authorized that disclosure.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official. Examples of where information may be released to a law enforcement official without your individual authorization include:

- In response to a court order;
- About certain types of wounds or wounds made by certain weapons;
- For medical examiner investigations;
- In emergency situations;
- For child abuse investigations;
- To identify a deceased person;
- About the victim of a crime if, under certain limited circumstances, we are able to obtain the person’s agreement; and
- About criminal conduct at the hospital.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about deceased patients to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state of conduct special investigations.

**Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy your medical and billing records. To inspect and copy your medical or billing records, you may submit your request in writing to the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455.

If you request a copy of the information, we may charge a fee for costs of copying, mailing or other supplies associated with your request. **We may deny your request to inspect and copy in certain very limited circumstances.** If you are denied access to medical information, you may request that the denial be reviewed in certain circumstances. If you so request, another licensed health care professional chosen by the University will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Request Amendments.** If you feel that medical information we have about you is incorrect or
incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, your request must be made in writing and submitted to the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. In addition, you must provide a reason that supports your request. We may deny your request if you ask us to amend information that:

- Was not created by us, unless you can show the person or entity that created the information is no longer available to make the amendment. If so, we will add your request to the information record;
- Is not part of the medical information kept by or for the University;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

We will notify you in writing if we deny your request. If the request is denied, you have the right to submit a written statement of reasonable length disagreeing with the denial.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of disclosures of medical information about you that were not for treatment, payment or health care operations and of which you were not previously aware. To request this list of accounting of disclosures, you must submit your request in writing to the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. If the cost will be greater than $50.00, we will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If one facility in the University of Minnesota agrees to a restriction, the restriction applies only to the facility that agreed, unless you submit the request to and receive written agreement to the restriction from other facilities at the University of Minnesota.

To request restrictions, you must make your request in writing--contact the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Alternative Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must make your request in writing-
- contact the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. We will not ask you the reason for your request. We will accommodate all reasonable requests within our technical capabilities. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- You may obtain a copy of this notice at our Web site, http://www.privacysecurity.umn.edu.

- You may obtain a copy of the notice by e-mailing the privacy office at privacy@umn.edu to request a copy of the notice.

- To obtain a paper copy of this notice, contact the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455.

**Changes to This Notice**
We are required to abide by the terms of our notice currently in effect. We reserve the right to change this notice, and make the changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in registration and admission areas of the health care units of the University, and on our Web site. The notice will contain on the first page, in the top corner, the effective date. In addition, each time you register at or are admitted to a University health care unit for treatment or health care services as an inpatient or outpatient, we will have copies of the current notice available on request.

**Complaints**
If you believe your privacy rights have been violated, you may file a complaint with the University or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the University’s Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. You may also call the University of Minnesota Privacy Office at (612) 624-7447 to discuss your question or complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You may also submit your complaint directly to the Department of Health and Human Services — Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

**Other Uses of Medical Information**
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you give us permission to use or disclose medical information about you for a particular purpose, you may revoke that permission, in writing, at any time by contacting the Privacy Office at MMC 501, 420 Delaware Street SE, Minneapolis, MN 55455. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**More Information**
For more information, contact the Privacy Office at (612) 624-7447.
Training
As part of the University’s ongoing commitment to comply with the HIPAA Privacy & Security Regulations, every University of Minnesota student, faculty member, researcher, and staff person who may have access to protected health information must complete one or more online courses about privacy and data security.

Providing Training and Education on Privacy of Health Information
Members of the University community who are required to complete training will receive an e-mail with specific information regarding the training schedule. Your Privacy Coordinator will be able to assist you through the training process as needed.

Training requirements
- These requirements will depend on your job duties and some of the options include:
- Introduction to HIPAA Privacy and Security Video
- Online HIPAA Courses accessible through the portal
- Safeguarding PHI on Computers
- Privacy and Confidentiality in Research
- Privacy and Confidentiality in the Clinical Setting

If you would like more information on the interconnectedness of the courses, please View the Diagram of Courses.

How to access training
All University employees and students can enter training through the "MyU" portal at http://www.myu.umn.edu. For further information on training, please View Step-by-Step Instructions to Training.

Alternative formats for training materials are available. Please contact the Privacy & Security Office at 612-624-7447. Or contact the School of Dentistry HIPPA Coordinator at 612-624-9696

Technical Requirements
For Technical Help on Training please call 1-HELP or 612-301-HELP. Please take the following steps to prepare for the training:
1. Check your browser settings.
2. Install the Flash 6 plugin. (download plugin).
3. Make sure you know your x.500 username and password.
Using the Records Center

Hours
The records area opens at 7:45 AM daily and closes at 5:00 PM. All records must be return by 5:00 PM.

Record Request
When a computerized appointment through AxiUm is made a request for the patient’s record is automatically generated.

Record Availability
The patient record will be delivered to the front desk of the clinic the appointment is in. All patient records must be signed out to an individual and be available in approved record use area. All clinic cubicles are approved record areas, as is an area within the Reading Room.

Requesting a Quantity of Records
In the event there is a need to review a quantity of patient records, individuals may order the records via the AxiUm system. Quantity record requests must be ordered two days prior to delivery.

Chart Requests
A reasonable number of charts may be requested “on demand” (also known as “7L” requests) at the Records Center each day. Such requests are made for informational use of charts only; chart requests involving patient treatment must be handled through the appropriate reception desk. Every attempt will be made to provide each person with the charts needed. The following steps need to be followed in order to make an “On Demand” request:

- A chart number is required. (Use the AxiUm system/rolodex.)
- The Records staff will pull these charts during the designated periods of 9:30 AM-4:00 PM and the charts can be picked-up at the Records Window from Records staff.
- All charts should be returned at the end of each day.
- Records staff will be available at other times to answer questions and may pull “7L” requests if the need is urgent.

Review of Record for Appointment Scheduled for Next Day
The steps to follow if a record is needed for review prior to an appointment already scheduled for the next clinic day:

- After the chart is requested in AxiUm, the paper chart is sent to the appropriate clinic floor and filed alphabetically at the reception desk.

Outside Request for Record
- If someone other than the patient asks to examine a record that is in your care, direct the request to the Patient Records Services Supervisor. Confidentiality must be secured; only persons with proper
patient permission may examine a patient record.
Patient Appointments

The patient appointing system, operatory assignments, and appointing limits will be outlined in this section. The procedural steps for reserving space in the UM dental clinics, and the limits for the number of reservations you may have at any one time are also discussed.

The primary objective of the clinical appointing system is to aid you and your patients make future appointments in the UM Dental Clinics. The patient appointing system also provides an effective means for allocating space and distributing student, staff, and faculty time.

The clinical appointing system is designed to facilitate the distribution of patient records, the preparation and distribution of instruments to cubicles, documentation of each patient visit and cumulative information about your clinical activities.

There are a limited number of spaces available in the UM dental clinics. This can create minor competition for chair space. However, if you work within the structure of the clinical appointing system, respecting the restrictions for the number of appointments you can carry, you should not have difficulty completing your required clinical practice. It is important that you strive to make "quality" appointments: this means that ideally you confirm appointments with your patients while they are still in the clinic.

Initial Appointment Following Admissions (IFC) Assignment

All new patients appointed into the Comprehensive Care will be screened by a student and faculty to determine whether their dental needs are appropriate for a School of Dentistry teaching case. Each patient will have a medical history review, a soft tissue exam, and an appropriate prescription for radiographs that will be entered into the AxiUm EHR/chart by the student. At this time, patients are typically assigned to the student completing the exam. Patients are escorted to the Radiology clinic where the prescribed digital radiographs are taken. The student will escort the patient to the reception desk after the exam appointment to process payment for the services rendered. A follow up appointment is typically made at this time. If a patient is not assigned to a student the Patient Management office will assign the patient. A post card will be sent to their registered address. They will be advised to call the phone number on the card to schedule and exam/treatment planning appointment with their assigned student.
Informed Consent

Prior to providing care to a patient, the patient must sign a statement indicating that he/she has been informed of the care that will be provided and that he/she consents to the treatment. Some patients, for various reasons, will not be able to sign or provide their consent themselves. Such situations include patients who are minors and patients who physically cannot sign a document.

Consent to Treat Minors

Minors under age 18 must have consent of parent or guardian for dental treatment. Consent from one parent is sufficient for services performed at the School of Dentistry.

Emancipated Minors may consent to ANY medical services. Emancipated means:

- Living apart from parents and managing own financial affairs
- Has been married
- Has borne a child
- Court declaration of emancipation

Emergency Treatment may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional’s judgment, the risks to the minor’s life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

Information to Parents

The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

Patient Unable to Sign Consent Form

Adult Patient without a Personal Representative Present

When a patient is unable to sign for treatment consent, write in the chart the reason the patient was unable to sign, and obtain the signature of a witness. (The treating student/dentist may not be the witness.) In addition to their signature, the witness should also print their name.

Adult Patient with a Personal Representative Present

If a personal representative is present, the personal representative should sign for the patient. The personal rep should also print their name and address, and describe their relationship to the patient and why the patient cannot sign.

Patient Appointing Limits

The computer system limits the number of comprehensive care clinic appointments each student can have scheduled at any time to thirty-five sessions. Appointments included in this limit are any scheduled during an open session, keeping in mind that the computer tracks sessions and not appointments. This means that in any
Scheduling

Initial Appointment for Friends, Relatives, and Patient Referrals
Anyone wishing to schedule an appointment for friends, relatives, and patient referrals should schedule a reverse admissions appointment at the 7th Floor Admissions Desk or any color group Patient Care Coordinator.

Re-Appointments
Each semester, a student will have several re-appointment times in his/her schedule. These are reserved for patients who need to return for completion of dental hygiene treatment. If the student has not appointed a patient in his/her reappointment slot one week prior to the appointment date, the reappointment will automatically be taken off the student's schedule to free the appointment time for other patients.

Initial Appointment with Transferred Patients
When a student has a patient transferred to him/her, he/she must review the patient chart, i.e. treatment plan (sequenced), and determine the procedure(s) to be performed at the next appointment. After the review, the student should call to introduce him/herself to the patient and discuss with the patient the intention of what treatment will occur at the next appointment.

After discussing the upcoming appointment, the student should inform the patient that all appointments are made by clinical staff. Students may request the next appointment with their color group PCC through the AxiUm messaging system. Students calling from the school should transfer the patient to either the 8th or 9th floor desks. Instructions for transferring calls are located in the clinical areas where phones are provided for your use. It is important that students make the call to patients from the school. This process will not only enable the student to transfer the patient to the front desk and immediately obtain an appointment, but will also insure that private information about the student (i.e., home or cell phone numbers) will not inadvertently be provided to patients.

As the call is transferred, the student should inform the staff member for his/her group that he/she is transferring a call, and ask that the staff member please appoint the patient. In order to facilitate the scheduling of the appointment, the student should be prepared to provide the patient's chart number, the student id number, and the type of clinical resource needed (i.e. oper, endo, etc.).

If the student is unable to speak with the patient, but is able to leave a message on an answering machine, a brief message telling the patient who is calling and why should be left. For example, "This is John Smith from the U of M Dental Clinics calling for Mary Adams. I'm your student dentist. Please call me at (PCC phone number) to discuss your next appointment. Thank you." In this situation, the student should message the PCC at their color group desk to schedule the patients next appointment. It is important to give the appointment information to any of the appointing staff in case your patient calls for an appointment.
A student who is unable to talk to the patient and unable to leave a message for your patient must complete the Student/Patient Appointing form and turn the completed form into the assigned staff member for his/her group.

Students are responsible for reviewing either their scheduling screen in order to know the date and time of the scheduled appointments. Students should also review the screen for blocks. It is important that the student review each of these screens several times a day. Appointments are made in several areas from 8:00 am to 4:30 pm. These screens are the link between the patient's and student's schedule.

**Patient Appointment Following Treatment Sessions**
At the completion of the current appointment, establish the details of the next visit with the patient and faculty member. Complete the chart entries for the patient encounter, including ADA code(s) and fee(s). Accompany your patient to the reception desk, take the patient to the reception desk and schedule the next appointment.

**Subsequent Patient Appointments (Patient Not Present)**
If a patient appointment is to be scheduled when the patient is not present, the student dentist will work with the PCC for future appointments.

- Attempt to contact the patient during business hours from one of the cubicles provided for student use. If the patient can make their appointment transfer the call to the front desk. Students may submit an appointment request through AxiUm.
- See the Patient Care Coordinator. It is then processed on a first come, first serve basis. Three attempts, at various times during the day, will be made to reach the patient by phone. If the staff is unable to contact the patient, Attempt to notify your patient will be documented in the patient contact notes in AxiUm.

If the staff is unable to contact the patient within a reasonable time period, the student dentist is contacted for follow-up.

**Cancellations**

**By Patient**
When the patient calls reception staff the appointment will be immediately canceled on the computer. If possible, patient is reappointed during this conversation. Students are responsible for reviewing their AxiUm scheduling screen for cancellations and messages.

**By Student**
In the event that the student finds out that an appointment needs to cancelled, either by the patient or the student, the student must report the cancellation to the reception staff. If student needs to cancel at last minute, e. g. taken ill the night before, the student will call the patient to let them know to call and reappoint with the staff. The student must also inform the clinic staff by calling the reception desk.

**Same Day**
Any of the staff (front desks) will work with the student to fill a time slot vacant due to a same-day or 24 hour
cancellation. If the student knows of a patient who can come in on short notice they can either contact that person or ask a staff member to do so. If the student arranges the appointment they must let the staff know as soon as possible.

It is the responsibility of the student to submit a request to have the patient rescheduled when they cancel or fail. Before submitting the request the student must verify that the patient has not already rescheduled their appointment.

**Failures**

If the patient fails, the student must report to their color group for further assignment. (9th floor) no later than 30 minutes after the patient’s scheduled appointment. An attempt to reach the patient should be made before that time.

**Miscellaneous Appointment Rules**

No appointments except emergencies will be made by the appointment staff unless the student has provided them with the necessary appointing information.

- Each student dentist will be responsible for:
  - Monitoring the schedule for new appointments and changes
  - Submitting leave (PERS), request forms to schedule out of clinic as allowed and in advance as much as possible
  - Notifying the proper persons regarding block schedule changes
  - Documenting each encounter in the patient chart and instructing the patient about payments for services
  - Notifying staff of the status of each appointment and submitting TEFs daily.

- Dental School staff will be responsible for:
  - Confirming patient appointments one to two days prior to the scheduled time
  - Contacting patients to reappoint after appointment cancels or failures upon student request
  - The Patient Management staff will Review of patient treatment plans to ensure work is being done in a sequential and timely manner.
Fees, Payments, Insurance

Students are expected to comply with the UM Dental Clinic payment policies and procedures. Students need to assure that patients pay for each service by cash, check, Visa, MasterCard or Discover at the time the service is provided. This includes co-payments from insurance or Minnesota Health Care Programs (MHCP). The fee should be explained to the patient and entered on the treatment plan in the electronic health record (EHR).

Down-payments are required for lab related treatment (i.e.: crowns, bridges, partials, dentures) defined by the clinic. Students are expected to see that these down-payments are made prior to beginning treatment. For cases requiring 1/3-1/2 down-payments, students must notify the patient before the day the procedure is scheduled to begin. This notification prepares the patient to pay and avoids sending the patient home. There can be no exceptions to down payments.

At diagnosis and treatment planning sessions, students are expected to review the patient's EHR. The Patient Card/Insurance Tab will indicate how the patient should plan to pay for the fees. If information is not in the record, or if the information is not up to date, bring the patient to the front desk area on the 7th, 8th, or 9th floor to update information.

Patients with no insurance information are expected to pay at each appointment for the services. When insurance is listed, confirm the insurance information with your patient. If there are changes or updates to the insurance information, immediately bring the patient to the front desk area on the 7th, 8th or 9th floor to update information. Check with patient accounting representative to be sure the patient insurance benefits are payable to the school. If not, patient is expected to pay at each appointment for services. Check with patient accounting representative for dental procedures requiring prior authorization or services not payable by the Minnesota Health Care program (MHCP/MA) regulations.

Patient accounting must review the U of M School of Dentistry - Treatment Plan and verify faculty approval and obtain patient's electronic signature of acceptance. Treatment plan financial consultation is accomplished when the student accompanies his/her patient to the accounting office, after the treatment plan has been presented to the patient (i.e.: case presentation). It is necessary that the student is present with his/her patient during the financial consultation, both to answer questions and to provide an opportunity to utilize alternate plans and achieve consensus on a final accepted plan. The Treatment Plan form will be used to document the fees. Down-payments or copayments will be due at each appointment. The treatment plan is used to clearly communicate patient financial responsibility.
The financial consultation must be completed prior to beginning treatment. Failure to complete the financial consultation may result in an electronic hold on the patient's record which will prevent future appointments with this patient.

As a part of the treatment planning/financial consultation, the accounting representative will discuss payment methods, down payment requirements, treatment plan changes, financial holds, and review payment due dates specific to your patient's treatment. Additionally, the accounting representative will provide assistance with financial forms, including insurance predeterminations, Minnesota Health Care Programs (MHCP) prior authorizations and demographic and insurance updates.

Payment Methods and Procedures

The patient accounting office needs to approve all fee payment methods. Students that need assistance or have questions are encouraged to stop in at the patient accounting office and discuss the issue with the staff. The various payment methods are described below:

Cash

Patients are expected to pay the full fee by cash, check or credit card (Visa, MasterCard and Discover) as each service is completed. 1/3-1/2 of the fee on any treatment requiring lab materials must be paid before the treatment begins and the balance is due at completion (i.e.: when the crown is seated or when the denture is delivered). Procedures are entered as C (completed) which creates a charge in axiUm when the dental service is completed.

Cash basis patients are expected to pay for each procedure at the time of completion. Under no circumstances should students continue to provide care for cash basis patients who have outstanding balances due. Contact the patient accounting office if there are any questions about the status of a patient.

Dental Insurance

All patients must provide current insurance information at each appointment. If a patient cannot provide complete insurance information, they will be considered a cash paying patient until such time all information necessary to file claims is provided. For dental insurance plans where the benefits to the patient/guarantor are NOT assigned to the School, the cash payment method applies.

Most commercial insurance plans have a yearly maximum on average of $1,000 to $1,500 per calendar year. In these cases, the cash method of payment will apply for services above the insurance maximum. It is helpful to re-enforce communications to patient when maximum benefits are near or met to avoid non-payment of services.
The insurance unit will submit an insurance claim within 3-4 working days after the completed service is entered into the EHR.

It is important to inform patient accounting staff when patients do not assign insurance benefits to the School because they must pay cash for services. There are several insurance plans for which the benefits must be assigned to the patient. Check with staff in the patient accounting office if you are unsure of the provider status before you begin any work!

Additionally, there are many insurance plans for which the School is not a provider. It is important to check with staff in the patient accounting office prior to beginning any work, if there is a question of the provider status.

A down-payment of 1/3-1/2 of the total fee for lab related procedures is required on insurance accounts. Students are expected to have the patient pay the down-payment prior to treatment. Co-pays are due at the time of service.

Many insurance companies pay approximately 50% for major services (i.e.: crowns, bridges, partials, dentures.) If a patient's insurance company pays 100% for lab related services, an exception may be made to the down-payment requirement. In this situation, the student will need to obtain an approval from the patient accounting office.

**Minnesota Health Care Programs (MHCP/MA)**

Students are responsible for making sure the patient has verified eligibility with front reception staff or patient accounting prior to every appointment. Students need to adhere to the warning notices in axiUm regarding the need for prior authorization on certain procedures. Prior authorization forms are available in the patient accounting offices for all services requiring approval; this is a must before beginning treatment. If a student has any doubts about the patient's eligibility, he/she should have the patient report to the front reception desk at the beginning of the appointment in order for the staff to verify the patient's eligibility.

It is important to remember that fees for non-covered services must be communicated with the patient. The patient must sign the Department of Human Services non-covered service agreement form in the patient accounting office acknowledging the communication.

Additionally, keep in mind that the normal response time from MA is 3-4 weeks. Failure to obtain approval on treatment requiring prior authorization results in non-payment of services to the School.

Treatment plans may be changed to allow patients to pay for their treatment in stages. In a case such as this, the student will need to discuss and finalize the alternative treatment options with the clinic faculty and patient. Once completed, finalize the payment methods with the patient accounting representative.

**Collection of Payment from Patients**

Inform patients when down-payment, co-payments and/or other payments are due and have the patient make payment at any of the reception desks on 6, 7, 8, or 9th floor or at the cashier's window on the 7th floor. Be sure
a copy of the Patient Walk-out Statement is given to the patient for their records. All payments are posted on the patient/guarantor account.
Patients paying by Visa, MasterCard or Discover will need to provide their credit card at the reception desk.

When a patient is making a down-payment, the student needs to inform the staff that the payment is for a down-payment. When a down-payment is made, all current or previous balances including co-pays on past services must also be paid in full.

Care Credit is a payment option available to patients who qualify. Please see a patient accounting representative for details.

**Payment Schedules for Specific Clinics**

The following clinical divisions have fee payment schedules with which students should be familiar.

**Fixed Prosthodontics**
Down payment is due at the time of the preparation and the balance is due upon completion. Procedures involving gold or other lab materials will not be dispensed and/or cases will not be sent to the lab without the down payment having been paid in advance for work which is done by commercial dental labs (or by Dentistry's in-house lab technicians).

**Operative and Endodontics**
Clinical fee is paid at the time of completion of each restoration or service. Gold will not be dispensed for casting without the down payment having been paid in advance.

**Periodontics**
The total treatment fee is due at the time of service. The fee is based on the number of teeth involved and/or quadrant involvement. Check the fee schedule.

**Removable Prosthodontics**
Down payment is due at the time of the impression and the balance is due upon delivery.

**Patient Fees**

**Reduced Clinic Fees U of MN Dental Clinic Student Discount (This section under review)**
Reduced clinic fees are available for pre-doctoral students, dental hygiene students, and post-doctoral students in graduate programs. Your immediate family members (spouse, mother, father, and your children) are eligible for the reduced costs. The reduced clinic fees may also be available for up to two other patients if you are not utilizing the student discount for immediate family members. Contact patient accounting in room 7-314, 8-200, or 9-214 to apply for this discount.

The fee will be one-half the regular cost for all non-laboratory procedures completed in the U of MN Dental Clinics. For procedures involving lab work, the fee is two-thirds of the regular cost.
Reduced clinic fee policies do not apply to orthodontic or TMJ treatment, Faculty Practice Clinic or implant services.

**Patient Fee Schedule**
A complete list of patient fees is found in the Links drop down in axiUm. To view the entire current fee schedule, click here. (leave the prior sentence in?

The U of MN dental fees are subject to changes during the year. Students are expected to quote the most recent fee estimate(s) to the patient and/or responsible party upon implementation of the revised fee schedule.

At the time of the treatment plan presentation, it is very important to inform the patient that the fees are an estimate and are subject to change when a new fee schedule is implemented. However, once a treatment plan is established and the patient has gone through the financial consultation, the fees on the treatment plan will be honored for a one year period. It is equally important as services are provided that patients are informed of the cost of each service before the service(s) begins.

Communicate and document treatment plan changes and quote the fee(s) for revised plan. For minor changes (i.e.: number of surfaces on filling, placing composite instead of amalgam), clearly record in the EHR Treatment History notes. If there is a significant change (i.e.: removable partial denture to complete denture), complete new treatment plan and discuss with patient accounting personnel. Be sure to obtain required faculty approval/signatures in either case.

For further information about patient fees, consult the patient accounting office.

**Financial Hardship Policy**
The school does not provide free care and does not have a sliding fee scale; there is no discount due to financial need. The financial polices for dental and medical charges are:

**Dental**
Dental fees are educationally discounted. Collection of fees on the day services are provided is expected. Payment policies are located in the Patient Information Brochure.

**Medical**
Medical fees are not educationally discounted, including waiving co-pays and deductibles, billing charges “insurance only,” and research participation discounts, etc. Consult the medical compliance office if you have any questions.

Fees, except co-pays are generally not collected on the day services are provided. Policy is to bill patients for balances remaining after insurance payment.
Billing Patient for Dental Service

The collection of down payments, co-payments and/or other payments including adjustments need to total the service provided. Every attempt should be made to remind patients payments are due on the day of service. If there is a remaining balance, a billing statement will be mailed to the patient for the difference. Billing statements are not mailed to patients/responsible party when full payment is made on the completed service unless other outstanding services were not paid.

If a patient expresses a problem or concern about a charge or payment on account billing, the student should immediately bring or refer a patient to the patient accounting office. Concerns regarding treatment should be addressed with Clinical Systems, Bonita Falkingham, room 8-434 Moos Tower.

Students need to initiate a charge by entering treatment as complete (C) in the EHR after the following conditions occur:

- When a service is completed and appropriate authorizations are obtained by faculty in the clinic at each appointment.
- When all required information is documented in the EHR Treatment History, including:
  - Date of Service
  - Tooth Number /Quadrant (if applicable)
  - Brief Description of Service
  - ADA Code or U of MN Dental Clinic code if applicable (from Fee Schedule)

Late Patient Payment

Under no circumstances should a student continue to provide care for a patient who is not paying for the care he/she receives. If a patient is not making payments he/she agreed upon, contact the patient accounting office (7-200, 8-200, 9-214, or 9-216) as soon as possible.

A hold will be placed on patient records when an account becomes past due. Students cannot start new treatment until the patient's payments have been brought up to date.

Additionally, students will not be issued lab materials and/or cases will not be sent to the lab until at least 1/3-1/2 of the fee has been collected and any current or past due balances have been paid.

Adjustment to Patient Fees

Complete an Accounts Receivable (A/R) adjustment form for fee adjustments via EPR forms in axiUm. Provide the requested information. Be sure to include a short and concise reason why the adjustment is needed (for accounting and auditing purposes), as well as being sure to obtain an authorized faculty's approval.
Electronic A/R adjustment requests should be routed to the Adjustment Requests group within 24 hours of the completion of treatment or when an adjustment on services is determined to be necessary. Delays in adjustment can cause incorrect or unnecessary insurance claim submissions and billings to patients.

Additionally, it is important to minimize missing information and/or questionable reasons why an A/R adjustment is necessary, as the lack of information or solid reason will cause delays in processing. Additional effort and time from you and/or the faculty will be required. Other consequences of delayed adjustments could be patient benefits, fee collections, public relations and other account problems and issues. It is important to process A/R adjustment forms quickly. Patient insurance benefits can be delayed and patient complaints or concerns may be received.
Medical-Related Documentation and Billing Policies

Medical Billing Compliance Webpage
The Medical Billing Compliance Office webpage is a reference tool for faculty, staff and residents to view the education, training, policy documents and requirements used in medical compliance initiatives.

In addition to the following medical compliance policies, you will find information about internal and external compliance resources and compliance office staff contact information:

- Addenda

Compliance Policies and Guidelines
Basic Information Elements in Patient Record
Legibility of Patient Record
Correction, Addenda, Late Entries in Record
Use of Documentation Templates
Timely Documentation
Referencing other Documentation in the Patient Record
S.O.A.P. Note Format
Medical vs. Dental Billing
Consult vs. Referral Billing
Documentation for Using Modifier 25
Evaluation and Management Documentation Guidelines
Prescription Drug Management
Billing Based on Time
Maxillofacial Prosthetics Billing
Financial Hardship
Checking the OIG Website
Information regarding Fraud and Abuse
Documentation for Oral Radiology Services
Teaching Physician Documentation requirements
Advance Beneficiary Notice Documentation
Research Related Documentation
Clicking on this link: https://intranet.ahc.umn.edu/SODintranet/facultystaff/MBCO.html directs you to your X-500 log-in. Once you are logged in your browser will go directly to the Medical Billing Compliance Office webpage. The webpage can also be found by navigating through the intra-net on the School of Dentistry website.

**Billing Compliance Program**
Below is the guiding document, titled "Billing Compliance Program" for School of Dentistry medical billing compliance.
Introduction
The University of Minnesota School of Dentistry (SOD) has established this Billing Compliance Program (the “Program”) to assure it continues to meet its compliance obligations. This Program will focus on improving compliance-related services and systems, awareness and education, oversight, and evaluation of billing practices and procedures. In adopting the Program, Clinical Systems affirms an ongoing commitment to identify to its employees areas of activity where standards of conduct are essential and conforming behavior expected.

General Policy Statement
The SOD is committed to operating in accordance with the highest level of professional, academic, and business ethics in compliance with applicable laws and University policies. This commitment is advanced and secured through the integrity and ethical actions of our officers, clinicians, students and employees.

All professional services rendered shall be provided and documented in accordance with federal and state laws, regulations, interpretations, and University policies. It is the policy of the SOD that all clinicians shall comply with the guidelines set forth in the Clinic Manual. In accordance with this Program, SOD policy prohibits the submission of any bill or claim by or on behalf of any faculty or non-faculty member for services that fail to satisfy applicable requirements for payment by government and private payers.

Scope
This Program shall apply to medical billing for clinical activity. Dental billing may be added to the program in the future. The Dean of the University of Minnesota School of Dentistry approves this Compliance Program. It has been developed with the assistance of counsel and the University Institutional Compliance Office.

Goals and Objectives
The goals and objectives of the Program are to:
1. Improve compliance-related services and systems;
2. Identify and respond to compliance risks, including Clinic-specific compliance initiatives, to ensure that practices reflect current requirements;
3. Clarify roles and responsibilities associated with billing compliance;
4. Assure appropriate billing policies and procedures are in place and followed;
5. Assure effective education and training programs are delivered to improve awareness of the required standards for professional medical billing and to ensure staff are updated in a timely manner on any changes in billing standards or policy changes;
6. Improve lines of communication to interested parties on billing compliance issues;
7. Provide a means for faculty, clinicians, students and staff to address questions and receive guidance, as well as a mechanism for individuals to report concerns of alleged non-compliance so that such reports can be investigated;
8. Adequately monitor and oversee billing activities;
9. Take corrective action to address issues of non-compliance with policies and procedures where appropriate; and
10. Continually evaluate the effectiveness of this Program and institute changes as appropriate based upon such evaluation.
Administrative Order of Responsibility

1. Dean of the School of Dentistry: The Dean of the School of Dentistry is responsible for the overall maintenance of an atmosphere conducive to ethical conduct and compliance with the Program. The Dean, in consultation with the Associate Dean of Clinical Systems will have authority for corrective action and the substance of corrective action for non-compliance with the Program.

2. Associate Dean for Clinic Administration and Patient Care: The Associate Dean will report to the Dean concerning the operation of the Program.

3. Compliance Director - Clinical Systems (Tom Messervey): The Compliance Director is responsible for implementation and maintenance of the program. The Compliance Director shall monitor the performance of the Compliance Coordinators. The Compliance Director will report to the Associate Dean for Clinical Systems concerning the operation of the Program.

4. Compliance Coordinator - Education, Documentation, Coding and Q.A. Program Associate (Sandra Overstreet): This specialist shall be responsible for documenting compliance efforts, prospective and retrospective chart audits, and education and training. This position will work with Information Systems to ensure accurate billing, and perform other billing compliance duties as assigned by the Compliance Director. This person shall report to the Compliance Director on all matters relating to the Program, including recommended Program changes and improvements.

5. Compliance Coordinator - HIPAA Privacy Coordinator and Insurance Supervisor (Gayle Waedekin):

   This specialist works closely with the Compliance Director and Compliance Coordinator – Program Associate, to ensure HIPAA privacy and electronic billing standards are followed, assists with claim and information system integrity, and other compliance duties as assigned by the Compliance Director.

Policies and Procedures

Policy on Billing Responsibility & Record Documentation

The School of Dentistry abides by all laws, rules, regulations and University policies that apply to billing and record documentation. In selecting codes to describe services rendered, SOD faculty, staff, students and clinicians are to select codes that they believe, in good faith, correspond to services actually rendered, as documented in the patient chart. SOD faculty, staff, clinicians and students have a collective responsibility to be knowledgeable about the meaning of the codes applicable to their area of practice, including relevant directives from billing authorities. The SOD further recognizes the importance of maintaining accurate patient records in accordance with applicable requirements. Billing guidelines and educational material are located in the intra-net section of the School of Dentistry website in the Clinic Manual at http://www.dentistry.umn.edu, and are also available in hardcopy from the Compliance Coordinator - Program Associate.
Policy on Direct Reports of Alleged Unethical or Illegal Conduct and Corrective Action

Anyone may report instances of alleged unethical or illegal conduct directly to the Compliance Director, Associate Dean for Clinical Systems, Dean or other appropriate SOD or University official, or through UReport Confidential Reporting Service. Such reports may be anonymous. No adverse action or any form of retaliation shall be taken against any person who in good faith reports alleged unethical or illegal conduct.

Billing compliance violations shall be reported to and acted upon by the Dean or Dean’s designee. Such designee shall have sufficient authority to deal objectively with the reported matters. The existence and nature of the reporting system shall be communicated to all employees of the SOD. No person may intimidate or impose any form of retribution on any employee who utilizes such reporting system in good faith to report suspected violations (except that appropriate action may be taken against such employee if such individual is one of the wrongdoers).

Any alleged violation of the Code of Conduct that could have a material adverse effect on the SOD or that is otherwise of material importance to the University shall be promptly reported to the Dean’s office.

Investigation of Violations

If, through operation of the SOD’s compliance monitoring and auditing systems or its confidential disclosure program or otherwise, the SOD receives information regarding an alleged violation of the Billing Compliance Program, the Associate Dean for Clinical Systems, Compliance Director and/or Compliance Partner (or such other person or persons authorized by the Dean to investigate alleged violations of the Program) shall take prompt corrective action, which may include:

a. evaluate such information as to gravity and credibility;
b. initiate an informal inquiry and/or, as the Associate Dean for Clinical Systems shall determine is necessary, a formal investigation with respect thereto;
c. prepare a report setting forth the results of such inquiry or investigation, including recommendations as to the disposition of such matter;
d. present the matter to the Dean for imposition of such disciplinary measures as the Dean shall deem necessary and appropriate;
e. if and as appropriate, recommend changes in the Program necessary or desirable to prevent further similar violations.

Corrective Actions

a. The SOD shall consistently enforce its Billing Compliance Program through appropriate means of discipline and corrective action. The Dean shall review whether violations of the Program have occurred. If a violation has occurred, the Dean shall determine the disciplinary measures to be taken against any employee, agent or independent contractor of the SOD who has violated the program.
b. Corrective actions, which may be invoked at the discretion of the Dean may include counseling, oral or written reprimands, warnings, probation, suspension or loss of clinical privileges, demotions, reductions in salary, denial of a salary increase, denial of a bonus, incentive compensation or merit increase and restitution.
Jurisdiction of the Dean
The Dean, together with administrative officers, is to be responsible to effectuate and maintain an effective Program.

Billing Policy for Teaching Clinician With Residents
The School of Dentistry will follow Medicare’s Teaching Clinician Guidelines. Guidelines can be found in Section O of this manual, “Supervising Physicians in Teaching Settings”, while hard copies may be obtained from the Privacy Coordinator - Program Associate.

Policy on Monitoring for Clinician’s Using Medical Procedure Codes
Under the supervision of the Compliance Director, a sample of patient records and corresponding bills will be periodically reviewed for compliance with the SOD’s billing policies and with legal requirements. Billed services and medical records from each Clinic submitting medical procedure codes shall be reviewed at least biannually, but the Compliance Director may require more frequent reviews. The results of such reviews will be reported to the Associate Dean for Clinical Systems and appropriate Clinic Director and/or provider who was audited. The Compliance Director shall maintain audit records. Dental billing may be added to the Program.

Policy on Revisions to this Program
The Billing Compliance Program is intended to be flexible and readily adaptable to changes in federal and state regulatory requirements. The Program will be regularly reviewed to assess whether it is working. The Program will be modified in response to evidence that indicates a certain approach is not effective or suggests a better alternative. The Associate Dean for Clinical Systems and Compliance Director with the approval of the Dean shall have the authority to modify or revise the program.
Introduction

Infectious diseases have been a concern of dentistry for a long time, but it has only been during the past several decades, with the emergence of the Hepatitis viruses and the Human Immunodeficiency Virus (HIV) that more attention has been turned to dental infection control. Most dental practices are concerned with preventing the spread of infectious diseases from patient to patient, from patients to health care providers, and from health care providers to patients. However the School of Dentistry is in an unusual position since dental students under the supervision of faculty provide almost all the dental care with the help of qualified staff. Therefore, this Infection Control Manual is written not only to protect the patients from infection during dental treatment but also the students, faculty and staff.

The University of Minnesota School of Dentistry’s Infection Control Manual therefore follows the laws as written by our state and federal government agencies in addition to following the recommendations of various organizations such as state and federal OSHA, the Centers for Disease Control and Prevention, and the American Dental Association. Primarily this guidance comes in the form of the regulations found in the Occupational Exposure to Bloodborne Pathogens Standard, which went into full effect on July 6, 1992.

In addition, since dental schools do research involving human tissues and fluids, strict infection control regulations again must be followed by law to protect the faculty, students and staff who might be involved in such research.

The Purpose of the Bloodborne Pathogens Standard

When brought to its attention, The Occupational Safety and Health Administration (OSHA) recognized that workers who came into contact with blood and other potentially infectious materials (such as saliva in the case of dental health care providers) were at risk of contracting a variety of infectious diseases. OSHA’s purpose in writing the Bloodborne Pathogens Standard, therefore, was to minimize or eliminate exposure of health care employees to these bloodborne diseases by a variety of means as enumerated in an Exposure Control Plan which was to be developed by every employer. The exposure control plan is, in essence, an infection control plan. The means by which exposure for these workers is to be minimized or eliminated includes the following:

- Identifying those workers who, in fact, are at risk (Exposure Determination)
• Identifying work practices or engineering controls that minimize or eliminate exposure (Methods of Compliance)
• Providing a schedule of training for health care workers to educate and train them (Awareness)
• Providing Hepatitis B vaccination for employees (Prevention)
• Providing post-exposure evaluation and follow-up as required (Post-Exposure follow-up)
• Communicating hazards to employees by labels, signs, and training (Warning)
• Keeping medical records and training records for the employees (Documentation)

It must be kept in mind that the School of Dentistry is in a unique position, since students by law are not considered employees. However, in order to ensure the same high level of protection that the Bloodborne Pathogens Standard allows for employees is available for our students in a health care setting, students will be considered in the same light as employees of the School everywhere in this manual except where specifically noted. Faculty and staff members are already considered employees. Therefore, as one reads the Infection Control Manual, it must be remembered that most of its provisions apply equally to students, faculty and staff. For that reason, throughout the Infection Control Manual the term “health care worker” shall be used to designate anyone in the School of Dentistry, be it student, faculty or staff, who may have exposure to infectious or contaminated materials. This infection control manual applies to all personnel in the dental school except where otherwise noted.

The Occupational Safety and Health Administration (OSHA) of the Department of Labor have put into law the Occupational Exposure to Bloodborne Pathogens Standard. This manual is to serve as the annual required review of the Exposure Control Plan and Infection Control Manual for the School of Dentistry as of September 15, 1992. Annual review and update occurs prior to the start of the new school year and in conjunction with the annual review of the SOD Clinic Manual. The Exposure Control Plan and Infection Control Manual will be modified during the year whenever new or modified procedures affect occupational exposure of the health care worker and if new job titles are created that have occupational exposure.

The person designated as the Health & Safety Officer is Ms. Teresa Ludwig. Her office is in 16-205 Moos Tower and her phone number is 625-5116. Ms. Ludwig reports directly to Greg Johnson, and works closely with Dr. Todd Thierer Associate Dean, Clinic Administration and Patient Care. However, since one person cannot oversee the day-to-day adherence to the provisions of this manual, the faculty – especially the faculty in the undergraduate clinics, the faculty in the pre-clinical areas, and the attending faculty in the graduate clinics – will have to be responsible for seeing that infection control is carried out in those areas for which they are responsible.

Glossary
(Taken from: CDC. Guidelines For Infection Control In Dental Health-Care Settings, MMWR 52 (RR17):1-66 (2003).

Alcohol-based hand rub: an alcohol-containing preparation designed for reducing the number of viable microorganisms on the hands.

Antimicrobial soap: a detergent containing an antiseptic agent.
**Antiseptic:** a germicide used on skin or living tissue for the purpose of inhibiting or destroying microorganisms (e.g., alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol [PCMX], quaternary ammonium compounds, and triclosan).

**Dental treatment water:** nonsterile water used during dental treatment, including irrigation of nonsurgical operative sites and cooling of high-speed rotary and ultrasonic instruments.

**Disinfectant:** a chemical agent used on inanimate objects (e.g., floors, walls, or sinks) to destroy virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms (e.g., bacterial endospores). The U.S. Environmental Protection Agency (EPA) groups disinfectants on their basis of whether the product label claims limited, general, or hospital disinfectant capabilities.
Disinfection: destruction of pathogenic and other kinds of microorganisms by physical or chemical means. Disinfection is less lethal than sterilization, because it destroys the majority of recognized pathogenic microorganisms, but not necessarily all microbial forms (e.g., bacterial spores). Disinfection does not ensure the degree of safety associated with sterilization processes.

Droplet nuclei: particles $\leq 5$ μm in diameter formed by dehydration of airborne droplets containing microorganisms that can remain suspended in the air for long periods of time.

DHCW: dental health-care worker. Sometimes the term DHCP, dental health-care professional is used.

Germicide: an agent that destroys microorganisms, especially pathogenic organisms. Terms with the same suffix (e.g., virucide, fungicide, bactericide, tuberculocide, and sporicide) indicate agents that destroy the specific microorganism identified by the prefix. Germicides can be used to inactivate microorganisms in or on living tissue (i.e., antiseptics) or on environmental surfaces (i.e., disinfectants).

Hand hygiene: general term that applies to handwashing, antiseptic handwash, antiseptic hand rub, or surgical hand antisepsis.

Intermediate-level disinfection: disinfection process that inactivates vegetative bacteria, the majority of fungi, mycobacteria, and the majority of viruses (particularly enveloped viruses), but not bacterial spores.

Intermediate-level disinfectant: liquid chemical germicide registered with EPA as a hospital disinfectant and with a label claim of potency as tuberculocidal.

Occupational exposure: reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or OPIM that can result from the performance of an employee’s duties.

OPIM: other potentially infectious materials. OPIM is an OSHA term that refers to 1) body fluids including semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures; any bloody fluid visibly contaminated with blood; and all body fluids in situations where differentiating between body fluids is difficult or impossible; 2) any unfixed tissue or organ (other than intact skin) from a human (living or dead); and 3) HIV-containing cell or tissue cultures, organ cultures; HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral: means of piercing mucous membranes or skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Persistent activity: prolonged or extended activity that prevents or inhibits proliferation or survival or microorganisms after application of a product. This activity can be demonstrated by sampling a site minutes or hours after application and demonstrating bacterial antimicrobial effectiveness when compared with a baseline level. Previously, this property was sometimes termed residual activity or substantivity.

PPE (personal protective equipment): specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes not intended to function as protection against a hazard are not considered to be personal protective equipment.
Sterile: free from all living microorganisms; usually described as a probability (e.g., the probability of a surviving microorganism being 1 in 1 million).

Sterilization: use of a physical or chemical procedure to destroy all microorganisms including substantial numbers of resistant bacterial spores.

Ultrasonic cleaner: device that removes debris by a process called cavitation, in which waves of acoustic energy are propagated in aqueous solutions to disrupt the bonds that hold particulate matter to surfaces.

Washer-disinfector: automatic unit that cleans and thermally disinfects instruments, by using a high-temperature cycle rather than a chemical bath.

I. EXPOSURE DETERMINATION
According to the Bloodborne Pathogens Standard, an exposure determination must be made if any health care worker has occupational exposure; that is, reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials. Other potentially infectious materials (OPIM) are most body fluids, including saliva in dental procedures, any body fluid that is contaminated with blood or any body fluid in situations where it is difficult to determine what the body fluid is. However, for the purposes of the School of Dentistry, since saliva and blood are likely to come into direct or indirect contact with most of the students, faculty and staff at some time, we shall have a large number of individuals who come under the purview of The Bloodborne Pathogens Standard. In addition, research efforts may necessitate the handling of body tissues, body fluids and cultures. Therefore, the majority of our health care workers will have occupational exposure.

To determine precisely which of these individuals are at risk, a list of tasks and procedures must be identified which could result in possible occupational exposure at our School. This exposure determination is made without regard to the use of personal protective equipment.

Tasks that could result in probable occupational exposure are the following:
- Patient treatment procedures
- Radiographic procedures
- Cleaning, disinfection and sterilization of instruments
- Environmental surface and equipment disinfection
- Dental laboratory procedures
- Handling contaminated laundry
- Handling infectious waste
- Repairing dental equipment
- Handling infectious tissues and body fluids in the research laboratory

NOTE: Custodial personnel are not employees of the School of Dentistry and, as such, are not part of our Exposure Determination Plan. However, all UMN custodial personnel working in the School of Dentistry are trained by Facilities Management on proper environmental cleaning procedures and disposal of all types of waste.
Tasks that could result in possible occupational exposure are the following: ☐ Filing and handling dental patient records at the main and auxiliary reception areas ☐ Filing and handling dental patient records at the specialty clinic reception areas ☐ Handling patient records in the dental insurance area ☐ Handling patient records at the data processing areas ☐ Handling patient records at the Cashiers’ Office ☐ Handling patient records at the Office of the Associate Dean Clinic Administration and Patient Care ☐ Handling prosthetic cases for shipment to outside dental laboratories ☐ Handling patient records in the patient accounting areas

Reflecting the tasks listed above, the job classifications that have probable occupational exposure include the following:

- Clinical Dentists, Dental Therapist and Dental Hygiene
- Clinical Instructors
- Clinical Staff
- Dental Engineering Services personnel

Reflecting the tasks listed above, the job classifications that have possible occupational exposure include the following:

- Receptionists (Patient Care Coordinators)
- Records clerks
- Data processing personnel
- Patient Accounting & Insurance personnel
- Cashiers
- Some research scientists & technicians

Tasks at our School that have no occupational exposure include the following:

- Routine secretarial work in non-treatment areas
- Dental School student admissions personnel
- Dental School finance personnel
- Dental School student affairs personnel
- Dental School student record keeping
- Dental School fund raising and development
- Handling and maintaining computer & audio-visual equipment
II. METHODS OF COMPLIANCE

GENERAL
The Bloodborne Pathogens Standard requires that health care workers practice dentistry using the concept of Universal/Standard Precautions. According to this concept, all human blood and certain other body fluids of our patients, including saliva, are treated as if they are infectious of HIV, HBV and other bloodborne pathogens. Remember that if you cannot distinguish between body fluids, you should assume that the fluid in question is infectious. Although a thorough medical history and physical exam is likely to uncover the possibility of an infectious disease in one of your patients, this is not always possible. Therefore, by assuming that all of your patients are infectious, you can proceed with the appropriate controls to protect yourself and others around you.

ENGINEERING AND WORK PRACTICE CONTROLS

1. Under the Standard, engineering controls and work practices shall be used to minimize or eliminate exposure of health care workers to infectious diseases. When these controls cannot effectively protect the health care workers, personal protection equipment as provided by the School shall be used such as the following:
   a. Engineering controls are those controls that isolate or remove the bloodborne pathogen from the workplace (e.g. sharps containers, self-sheathing scalpels and needles, foot controls for the faucet).
   b. Work practice controls are controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles using a two-handed technique).

2. Engineering controls will be examined or maintained or replaced on a regular schedule. For example, sharps containers will be replaced before they become too full. The Dental Engineering Services Department is responsible for facilitating the timely removal of these containers.

3. Employer shall provide hand-washing facilities. In the School there are hand-washing facilities in every cubicle and in other appropriate convenient locations. These hand-washing facilities include a sink, disposable paper towel dispenser, antimicrobial soap and an appropriate waste disposal container for the used paper towels. Washing your hands is one of the most effective ways of controlling the microorganisms on your hands, whether they are resident or transient. OSHA recognizes this fact and, as a result, wrote several provisions of the Bloodborne Pathogens Standard to reflect the significance of hand washing as protection to the health care worker and patient alike.

4. Health care workers at the School must wash their hands immediately at the beginning of the day, before they glove, using an antimicrobial soap. Hands must be washed or an alcohol hand rub must be used before regloving. Gloves must be changed between patients and in the event of any interruption of treatment that results in hands coming into contact with objects other than those items being directly used in the treatment of that patient. For example, if you drop an instrument, you must pick up the instrument with your gloved hand, place the dirty instrument in your sink, then deglove, wash hands or use an alcohol based rub and reglove before resuming treatment of the patient.

5. Health care workers must wash hands and any other skin or flush mucous membranes with water immediately after contact of said body area with blood or OPIM (e.g. saliva). Such contact could occur if ungloved hands or any other area of unprotected skin comes into direct contact with the patient or if
Ungloved hands happen to come in contact with an inanimate object that is likely to be contaminated with body fluids from a patient. Contact could also occur if blood or OPIM penetrate personal protection such as gloves, mask, eye protection or clothing.
6. Contaminated needles shall not be bent, recapped or removed unless they need to be recapped for specific medical reasons. In the case of many dental procedures, it is desirable to perform multiple injections during treatment. The needles can be recapped between injections on the same patient if the recapping is accomplished using the one handed “scoop” technique or using a mechanical device. After using the needle for the last time, recap it; and, with the used anesthetic cartridges, deposit them in the nearest sharps container.

7. Sharps containers are provided at accessible locations throughout clinical areas and close to the immediate area where sharps are found. Sharps containers will be as follows:

   a. Closable
   b. Puncture resistant
   c. Leakproof on sides and bottom
   d. Labeled or color coded (red) in accordance with the labeling requirements of the Standard
   e. Maintained upright throughout use

If you must move a sharps container, close the container immediately to prevent spillage or protrusion of contents before you handle it or move it. If it appears leakage is possible, place it in a secondary container that is closable, leakproof and color coded or labeled.

Any other sharps, such as scalpel blades or orthodontic wire, must be deposited in the sharps container after use. Use a mechanical device or hemostat to remove a disposable blade from the handle.

8. Other regulated waste, such as blood-soaked gauze, will also be placed in appropriate containers. Regulated waste is liquid or semi-liquid blood or OPIM plus the following: contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or OPIM. In the clinical area of the School of Dentistry, waste is classified as:

   a. Biohazardous waste (regulated)
   b. Regular or non-biohazardous waste
   c. Hazardous chemical waste

Regular non-biohazardous waste in the clinics is to be disposed of in the regular waste cans provided in each cubicle. Regular non-biohazardous waste not in the clinic areas is to be disposed of in the regular waste cans provided.
Biohazardous waste must be disposed of into the red bags, available in the Dispensary and each cubicle. Red bag biohazard waste is picked up daily by the University’s Facilities Management staff trained in biohazard waste removal.

Amalgam contains small amounts of mercury, which is considered Hazardous Waste. All excess amalgam (i.e. scrap and capsules) from dental procedures will be collected in properly labeled waste containers. Once a container is full it will be removed by DES as hazardous waste and disposed of according to University, federal, state, and local regulations.

Suitable containers are as follows:

- Closable, Plastic Container
- Constructed to contain all contents and prevent leakage during handling, storage or transport
- Labeled as Hazardous Material or Amalgam Scrap.
- Closed prior to removal to prevent spillage during transport

9. One of the simplest work practices that minimizes or eliminates exposure is to not eat, drink, smoke, apply cosmetics or lip balm, or handle contact lenses in dental treatment areas, dental laboratory areas or sterilization areas.

**NO EATING OR DRINKING IN ALL CLINICAL AND PRE-CLINICAL AREAS. THIS INCLUDES STUDENTS, STAFF, FACULTY AND PATIENTS.**

1. Do not store or keep food or drink in refrigerators, freezers, shelves, cabinets, countertops or bench tops in the clinics or where blood or OPIM are present.

2. Perform all dental procedures in such a manner so as to minimize splashing, spraying, and spattering or generation of droplets that might contain infectious materials. This would include the use of high volume suction, the rubber dam, judicious use of the air/water syringe, and properly positioning the patient. Do not mouth pipette or mouth suction blood or any OPIM.

3. Before servicing or shipping any dental equipment that may have been contaminated, decontaminate the equipment. Label the parts of the equipment that have not been decontaminated and be sure to tell any serviceman, shipper or manufacturer the exact state of contamination the equipment is in.

**PERSONAL PROTECTIVE EQUIPMENT**

OSHA feels that engineering and work practices are not always enough to provide absolutely the maximum protection to health care workers or others exposed to infectious disease. Another layer of defense against infectious organisms is the use of personal protective equipment.

OSHA requires that employers (in our case the School of Dentistry) provide at no cost to employees, appropriate personal protective equipment such as, but not limited to, gloves, gowns, masks, eye protection, resuscitation bags, pocket masks or other ventilation devices. Students shall be provided with gloves, masks, eyewear and gowns. Students provide their own eye protection and eyewear is also available at dispensing. Personal protective equipment is only appropriate if it does not allow blood to pass through and reach the
employees work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use. The School of Dentistry will also provide eye protection to all patients. Students and Faculty must request that patients wear eye protection during any and all dental procedures. If a patient refuses the eye protection, this refusal must be noted in the patient’s dental record. Patients may use their own eyewear for protection.

1. Protective garments

Blue clinic gowns are to be worn by students, staff, or faculty at all times in the clinical areas when providing patient care. The blue clinic gowns that are high-necked and long-sleeved are of sufficient length and size; and are made of a material that will not allow body fluids to pass through under normal conditions. This gown must be worn whenever there is likely to be exposure to infectious fluids or contaminated materials and during intra oral examinations.

All students and staff are required to wear the blue clinic gown when performing dental treatment, when handling or exposing radiographs, or performing any other task in which exposure to OPIM is likely to occur. Blue clinic gowns are to be removed when leaving the clinic area. Hooks are available in each cubicle and clinic area for placing these gowns. Yellow disposable gowns are worn only in laboratory areas. Dispensary personnel, dental laboratory personnel, and darkroom technicians will wear appropriate protective clothing when necessary.

You will draw a blue clinic gown from the Dispensary at the start of each clinic day. Gowns will be turned in to the “dirty” Dispensary at the end of each session, unless the gown becomes reasonably soiled or OPIM penetrates the material during the day. In that case you will return the soiled gown as soon as possible and draw a clean gown. Under no circumstances are gowns to be left in clinic spaces overnight or removed from the clinics (i.e., not stored in a personal locker). Blue clinic gowns will be cleaned, laundered repaired or replaced as necessary by the School of Dentistry.

Dispensary personnel will wear appropriate gloves when handling contaminated laundry.

Dispensary personnel will ensure that the containers holding the contaminated laundry are properly labeled or color-coded. In addition, before transporting the contaminated laundry to be laundered, it must be covered to prevent the potential spread of infectious microorganisms.

To summarize:

- Wear your blue clinic gown in clinic when exposure is likely to occur.
- Wear your yellow disposable gowns in laboratory areas.
- When leaving the cubicle to eat or do other tasks remove your clinic gown and leave it in your cubicle or treatment area until you return. However, at the end of the session, return the clinic gown to the dirty dispensary.
- All students will wear heavy-duty gloves and protective eyewear when hand cleaning instruments.
- In addition all students will wear eye protection and facemasks when performing laboratory work in all areas, clinical or pre-clinical.

2. Gloves

Because our hands can easily be the source of bacteria that can infect our patients, hand washing or
rubbing with an alcohol based handrub alone may not be sufficient to protect our patients from cross-infection. In addition, it is easy enough for bacteria from our patients to enter our bodies through minute breaks in our skin. Therefore, gloves protect both the patient and health care worker. For these reasons, OSHA has ordered that all health care workers wear gloves when it can be reasonably anticipated that health care workers may have hand contact with blood or OPIM, non-intact skin, or patients or when handling or touching contaminated items or surfaces.

- Disposable non latex (single use) gloves, such as surgical and/or examination gloves, shall be replaced as soon as feasible when contaminated, when they are torn or punctured, or when their ability to function as a barrier is compromised.
- Disposable (single use) gloves shall not be washed or decontaminated for re-use.
- Utility gloves may be decontaminated for re-use if the integrity of the gloves is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.
- The School of Dentistry will provide hypoallergenic gloves for those who are allergic to the gloves normally used.
- **Do not leave your cubicle or other treatment area with your gloves on, since this could lead to contamination of other areas.** In addition, do not handle charts while wearing gloves. Only after a procedure is completed and gloves are removed, should charts or other objects be touched. If, during a procedure, treatment is interrupted and you must touch another object, either deglove or overglove.

3. **Masks**

Wear facemasks or full-length face shields with facemasks while treating patients or whenever splashes, spray, splatter or droplets of blood or OPIM could be generated. These masks should be able to prevent the passage of microorganisms. If your mask becomes damp during use, discard the mask as soon as possible, and put on a fresh mask.

4. **Eye Protection**

Eye protection must be worn in all clinical patient treatment areas. Wear appropriate eye protection whenever there is the possibility of an aerosol spray, splatter, splashes, droplets or contaminated foreign objects (i.e. pieces of amalgam). This means the use of eye protection when doing patient treatment as well as while doing laboratory work. Eye protection can be eyeglasses with solid eye shields, Googles™, goggles or full-face shields; but **must be** appropriate to the task. Remember, during dental treatment, the patient’s eyes must also be protected. Therefore, leave the patient’s eyeglasses on if he/she normally wears them. Otherwise, protect the patient’s eyes with suitable eye protective glasses that are provided for this purpose.
5. Surgical Caps or Hoods and/or Shoe Covers or Boots
These should be worn in instances where gross contamination could be generated. For example, this might be the case during surgery, when an aerosol-generating handpiece is causing a great deal of contamination.

6. Computer Keyboard and Mouse
If a student is recording information during the exam and going from the patient to the keyboard, the keyboard and mouse are to be covered with a plastic bag provided at the dispensaries.

HOUSEKEEPING
1. General
The School of Dentistry shall ensure that the work site is kept clean and in sanitary condition. The School of Dentistry has determined and implemented an appropriate written schedule for cleaning and decontaminating various locations within the facility.

2. Equipment and Services
All equipment and environmental surfaces shall be cleaned and decontaminated after contact with blood or OPIM.

- Contaminated work surfaces should be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible, when surfaces are overly contaminated or after any spill of blood or OPIM; and at the end of the work shift if the surface may have been contaminated since the last cleaning.
- Protective coverings such as barrier film, plastic wrap, and aluminum foil or imperviously backed absorbent paper may be used to cover equipment and environmental surfaces, but shall be removed and replaced between patients, as soon as they may become inadvertently contaminated, or at the end or the work shift. Protective covering are useful in dentistry to protect those surfaces and pieces of equipment that are difficult to disinfect, such as light handles, x-ray tube heads, etc. In addition, barriers are faster and more effective than using disinfectants to decontaminate an area.
- All bins, pails, cans other similar receptacles intended for re-use which have a reasonable likelihood of being contaminated with blood or OPIM will be inspected and decontaminated on a regularly scheduled basis and cleaned an decontaminated immediately or as soon as feasible upon visible contamination.
- Broken glassware, which may be contaminated, shall not be picked up directly with the hands. It shall be cleaned up using mechanical means such as a brush and dustpan, tongs or forceps. If such an incident should occur, report to the dispensary, where appropriate clean up equipment is available. Remember to wear utility gloves, mask, eye protection and a protective garment during the clean up. After the spill is cleaned up, decontaminate the area using disinfectant; then decontaminate the equipment.
- Do not place reusable contaminated sharps (i.e. dental instruments) into a container that you have to reach into by hand in order to retrieve. The sink may be used since it is a large container and your risk of sustaining a puncture wound would be slight. However, should it become necessary to wash instruments by hand, caution should be exercised. Place only a few instruments into the sink at one time and do not use a soap that creates too many suds. Also, wear utility gloves that are puncture-resistant as well as being capable of being disinfected or sterilized.
3. Regulated Waste

Contaminated sharps that are disposable shall be discarded immediately or as soon as possible after their use. They shall be placed into containers that meet the standards for sharps as described in the Engineering Control section of Methods of Compliance. As stated earlier, these containers will be accessible and close to the area where they are used. They will not be allowed to overfill. Other regulated waste will be placed in containers that are suitable. In instances where blood, vomitus, fecal matter, urine or other body fluids are involved, report to the dispensary and obtain a kit which will help you safely clean up the material involved. Again, wear proper eye protection, mask, utility gloves and protective clothing. Decontaminate the area using the wipediscard-wipe technique; then decontaminate the equipment before returning it to the dispensary.

4. Laundry

Contaminated laundry shall be handled as little as possible. When you are finished with your clinic gowns at the end of the day, when it becomes visibly soiled or if OPIM penetrates the material, turn it in to the dirty dispensary. Faculty will also turn in their clinic gowns when they become visibly soiled, contaminated or if OPIM penetrates the material, and at the end of the day. Dispensary personnel shall handle the laundry in the dispensary as little as possible. Minimum sorting should be done. Dispensary personnel will place the contaminated laundry into bags or containers that are labeled or color-coded. Since our dispensary utilizes Universal/Standard Precautions in the handling of our laundry, alternative labeling or color-coding is acceptable if it permits all health care workers to recognize the containers as requiring compliance with Universal/Standard Precautions. If dispensary personnel must handle the contaminated laundry, they will wear protective gloves and aprons or gowns.

DAILY PROTOCOL

1. General

The real issue of infection control revolves around how we as faculty, students and staff, on a daily basis, go about our work of providing dental care for our patients in a safe manner by a routine that minimizes or eliminates the possibility of transmitting infectious diseases. This daily routine consists of a combination of using what engineering means we have at our disposal as well as using work practices. This keeps our patients and us safe. Therefore, we shall discuss some of the practices and procedure we should be following in order to achieve the maximum protection possible. Keep in mind that the principles of Universal/Standard Precautions are followed while doing all these routines.

2. At the Beginning of the Clinic Treatment Day

- When you first arrive at your treatment area, wash your hands thoroughly as described in the Hand Washing Technique section of the Appendix.
- Students and staff alike should prepare their equipment, draw whatever supplies are necessary (such as instruments, disposable items and unit doses of dental materials such as restorative materials) for the treatment to be rendered, secure the patient’s chart, and do what is essential to prepare for smooth, uninterrupted treatment. By being properly prepared, one does not have to stop to get additional supplies, instruments or equipment.
As interruptions occur, the chance of spreading contamination increases greatly. Also, uninterrupted treatment means safe, efficient treatment. To achieve safe dental treatment, one must keep the area of contamination as small as possible. Thus, all equipment and supplies should be within easy reach of the dental student and assistants. It goes without saying that the cubicle or dental operating area should be in a sanitary condition. Countertops should be clean and clear of clutter.

- How to prepare the dental operatory for treatment:
  - Gather all materials needed from the clean dispensing area. Place instruments on covered counter top. Wash hands, place gown, glove, mask and eyewear on.
  - Place a clean plastic barrier over the headrest and the back of the chair.
  - Remove air-water syringe and slow & high speed evacuation houses. Place a clear plastic barrier on the assisting arm. Place clear barrier bags over the air water syringe and slow & high speed evacuation hoses.
  - Remove handpiece hoses, air-water syringe and cavitation hose. Place clear plastic barrier over the headrest and the back of the chair. Remove air-water syringe and cavitation hose. Place clear plastic barrier over the handpiece control arm. Place clear plastic barrier over the air water syringe, hand piece hoses and cavitation hose.
  - Place blue barrier film (4” x 6” piece) over the dental light handles, dental light switch, viewbox switch, intercom buttons, and curing light handle.
  - Place plastic barrier over curing light wand.
  - Place plastic barrier over curing light wand.
  - Fill water bottle with tap water.
  - Flush the water lines (handpiece and air-water syringes) for one to three minutes.
  - Remove gown, mask, and eyewear; wash hands. Go to reception area to greet patient; escort patient to your cubicle.
  - Seat patient. Follow the use of PPE guidelines.
  - At this time your operatory should be prepared for patient treatment. Instructors or Dental Assisting staff must verify visually that all handpieces and instruments have been sterilized (are in sealed bags) and the operatory is properly prepared. Upon approval, the clinic instructor or Dental Assistant will swipe the Infection Control start check in the AxiUm system. Kits may then be opened in front of the seated patient, treatment may be started.

3. During Patient Treatment
   During patient treatment, the following procedures should be observed:
   - Give/offer the patient a pair of protective eyewear to wear during dental treatment, even if the patient has eyeglasses.
   - Mouth rinse will be available for patient use.
   - Just before gloving, wash and dry your hands using antimicrobial soap.
   - Place rubber dam whenever possible. Non-use of rubber dam must be approved by your clinic instructor.
   - If making entries in patient’s record during treatment plastic barriers must be placed on the keyboard and mouse.
   - Once gloved, do not touch anything but the patient, barrier and covered areas or areas that were already decontaminated at the end of the last patient visit.
   - If you leave your cubicle for any reason, deglove and wash your hands; no one is to walk around the clinics outside their cubicles or immediate treatment areas with gloves on.
• When taking radiographs, set up the x-ray room before regloving. Prepare the record in AxiUm to take digital radiographs. Cover tube head, chair, and controls with protective covers and barrier film. After patient is seated, place lead apron on patient. Glove. Expose radiograph(s). Save radiographs in the system. Release the patient and disinfect the x-ray area.

• Use high-speed evacuator to prevent spread of contamination when using high-speed handpieces, water spray, ultrasonic scalers, or any other piece of equipment likely to produce aerosols, splatter or droplets.

• If an instrument is dropped, do not pick it up and re-use it. Leave it where it has fallen, unless it is a hazard, until you are finished with your treatment; then pick it up with your gloves. If you must remove it immediately, pick it up with your gloves and then place it in the sink or any other appropriate place out of your immediate operating area. Deglove, wash your hands and reglove before proceeding.

• Disposable items are what the name implies. Use them once and only once, and then discard. This includes gloves, masks, saliva ejectors, etc.

• If, during treatment, prosthetic-related items need to be transported somewhere else in the clinic such as the laboratory, these items must be cleaned and disinfected before leaving the treatment area. These items include impressions, models, die, prostheses, bite registrations, crowns, wax-ups, etc. Clean, place in plastic bag, disinfect to transport to labs and remove gloves; then you can safely take the items to another area or ship them outside the School. All items must be disinfected in the plastic bag for 10 minutes.

4. Upon Completion of Treatment After the patient’s treatment is completed, remove patient napkin and place in your trash container. Take off your gloves, wash your hands, and make your appropriate entries on the dental record. Escort the patient to the reception area.

Return to your cubicle:
• Put on your gown, gloves, and mask and proceed with cubicle cleanup.
• Place sharps in sharps container and any regulated waste product (i.e. amalgam, biohazardous) in appropriate waste container.
• Gather your instruments. Remove your handpiece(s) and air-water syringe tip, flush the hoses with water for 1-3 minutes to purge the lines of any contaminants. Direct the spray into your high volume evacuator or sink. The rest of your instruments should be placed back into your cassette or sterilization pouch along with your sterilizable air/water syringe tip. This cassette is then closed. Any instruments that do not go into the cassette should be returned to the dirty dispensary with your cassette. All instruments will be sent to the central sterilization area.
• Dispose of all barriers (patient napkin, plastic wrap, chair covers, dental light cover, bracket table cover, etc.) saliva ejector tip, paper cups, rubber dam and any other non-regulated waste. Disinfect all areas of your cubicle, with hospital level disinfectant supplied by the School. Use the wipe-discard-wipe technique. Be sure to use this disinfectant according to the manufacturer’s recommendations.
• Remove barriers from and disinfect all equipment that will be returned to the dispensary.
• Remove your gloves, wash your hands and return any equipment to the dispensary that needs to be returned. If you have another patient, start over again with step 2 by gathering your materials (instruments, etc.), make ready your cubical with the appropriate barriers, etc.
• Remove your eye protection touching only the earpiece, and your facemask touching only the ties – not the mask itself.

5. At The End Of Each Clinic Treatment Session
When the end of the treatment session is reached and the protocol following the dismissal of the last patient has been carried out, then additional tasks must be carried out before leaving. While still wearing protective equipment, disinfect all clinic contact surfaces. Disinfect the countertop, dental unit, chair and light using the wipe-discard-wipe technique. Be sure the base of the dental chair is clean. Also be certain your dental stool and walls of your cubicle are clean. A neat appearance promotes patient confidence.

The end of the session also offers the opportunity to attend to other details that make for a clean and neat cubicle. Dental chairs should be raised to the highest position, dental light should be placed over the head of the chair. Be sure items such as Hanau torches and rubber bowls are cleaned and disinfected and returned to the dirty dispensary.

To be sure the standards of cleanliness and infection control are upheld, inspections of your cubicle, work practices, and equipment will be overseen by your faculty instructors daily.

SPECIAL PROTOCOLS
1. General
So far this manual has described procedures for daily routine in your dental cubicles, but there are protocols for special tasks such as sterilization and disinfection as well as prosthodontic, orthodontic and radiographic procedures. These will be described in the pages to come.

2. Sterilization
Sterilization is at the center of what we do to prevent cross-infection, since sterilization is a process that kills all forms of life. If an instrument is sterile, there is no way it can pass on an infectious agent to another patient or health care worker. It is the ideal. Sterilization is carried out most effectively and easily with the use of the steam autoclave. The sterilization of instruments for our undergraduate students is done in the Central Sterilizing areas, although some sterilization is also done in the graduate clinics. In all these areas, the steam autoclave is also utilized. Of course, for any sterilization process to be effective in killing all the microorganisms, the instruments must be clean. Here at the School, the washer-disinfector and the ultrasonic (and occasional manual washing) techniques are used. Both are good if used properly; however, use the washer-disinfector method whenever possible since it is safer and probably more effective. Students can turn their cassettes in for processing at the dispensary or the appropriate sterilization area in their respective clinics.

a. Washer-disinfector Method
Dispensary and other authorized personnel using the washer-disinfector method should ensure that:
i. The proper solutions are used in the washer-disinfector equipment. Improper solutions may damage the equipment and/or dental instruments.

ii. The washer-disinfector is run for the recommended period of time and according to manufacture's instructions.

iii. The instruments or cassettes are placed correctly in washer-disinfector (not too near the bottom or sides) so that the equipment can function properly.

iv. Instruments are rinsed thoroughly and then dried thoroughly when the washer-disinfector cycle is complete.

b. Ultrasonic Method

Dispensary and other authorized personnel using the ultrasonic method should ensure that:

i. The proper solution is used in the ultrasonic cleaner. Improper solutions will damage the cleaner and are not as effective as the ones that have a detergent action.

ii. The ultrasonic cleaner has been run for the recommended period of time.

iii. The ultrasonic cleaner is covered while in operation.

iv. Baskets are used to prevent sharps injuries.

v. The solution is changed when recommended or if it becomes too dirty.

vi. The instruments or cassettes are placed in the cleaner correctly (not too near the bottom or sides) so that the cleaner will function properly.

vii. Instruments are rinsed thoroughly after the ultrasonic cycle is completed.

viii. Instruments are dried thoroughly, either with air-drying or clean paper.

c. Personnel Using Manual Scrubbing

When manually scrubbing, you should:

i. Wear protective gear (eye protection, mask, utility gloves and protective clothing).

ii. Use a detergent that allows you to see the instruments clearly.

iii. Cover the instruments with sufficient water so that both the instrument and brush are beneath the surface of the water in order to prevent splashing or splattering. Have and scrub only one instrument at a time in the sink.

iv. Rinse the instruments thoroughly.

v. Dry the instruments completely.

After the instruments are cleaned and dried, inspect them carefully to be certain that all visible debris has been removed. The instruments for the steam autoclave must be bagged or wrapped. The use of cassettes is an ideal way to contain the instruments, for it not only helps prevent needle sticks, but also helps to minimize the loss of instruments since the instruments are kept together in a container. Sterilization pouches can be used for one or several instruments, but use caution since there is always a danger of puncture, which could result in a sharps injury or a contaminated instrument. Do not overpack cassettes or pouches with instruments, for that might impede the circulation of steam throughout the cassette or pouch. Open hinged instruments so that the steam will reach all areas of the instrument.

Dispensary and other authorized personnel will see that the cassettes are put through the washer-disinfector, rinsed and dried before being bagged or wrapped for sterilization.
After being sterilized, the students’ cassettes and pouches are in the dispensary until they are returned to the students.

Dispensary and other authorized personnel operating autoclaves in other locations will ensure the autoclaves are working properly by using process indicators such as sterilization tape placing a chemical indicator inside each package and by performing biological monitoring using the appropriate spore tests. BoweDick Testing (SPS Medical #LCR-025) monitors are completed at the start of each day. Every load has a test pack that includes One Certol Integrator (Class 4) and one Steam Plus Class 5 integrator monitor which are processed in the steam sterilization cycle. The sterilization pouches used are the Crosstech Sure Check Multiparameter Indicator (Dual test) Class 4 pouches. They will keep a log of the sterilization cycles. This log will contain the results of biological monitoring. The Central Sterilization supervisors will monitor all results. The spore tests will be performed at least weekly, or more often if circumstances dictate. Biological monitoring is the most reliable form of testing since live spores are used. To properly perform biological monitoring, place the biological monitors within the instrument pack according to directions and then run normal cycle of the autoclave. For a control, select a biological monitor that has not been run through the autoclave. After processing the monitors, the results will be satisfactory if the test monitor is negative and the control monitor is positive. If the biological monitor that was placed in the autoclave is positive, then these additional steps must be taken:

- Stop using the autoclave immediately.
- Re-sterilize all packs that have been processed through the sterilizer since the last negative results.
- Notify repair personnel as soon as possible.
- After repairs are complete, retest the autoclave immediately. If test results are still positive, continue to seek the cause for the positive results.
- Do not begin routine use of the autoclave until negative results from the spore tests are obtained.

3. Disinfection

   a. General

Disinfection is the process by which most, but not all, microbial life is killed or inhibited; therefore, it is not an ideal method of eliminating pathogens, however, it is very effective for semi-critical items, which are those items that come into contact with mucous membranes or non-intact skin but do not penetrate soft tissues, contact bone, enter into or contact the bloodstream or other normally sterile tissue. An example of a semi-critical item is the plastic rulers used in clinic. Non-critical items are items that come into contact with only intact skin, not mucous membranes.

As said earlier, it would be ideal to sterilize everything. But for non-critical items such as countertops or the dental unit, this is neither practical nor necessary. Therefore, all surfaces touched by hands contaminated by blood or OPIM need to be cleaned and disinfected before each patient. When using a disinfectant, be sure that the disinfectant is an intermediate level EPA registered, FDA approved solution that is anti-tuberculous. An alternative to using disinfectants is to cover these surfaces with barriers, which can be made of plastic, aluminum foil or impervious-backed paper. In fact, covering a surface with a barrier is faster, easier on the equipment (almost all disinfectants are potent, corrosive chemicals) and is probably more effective. In addition, a barrier is a visible sign to the patient that infection control procedures are being followed. Thus, whenever possible, use a barrier to prevent
environmental surfaces from being contaminated. When using and changing barriers between patients, it is not necessary to clean and disinfect those surfaces until the end of the clinic session, unless the barrier is damaged or gross contamination occurs. Then remove the spoiled barrier, disinfect the area, and place a new barrier before proceeding with treatment.

b. Cleaning
Before disinfecting a surface, it must be clean. Cleaning destroys many bacteria and removes any bioburden or debris that may interfere with the effectiveness of the disinfectant to be applied. It is possible to combine the cleaning and disinfecting steps by using an appropriate disinfectant with the “wipe-discard-wipe” technique. This technique will accomplish cleaning and disinfecting clinical contact surfaces.

The wipe-discard-wipe technique is accomplished as follows:

i. Saturate two pieces of 4 X 4 gauze with hospital level disinfectant or use a commercial product like Caviwipes. Wipe and wet the surface with the appropriate level of cleaner/disinfectant solution to clean.
ii. Repeat the above procedure, leaving surface wet.
iii. Allow the surface to remain wet for at least ten minutes.
iv. At the end of ten minutes, wipe the surface dry with a paper towel or let it continue to air dry.

4. Laboratory Protocols
The protocols for prosthodontics and orthodontics are similar since there are both a patient treatment and laboratory phase for these areas of dentistry. As a result, there is a great danger of transmitting infectious agents from the cubicles to the laboratory which many students and staff use. It is easy to see that there are multiple opportunities for cross-infection. Thus, great care must be taken by all. Think before you leave your cubicle or other patient treatment with contaminated impressions, orthodontic appliances and removable and fixed prostheses. Let’s examine some of the possibilities for cross-infection.

Impressions – to prevent carrying contaminated impressions to the labs, first rinse the impression with water to remove all saliva and blood. Then disinfect it using an appropriate disinfectant. While performing these tasks, be sure you are wearing protective clothing, mask, eye protection and gloves. Disinfecting impressions must be completed before leaving the cubical area. Pour the disinfectant on material to cover the impression. Place the impression in plastic bag to transfer to laboratory for processing.

When impressions or interim prostheses are sent to an outside lab, or the School of Dentistry’s internal technician’s lab, they must be appropriately labeled to indicate whether they have been disinfected. Use a biohazard label if the case has not been disinfected. If they have been disinfected, the label should also clearly state that fact; otherwise, the lab will disinfect the impressions again. Cases shall also be packed to as to protect those handling the prosthesis from being stuck or injured by the prosthesis.

Laboratory areas and equipment require disinfection regularly. If possible, separate areas and equipment should be set aside for prostheses that have made intraoral contact and for prostheses that are new.
Cover the work area with disposable barriers as much as possible and change these barriers between cases. Disinfect these areas at the end of the day. Areas that are not covered should be disinfected between cases.

- Do minor adjustments of interim and completed prostheses in your cubicle using sterilized burrs, polishing wheels and disks.
- If adjustments need to be made in the student labs, rinse, disinfect for required minimum time, and bag item before going to the lab.
- In the case of completed prostheses or prostheses that need adjustment in the laboratory, use sterilized burs and disposable rag wheels and pumice.

Disposable paper basket should be placed in the lathe. When finished, dispose of all pumice and the paper basket in the regular waste.

All health care workers who work in a dental laboratory or handle laboratory cases on a regular basis should be vaccinated against Hepatitis B.

**ORAL RADIOLOGY PROTOCOL**

*Standard operating procedure in Clinic*

1. Report to the Radiology technologists. Radiographs are taken in the AxiUm system and are digital.
2. Select a cubicle.
   a. Check control panel for proper settings. Obtain staff signatures.
   b. Review and follow Operational Check-List and Radiation Safety Check-List posted by machine controls.
3. Cubicle will be prepared in advance by staff.
   a. They will wipe tube head and cone, the control buttons, and chair headrest with Cleaner/Disinfectant.
   b. Tube head and headrest will be bagged. The parts of the tubehead and handles that can’t be covered with bag will be covered with cling type wrap. Exposure switch is to be covered with disposable cling type plastic cover. Tubehead and head rest covers and tubehead bags must be changed between patients.
   c. Lead aprons and thyroid shields are to be cleaned and disinfected between uses.
4. Organize supplies needed on plastic coated paper bib napkin on the counter outside the cubicle. All supplies and instruments are to be kept on this napkin. Student is to keep personal items such as eyewear in a separate area of the work surface. Student is to ask staff for additional supplies.
5. Use universal infection control precautions for all patients. Staff will monitor students for compliance and inadequacies will be brought to the student’s attention for correction.
6. Explain the procedures.
   a. Do a brief clinical examination; determine the number of films to be exposed. Faculty in the Comprehensive Care group clinics will approve the radiographin request.
   b. Place lead apron on patient, position thyroid shield.
   c. Have patient remove dental appliances, glasses, very large earrings, nose or lip piercing, etc. Student
will put dental appliances on a moisture proof napkin or in a plastic cup.

d. Student is required to wear protective eyewear, gown, mask and gloves. Hands are to be washed and gloves are put on last.

7. Expose radiographs.
   a. Digital sensors are to be covered with plastic barriers.
   b. After exposing the last film; lower chair.
   c. Remove gloves and discard.
   d. Remove lead apron and thyroid shield and hang them up.

8. Return the patient to waiting room.
   a. Disinfect radiographic area. Dispose of adjunct supplies.

9. Evaluate radiographs
   a. discuss evaluation with staff and faculty.

10. If you have no retakes:
    a. Staff will bring chart to front desk for billing.
    b. Fill out encounter form, Progress Notes, and Radiology Log including type of exam and number of retakes.
    c. Escort patient to front desk for payment (if “cash account”) before dismissing patient.
    d. If you have retakes to do:
       e. Expose radiographs with assistance from technologist when necessary.
       f. Escort patient to Cashier for payment.

11. Discuss retakes with staff.
12. Call an instructor to discuss evaluation.
13. Clean your cubicle, if requested by staff.
14. Fold up arm and place tube head against wall.
15. Lead apron hung on wall hooks.
16. Discard all used materials. XCP instruments are to be rinsed and placed in Ultrasound unit. Staff will cleaned, bag and have XCP instruments sterilized.
17. Wipe off all work surfaces; wear gloves, mask and eyewear when using approved cleaner/disinfectant and sink, all scraps, etc., off floor.
   a. Place new covers on headrest, tubehead and exposure switch.
   b. Shut off x-ray unit and room light when done for the day.
   c. Place completed Evaluation Slip at the appropriate place near Output Station.

**Radiographs in Satellite areas**

1. Students are to follow Universal precautions. Students must wear protective eyewear, mask and clean gloves for taking radiographs.
2. Tube heads and headrests are to be bagged before a patient is seated. These are to be discarded after each patient and the student taking the radiographs must clean/disinfect the tube head and chair. The lead apron is to be hung up after removing from patient and cleaned/disinfected. Prior to seating the next patient, the student must bag the tube heads and headrests. Prepare digital sensors with barriers, prepare AxiUm record.
3. Disposable cling type covers are to be used to cover x-ray exposure switches. These are to be applied prior to each patient being seated and discarded as a part of clean up after taking radiographs.
4. Cups are to be used to transport films to darkroom. Clean gloves are to be worn for processing and discarded after loading films into processors or using quick dip type solutions.
5. Lead foils are to be placed in recycling box.
6. Students must mount films, put name and date on mounts. Duplicate films are to be put in envelope
with name and date and placed in appropriate box for pick up by Radiology staff.

**EXPOSING FILMS**
- i. Place barriers over the tube head and chair.
- ii. Cover the controls with blue plastic wrap.
- iii. Seat the patient. Place lead apron and thyroid collar over patient. Wash your hands, then glove and mask.
- iv. Student may use autoclaved or disposable position indicating devices. Rinn kits should be turned in to the dispensary for sterilization between patients.
- v. Use autoclaved or disposable panoramic bite block or cover it with a disposable cover.

**DEVELOPING RADIOGRAPHS/Quick Dip**
- i. To develop a film packet without barriers, clean gloves are to be used for processing after loading films into processors or using quick dip type solutions.
- ii. Put on new set of gloves, located outside the darkroom.
- iii. Place film cup on covered surface. Discard film wrappers. Place lead foil in lead receptacle.
- iv. After processing, discard gloves and wash your hands.

**III. AWARENESS**

**GENERAL**
In order for health care workers to be knowledgeable of the latest infection control techniques and information, they must be continually trained. Through this training health care workers learn how to minimize or eliminate their exposure to bloodborne pathogens. OSHA has recognized this fact and requires that the employer provide training for their employees. In our case, as required by OSHA, the School of Dentistry provides the following training for faculty and staff. Students constantly receive this information throughout their four years of dental education, beginning with the freshman year.

- Training for faculty and staff shall be provided as follows:
  - At the time of initial assignment of tasks where occupational exposure may take place;
  - At least annually thereafter.
  - For our faculty and staff who have received instruction on bloodborne pathogens in the year preceding the effective date of the Standard, only training with respect to the provisions of the Standard, which were not included in earlier training, will be provided.

- Annual training for all faculty and staff shall be provided within one year of their previous training.

- The School of Dentistry will provide additional training when changes, such as modification of tasks or procedures or institution of new tasks or procedures, affect the occupational exposure of health care workers. The additional training may be limited to addressing the new tasks or procedures.

- Material appropriate in content and vocabulary to the educational level, literacy, and language of our health care workers will be used.
The training program will contain at a minimum the following elements:

- An accessible copy of the regulatory text of the Standard and an explanation of its contents;
- A general explanation of the epidemiology and symptoms of bloodborne diseases;
- An explanation of the modes of transmission of bloodborne pathogens;
- An explanation of the School of Dentistry’s exposure control plan and the means by which the health care worker can obtain a copy of the written plan;
- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIM;
- An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;
- Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
- An explanation of the basis for selection of personal protective equipment;
- Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM;
- An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
- Information on the post-exposure evaluation and follow-up that the School of Dentistry is required to provide for health care workers following an exposure incident;
- An explanation of the signs and labels and/or color coding required by the Standard to warn health care workers of potentially infected items;
- An opportunity for interactive questions and answers with the person conducting the training session.
IV. PREVENTION

GENERAL
According to Federal and Minnesota OSHA (MNOSHA) employees who have occupational exposure to bloodborne pathogens must be offered the hepatitis B vaccination free of charge. In addition, it is HIGHLY RECOMMENDED that all clinical personnel, if they are not already immune, be immunized against measles, mumps, rubella, varicella, tetanus and influenza, and to be tested for exposure to Mycobacterium tuberculosis by means of a TST, tuberculin skin test. Employees and students should always consult their own health-care provider prior to any immunization.

ALL STUDENTS matriculating into the School of Dentistry are required to submit verification of:

- Proof of vaccination, initiation of vaccination, or immunity for hepatitis B
- Proof of vaccination or immunity for varicella
- Proof of vaccination or immunity for rubella, mumps, and measles
- Proof of vaccination or immunity for tetanus/diphtheria
- Screening for tuberculosis

Note: First year student are given until the end of their 1st semester to complete all requirements, after that time registration will be withheld until completion of immunization requirements.

Influenza (flu) shots are offered free of charge in the Fall of each year to all AHC students, faculty, and staff.

HEPATITIS B VACCINATION
Dental health care workers are at a substantial risk for acquiring hepatitis B if exposed to infected patient’s blood via puncture injury, mucous membrane, or non-intact skin exposure. A safe and effective vaccine is available. The vaccine is offered to employees with occupational exposure to blood or body fluids unless: 1) the employee has received the complete hepatitis B vaccination series; 2) previous antibody testing has revealed that the employee is immune, or 3) the vaccine is contra-indicated for medical reasons. The vaccine is provided at no cost to the employee. The vaccine is strongly recommended for all employees with occupational exposure. Post-vaccination testing to document antibodies have been acquired is also provided by the School of Dentistry at no cost to the employee. If an employee declines to accept the vaccination, a Hepatitis B Vaccination Declination form must be signed. If an employee later decides to receive the vaccination, it will be made available if occupational exposure can be reasonably anticipated.

Rationale: It has been historically shown that DHCW had much higher rates of hepatitis B infection than the general population. Additionally, transmission of HBV infection from DHCW to patients has been documented. This disease can have severe and even fatal consequences. The vaccines currently used are safe and effective. They stimulate the production of protective antibodies in up to 96% of those immunized.

MEASLES, MUMPS, RUBELLA (MMR), VARICELLA (CHICKEN POX), AND TETANUS
Employees should check with their physician to be assured that these vaccines have been administered, if they are not already immune, and that they are protected against these diseases.

TUBERCULIN SKIN TEST
The tuberculin skin test (TST) is sometimes referred to as a PPD (purified protein derivative) or a Mantoux test. It is highly recommended that employees consult with their own health care provider to discuss a
tuberculosis screening based on the latest recommendations as well as their medical history. A baseline 2-Step TST is preferred, followed by a yearly TST. If the skin test reveals a positive reaction, the employee should discuss with their physician what steps, if any, need to be taken (e.g.: chest x-ray, prophylactic mediation).

The purpose of the immunization policy is to protect the student, the employee, and the patient; to provide expert and safe patient care, and to provide a safe learning and working environment.

V. MANAGEMENT OF BLOOD AND BODY FLUID EXPOSURE

GENERAL
The Centers for Disease Control and Prevention (CDC) has published guidelines for dealing with exposure of health care workers to body fluids. The following Exposure Incident Protocol outlines the steps to be taken to meet these guidelines.

Any employee/student experiencing a percutaneous (skin puncture) or mucosal exposure to body fluids MUST follow the Exposure Incident Protocol. **Adherence to steps described in the following flow charts and reporting forms is essential for timely and appropriate management of exposure incidents.**

A. Immediately after an exposure incident:
   i. Bleed and wash the wound with antimicrobial soap and cool water.
   ii. Report to your supervising faculty.
   iii. Perform first aid.
   iv. Supervising faculty will determine ability to complete procedure enough to ensure patient comfort and safety.
   v. Review patient’s medical history. Do not release the patient at this time, even if they have a negative history and there is no suspicion of disease.
   vi. Complete the exposure incident reporting form. Obtain the appropriate form from the desk area. Document the route(s) of exposure and the circumstances of the exposure incident. To be signed by the exposed individual, reviewed and signed by the supervising faculty and then forwarded to the Clinical Systems Office.

B. Source Individual
   i. Identify the source individual, if possible.
   ii. Supervising faculty and/or student will talk to the source patient. The patient will be informed of the incident and asked to consent to blood tests at the appropriate health care facility. See chart.
   iii. The supervising faculty will obtain consent and send the source individual to the appropriate health care facilities for a blood test, at no cost to the patient, for HBV, HCV, and HIV infectivity. This is voluntary.
   iv. If consent for a blood test for HBV, HCV, and HIV infectivity can not be obtained from the source individual, document it on the Exposure Incident Report Form.

C. Exposed Employee/Student
   i. Refer the exposed individual to the appropriate health care facility. See chart.
   ii. The health care facility to provide treatment should receive a copy of the Exposure Incident Report form and a copy of the Bloodborne Pathogens Standard.
INJURIES REQUIRING TREATMENT OUTSIDE THE U OF M DENTAL CLINICS

The following information describes policies/procedures for referring people for medical treatment after an accident that requires treatment outside of the School of Dentistry’s Dental Clinics.

This information covers:
- Patients
- Dental, Dental Therapy and dental hygiene students
- Graduate students and residents
- Auxiliary education trainees
- Faculty and Staff

NEEDELESTICKS AND OTHER EXPOSURE TO BLOOD OR BODY FLUIDS Between the hours of 8:00 a.m. and 4:30 p.m. for injuries involving exposure to blood, the injured person and the source patient should report to Boynton Health Center within two hours of the incident. After 4:30, if a student is involved in an exposure, the injured person and source patient should contact the Boynton Health Center at (612) 625-7900 to receive step-by-step directions as to where and when to go to get the services that are needed. In exposures that involve faculty and/or staff members and it is after 4:30 PM, the injured person and source patient should report to the University of Minnesota Medical Center, Fairview, Emergency Room. Patients may decline treatment. When a patient consents to testing, charges will be paid by the U of M Dental Clinics.

ALL OTHER INJURIES:
- Patient Injuries and Medical Emergencies
  - Call 1, 2, 3, 4, 5 (Fairview Southdale ER Coordinator) for immediate assistance. Patients requiring further evaluation and/or treatment are to be escorted to the University Hospital Emergency Room.
  - When patients are taken to the Emergency Room, the patients will not be billed for accidents arising as a direct result of dental treatment. Inform the Emergency Room nurse that billing should be directed to the Clinical Affairs Office, Room 8-434 Moos Tower.

- Dental, Dental Therapy and dental hygiene students, graduate students and residents
  - All students must report to Boynton Health Service if medical treatment is required following personal injury.
  - Student charges at Boynton Health Service and related referrals may be covered by health service fees. University policy stipulates that all students carrying more than six (6) credits must pay the health service fee. The health service fee does not cover hospitalization or surgery expenses and Regents policy stipulates that all students must carry supplemental hospitalization coverage. This additional coverage may be purchased from the University and proof of coverage may be requested by the School of Dentistry to assure compliance with the Regents policy.
  - Students who self-refer to the University of Minnesota Medical Center, Fairview Emergency Room.
Room between the hours of 8 a.m.-4:30 p.m. or go to the outpatient clinics in Phillips-Wangensteen will incur expenses for which they, not the UofM will be responsible.

- **Auxiliary education trainees**
  - Dental assistant trainees are referred to Boynton Health Service for emergency medical treatment. Payment for Health Service treatment is the responsibility of the student or his/her training program. The on-site dental assistant coordinator should be informed and accompany the trainee to Boynton Health Service.

- **Faculty and Staff**
  - All faculty and staff report to Boynton Health Services, their own clinic/doctor or Minnesota Occupational Health, 1661 St. Anthony Avenue, St. Paul, MN 55104. Their phone number is 651-842-5300. If the condition is life threatening, you go to the University of Minnesota Medical Center, Fairview Emergency Room.

## University of Minnesota Dental Clinics
### Accidental Injuries Requiring Treatment Outside of the UofM Dental Clinics

<table>
<thead>
<tr>
<th>Patients</th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairview University Hospital Emergency Room</td>
<td>Fairview University Hospital Emergency Room</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Systems Office, 8-434 Moos Tower</td>
<td></td>
</tr>
</tbody>
</table>

| All Students | Between 8-4:30: | After 4:30: | Complete: | Submit Form To: |
| Predoctoral, Graduate, Resident, Trainees | Boynton Health Service | Fairview University Hospital Emergency Room | UofM Dental Clinics Incident Report (SD130) | Clinical Systems Office, 8-434 Moos Tower |
### Faculty and Staff

<table>
<thead>
<tr>
<th>Department</th>
<th>Address Details</th>
<th>Exit Injury Site</th>
<th>Submit Form To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boynton Health Service, Employee choice or Occupational Medicine Clinic Health Partners</td>
<td>2220 Riverside Avenue So Minneapolis, MN 55454 952-883-6999</td>
<td>Fairview University Hospital Emergency Room</td>
<td>Supervisor for forwarding to Workman's Compensation Department</td>
</tr>
<tr>
<td><strong>Critical Care Injuries</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
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<td></td>
</tr>
</tbody>
</table>

### NEEDLESTICKS and other Exposures to Blood or Body Fluids

<table>
<thead>
<tr>
<th></th>
<th>Between 8-4:30:</th>
<th>After 4:30:</th>
<th>Complete:</th>
<th>Submit Form To:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients, Students</strong></td>
<td>Boynton Health Service within two hours of the incident</td>
<td>Contact Boynton health Center (612)625-7900 for step-by-step directions within two hours of the incident</td>
<td>UofM Dental Clinics Incident Report (SD130)</td>
<td>Clinical Affairs Office, 8-434 Moos Tower</td>
</tr>
<tr>
<td><strong>Staff and Faculty</strong></td>
<td>Boynton Health Service within two hours of the incident</td>
<td>Fairview University Hospital Emergency Room within two hours of the incident</td>
<td>U of M Employee Incident Form and First Report of Injury (UM1536)</td>
<td>Supervisor for forwarding to Workman's Compensation Department</td>
</tr>
</tbody>
</table>

*Critical Care Injuries are defined as those injuries which prohibit travel and demand immediate active medical attention but are not so severe as requiring 911 service. Examples are chemical burns or eye injuries. Sprains, strains, and contusions are not considered Critical Care Injuries. All required forms are available at the clinic reception desks.*
VI. WARNING

GENERAL
Even though a health care worker may be well trained in infection control procedures and may have his/her vaccinations up to date, he/she may still be at risk. Infectious organisms are invisible to the naked eye. Therefore, at times, only warning a health care worker has that he/she is about to come into contact with contaminated materials or surfaces is by the use of labels and signs. OSHA has recognized this danger and mandated the use of labels and signs.

LABELS
Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or OPIM, and other containers used to store, transport or ship blood or OPIM.

Labels required by the Standard shall include the following legend:

BIOHAZARD

These labels shall be fluorescent orange or orange-red and predominantly so, with lettering or symbols in a contrasting color. Labels required to be affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal. Red bags or red containers may be substituted for labels.

Containers of blood components or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from labeling requirements.

Individual containers of blood or OPIM that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement. Labels required for contaminated shipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated. Regulated waste that has been decontaminated need not be labeled or color-coded.
**SIGNS**
The School of Dentistry will post signs at the entrance to work areas specified as HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

**BIOHAZARD**

(Name of the infectious agent) (Special requirements for entering the area) (Name, telephone number or the laboratory director or other responsible person)

These signs shall be fluorescent orange-red and predominantly so, with lettering or symbols in a contrasting color.
VII. DOCUMENTATION

GENERAL
The last part of the Standard is concerned with recordkeeping. OSHA has mandated that certain records be kept. These include medical records and training records.

STERILIZATION LOGS
Each area that operates an autoclave will keep an operating and testing log. This log will indicate when the loads of instruments were processed, whether they reached temperature as indicated by the sterilization tape or wheel, and results of the integrator test. Biological spore monitors must be done at least weekly. Multiparameter integrators are placed in each autoclave load run in Central Sterilizing. The load must pass the integrator test before it is released to the clinics. The sterilization log should be checked and initialed by the Central Sterilizing supervisors.

MEDICAL RECORDS
The School of Dentistry shall establish and maintain accurate records for each dental health care worker in accordance with Federal, State, and local regulations.

CONFIDENTIALITY
The School of Dentistry shall ensure that the following health care worker medical records required by the Standard are:

- Kept confidential
- Not disclosed or reported without the health care worker’s express written consent to any person within or outside the workplace except as required by the Standard or as may be required by law.
- The School of Dentistry shall maintain the medical records as specified by the section on Recordkeeping for as least the duration of employment plus 30 years.

TRAINING RECORDS
Training records shall include the following information:

- The dates of the training sessions;
- The contents or a summary of the training sessions;
- The names and qualifications of persons conducting the training;
- The names and job titles of all persons attending the training sessions.
- Training records shall be maintained for three years from the date on which the training occurred.

AVAILABILITY
- The School of Dentistry shall ensure that all records required by the Standard shall be made available on request to the Assistant Secretary of Labor for Occupational Safety and Health or designated representative (hereafter referred to as “Assistant Secretary”), and the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative (hereafter referred to as (“Director”), for examination and copying.
• Health care workers’ training records shall be provided upon request for examination and copying to health care workers, to health care workers’ representatives.
• Health care workers’ medical records shall be provided upon request for examination and copying to the subject health care worker, and to anyone having written consent of the subject health care worker.

**TRANSFER OF RECORDS**
If the school of dentistry ceases to do business, medical and training records must be transferred to the successor employer. If there is no successor employer, the employer must notify the Director, NIOSH, U.S. Department of Health and Human Services, for specific directions regarding disposition of the records at least three months prior to intended disposal.
APPENDIX A

HAND WASHING TECHNIQUES AND HAND CARE

The following guidelines apply to ALL clinic personnel including students, residents, faculty, and staff who may come in contact with blood, body fluids, and/or tissues.

PERSONAL AND H AND HYGIENE

1. Eating, drinking, smoking, applying cosmetics or lip balm, or handling contact lenses is prohibited in the clinics, laboratories, sterilization, and dispensary areas. Additionally, food and drink may not be stored in these areas.

2. Long hair must be pulled back to avoid contamination.

3. Hands must be thoroughly washed and dried just before placing gloves, and immediately after removal of gloves. Hands must also be washed immediately after barehanded contact with contaminated objects or surfaces. Hands should be free of large and rough surface rings that could damage gloves. Excess moisture and organisms also tends to collect under rings, contributing to the development of dermatitis. Wrist should be free of watches and jewelry that cannot be decontaminated if exposed to patient's body fluids. Items may be worn on the wrists or arms if protected by clinic coat sleeve during the procedure.

4. Individuals with open lesions or weeping dermatitis of the hands must refrain from direct patient contact and contact with patient care equipment until the condition is resolved.

5. Keep fingernails short with smooth, filed edges to allow thorough cleaning and prevent glove tears. Use of artificial fingernails is not recommended.

Rationale: Hair and nails are known to harbor higher levels of bacteria than skin. Long nails are more difficult to clean and may potentially penetrate gloves. Jewelry must be removed for the same reasons. DHCW with injured or cracked skin, erosions, or eczema on hands or arms should exercise additional caution until the lesions are healed.

HAND HYGIENE PROCEDURE

Hand hygiene is mandatory 1) when hands are visibly soiled; 2) after barehanded touching of inanimate objects likely to be contaminated by blood, saliva, respiratory secretions, or OPIM; 3) before and after treating each patient; 4) before donning gloves; 5) immediately after removing gloves; and 6) before leaving the cubical.

The following is the recommended procedure for hand washing for routine dental procedures in clinics, as well as for routine laboratory work.

1. Wet hands and wrists under cool running water.

2. Dispense sufficient antimicrobial hand wash to cover hands and wrists.

3. Rub the hand wash gently onto all areas, with particular emphasis on areas around nails and between fingers, before rinsing under cool water.

4. Dry thoroughly with paper towels.

Rationale: Hand washing (1 minute [initial] and for 15 seconds minimum [subsequent]) is a basic and an extremely effective procedure for the prevention of many infections that are acquired from the transmission of organisms on the hands. Cool water minimizes the shedding of microorganisms from the subsurface layers of the skin and assists in reducing the potential for skin irritation. The antiseptic hand wash used in the clinical areas has a residual long lasting antimicrobial effect on the skin that improves with more frequent use throughout the day. It also contains emollients to help protect the skin from irritation.
In 2002 updated CDC guidelines included recommendations for inclusion of alcohol-based hand antiseptics as components of a hand hygiene program. These may only be used instead of hand washing when hands are not visibly soiled. This is designed to serve as an adjunct to the dental school’s primary antiseptic mode of hand washing with a parachlorometaxlenol (PCMX) antiseptic soap.

**Surgical Scrubs**

A surgical procedure requires a higher standard of hand washing, since invasive procedures would allow a greater transmission of bacteria. Therefore, before surgery:

1. Be sure all jewelry is removed. This would include rings, bracelets, watches, etc.
2. Clean fingernails.
3. Scrub hands, fingernails and forearms to the elbows with antimicrobial soap for two minutes.
4. Rinse thoroughly, first the hands, then forearms, allowing the water to run from your hands down the forearms.
5. Repeat this several times.
6. Dry with a sterile towel.
7. Use an alcohol based Handrub, apply to palm of one hand, rub hands together covering all surfaces until dry.

Hand lotion can be applied at lunchtime, after the treatment day, and before bedtime to help keep your skin from drying and chapping.
APPENDIX B

COMMON PROSTHODONTIC / ORTHODONTIC ITEMS

To Be Sterilized (Autoclaved)

- bristle brushes
- orthodontic pliers
- all burs including acrylic
- stock impression trays
- central bearing plates for articulator
- rag wheels
- compound heater tray
- #7 wax spatula
- metal handle mixing spatulas
- facebow fork

To Be Disinfected

- articulator
- trial bases
- casts
- torch
- compound heater
- shade guides
- facebow (minus fork)
- rulers
- knives
- mold guides
- mixing bowl & mixing spatulas

APPENDIX C

DISINFECTION OF DENTAL MATERIALS AND USE OF DISPOSABLE PUMICE WHEELS

Items such as impressions, jaw relation, records, casts, prosthetic restorations and devices that have been in the patient’s mouth should be properly disinfected (as shown in the table below) prior to transferring a student laboratory to a dental laboratory. Disinfected impressions that are sent to the dental laboratory should be labeled as such in order to prevent duplication of the disinfection protocol. Impressions must be rinsed to remove saliva, blood and debris, and then disinfected at the cubical area. Impressions can be disinfected with an EPA registered hospital level disinfectant. Since the compatibility of an impression material with a disinfectant varies, manufacturers’ recommendations for proper disinfection should be followed. The use of disinfectants requiring times of no more than 10 minutes is recommended.

DISINFECTION OF PROSTHETICS AND IMPRESSIONS PROTOCOL

The required protocol for disinfection of Prosthetic and Impression materials is:

1. Place Items in Plastic Bag.
2. Apply EPA-Registered Hospital Level Disinfectant Thoroughly.
3. Disinfect For Time Recommended by Manufacturer. Materials Included in this protocol are:
   1. All Impressions
   2. Acrylic Prostheses
   3. Wax Bites/Rims & Bite
   4. Removable Prostheses w/ Metal Frame/Base
   5. Porcelain/Gold

INSTRUCTIONS FOR THE USE OF DISPOSABLE PUMICE WHEELS

Disposable wheels, single dose pumice and disposable trays are available at the dispensing station.

1. Mount wheel on blue mandrel only and secure with black “O” ring*
   a. If not secured by the “O” ring the wheel will not stay on the mandrel.
   b. The disposable wheels will not work on any other type of mandrel.

2. Make stiff slurry of pumice and water. Apply liberal amounts of pumice slurry to the restoration to be polished. It is important to keep the wheel and restoration wet with the pumice slurry, if the wheel becomes too dry it will burn the acrylic.
   a. Initially more pressure may need to be applied to the area to be polished. To achieve a higher polish, thin the pumice slurry and use lighter pressure to polish. Always use liberal amounts of pumice slurry to prevent burning the acrylic.

3. When finished, remove the wheel replacing the black “O: ring on the mandrel and dispose of the wheel and unused pumice. Disinfect “O” ring with hospital grade disinfectant. Be sure to save the black “O” ring! Replace on mandrel for further use.
4. Rinse the restoration and place in a plastic bag with hospital grade disinfectant according to the school’s infection control policy.
   a. Instructions are posted on the yellow signs by each sink in the labs.
*If “O” ring is missing or broken please get a new “O” ring from dispensing, as the wheel will not stay on the mandrel when polishing.*
APPENDIX D

DISPOSAL OF WASTE MATERIALS
Disposable materials such as gloves, masks, wipes, paper drapes and surface covers that are contaminated with body fluids should be carefully handled with gloves and discarded in the appropriate waste container. Blood, disinfectants and sterilants may be carefully poured into a drain connected to a sanitary sewer system. Care should be taken to ensure compliance with applicable local regulations. It is recommended that drains be flushed or purged each night to reduce bacterial accumulation and growth. Sharp items, such as needles and scalpel blades, should be placed in puncture-resistant containers marked with the biohazard label. Human tissue may be handled in the same manner as sharp items, but should not be placed in the same container. Regulated medical waste (sharps and tissues, for example) should be disposed of according to the requirements established by local or state environmental regulatory agencies (see U of M Infectious and Pathological Waste Management Plan).

PRACTICES FOR THE DENTAL LABORATORY
Dental laboratories should institute appropriate infection control programs. Such programs are to be coordinated with the School of Dentistry.

9 TH FLOOR GOLD ROOM (RECEIVING AREA): A receiving area has been established separate from the production area. Countertops and work surfaces should be cleaned and then disinfected daily with an appropriate surface disinfectant used according to the manufacturer's directions.

INCOMING CASES: All cases should be disinfected before they are received. Containers should be disinfected after each use. Packing materials should be discarded to avoid cross contamination.

DISPOSAL OF WASTE MATERIALS: Solid waste that is soaked or saturated with body fluids should be placed, and then sealed, in a sturdy impervious bag labeled as BIOHAZARD. The bag should be disposed of following regulations established by local or state environmental agencies.

PRODUCTION AREA: Persons working in the production area should wear a clean uniform or laboratory coat, a facemask, protective eyewear and disposable gloves. Work surfaces and equipment should be kept free of debris and disinfected daily. Any instruments, attachments and materials to be used with new prostheses or appliances should be maintained separately from those to be used with prostheses or appliances that have already been inserted in the mouth. Disposable rag wheels and single use disposable containers of pumice are available for individual use on each case. Brushes and other equipment should be disinfected at least daily. The excess should be discarded.

OUTGOING CASES: Each case should be disinfected before it is returned to the School of Dentistry. The School of Dentistry should be informed about infection control procedures that are used in the dental tech laboratories.
APPENDIX E

HEPATITIS B VACCINE DECLINATION
I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee signature

Date
APPENDIX F

HAZARD COMMUNICATION

I. GENERAL
This written hazard communication program has been established for the University of Minnesota School of Dentistry in compliance with federal and state regulations. This program applies to all procedures and tasks in this department where employees may be exposed to hazardous substances under normal working conditions or during an emergency situation.

Under this program, employees will be informed of the contents of the hazardous properties (if any) of the chemicals, products and materials with which they work, safe handling procedures and measures to take to protect themselves from chemical hazards. Employees will also be informed of the hazards (if any) associated with non-routine tasks or outside contractors working within this department.

II. HAZARD DETERMINATION
This School of Dentistry relies on the evaluation of the chemical manufacturer, distributor, and importers shown in the MSDSs, to meet hazard determination requirements.

III. LABELS
A. The School’s Materials Manager or the person in charge of ordering or receiving supplies will be responsible for seeing that all containers of hazardous products coming into the department are properly labeled.
   —. Identity
   —. Appropriate hazard warning
   —. Company name and address
B. If employees transfer materials containing a hazardous chemical from labeled container to a portable container that is intended for immediate use only, no labels are required on the portable container.
C. If employees become aware of any portable or non-portable container holding a product or material containing a hazardous chemical that may be used more than once, it is their responsibility to immediately notify their supervisor or the health & safety officer.
D. The following are exempt from the labeling requirements:
   —. Consumer products and hazardous substances subject to a consumer product safety standard of labeling requirements.
   —. Distilled beverage alcohols.
   —. Pesticides subject to the labeling requirements of the Federal Insecticide, Fungicide, and Rodenticide Act.
   —. Any food, food additive, color additive, drug or cosmetic.
E. Medical devices are exempt from labeling requirements if they are in their original container.
   —. Amalgam alloy
   —. Resin tooth bonding agent
   —. Calcium hydroxide cavity liner
   —. Cavity varnish
   —. Zinc-oxide eugenol dental cement
   —. Dental cement other than zinc oxide eugenol
   —. Coating material for resin fillings
   —. Partially fabricated denture kit including teeth
Impression material
- Resin impression tray material
- Tooth shade resin material
- Dental mercury
- Bracket adhesive resin and tooth conditioner
- Denture relining, repairing or rebasing resin
- Denture adhesive or cleaner
- Pit and fissure sealant, and conditioner
- Temporary crown and bridge resin
- Root canal filling resin, paper point, silver point, gutta percha
- Oral cavity abrasive polishing agent
- Intraoral dental wax
- Stabilizing splints
- Articulating paper
- Base plate shellac
- Rubber dam and accessories
- Dental floss
- Disposable fluoride trays

F. All labels shall contain:
- Identity
- Physical and Health hazards (including target organ effect)
IV. MATERIAL SAFETY DATA SHEETS
A. The Materials Manager is in charge of ordering and receiving supplies and will assist the Health & Safety Office to maintain a file with an MSDS on every product that contains a hazardous chemical.
B. Copies of MSDSs for all hazardous chemicals to which the school may be exposed are available from vendors electronically online or by fax by phoning the School of Dentistry, Dental Engineering Services, Health & Safety Office.
C. MSDSs will be available for review by all employees during working hours. Copies will be available upon request from the Health & Safety officer.
D. The school's health and safety coordinator and/or the person in charge of ordering supplies is responsible for acquiring and updating MSDSs. He/She will request MSDSs on all orders of new products or if an MSDS had not been supplied with an initial shipment.
E. This school posts the required MNOSHA posters.

V. EMPLOYEE INFORMATION AND TRAINING
A. Everyone in the school who works with (or is potentially exposed to) hazardous chemicals will receive initial training on the Minnesota Employee Right To Know Act, The Federal Hazard Communication Standard and the safe use of chemicals.
B. The training program will be administered by the Health & Safety Officer. She will maintain the training records.
C. Regular departmental meetings are used to review information presented at the trainings and any new hazard in the work area. Employees would be asked to sign health & safety review session records.
D. Before starting work, or as soon as possible thereafter, each new employee will be trained on the hazardous materials in their department/division.
E. Information and training includes:
   — Any task in the department where hazardous chemicals are present.
   — The location and availability of the written hazard communication program, including the required list(s) of hazardous chemicals and MSDSs.
   — Methods and observations that will be used to detect the presence or release of a hazardous chemical in the work area.
   — The physical and health hazards of the chemicals in the work area.
   — The measures employees can take to protect themselves from these hazards.
   — The details of this written hazard communication program including an explanation of the labeling system and the MSDSs and how employees can obtain and use the appropriate hazard information.
F. Employees are informed that: The employer is prohibited from discriminating against an employee who exercises their rights regarding information about hazardous chemicals in this department.
VI. HAZARDOUS NON-Routine TASKS
A. Prior to starting work on non-routine tasks, each employee will be given information about the hazards involved with non-routine tasks. This information will include:
   - Specific chemical hazards.
   - Protection/safety measures employees can take to lessen risks.
   - Measures the department has taken to lessen the hazards including ventilation, safety glasses, gloves, masks, presence of another employee, and emergency protocol.

B. It is school policy that no employee is allowed to begin work on any non-routine task without first receiving a safety briefing.

VII. INFORMING CONTRACTORS
A. The Dental Engineer Services supervisor Greg Johnson, and the Health & Safety Officer, Teresa Ludwig, will advise outside contractors with employees exposed to dental chemicals, of any chemical hazards that may be encountered in the normal course of their employees work on the premises, the labeling system used, the protective measures to be taken and the safe handling procedures to be used. These contractors will also be notified of the location and availability of MSDSs. It is the responsibility of the contractor to inform his/her employees.

B. Any outside contractor bringing chemicals onto the premises where our staff may be exposed to them must provide the appropriate hazard information, including labels used and the precautionary measures to be taken with these chemicals. It is the responsibility of the Director of Infection Control and Safety to obtain this information and pass it on to the employees of this department.
VIII. PIPES AND PIPING SYSTEMS
A. Information on the hazardous contents of pipe or piping systems will be obtained by Joyce Lantto in DES.
B. Piping systems shall be identified at access points and labeled every ten feet where the piping is eight feet or closer to employee contact by Facilities Management for the University.

IX. HOW TO REVIEW MSDS
A. The MSDSs are arranged alphabetically. A database of MSDSs is in the Health & Safety Office.
B. If in place of an MSDS you find a letter requesting the MSDS this means the manufacturer, distributor or importer has not responded to our request for an MSDS. This letter is proof of our intent.
C. In place of an MSDS you may find a letter from the manufacturer stating that either the product is non-hazardous or that they do not need to comply with the Federal Hazard Communication Standard.
D. For your information The Federal Hazard Communication Standard does not apply to:
   →. Hazardous waste
   →. Tobacco or tobacco products
   →. Wood or wood products
   →. Articles
   →. Food, drugs or cosmetics intended for personal consumption by employees in the workplace.
APPENDIX G

PRE-CLINICAL LABORATORIES

During sessions in the pre-clinical laboratories, appropriate barrier precautions (masks, gloves, gowns, and protective eyewear) must be worn. Work habits should be taught which will enhance infection control procedures during clinical performance. Tissues, blood, and other body fluids from all patients should be considered infectious. To conform to the standard blood and body fluid precautions, the following precautions are recommended for students in pre-clinical laboratories.

- A protective blue clinic gown must be worn for work in all clinic areas (patient treatment).
- White lab coats will be worn in the 8 South and 8 Central Pre-Clinic Lab. The lab coats may also be worn throughout Moos Tower.
- Laboratory work surfaces should be cleaned and disinfected with the intermediate disinfectant provided when work activities are completed. This is an EPA registered tuberculocidal, hospital grade disinfectant.
- Laboratory equipment that has been contaminated with blood or other body fluids should be cleaned, and disinfected or sterilized, before being repaired in the laboratory or transported to the manufacturer for repair. If unable to disinfect all parts of laboratory equipment, prior to servicing, a label must be attached to the equipment identifying which parts remain contaminated.
- Hands must be washed before and after completion of laboratory activities.

8 SOUTH PRE-CLINICAL AREA INFECTION CONTROL PROTOCOL

1. Fill plastic water bottle with tap water but DO NOT OVERTIGHTEN.
2. Place white cover paper on countertop with the plastic side down.
3. Mount typodont and manikin assembly to dental chair.
4. Set up instruments and connect handpieces.
5. Wear required scrub and shoes, clean white lab coat with name tag, gloves, protective eyewear, and mask.
6. NEVER wear gloves outside cubicle.
7. Use approved disinfectant wipes located in each cubicle to wipe down dental chair (twice, if needed), hoses, dental unit, curing light, LCD monitor screen, countertop, sink, etc. ALL surfaces must be wiped clean.
8. Remove handpieces, typodont and manikin assembly and put away.
9. Empty water bottle and return to original location.
10. Raise chair to the highest position and lower overhead light on top of headrest.
11. Turn unit off.
LATEX ALLERGY POLICY

INTRODUCTION

Background
Latex gloves have proved effective in preventing transmission of many infectious diseases to health care workers. But for some workers, exposures to latex may result in allergic reactions. Reports of such reactions have increased in recent years, especially among health care workers.

Latex allergy is a reaction to certain proteins and chemicals in latex rubber products. The amount of latex exposure needed to produce sensitization or an allergic response is unknown; however, increasing the exposure to latex increases the risk of developing allergic symptoms. Health care workers are at risk due to their continued exposure to the latex proteins. Since 1988, FDA reported the number of allergic reactions to latex-containing medical devices at 1% of the general public and 8-12% of healthcare workers and others exposed to latex on their jobs.

In sensitized persons, symptoms usually begin within minutes of exposure; but they can occur hours later and can be quite varied. Mild reactions to latex involve skin redness, rash, hives, or itching. More severe reactions may involve respiratory symptoms such as runny nose, sneezing, itchy eyes, scratchy throat, and asthma (difficult breathing, coughing spells, and wheezing). Rarely, shock may occur; however, a life-threatening reaction is seldom the first sign of latex allergy.

Latex is a common component of disposable gloves, stethoscopes, adhesive bandages, syringes, rubber dams, prophyl cups, suction tips, bite blocks, IV tubing, rubber bands, pencil erasers, and many other medical and dental supplies. Because of frequency of use, latex gloves are the most significant source of exposure among healthcare workers. Cornstarch powder previously used to line disposable gloves can absorb latex proteins and then become airborne resulting in asthmatic reactions among individuals who did not use gloves but merely inhaled latex-containing dust.

Definitions

Irritation Dermatitis - is the most common reaction to latex products and is characterized by development of dry, itchy, irritated areas on the skin, usually the hands. This reaction is caused by skin irritations from using gloves, powder in the gloves, and possibly exposure to other workplace products and chemicals. Irritation dermatitis is a non-specific response and a true immune allergic reaction.

Allergic Contact Dermatitis (Type IV hypersensitivity or delayed hypersensitivity) - results from exposure to the chemicals added to latex during harvesting, processing, or manufacturing. These chemicals can cause skin reactions similar to those caused by poison ivy. As with poison ivy, the rash usually begins 24-48 hours after contact and may progress to oozing skin blisters.

Latex Allergy (Type I or immediate) - the most serious of the reactions that usually begins within minutes of exposure to latex, but can occur hour later with a variety of symptoms. Mild reactions to latex involve skin redness, hives, or itching. More severe reactions may involve respiratory symptoms such as runny nose, sneezing, itchy eyes, scratchy throat, and asthma. Anaphylactic shock may occur on rare occasions.
Incidence of latex Reaction

Studies indicate that 1-6% of the general population are sensitized to latex. A smaller group of the population has been classified as higher risk for latex sensitization. Those individuals include:

1. persons with multiple allergies, including food allergies,
2. persons with spina bifida or other neural tube defects,
3. persons who have undergone multiple surgical procedures
4. persons requiring multiple bladder catheterizations.

Severity of Latex Reaction

The type and severity of reaction depend on the level of sensitivity, the amount of allergen, and the site of exposure. A number of exposures may occur before any clinical symptoms appear. In attempting to predict latex reaction, it is important to remember three key factors:

1. the severity of a previous reaction does not reliably predict the severity of a future reaction,
2. even casual contact with latex can cause severe reactions in highly sensitive individuals, and
3. latex allergy can be mistaken for other allergies.

Exposure Control for Health Care Workers

Implementing the following recommendations outlined by NIOSH (National Institute for Occupational Safety and Health) can minimize latex exposure in the dental setting:

1. Use non-latex gloves for activities that are not likely to involve contact with infectious materials, e.g., routine housekeeping.
2. Use powder-free latex gloves for activities that potentially involve contact with infectious materials.
3. When wearing latex gloves, do not use oil-based hand creams or lotions unless they have been shown to reduce latex-related problems.
4. Wash hands with a mild soap and dry thoroughly after removing gloves.
5. Frequently clean work areas that may be contaminated with latex particles.
6. If you develop symptoms of latex allergy, avoid direct contact with latex gloves and products until you can see a physician experienced in treating latex allergy.
7. Attend continuing education programs and review training materials about latex allergy.

PROCEDURES FOR TREATING PATIENTS

Identification

Identifying patients at risk should be a specific and integral part of the medical history, both initial and update. The following questions can help determine the likelihood of a patient with a latex allergy:

1. Have you ever had or been told you had an allergy to latex (rubber) products?
2. When exposed to rubber gloves, glove powder, balloons, adhesive bandages, rubber toys, or other rubber products have you ever experienced: itching, swelling, watery eyes, hives, wheezing, or other breathing difficulties.
3. Have you ever experienced itching, swelling of the lips, or other allergic reaction during a dental exam or during the use of a dental rubber dam?
4. Have you ever experienced an unexplained allergic reaction during surgery, a urinary catheterization, barium test, or other medical procedure?
5. Have you ever experienced itching or swelling of the mouth or other allergic reaction.
when eating avocados, chestnuts, bananas, kiwi, papaya, or other tropical fruits? If the patient answers YES to any of these questions, the dental healthcare provider should consult with the patient’s allergist before proceeding with any dental care.

**Precautions for latex allergic patients**

1. Obtain latex-free materials from the Dispensary for each appointment. Vinyl and nitrile examination gloves are available.
2. Encourage latex-allergic, latex-sensitive patients to obtain and carry with them some type of allergy identification such as a medical alert bracelet.
3. If a patient demonstrates symptoms of latex allergy, immediately stop procedure, remove any problematic items from contact with patient, and notify your supervising faculty. They will determine if a medical emergency response is necessary.

**Exposure control for patients**

The amount of exposure necessary to sensitize individuals is not known, but reductions in exposure to latex proteins can result in decreased sensitization and symptoms, according to NIOSH. Care must be taken with all patients to reduce their levels of exposure to latex by:

1. Wear non-latex gloves when setting up the dental operatory and handling instruments.
2. To reduce the possibility of the latex protein becoming airborne, care must be taken by the healthcare worker not to snap powdered gloves off and on.
3. By touching any latex object, or object that has been stored with a latex product, then touching the patient, the healthcare worker can transmit the latex allergen to the patient. Caution should be taken to keep glove powder away from the patient since the powder will act as a carrier for the latex protein; hands should be washed after removing gloves.
4. Non-latex gloves and Non-powdered latex gloves should be utilized whenever possible.
APPENDIX I

HANDLING OF EXTRACTED TEETH

Extracted teeth used for the education of dental health care personnel (DHCP) should be considered infectious and classified as clinical specimens because they contain blood. If extracted teeth are to be saved for educational exercises, the teeth first should be cleaned of any gross debris, then immersed in a solution of 10% buffered Formalin (4% Formaldehyde). Extracted teeth must be placed in a well-constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting the teeth to avoid contamination of the outside of the container. Prior to use in an educational setting, extracted teeth may be heat sterilized. Heat sterilization of extracted teeth containing amalgam restorations could create a potential health hazard due to the risk of mercury exposure, therefore the use of teeth that do not contain amalgam may be preferred because they can be autoclaved. Autoclaving teeth for pre-clinical laboratory exercises does not alter their physical properties sufficiently to compromise the learning experience.

Gloves need to be worn when handling extracted teeth that have not been sterilized. Gloves should be disposed of properly and hands washed after completion of work activities. Additional personal protective (e.g., face shield, surgical masks, protective eyewear, gowns) should be worn if mucous membrane contact with debris or spatter is anticipated when the specimen is handled, cleaned, or manipulated. Environmental surfaces should be cleaned and disinfected with an appropriate environmental surface disinfectant after completion of work activities. Because preclinical educational exercises simulate clinical experiences, students enrolled in dental educational programs should adhere to standard precautions in both preclinical and clinical settings, even if the teeth have undergone heat sterilization.

The handling of extracted teeth used in dental educational settings differs from giving patients their own extracted teeth. The School of Dentistry allows patients to keep such teeth, because these teeth are not considered to be regulated (pathologic) waste or because the removed body part (tooth) becomes the property of the patient and does not enter the waste system.
SHARPS MANAGEMENT AND DISPOSAL PROTOCOL

“Sharps” must be placed in disposable, closable, leak proof, puncture-resistant containers that are labeled or color-coded (red). These containers are located in clinic cubicles, laboratories and dispensing areas. These containers should not be over-filled or have any objects protruding from the opening. Sharps containers are checked weekly by the SOD’s Dental Engineering Services (DES) staff and collected when full. Individual containers are then transported to a central collection location where they are placed in large color coded tubs. The University’s Hazardous Waste Management staff will pick up the tubs when full, approximately every other week.

New containers are available from DES. Call 625-7112

Dental assistants or designated staff will periodically check the sharps containers to assure safe function. Containers should not be over-filled.

Dental assistants, or designated personnel, will close and lock the container when full.
APPENDIX K

HAZARDOUS CHEMICAL WASTE MANAGEMENT AND DISPOSAL PROTOCOL

The School of Dentistry handles & disposes of all hazardous materials as directed by the University of Minnesota’s Department of Environmental Health & Safety, division of Hazardous Waste Management. Policies are enforced by the School of Dentistry’s Health & Safety Officer, clinic supervisors, and lab supervisors. Faculty and staff provide observational oversight assistance.

Furthermore, the Faculty and Dental Assisting staff works with the Health & Safety Officer and will alert her any time hazardous materials are found in the clinics and throughout the school or when expired dental materials disposal is needed. When alerted of material either the Health & Safety Officer or the Dental Engineering staff will remove the material from the location and will store it in the Dental Engineering workspace. Once these materials are brought to the Dental Engineering work area, they are boxed and packaged as required for safe transportation and the appropriate paperwork (including a manifest) is completed prior to arranging for the University’s Hazardous Chemical Waste Management division to pick up the material.

X-ray Fixer Solution

In a similar fashion, x-ray fixer solution is collected in the x-ray rooms in small quantities less than or equal to 3 gallons. Whenever a collection container is near full, the staff will contact SOD Dental Engineering Services to request a pick-up and the SOD Dental Engineering staff picks up the used fixer solution. This solution is then added/pooled in a 35-gallon drum, which is stored in the Dental Engineering area. The University’s Hazardous Waste Management staff checks the status of the drum minimally once a week, and will swap out a full drum for an empty one when appropriate. The agreement with the University’s Hazardous Waste Management division is such that both the contaminated “sharps” and the x-ray fixer are on a routine pick-up schedule and the SOD staff is responsible for the safe collection of the material from the clinics and the transportation of these materials to the appropriate collection sites.

Lead Foils and Film

The collection of lead foil from exposed/developed x-ray film packets and developed or unused film also takes place in the x-ray room in appropriate collection containers. The x-ray staff is responsible for notifying Dental Engineering Services when containers are full to arrange for pickup of the material by the SOD Dental Engineering staff. Once these materials are brought to the Dental Engineering work area, they are boxed and packaged as required for safe transportation and the appropriate paperwork (including a manifest) is completed prior to arranging for the University Hazardous Chemical Waste Management division to pick up the material.

Amalgam

In a similar fashion, amalgam scraps are collected in each cubical and in the laboratories in airtight containers. Whenever a collection container is full, the staff will contact SOD Dental Engineering Services to request a pick-up and the SOD Dental Engineering staff will pick up the scrap amalgam. This material is again brought to the Dental Engineering work area and is prepared for disposal in the same fashion as that used for the lead foil.
Other Materials
Furthermore, the Faculty and Dental Assisting staff works with the Health & Safety Officer and will alert her any time hazardous or “unknown” materials are found in the clinics and throughout the school or when expired dental materials disposal is needed. When alerted of material either the Health & Safety Officer or the Dental Engineering staff will remove the material from the location and will store it in the Dental Engineering work space. Once these materials are brought to the Dental Engineering work area, they are boxed and packaged as required for safe transportation and the appropriate paperwork (including a manifest) is completed prior to arranging for the University’s Hazardous Chemical Waste Management division to pick up the material.
APPENDIX L

TUBERCULOSIS INFECTION CONTROL POLICIES AND GUIDELINES

Tuberculosis (TB) has remained a major public health problem for much of the world's population for centuries. It is responsible for the largest number of deaths caused by a single infectious agent in the world (1 in 4 preventable deaths), with the total mortality estimated at 3,000,000 annually. The reemergence of Mycobacterium tuberculosis (Mtb) infection and TB in the United States as a significant health problem, appears to be due to a combination of factors, primarily that of changing host susceptibility and declining societal conditions for particular population groups and geographic locations. Within the past 15-20 years many hospitals and other health facilities continued to report a number of patient admissions with TB.

A variety of compromising conditions can predispose a person to develop clinical TB following infection with Mtb (Table 1).

<table>
<thead>
<tr>
<th>TABLE 1. FACTORS THAT INCREASE TB RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV infection</td>
</tr>
<tr>
<td>2. Medical conditions that increase risk of TB (i.e. diabetes mellitus, silicosis)</td>
</tr>
<tr>
<td>3. Prolonged corticosteroid therapy</td>
</tr>
<tr>
<td>4. Immunosuppressive therapy</td>
</tr>
<tr>
<td>5. Persons with close contacts with infectious patients</td>
</tr>
<tr>
<td>6. Persons from countries with high TB prevalence</td>
</tr>
<tr>
<td>7. Alcoholics or parenteral drug abusers</td>
</tr>
<tr>
<td>8. Prisoners or long-term nursing home residents</td>
</tr>
<tr>
<td>9. Being 10% or more below ideal body weight</td>
</tr>
<tr>
<td>10. Healthcare workers with occupational exposure</td>
</tr>
</tbody>
</table>

FEATURES OF Mtb INFECTION AND CLINICAL MANIFESTATIONS OF TB

Mtb is an aerobic, acid-fast bacillus which is primarily transmitted the air in small "microdroplet" particles less than 5 microns in size. These microdroplet nuclei are produced by a person with untreated TB during breathing, coughing, sneezing, speaking, or forced exhalation. When susceptible people have prolonged contact with the air contaminated by an infectious individual, the tubercle enter the alveoli. With weeks after the infective exposure, the tubercle bacilli can spread through the lymphatics to regional lymph nodes and hematogenously to more distant tissues and organ sites. Administration of the tuberculin skin test is used to identify people who have been exposed to and are infected with Mtb. A significant positive test reaction to mycobacterial Purified Protein Derivative (PPD) normally can be detected with 2-10 weeks post-infection, however, the individual is not normally considered infectious unless they demonstrate clinically active pulmonary or laryngeal disease. Only 5-10% of immunocompetent persons infected with Mtb develop active TB at some time, and this percentage can be reduced when preventive chemotherapy is given. Unfortunately, persons with a variety of compromising conditions are at greater risk of developing clinically active disease following microbial infection. The risk of clinical TB is greater within the first year following establishment of Mtb infection.
It is extremely important to note that Mtb is not a highly contagious microorganism. The wax and lipid coating on the cell surface appears to be the major factor responsible for the organism's pathogenesis. The ability of tubercle bacilli to multiply with host tissues, while at the same time resisting host phagocytic and cellular immune defenses, constitutes the basic mechanism for mycobacterial infection. In addition, infection with Mtb typically requires extended close contact of a susceptible host with an infectious source person. The closeness of the contact and the degree of infectivity of the source are the most important considerations for Mtb infection.

**INFECTION CONTROL**

The CDC finalized a series of guidelines in 1994 which were intended to minimize TB risks to healthcare workers and their patients. These were updated in 2003 in the most recent CDC Guidelines for infection control in dentistry. Specific recommendations were incorporated into U of M SOD Infection Control Policies that same year. The following text is taken from the 2003 CDC recommendations, and has been adapted for all U of M SOD M clinical settings.

TB transmission is controlled through a hierarchy of measures, including administrative controls, environmental controls, and personal respiratory protection. The main administrative goals of a TB infection-control program are early detection of a person with active TB disease and prompt isolation from susceptible persons to reduce the risk of transmission. Although DHCP are not responsible for diagnosis and treatment of TB, they should be familiar with the signs and symptoms to help with detection.

A community risk assessment should be conducted periodically, and TB infection-control policies for each dental setting should be based on the risk assessment. The policies should include provisions for detection and referral of patients who might have undiagnosed active TB; management of patients with active TB who require urgent dental care; and DHCP education, counseling, and tuberculin skin test (TST) screening.

DHCP who have contact with patients should have a baseline TST, preferably by using a two-step test at the beginning of employment. The facility's level of TB risk will determine the need for routine follow-up TST.

While taking patients’ initial medical histories and at periodic updates, dental DHCP should routinely ask all patients whether they have a history of TB disease or symptoms indicative of TB.

Patients with a medical history or symptoms indicative of undiagnosed active TB should be referred promptly for medical evaluation to determine possible infectiousness. Such patients should not remain in the dental-care facility any longer than required to evaluate their dental condition and arrange a referral. While in the dental health-care facility, the patient should be isolated from other patients and DHCP, wear a surgical mask when not being evaluated, or be instructed to cover their mouth and nose when coughing or sneezing.

Elective dental treatment should be deferred until a physician confirms that a patient does not have infectious TB, or if the patient is diagnosed with active TB disease, until their physician confirms that the patient is no longer infectious (i.e., negative check x-ray or three (3) negative sputum AFB cultures).
If urgent dental care is provided for a patient who has, or is suspected of having active TB disease, the care should be provided in a facility (e.g., hospital) that provides airborne infection isolation (i.e., using such engineering controls as TB isolation rooms, negatively pressured relative to the corridors, with air either exhausted to the outside or HEPA-filtered if recirculation is necessary). Standard surgical face masks do not protect against TB transmission; DHCP should use respiratory protection (e.g., fit-tested, disposable N-95 respirators).

Settings that do not require use of respiratory protection because they do not treat active TB patients and do not perform cough-inducing procedures on potential active TB patients do not need to develop a written respiratory protection program.

Any DHCP with a persistent cough (i.e., lasting > 3 weeks), especially in the presence of other signs or symptoms compatible with active TB (e.g., weight loss, night sweats, fatigue, bloody sputum, anorexia, or fever), should be evaluated promptly. The DHCP should not return to the workplace until a diagnosis of TB has been excluded or the DHCP is on therapy and a physician has determined that the DHCP is noninfectious (CDC. MMWR 52(RR-17):1-66, 2003).
APPENDIX M

DENTAL UNIT WATERLINE MAINTENANCE
The U of M School of Dentistry currently uses long-acting DentaPure® Iodine tubes inserted in units to reduce microbial growth in dental waterlines. Follow manufacture instructions.

Water lines must be maintained following these guidelines before patient treatment and after:
a. Check water reservoir and fill with tap water.
b. Turn on master switch, wait a few seconds for system to pressurize.
c. Flush water lines for at least 1 minute.
d. After patient treatment, empty water bottle and replace on unit.

AT THE END OF THE DAY: Empty all water bottles.
APPENDIX N

EXPOSURE CONTROL PLAN

For the University of Minnesota School of Dentistry

This Exposure Control Plan is located: in the Health & Safety Office and on the School of Dentistry’s website.

Employer Responsibilities: The University of Minnesota School of Dentistry will:
1. Accept responsibility for leadership of the exposure control program and infection control in the School of Dentistry.
2. Determine which employees have occupational exposure.
3. Ensure that the provisions of this exposure control plan are followed by all employees who have occupational exposure.
4. Ensure that new employees are trained within 10 working days.
5. As appropriate provide free of charge:
   - Gloves
   - Masks
   - Eye protection
   - Face shields
   - Gowns or lab coats
   - Ventilation devices
   - Any equipment designed to remove or isolate the hazard of bloodborne pathogens from the employee
   - Hepatitis B vaccination
   - Medical evaluation and follow-up treatment following an exposure incident
   - Training

Employee Rights: Employees are entitled to a clean and sanitary workplace and have the right to be provided with appropriate protective equipment and measures to eliminate or minimize occupational exposure to bloodborne pathogens.

Employee Responsibilities: The employees of the School of Dentistry will:
1. Comply with the provisions of this exposure control plan.
2. Utilize personal protective equipment designed to protect them from occupational exposure to bloodborne pathogens as described in this plan.
3. Follow established work practice controls.
4. Report all occupational exposures.
Important Definitions To Know

**Contaminated** - the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

**Contaminated Laundry** - laundry which has been soiled with blood or other potentially infectious materials or which may contain sharps.

**Contaminated Sharps** - any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wire.

**Decontamination** - the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

**Disinfect** - to inactivate virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms, on inanimate objects.

**Engineering Controls** - controls that isolate or remove the bloodborne pathogens hazard from the workplace.

**HBV** - hepatitis B virus.

**HIV** - human immunodeficiency virus.

**Licensed Healthcare Professional** - a person whose legally permitted scope of practice allows him or her to independently perform the activities of hepatitis B vaccination and post-exposure evaluation and follow-up.

**Occupational Exposure** - reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

**Other Potentially Infectious Materials (OPIM)** - semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; and any unfixed tissue or organ (other than intact skin) from a human (living or dead).

**Personal Protective Equipment** - specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes not intended to function as protection against a hazard are not considered to be personal protective equipment.

**Regulated Waste** - liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.
Standard Operating Procedures - Written policy, procedure, directive, standard of practice, protocol, system of practice, or element of infection control program which addresses the performance of work activities so as to reduce the risk of exposure to blood and other potentially infectious materials.

Source Individual - any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee.

Sterilize - the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal / Standard Precautions - all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls - controls that reduce the likelihood of exposure by altering the manner in which a task is performed.

Work Area - the area where work involving exposure or potential exposure to blood or saliva exists, along with the potential for contamination of surfaces, equipment and instruments.

Occupational Exposure in Dentistry
Occupational exposure means contact with blood or OPIM.

Universal/Standard precautions, careful patient assessment, the use of adequate personal protective equipment, sterilization and/or chemical disinfection of instruments, environmental surface and equipment disinfection, and aseptic technique will be conscientiously utilized to prevent or minimize the occupational exposure of employees to blood and other potentially infectious materials.

Communicating Hazards to Employees
1. A BIOHAZARD warning label must be placed on containers and bags containing regulated waste and any other containers used to store, transport, or ship blood or other potentially infectious materials.
2. These BIOHAZARD labels must be fluorescent orange or orange-red with lettering or symbols in a contrasting color.
3. Red bags or red containers may be substituted for BIOHAZARD labels.

Exposure Determination
1. All the employees in clinical staff have occupational exposure including:
   • Dentists, Dental Therapist, Dental Hygiene
   • Instructors
   • Clinical Researchers
   • Clinical Staff

Category A consists of occupations that require procedures or other occupation-related tasks that involve exposure or reasonably anticipated exposure to blood or other potentially infectious material or that involve a likelihood for spills or splashes of blood or other potentially infectious material. This includes procedures or tasks conducted in non-routine situations as a condition of employment.
Category B consists of occupations that do not require tasks that involve exposure to blood or other potentially infectious material on a routine or non-routine basis as a condition of employment. Employees in occupations in this category do not perform or assist in emergency medical care or first aid and are not reasonably anticipated to be exposed in any other way.

- An exposure determination shall be made without regard to the use of personal protective clothing and equipment.
- An employer shall determine and document a rationale for an exposure determination.
- An employer shall maintain a list of all job classifications which are determined to be Category A.

Some employees in the following job classifications have occupational exposure.

All Category A employees

**Employee Training**

Employees will receive initial training within 10 working days of their first day of work at no cost to the employee and during working hours. Retraining will take place when changes in procedures or tasks occur will affect occupational exposure. Annual update training will take place one year from the initial training date or sooner. Training will include the following areas:

- An explanation of the Bloodborne Pathogens Standard, its contents and how it relates to the employee's position within this dental office.
- A general explanation of the epidemiology and symptoms of bloodborne diseases like HBV, HCV, and HIV.
- An explanation of the modes of transmission of bloodborne pathogens such as HBV, HCV, and HIV.
- A general explanation that a number of other occupational diseases other than HBV and HIV exist, such as hepatitis C, herpes simplex virus infections, and staphylococcal infections.
- An explanation of this exposure control plan, where it is located and how the employee can obtain a copy of it.
- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood, saliva or unfixed tissue.
- An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.
- Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment.
- An explanation of the basis for selection of personal protective equipment based upon the task being performed and the degree of exposure anticipated.
- Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials outside the normal scope of work. An explanation of the procedures to follow if an exposure incident occurs, including the method of reporting the incident, and the medical follow-up that will be made available.
- Information on the post-exposure evaluation and follow-up that the employer is required to provide for
the employee following an exposure incident.

- An explanation of the signs and biohazard labels and/or color coding used in the office

The person(s) conducting training sessions will be knowledgeable in the Bloodborne Pathogens Standard, the subject matter covered by the training program and how it relates to the dental office environment. There will be an opportunity for interactive questions and answers with the person conducting the training session.

**Preventing Occupational Exposure**

The primary means of eliminating or minimizing employee exposure is through the use of engineering controls and work practice controls.

1. **Engineering controls** act on the source of the hazard and eliminate or reduce employee exposure without reliance on the employee to take self-protective action. This is achieved through the use of equipment designed for this purpose. This department/clinic utilizes the following engineering controls:
   - Needle recapping devices and techniques
   - Disposable sharps container
   - Tongs/forceps
   - Emergency eye wash
   - Utility gloves

For each engineering control checked above, detail its use on the Engineering Controls chart on the next page. This chart describes when and how these items are used (under what circumstances or in which particular tasks or procedures).

The engineering controls will be inspected and maintained according to the following schedule:

- The needle recapping device, utility gloves and tongs/forceps will be visually inspected before they are used.
- The disposable sharps container(s) will be visually inspected daily and not allowed to overfill.
- The emergency eyewash station will be tested weekly to ensure proper functioning.

The Health & Safety Officer will evaluate the effectiveness of existing engineering controls and review the feasibility of instituting more advanced engineering controls.
2. **Work practice controls** also work on the source of the hazard. They reduce the likelihood of exposure to blood or other potentially infectious materials through changes in the way in which a task is performed. The protection they provide is based upon the behavior of the employee. The following work practice controls are employed by the School of Dentistry:

- Contaminated equipment will be labeled prior to servicing or shipping.
- Hands will be washed after removal of gloves and other personal protective equipment.
- Hands will be washed after contact with blood or saliva.
- Antiseptic handwash will be used every time hands are washed.
- All personal protective equipment will be removed when leaving the work area to go to a "clean area" or a non-patient treatment area.
- Glasses will be decontaminated prior to leaving the work area or prior to leaving the lab.
- Broken glass will be picked up by using a brush and dust pan, and discarded into a sharps container. Broken glass will not be picked up by hand and/or vacuum.
- No two-handed needle recapping is allowed, but the one-handed scoop technique or use of a needle recapping device is acceptable.
- Needles will not be broken or sheared.
- Eating, drinking or smoking is prohibited in the work area.
- Application of cosmetics or lip balm is prohibited in the work area.
- The handling of contact lenses is prohibited in the work area.
• The storage of food or drink is prohibited in the work area.
• Biopsy specimens will be placed in a container that is labeled with a biohazard label. Care will be taken not to contaminate the outside of the container by handling it with a contaminated gloved hand.
• All reusable equipment will be sterilized.
• If it is not feasible to sterilize some reusable equipment, it will be decontaminated.
• When reusable equipment is heavily soiled, it will be precleaned to remove the heavy contamination prior to decontamination or sterilization.
• All tasks and procedures, will be performed in such a manner as to minimize splashing, spraying, spattering or generation of droplets of blood or saliva.
• Personal protective equipment will be utilized during every situation or procedure where exposure to blood or saliva is reasonably anticipated intra oral exam.
• While working in the lab, students and employees will refrain from touching anything not needed for the procedure.
• Employees should keep gloved hands away from eyes, nose, mouth or hair.
• Hair should be kept away from the face.
• Nails must be clean and short.
• Paper work should never be touch by a contaminated gloved hand.
• University of Minnesota School of Dentistry policies and procedures outlined within this manual will be followed.
• Single and disposable use items, such as needles, are not to be reused.

**Personal Protective Equipment**

Where occupational exposure remains after institution of engineering controls and work practice controls, personal protective equipment will be provided as supplemental equipment.

The following personal protective equipment is supplied by the University of Minnesota School of Dentistry and intended for employee protection against occupational exposure. The personal protective equipment will be of the proper size, material and will be readily accessible by all employees.

Gloves  Face shields  Masks  Protective clinic gowns

Glasses with side shields

Pocket masks for CPR  Goggles

Emergency ventilation devices

• The type and amount of personal protective equipment chosen to protect against contact with blood or saliva is based upon the type of exposure and quantity of these substances which can be reasonably anticipated to be encountered during the performance of a dental procedure.

• The University of Minnesota School of Dentistry is responsible for providing, laundering, repairing, replacing and disposing of personal protective equipment.

• Personal protective equipment that is penetrated by blood will be removed immediately or as soon as feasible.
• All personal protective equipment will be removed prior to leaving the work area.

• A new pair of gloves is to be used with each procedure. Gloves are not to be washed or decontaminated for re-use.

• All personal protective equipment shared by employees must be decontaminated between employee uses.

• Personal protective equipment will be considered "appropriate" only if it does not permit blood or saliva to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time the protective equipment will be used.

• For all personal protective equipment checked above, refer to the chart on the next page which describes where personal protective equipment is located, when it is to be worn, when it is to be changed, how it is to be decontaminated or disposed of and where it is to be stored after removal.

• To minimize the need for emergency mouth-to-mouth resuscitation, pocket masks, resuscitation bags or other ventilation devices will be provided in strategic locations where the need for resuscitation is likely.

PERSONAL PROTECTIVE EQUIPMENT
Schedule

<table>
<thead>
<tr>
<th>PERSONAL PROTECTIVE EQUIPMENT</th>
<th>LOCATION</th>
<th>TO BE WORN WHEN...</th>
<th>TO BE CHANGED WHEN...</th>
<th>DECONTAMINATE OR DISPOSE OF IN THIS MANNER</th>
<th>AFTER REMOVAL IT IS TO BE STORED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloves</td>
<td>Lab / Clinic</td>
<td>Contacting blood, saliva or contaminated items</td>
<td>After each laboratory procedure</td>
<td>Dispose of in unregulated trash can</td>
<td>---------</td>
</tr>
<tr>
<td>Masks</td>
<td>Lab / Clinic</td>
<td>Anticipating splashing and splattering</td>
<td>Moist or visibly contaminated</td>
<td>Dispose of in unregulated trash can</td>
<td>---------</td>
</tr>
<tr>
<td>Glasses with side shields or goggles</td>
<td>Lab / Clinic</td>
<td>Anticipating splashing and splattering</td>
<td>Moist or visibly contaminated</td>
<td>Decontaminated with surface disinfectant</td>
<td>Dispensary with staff member</td>
</tr>
<tr>
<td>Gown – disposable</td>
<td>Lab / Clinic</td>
<td>Anticipating splashing and splattering</td>
<td>Visibly contaminated</td>
<td>Dispose of in unregulated trash can</td>
<td>---------</td>
</tr>
<tr>
<td>Gown – cloth</td>
<td>Lab / Clinic</td>
<td>Anticipating splashing and splattering</td>
<td>Visibly contaminated</td>
<td>Dispose of in “dirty” dispensary laundry hamper</td>
<td>On critical hook or disposed at “dirty” dispensary</td>
</tr>
<tr>
<td>Pocket mask for CPR</td>
<td>Lab / Clinic</td>
<td>Administering CPR</td>
<td>After each use</td>
<td>Dispose of in unregulated trash can</td>
<td>---------</td>
</tr>
</tbody>
</table>
Housekeeping

1. Cleaning and Disinfection

a. The University of Minnesota’s Facilities Management department will ensure that the School of Dentistry is maintained in a clean and sanitary condition.

b. An appropriate schedule for cleaning and disinfecting the various surfaces, equipment and rooms in this department/clinic has been determined. Refer to the Cleaning and Disinfection schedule on the next page.

c. The following sterilants and disinfectants are used in this department/clinic according to manufacturer’s directions. All disinfectants meet the following criteria: they will be EPA registered tuberculocidal hospital disinfectants.

d. Contaminated reusable instruments are ultrasonically cleaned, rinsed, and sterilized in the autoclave or processed in the washer-disinfector.

e. Contaminated instruments, which could penetrate the skin, are considered reusable sharps in the department/lab. When such instruments are stored or processed in containers, employees will not reach into the container by hand to remove these instruments. They instead, will be removed from the container with tongs or forceps.

CLEANING AND DISINFECTION

Schedule

<table>
<thead>
<tr>
<th>WORKSITE LOCATION</th>
<th>PROCEDURES PERFORMED</th>
<th>TYPES OF CONTAMINATION</th>
<th>SURFACE(S) OR ITEM(S) TO BE CLEANED</th>
<th>DISINFECTANT USED</th>
<th>DISINFECTION PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL laboratory/clinic areas</td>
<td>Research procedures</td>
<td>Blood and saliva</td>
<td>Environmental surfaces</td>
<td>Cavicide</td>
<td>wipe-discard-wipe</td>
</tr>
<tr>
<td></td>
<td>Research procedures</td>
<td>Blood and saliva</td>
<td>Non-autoclavable equipment</td>
<td>Cavicide</td>
<td>wipe-discard-wipe</td>
</tr>
<tr>
<td></td>
<td>Research procedures</td>
<td>Blood and saliva</td>
<td>Reusable instruments</td>
<td>--------</td>
<td>Washer disinfect or ultrasonic then autoclave</td>
</tr>
<tr>
<td></td>
<td>Intra oral procedures</td>
<td>Blood and saliva</td>
<td>Environmental surfaces</td>
<td>Cavicide</td>
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<td>Reusable instruments</td>
<td>--------</td>
<td>Washer disinfect or ultrasonic then autoclave</td>
</tr>
</tbody>
</table>

Regulated Waste

a. Regulated waste will be properly contained and disposed of so it will not become a means of transmission of disease to employees.

b. Contaminated disposable sharps will be discarded into a sharps container immediately or as soon as feasible after use. In the SOD sharps containers will be:
c. Other non-sharps regulated waste will be discarded into appropriate containers. In this dental school containers will be:

- closable (closed prior to removal or replacement)
- puncture resistant
- leak-proof on sides and bottom
- labeled with a biohazard label or be red in color
- maintained upright during use
- replaced routinely, and disposed of according to the U of M waste management policy
- located in each laboratory, patient care area, dispensary and clinical support labs

d. Whenever the outside of a primary container holding regulated waste becomes contaminated, it should be placed into a secondary container that meets the requirements of the first container.

3. Laundry

Clinic gowns used in the School of Dentistry must be turned in at the reprocessing “dirty” dispensary. Gowns are placed in appropriate bins (containers), and are picked up by the laundry service.

Disposable gowns are to be discarded with regular waste.

Hepatitis B Vaccination

Hepatitis B vaccination is available to all employees in the School of Dentistry who have occupational exposure. The vaccination series will begin after the required training is given and within 10 working days of an employee's first day at work. The vaccination is available at no cost to the employee and is administered at Boynton Health Service.

The hepatitis B vaccination will not be given if the employee:

- has previously received the vaccination series
- is found to be immune through antibody testing
- should not receive the vaccine due to medical contraindications
- declines vaccination

Employees who refuse to be vaccinated must sign the Hepatitis B Vaccine Declination form.
If an employee initially declines Hepatitis B vaccination, but at a later date decides to accept vaccination it will be made available at no cost.

While current U.S. Public Health Service guidelines do not recommend Hepatitis B vaccine booster doses, if they should in the future, the University of Minnesota School of Dentistry will provide these at no cost.

**Recordkeeping**
The University of Minnesota School of Dentistry Health and Safety Office will maintain the following records.

1. **Medical Records:**
   - Employee's name and Employee ID number.
   - Copy of employee's Hepatitis B vaccination status, dates of all Hepatitis B vaccinations.
   - Signed Declinations. Employee medical records must be kept for the duration of employment plus 30 years.

3. **Training Records:**
   - Dates of the training sessions.
   - Contents or a summary of the training sessions.
   - Names and qualifications of persons conducting the training
   - Names and job titles of all persons attending the training sessions

Training records must be kept for 3 years from the date on which the training occurred.

The Office of the Associate Dean keeps the following records:

- Copy of Exposure Incident Records, Hepatitis B Vaccine Declination, Post-Exposure Medical Evaluation
- Copy of licensed healthcare professional's written opinion concerning Hepatitis B vaccination.
- Copy of all results of examinations, medical testing and follow-up procedures.
- Copy of licensed healthcare professional's written opinion concerning post-exposure evaluation.
- Copy of information provided to the licensed healthcare professional.
- Copy of student CPR documents
APPENDIX O

MANDATORY COMPLIANCE

The provisions contained in this infection control manual shall be adhered to by all faculty, staff and students.

Name (please print clearly)

Student Number

Signature

Date

Please sign and return this form to the Associate Dean office.
Medical Policies

Standards for Medical Evaluation

All individuals treated in the U of MN Dental Clinics must be registered as patients and must complete and sign a Dental and Medical Information Questionnaire (Bus. Adm. Form 587 Rev 4/92). This activity will occur at the initial admission appointment for each patient and must be completed prior to any other clinical activity. The questionnaire must be reviewed in an oral interview with the patient. Measurement and recording of vital signs and proper review of systems (ROS) follows the oral interview.

Review medical status each patient visit. Update the Health Status Summary (SD86) and the medical history form accordingly and have the patient sign and date the revision every semester or after any lapse in treatment of three months or more or upon discovery of changes in medical status or new medical problems. Any significant medical problems should be reviewed with Oral Medicine-Diagnosis (OMD) faculty and the Group Directors? with the appropriate dental management outline listed in the record. Review of physical status along with vital signs should be updated accordingly.

U of M Dental Clinics policy on head and neck soft tissue examination

A limited evaluation of the head and neck soft tissues (extra-and intra-orally) will occur at the initial appointment for each patient, following the physical evaluation and prior to any other activity (including radiographs, by state law). Any significant soft tissue problems should be reviewed with faculty.

Policy on removed hard and soft tissues

Consistent with proper care for all our patients and regulations concerning the use of human subjects in research, the Tissue Policy of the School of Dentistry requires all human tissue, hard and soft, removed from patients to be examined grossly and/or microscopically. The primary care practitioner (student, graduate student or faculty) must examine all tissue for unusual deviation(s) from normal. When any reasonable doubt exists, (be it clinical, or radiographic or macroscopic) that the tissue is abnormal, the clinician should submit the tissue to the Division of Oral Pathology for pathologic examination.
Adherence to the above policies is essential to assist in the diagnosis of unsuspected systemic disease processes, to confirm the clinical diagnosis with a written pathologic report, and to promote quality assurance of optimal health for our patients and educational role modeling for our students.

**Hepatitis B Vaccination Policy**

All students, staff, and faculty members with direct patient care contact are required to present evidence of having received vaccination against Hepatitis B or evidence of antibodies as a result of previous infection. The first two doses of the three-dose series must be acquired before participation in patient care activities will be permitted. Students can receive Immunizations at Boynton Health Service.

**TMJ, Orofacial Pain and Oral Medicine Clinic**

The Division of TMJ and Orofacial Pain provides clinical and consultative services for referred temporomandibular disorders (TMD), orofacial pain and oral medicine conditions. Common TMD and orofacial pain symptoms include TMJ noise, jaw pain, limited mouth opening, headaches, tooth pain and ear pain. Common oral medicine symptoms are mouth sores and lesions, pain in the oral mucosa and dry mouth.

**Patient Scheduling**

The TMJ, Orofacial Pain and Oral Medicine consultation schedule is Monday-Friday, from 9.00 am to 12.00 pm and from 1.00 pm to 4.00 pm.

Consults are available through the TMJ, Orofacial Pain and Oral Medicine Clinic located on the sixth floor during regular clinic hours. If your patient requires a consultation, bring them to the clinic or call the clinic’s scheduling desk (6-0140). The faculty encourages you to make use of the consultation services.

**Clinic Treatment**

If your patient requires an evaluation, the patient will be scheduled for a full evaluation in the TMJ, Orofacial Pain and Oral Medicine Clinic after the consultation. A full evaluation can be scheduled without a consultation. Treatment plans occasionally require prior authorization and this will be discussed at the evaluation appointment.

Treatment is provided by the faculty and residents of the TMJ, Orofacial Pain and Oral Medicine Clinic. The **dental student is not responsible for this care**. Any required coordination of dental care with TMD or Oral Medicine treatment will be discussed with the dental student.

**Clinical Requirements**

At the present time there are no TMD or Oral Medicine requirements for the undergraduate dental student. Senior students may sign up for the TMJ continuing education course (“TMJ Miniresidency”) as an elective. This three day CE course is available one time per year. Information about this course is available in the dental CE department. Enrollment is limited. The faculty also encourages the students to rotate through the TMJ, Orofacial Pain and Oral Medicine Clinic. To arrange rotation times, please contact Dr. Eric Schiffman at 4-3130.
Oral Pathology

The Division of Oral Pathology provides consultation services.

Obtain an Oral Pathology Consult
If you wish to obtain a consultation ask the clinic receptionist to call the divisional secretary of 4-5478. If a pathologist is available, the secretary will have an oral pathologist meet you and your patient in the clinic. If one is not available, you should schedule an appointment for a consultation.

If you wish to consult with a particular faculty member, arrange the appointment with the faculty member or his/her secretary, preferably in advance.

Students must be present at all consultations. Consultations are part of your patient's treatment and are an educational experience for you.

Arrange necessary patient reexamination appointments. It is preferable to arrange additional appointments with the same faculty member. If you will graduate before the recall appointment, record a recall request with the name of the consulting faculty member on the patient's chart with a copy to faculty.

Fees for Oral Pathology services
Consultation fees in Oral Pathology may be assessed, as will other professional, laboratory-related services.

Fees and methods of payment should be discussed with patient only following familiarization with reimbursement processes. Oral Pathology services are broadly covered by both medical and dental insurance carriers. Special contracts for pathology services may impact patient's access to reimbursement.
Facilities and Equipment

This section of your manual contains helpful information about how to utilize the equipment and instruments available in the University of Minnesota dental clinics and laboratories. Included in this section are discussions of the instrument usage and special supplies fees, instruments and sterilization, equipment in the clinical labs, and the use of clinic kits.

As a practicing student dentist you are responsible for the cleanliness of the areas in which you work. This includes the clinical labs, operatories, and all dental equipment you use.

The School of Dentistry provides you, the student dentist, with instruments for a three-fold purpose: one, to ensure that you have all the instruments necessary to complete your patient’s required dental care; two, to ensure that all instruments used in the UM dental clinics are completely sterile; and three, to keep the cost to you at a minimum.

This system of supplying, sterilizing, and maintaining virtually all instruments and materials for students is one of the few, and is the largest system of its kind, in the U.S.

The School has an excellent sterilization facility. The facility has two thermal washer-disinfectors and three large steam autoclaves, each with a capacity for 108 large or 324 small instrument kits. Each day over 16,000 basic instruments plus numerous other instruments and materials are sterilized through the facility.

Equipment and Instruments

Amalgam Composite, Restorative  The handpieces are in a separate container and will be checked out on a session basis. All instruments are checked out under the AxiUm system.

You have also been assigned your own Perio Kit. This kit only contains the hand instruments. The Perio handpiece and kit are available at the 7thNorth dispensary. This is the same kit you were assigned in the pre-clinic area.
Please refer to the following lists for contents of the "Basic Restorative Kit" and "Basic Perio Kit". You will have to refer to this list to insure that your kits are complete and to organize the kits for return upon leaving the School. You will also find a listing of additional check-out kits and materials available for check-out at the dispensaries. These listing are included in this section.

<table>
<thead>
<tr>
<th>RESTORATIVE CASSETTE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Each</td>
<td>1 Each</td>
</tr>
<tr>
<td>Articulating paper forcep</td>
<td>Plier, Cotton Meriam, serrated tips</td>
</tr>
<tr>
<td>Base placement instrument</td>
<td>Probe, SE, PCP 10</td>
</tr>
<tr>
<td>Bursisher, SE, Beaver Tail #2</td>
<td>Scissors, Iris, curved, 4”</td>
</tr>
<tr>
<td>Carver, Woodson #2</td>
<td>Scissors, Littauer, Straight, 4½”</td>
</tr>
<tr>
<td>Cord Packer, DE NU7</td>
<td>Spatula, Cement #24</td>
</tr>
<tr>
<td>Excavator, Spoon, DE 17</td>
<td>Syringe, Anesthetic, aspirating 1.8mm</td>
</tr>
<tr>
<td>Excavator, Spoon, DE 19</td>
<td>Tip, Aspirating #D</td>
</tr>
<tr>
<td>Explorer, DE #5</td>
<td></td>
</tr>
<tr>
<td>Explorer, DE #2H</td>
<td>2 Each</td>
</tr>
<tr>
<td>Grasping Forceps</td>
<td>Minor Handle</td>
</tr>
<tr>
<td>Hemostat, Kelly, Straight</td>
<td>Frout surface, cone socket #4</td>
</tr>
<tr>
<td>Occlusal Reduction Gauge</td>
<td>Tip, 3-way, syringe, ADEC</td>
</tr>
</tbody>
</table>
**Handpiece Kit**
- Tradition Fiber Optic Push Button
- Midwest Shorty Single Speed Motor
- Straight Attachment
- Contra Angle Sheath
- Push Button Contra Angle Head
- Push Button RA/Latch Head

**Prophy Contra Angle Head** OR Star Titan Motor
- Straight Nose Cone Attachment
- Motor to Angle Adaptor
- Push Button Friction Grip Contra Angle
- Push Button RA/Latch Head
- Five Star Prophy Angle

**Senior Kit** — instrument tray holder

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**RESTORATIVE BASIC KIT**

**ROTARY INSTRUMENTS (3/2003)**

1 **Bur caddy, PREPARATION (Blue)**

- 1 Each, Bur, carbide, FG ½—2—4—8 round
- 331/2—35 inverted cone
- 245 straight fissure
- 170L cast preparation
- 330 amalgam preparation
- 669L line angle retention
- 1931-1957 gold removal

1 **Bur caddy, FINISHING (Purple)**

- 1 Each Bur, carbide, FG, T&F, 7004-7006 round
- 7404 egg
- 7801 bullet

---

- 7902 needle

**1 Each Stone**
- white FG FL2
- green, FG, FL2—RD2—IC2—TC1
- green, SHP, FL2-WH4

**1 Each Point**
- Mini
- FG
- Brownie
- Greenie
### AMALGAM/COMPOSITE ADDITION

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Each Carver, IPC</td>
<td></td>
<td>Carver, IPC 1, Carver, IPC 2, Carver, PKT 3, Composite Placement Instrument, Goldstein #4, Composite Instrument, Greenstein Color, Composite Placement DE 5 – Premier Anodized Condenser, Super Plunger, Small/Medium Handle, Surgical #3, Knife, DE contangle 2-3 #TK 23, Matrix retainer, toffelmire, Plier, Matrix removing, Plunger, Amalgam, non-serrated DE, U of M #2, Rubber Dam Frame, Rubber Dam Forcep, Stone, sharpening Medium #STM</td>
</tr>
</tbody>
</table>

### CAVITY PREPARATION KIT

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Each Chisel, DE 5/6</td>
<td></td>
<td>Hatchet, DE 15/16, Hatchet, DE 17/18, Hatchet, DE 8-8, Hatchet, DE 9-9, Hatchet, DE, off-angle 14-0, Hatchet, DE off-angle 15-0</td>
</tr>
</tbody>
</table>
Using Your Clinical Kits

**Before Clinic**
Each student’s assigned kit is reserved and is readily available from the clean dispensary whenever a patient appointment is made through centralized appointing. Students may pick up their kits at dispensing 15 minutes before clinic time begins.

Students can check out additional items and supplementary kits at the dispensing station.

Replacement instruments, etc., are always available at the dispensary. Students must return the item to be replaced and will be given a new one. Students will be asked to fill out a replacement slip available at the dispensary. Replacements for Perio instruments must be approved by a Perio faculty member prior to getting a new instrument. Replacement slips for replacing perio instruments are in the Perio cubicles.

**Surgical Clinics**

**PERIODONTAL SURGERY**
A surgery and/or postoperative tray is distributed to each reserved operatory before clinic time begins. It is the student’s responsibility to return the instruments to the second dispensing window for cleaning.

**ORAL SURGERY**
Students must request the instruments they will need, and the dental assistants (D.A.s) will pick up all instruments and will return them to the dispensary for cleaning and processing.

**Rotations**

**UCC**
Students scheduled in the UCC clinic will triage their patient with an Exam kit. After determining the type of treatment needed, the student will then get the appropriate instrument kit, along with handpieces, from the 7North dispensary. Once the treatment is complete, the students must return the kits he/she checked out to the dirty/reprocessing cart.
**PEDiATRIC DENTISTRY**

Students scheduled into their Pediatric Dentistry rotation will pick up their Restorative Kit and Handpieces from the Pediatric clean dispensary. When the student has completed treatment, he/she must return his/her kits to the covered cart for dirty instruments located in Aisle 1 of the Pedo clinic.

**After Excusing the Patient**

Students have total control of the contents and cleanliness of kits assigned in your name. *It is the individual's responsibility to remove gross debris and replace all used instruments in the kit before returning the kit to the dispensary.* The cassette and hand instruments are color coded to assist you in placing them in the correct cassette. The clinic hours include a 15-minute period for the clean-up of instruments and the operatory.

Please follow this procedure to prepare the kit for return to the dispensary after dismissing your patient.

1. Place all used burs and clamps in the red metal dish inside of the handpiece kit *(the dispensing staff will clean ONLY these items and will place burs back in the bur caddies.)*
2. Using a one-hand method, wipe all debris from the instruments that were used during the appointment
3. Neatly replace all items back inside of the kit. Remember handpieces, air/water and high volume suction tip.
4. Follow infection control protocol to disinfect the cubicle.
5. Return all the items that were checked out to the dirty/reprocessing dispensary/carts. Wait at the dispensary window until our staff has had time to inspect the returned items.
6. Once a student has treated his/her last patient of the day, the student’s used gown is to be deposited in the hamper located outside of the dirty dispensary. STUDENTS MUST NOT LEAVE THE CLINICAL AREA WITH A GOWN ON.

Cleanliness of instruments is essential in infection control and will be monitored by the clinical faculty. Using dirty instruments is unacceptable and will result disciplinary action.

You will be using non-assigned, "generic" kits for Restorative, Amalgam/Composite Add on, Cavity Preparation Add on, Basic Exam, Removable Pros, Endo, and Treatment Planning. The dispensing staff will have to check in these kits after you have used them in clinic. You will be checked in on a first come first served basis. Please remain at the window until everything is checked in. It is your responsibility to clean gross debris, cements, etc., from your kit and instruments. The kit is issued to you in a sterile, clean, and dry condition; you must clean the kit BEFORE you turn it in to the dispensing station.

There are a limited number of alginate trays, perforated trays, springbows and surveyors. These must be returned as soon as you are finished with them.

**Equipment Repair and Maintenance**

Maintenance personnel are available 7:45 a.m. to 4:30 p.m. Students should following the steps below should he/she experience equipment difficulties:
• If you are having a mechanical problem, turn on the white light in your cubicle in order to alert the clinic supervisor or a dental assistant. Do not move to another cubicle until you have contacted the clinic supervisor/group dental assistant.

• If your mechanical problem warrants a service call, the supervisor/Dental Assistants will call maintenance.

• If a lengthy repair is necessary, or if a service person is not currently available, the supervisor/Dental Assistants will make arrangements to move you to another cubicle.

• Minor defects you notice during clinic time should be reported to the clinic supervisor/Dental Assistants before you leave the clinic.

Instrument Usage and Special Supplies Fees
Instrument usage and special supplies fees help cover the costs associated with the School's program for providing all instruments and supplies for clinical work. These fees are assessed in addition to the UM tuition fee and are included on your tuition fee statement.

The Materials Management Office (Room 8-216) maintains a record of lost and/or broken instruments. This record will be reviewed at the time of a student’s final checkout to ensure he/she has turned in all assigned clinic instruments. If a student's record shows unusual or excessive loss and/or breakage of instruments, an additional assessment will be made.

Gold for Cast Restorations
Only gold issued by the gold room may be used to make castings for patients. No other gold may be used.

Gold is issued after signed approval of wax patterns by an instructor. Operative wax pattern checks are optional after completion of the inlay practical.

One-third, or more, of the fee must be paid prior to issuing gold for patients. Verification of account status may be required from Patient Accounting (7th floor). Instruct patients to bring at least one-third of the fee to the tooth preparation/impression appointment.

The gold dispensary is located in Room 9-525. Gold dispensary hours are posted on the door.

Weigh-in for castings occurs after cutting the sprue and before polishing the final restoration. Take both the completed casting and sprue/button to Room 9-525 for weigh in. A loss equal to 15 percent of the weight of the casting will be allowed (ex. if a crown weighs one and one-half dwt (36 grains), the allowance is 7.2 grains). Excess losses will be carried forward and charged at current gold costs sometime prior to clearance for graduation.
Face Masks, Safety Glasses, Gloves, and Overgarments

Due to our concern for personal health and safety while carrying out our professional responsibilities, the "Universal precautions" are utilized in all clinics. Adherence is mandatory for faculty, students, and staff members.

Gloves, masks, and overgarments are available in the clinics. The garments must be changed daily except when visibly soiled, in which case they should be changed immediately. Garments do not need to be changed after each patient or at the end of each clinic period. Students are responsible for providing your own safety glasses. Safety glasses must include solid side shields. Staff and faculty safety glasses are provided by the School and are available at the clean dispensary.

Blue clinic gowns are available from the clean dispensaries. Gowns used in clinic MUST BE returned at the end of the day. Blue gowns should not be worn outside of designated patient treatment areas, in labs or taken to the locker room. Yellow, disposable gowns are to be worn in the labs. They are available in the lab and must be disposed of in the lab area.

Clinical Materials

Most of the materials students need are located at the clean dispensary. Materials are also available in the assisting mobile cart. Dental Assistants will assist with materials (amalgam, fugi, etc.) in this cart. Special materials are also available at the clinical dispensing stations.

Toothbrushes are given out to patients at no charge during a hygiene or perio appointment only. Oral hygiene aids are available for purchase at a vending machine located on the 6th floor if you wish to purchase an item such as a toothbrush to give to a patient.
ITEMS AVAILABLE AT DISPENSING

Acid Etch
ADHESVIE hold for alginate
Adhesive 910
Adhesive VPS
Adhesive Rubber Base
Adhesive Scotchbond
Adhesive Single Bond
Alcohol: Isopropyl, Denatured
Alginate trays
Amalgam: Dispersalloy and Titan
Anesthetic Cetacaine Spray
Anesthetic Dyclone 1%
Anesthetic Marcaine
Anesthetic Polocaine 3%
Anesthetic Septocaine
Anesthetic Stabident
Anesthetic Topical Hurricane
Anesthetic Ultracare

Arestin
Analgescics
Articulating Paper Acufilm
Articulating Film Red and Blue film
Astringent Tissue Management
Astringent Syringe and Tips
Auto Condenser
Bags: Sterilzing Pouch (various sizes)
Bandages
Bard Parker
Bib-Eze Disposable Bib clips
Bite Blocks
Blades #11, #12, #12B, #15, #20, #25
Bleaching Block out Material
Bleaching Opalescence 10% and 15%
Bleaching Shade guide
Bleaching superoxyl
Bleaching tray material
Blood pressure cuff: child, regular adult, large
Blood and spumla
Brush Bur cleaning
Brush bur cleaning
Brush composite short and long
Brush PIP
Brushable #0, #2, #3
Burs: replacements (all types)
Calasept
Caliza Cement
Cavicide Disinfectant
Cavit
Cavitron Tips focus spay
Cavitron Tips FSI-1000
Cavitron Tips Slim Line
Cavity Conditioner
Cement IRM
Cement B & T
Cement Ketac Maxicap
Cement Zinc Phosphate
Centrix Syringe
Centrix Tubes and plugs
Citace Disinfectant
Check Retractors
Cleaner Lysol Foam
Composite Flowable Revolution
Composite Fugi II
Composte Filtek Z-250
Composite disposable wells
Composite Gun
Compound Green sticks
Compound Red cakes
Compound Red sticks
Compound Cakes
CoreRestore Core Material
Cotton Roll Holders
Cotton Rolls-Long and Short
Cups Dixie
Cups Plastic Medicine
Cups Souffle
Dental Dam Latex Free
Dental Floss
Denture Bath
Denture Brush
Desensitizer Ghuma
Disclosing Solution
Disclosing tablets
Disks
Dia-angle saliva absorber
Dullly Gates Glidden Size 2-6
Du-Glo Duplicator
Dunhath
Electro-Surg Unit
Electro-Surg tips
Endo Absorbant Pts
Electric Pulp Tester
Endo Z tips
Endo Z
Endo files
Endo Gutta Percha
Endo Ni-Ti Handpiece and rotary files
Endo RC Prep
Endo Roth's cement
Endo sodium perborate
Endo System B Tips
Endo Transilluminator
Endo Ice
Endowells
Enhance Finishing and Polishing Kits
Envelopes-Coin
Erasers
Esthet-X
Examix
Exalbite
Express
EZ Post
Facebows
Phosphide
Fouride Trays
Gauze
Gel-Cam Desensitizing
Gel-Cam slab
Glasses-Patient Protection
Glasses-Provider Protection
Glasses-Side Shields
Gloves-Sizes Surgical
Hand lotion
Handpiece Lab high speed
Handpiece replacements
Hydrogen Peroxide 3% and 30%
Ice packs
Impression Material
Alginate
Gun
Impxegum/adhesive
Opotow
Rubber Base Fast Set
Rubber Base Heavy
Rubber Base Regular
VPS Examix
VPS Imprint II
Instruments Implant cleaning set
Instruments Mini eurette
Instruments replacements for all kits
Instruments on call
204B scaler
Back action plunger
Jeffrey 7
Left handed Jeffrey 7
Intricacy and Gun
Jiffy Tubes
Kleenex
Lab
  Large Casting ring and spine base
  Large crucible
Lubricant Vaseline
Lubricant H & R Jelly
Magnifier
Matches
Matrix materials
  Composi-tight system
  Contour
  Ivory retainers and bands
  Palodent Byline rings
Matrix Materials
  Polyester Tape
  Tofflemire Bands
Medicants
  Advil
  Ammonia capsules
  Amoxicillin
  Aspirin
  Chloramphenicol
  Emergency Kit
  Erythromycin
  Nitroprusside Spray
  Tylex
Metabond
Microetcher
Miror-Intraoral
Miror-hand held
Mixing pads
Mizay silicone spray
Monobond
Mouthguard material
Needles-27 ga long and short
  30 ga short
  Calasept
  Endo irrigating
  Side port irrigating
Oralseal
Oxygent
Panavia 21 bonding
Parapost
Parapost cement
Parapost fiber white
Patient Aids
  Biotech
  Bridge and clasp brush
  Dental Floss POH
  Dental Floss glide
  Dental Floss unwaxed
  Dental Floss waxed tape
  Denture bath
  Denture Brush
  Denture Cleaning Tablets
  End tuft brush
  Floss handle
  Peridex
  Perio Aid-toothpick
  Proxybrush and tips
  Sensitive tooth paste
  Stim-u-dent
  Super Floss
  Toothbrush
  Glide floss picks
  Prevident
  Pesos Reamers
  Pencil Red/Blue
  Perio Chip
  PDR
  Pic-n-stick
  Pillow
  PIP paste
  PoGo Polishing Systems
  Porcelain Bonding Indirect-Kit
  Prescription Blanks
  Provident
  Probe PSR + stickers
  Prophy Brushes
  Prophy cups
  Prophy paste
  Rely-X Arc Resin cement
  Rely-X veneer Cement
  Retraction Cord
  Rubber Bands
  Rubber Dam
  Non-Latex Dam
  Ruler 6 inch see-thru
  Ruler 6 inch Metal Endo
  Ruler Endo Finger
  Sealant
  Delton
  Helioseal
  Seek cavity detector
  Shade guides
  Bioblend
  Bioform
  Ivoclar
  Lumin
  Portrait
  Shimstock
  Silane and Tips
  Soap
  Spring Bows
  Suction G-tip
  Suction Disposable High Volume
  Surveyors
  Suture #4.0 Plain gut
  Suture #4.0 Chromic gut
  Syringe
  #412 curved irrigating tip
  Anesthetic
  Astringedent
Centrix
Endo Irrigating 27 ga
Endo Irrigating 30 ga
Luer-lock
Temp Bond NE
Temporary Bridge Resin Acrylic
Temporary Crowns
Tetric Color Staining Kit
Thermometer-Automatic
Tin Foil
Tongue depressors
Total Etch and Tips
Towel Clamp
Transfer applicators
Trays
Rim Lock Alginate
Disposable
Metal Perforated
Ultrasonic Cleaner
Ultrasonic solutions
Variolink Try-In Paste
Waxes
Alulon
Blue Inlay
Boxing
Occlusal
Orange Sticky
Pink Beauty
Red Rope
Shut Wax
X-Ray Cleaner
X-Ray Film
X-Ray Holder Bite Wing tabs
X-Ray Holder Stabe
S-Ray Mounts
X-Ray Solutions
Perio-Pro
Rapid Access
Zap-it
Zip-Lock Baggies

Endodontics
21mm Files
30mm Files
Apex Locator
Burnish Burs
Calasept/calaspert needles
CO-2 odontotest tube
Coin Envelopes
D-11-T spreader
Diamond Kit
Endodontic Envelope
Endo-Ray
Eucalyptol
Eugenol

Formocresol
Ligjet
Lip Clip
Office Wideners
Pulp tester and tips
Snap-a-ray
Stabident anesthetic system
Patient Thermometer
Wakai Spreader
X-ray Film

Hygiene Only
Amalgam Polishing Kit
CaviJet
Curettes-Gracey
#7/8, #15/16, #17/18
Implant Cleaning instruments
Irrigating Syringe with Side-Port Canula
Irrigating Syringe (Subgingival)
Mouthguard Material
Opalescence bleaching materials
Prophy Jet/tips/powder
Rubber Dam Kit
Scalers
Columbia #13/14, U-15, 204-S

Hygiene/Perio
7K Hoe
Acidite fiber
Anesthetic Syringe
Atridox
Automatic Blood Pressure Cuff
Blood Pressure Cuff/stethoscope
Curvettes aka Mini curettes
"D" High volume suction tip
Deep Pocket Curettes aka After 5's
Dentonic Scaler
Floss Handle
Fluoride trays - Small, Medium, Large
Fluoride Gel:
APF Mint-Acidulated
NSF Mint - Neutral Sodium
APF Cherry - Acidulated phosphated
Sealant material: Concise –light and helioskal
Hirschfield File sets
Jacquette scalers
Needles, anesthetic
Orban Files
Peridex
Perio chip
Perio-flex tips
Peroxyl
Prevident Fluoride Gel
Proxabrush/Tips
Pumice/Seneodyne dentin desensitizer
Sharpening stones grey peri and 309 India
Super Floss
Titan scaler and tips
Ultrasonic tips-slim-line/focus spray
Whiting
Restorative Items
#7 Left handed Jeffrey
3-prong plier
3½" spanula (hot mama)
Alcohol Lamp-glass
Alcohol torch-Hanna
Amalgam instrument kit
Ash’s Soft Metal
Atwood Crown and Bridge seater
Back-action amalgam plunger
Block-out resin
Boley Gauge
Centrix Access Syringe
Coe-Comfort
Coe-Soft
Composite-tight Matrix
Composite Instrument Kit
Composite Syringe
Composite Syringe for dowel & core
Composite Impression trays
Crown formers: Molar and bicuspid
Crown removers
Diamond bur 10R1.25
Distal extension rubber dam clamps
Dowel Puller
Duralon cement
Electro-mallet and tips
Exahite bite registration material
Extra long finishing strips
E-Z Post
Fit Checker
Fox plane
Framework adjustment kit
Gates-Glidden drills
Gold foil addition kit
Hold tray adhesive
Hot water bath insert
Hot water bath thermometer
Hydrocast
Inlay seater
Instrument replacements
Iowa wax
Iwanson gold gauge
Lavoris mouthwash
Lentulo spiral
Ligajet syringe
Lightening strips
Liqua mark counter indicator
Lumin porcelain shade guide
Lynal
Mouthguard material
Narrows instrument kit
Ney Indicator spray
Occlusal place plane
Orthodontic Pliers
Pattern Resin-GC America
Periphery Wax
Piers kit
Porcelain polishing kit
Propipont
Remounting jig
Retraction Cord
Richwill crown & bridge removers
Rubber dam weights
Sharpening stone & Oil
Shot glasses
Superbrite bite registration material
Temporary Crowns:
Iroforms
Polycarbonates
Celluloids
Stainless steel
Aluminum shells
Copper Bands
Tooth separators
Total reline material
Towel clamp
Tube-lock precision attachment kit
V.I.P. Cast pin kit .6mm, .7mm
Vacidamet, 200 cc. Complete
Vadoclink
Vital tooth whitening system
Clinical Laboratories

When students begin their clinical work they will be assigned their own laboratory kit and either a wall locker or lab drawer. The kit contains the basic laboratory instruments. Students will share benches with other students, but each of individual has his/her own instruments. The slow speed hand-piece is located in the middle drawer and is shared by all students.

Students will also be issued Hanau articulators. Please keep in mind that the Hanau articulators are issued by serial number and each individual must turn in the correctly numbered articulators when he/she leaves the School.

It is important that each student monitor his/her equipment and locks his/her bench and/or wall locker whenever he/she leaves the laboratory to minimize losses. Students should be mindful of both instruments and laboratory work.

Instrument replacements can be obtained from the 9South dispensary. With the exception of lost or used-up items, all replacements must be on an exchange basis. This means students must turn in a broken or worn-out item to obtain a new one. A record of all replacements, clinical and laboratory, is kept by School of Dentistry personnel. An assessment is made at graduation check-out to determine whether the amount of replacements warrant an additional fee.

Items such as surveyors, large casting rings, or other items not included in the individual bench kits items can be check them out from the dispensing station. Students should be mindful of the deadlines for returning items and any penalties for late returns. If penalties are administered, they will be billed on the next semesters “Instrument Usage and Special Supplies Statement.”

Materials that are not part of the individual bench kits are available in each laboratory. Please use these items carefully to keep expenses as low as possible.

The laboratories are provided for the student's convenience in carrying on his/her patients' dental treatment. It is not possible to provide materials, space, and equipment for students to do laboratory work or other procedures that are not required by patients in the UM clinics. Additionally, students are not to use clinic cubicles for doing laboratory procedures. Any student found doing laboratory work in a cubicle will be asked to relocate to the clinical laboratory by the staff.

Hours

Laboratory hours are between 6:30 a.m. and 9:00 p.m., Monday through Thursday evenings. The labs closed at 7:30 p.m. on Friday evenings. Labs are not open on weekends, holidays, and during semester breaks.

Prosthodontics Commercial Laboratory Protocol

This document outlines the new protocol for commercial laboratory prescriptions during fixed and removable treatment. The protocol will be initiated at the start of Fall Semester 2006. The following outline provides a guide and is subject to alteration by a supervising instructor (e.g., some items may have to be done in-house due to time restrictions).
The protocol is as follows:

**Fixed – Crowns (including implant-supported) and FPD**

**IN-HOUSE (STUDENT AND/OR SUPPORT TECHNICIAN)**
- Pouring of all irreversible hydrocolloid impressions
- Diagnostic cast preparation and fabrication of custom trays
- Final die trimming (margin exposure)
- Mounting of casts onto articulator
- Case-specific diagnostic wax-up (supervisor decision)
- Limited glazing and final polishing of custom-characterized crowns
- Preparation of custom abutments for implant-supported crowns

**ITEMS TO BE PRESCRIBED FROM A CONTRACTED COMMERCIAL LABORATORY:**
- Case-specific diagnostic wax-up (supervisor decision)
- Pouring of precision impressions
- Fabrication of master cases (including soft tissue implant casts) and initial die preparation (to be returned to school for final die trim and articulator mounting)
- All casting and porcelain applications
- Glazing and final finishing/polishing of specific prostheses (most posterior and non-custom shades)

**Removable – RPD, CD, Occlusal Guards**

**IN-HOUSE (STUDENT AND/OR SUPPORT TECHNICIAN)**
- Pouring of irreversible hydrocolloid impressions
- Diagnostic cast preparation
- Case-specific custom trays (supervisor decision)
- Fabrication of RPD framework cast
- Cast mountings and remounts onto articulators
- Setting Maxillary and Mandibular anterior prosthetic teeth for Complete Dentures and case-specific RPD applications (in the cubicle during the patient appointment)
- Custom tray, baseplate, and occlusion rim for altered cast application (Case-specific – supervisor decision)
- Festooning – (case-specific – limited to supervisor request)
- Fabrication prosthetics of self-curing resin, repairs – e.g. emergency provisional prosthesis (case-specific – supervisor decision)
- Final resin finishing/polishing

**ITEMS TO BE PRESCRIBED FROM A CONTRACTED COMMERCIAL LABORATORY:**
- Fabrication of CD master casts
- Custom trays (supervisor decisions)
- Stabilized baseplates and occlusion rims for Complete Denture
- Setting of posterior prosthetic teeth for CD and selected RPD
- Festooning – most final festooning of CD and RPD
- Custom tray, baseplate, and occlusion rim for altered cast application (supervisor decision)
- Resin flasking, boilout, packing, processing, recovery, and initial resin trimming
- Fabrication of resin-based prostheses – e.g. provisional RPD, occlusal guards, selected repairs (supervisor decision)

**Lab Kit**

The items that make up each student’s lab kit are as follows:

1 Kit Box

**Removable Tray Contents:**
Brush, DE Plate Brush, DE Sable #3
Handle #6 (for 25 Blade) Instrument, 
DE Carver, ½ Hollenbeck Instrument, 
DE Carver, PKT #1 Instrument, DE Carver, PKT #2 Instrument, DE Carver, Roach Instrument, DE Carver, 
Walls # 1 Instrument, DE Carver, 
Hollenback 1/2 DE Spatulas, #7 Was DE Spatulas, Plaster mixing Tweezers, 
AA Tweezers, K Locking

**Bottom of Kit box**
#E –cutter (acrylic Bur)
Wheel 4 Discs and Rubber Wheels Die saw Handle and Blade Knife, #7R Knife, #12 Occlusal Plane Plate 500 cc vacumixer (trap and cap) Plaster mixing bowl
Cleaning the Clinic Kit

All items in the clinic kit must be free of all debris -- this means wax, cement, and any other foreign material. Use a one-hand method to drag instrument tips across a wet gauze square to clean all items completely and carefully before taking the kit to the dispensing window.

1. Remove cement from the tips of instruments.
2. Reattach the scissors, hemostat and air/water tip in the lid of the cassette.
3. Place the following items in the red empty container in the handpiece kit if they were used in a dental procedure: used burs, stones, endo files. This separation will allow these items to be cleaned ultrasonically in the dispensary by the staff.
4. Reassemble the kit in the order received.
5. Take a few minutes and check the kit for completeness.
6. Take the clinic kit to the South dispensary or covered cart.
7. Make sure instruments are placed in the correct cassette. The color-coded rings and cassette should be the same color.
8. All instruments are sterilized in the sterilization facility.
POLICY FOR THE USE AND CONTROL OF IONIZING RADIATION FOR DIAGNOSTIC IMAGING AT THE SCHOOL OF DENTISTRY, UNIVERSITY OF MINNESOTA


Due to continuing concern about the use and potential harmful effects associated with exposure to ionizing radiation, the following policy has been developed with an overall objective to implement those procedures which will assure the safe and effective use of ionizing radiation producing equipment and to minimize as much as possible any potential risks to patients, students, faculty and staff. Control and use of radioactive materials for research purposes, i.e. radioactive isotopes and radiopharmaceuticals, is specifically excluded from the scope of this policy. Responsibility for monitoring the use of such materials continues to lie with the Radiation Protection Division of the Department of Environmental Health and Safety, University of Minnesota.

I. ADMINISTRATIVE

1. This radiation policy must comply with all provisions of the Minnesota Department of Health Ionizing Radiation Rules Chapter 4730, Minnesota Dental Practice Act and the Radiation Protection Division of the Department of Environmental Health and Safety of the University of Minnesota.

2. Dr. Mansur Ahmad, the Director of the Oral and Maxillofacial Radiology Program shall serve as the Radiation Protection Representative/Officer (RPR) of the School of Dentistry.

3. The RPR has the full and complete responsibility and authority for establishing school-wide guidelines and policies on radiographic practices and, in cooperation with the University Radiation Protection Program, has responsibility for developing procedures to coordinate, monitor, and control the use of ionizing radiation producing and image processing equipment.

4. Radiographs/copies/digital radiographic files will be made available to private practitioners, patients or other appropriate professionals when so requested by patients in writing.

5. All intra-oral radiographs obtained in all clinics shall be exposed with digital sensors or double-film packets. Double-film packets will assist in making radiographic records available in case of misplaced charts, misplaced radiographs, or films separated from charts. The duplicate films must be sent to and filed in the Oral and Maxillofacial Radiology clinic. All digital images should be stored in the PACS system.

6. Individuals who may make exposures:
   a. Licensed practitioners of healing arts (dentists, physicians, etc.)
   b. Licensed dental hygienists, dental therapists, and radiologic technologists (ARRT) under general
supervision

c. Registered dental assistants and students of dentistry, dental hygiene, and dental therapy under indirect supervision

7. If the RPR determines that an individual operator lacks required skills, he/she will be asked to submit to and successfully complete a review of his/her proficiency in radiographic technique and knowledge of principles of radiation hygiene and protection. If the individual fails the review, he/she shall not be allowed to expose patients.

8. New employees, who will operate X-ray and processing equipment, will review radiation safety protocols of the School of Dentistry. This program will include material concerning information on the effects of radiation exposure to the human body and the embryo/fetus, radiation hazards, safety practices, quality assurance and radiation rules and regulations. All individuals must sign attendance records.

9. All departments shall inform the RPR before the acquisition of any X-ray machine. The RPR will make arrangements to ensure registration of the machine with the University Radiation Protection Division of the Department of Environmental Health as required by the University Regulations. A radiation-protection survey must be made by the Radiation Protection Division before this machine can be used.

10. The RPR shall implement and monitor a school-wide radiographic quality assurance program.

II. PHYSICAL FACILITIES AND EQUIPMENT

1. All radiographic facilities and equipment shall be designed or upgraded to maintain radiation exposures well within permissible limits to individuals in adjoining areas. All rooms containing X-ray machines shall be provided with appropriate primary and secondary barriers to ensure radiation protection.

2. Portable X-ray machines present difficult radiation protection problems. Such equipment shall be used only if the patient cannot be transferred to a permanent radiographic facility. Only the patient shall be exposed to the primary beam of radiation. All other personnel shall stand behind an appropriate barrier to ensure radiation safety during exposure. In addition, if the primary beam is directed at the wall(s) of adjoining room(s) or hallway and these wall(s) do not provide adequate shielding for radiation protection, one of the following provisions shall be complied with:

   a. All individuals (faculty, staff, students, patients) shall be cleared from these areas during exposure.

   b. A portable lead shield or a portable partition draped with 1/2 millimeter lead equivalent vinyl sheet lead shall be placed in the path of the primary beam.

      It is recommended that all facilities using portable X-ray equipment should give a serious consideration to purchasing a protective barrier described in b. above.

      This policy shall also apply to portable X-ray machines used for animal studies and preclinical laboratory exercises.

3. The darkroom shall be light-tight. The safelight filters must be compatible with the films being processed.
4. A Quality Assurance (Q.A.) program must be implemented and followed to ensure that high quality films are produced consistently at minimum cost and minimum exposure to patient and operator. The following Equipment Performance tests and procedures shall be performed according to the frequency specified. Any corrective actions must be documented.

a. **DAILY**
   (1) Sensitometry and densitometry - manual and automatic processing. Test films must be kept on file.
   (2) Temperature check

b. **WEEKLY** - Processor cleaning and total chemistry change for high volume areas. This may be done every two weeks for low volume processors.

Calibration of the cone beam CT unit will be done every week according to the manufacturer’s recommendation.

c. **SEMIANNUALLY** - Darkroom fog

d. **ANNUAL**
   (1) Screen-film contact
   (2) Screen-film-cassette speed match

e. **BIANNUAL**
   (1) SID accuracy
   (2) X-ray and light field alignment
   (3) X-ray and bucky alignment
   (4) Collimator dial accuracy
   (5) Reproducibility
   (6) mR/mAs
   (7) Linearity
   (8) Timer accuracy and reproducibility
   (9) Half-value layer
   (10) kVp accuracy
   (11) Phototimer reproducibility
   (12) Filtration-intraoral units
   (13) Radiation exposure at end of cone (intraoral units)

5. The Radiation Protection Division (RPD) at the University of Minnesota has the following provisions related to X-ray machines and facilities that must be complied with:

a. All purchase requests and orders for X-ray machines require the approval of the RPD.

b. If a radiation-producing machine is to be sold, traded, transferred, or disposed off, RPD must be notified and approval received.

c. Any change in the use, design, or location of an X-ray machine must be approved by the RPD. Such changes may require amendment of registration form, along with a new radiation protection survey of the machine.

d. All plans for new and remodeled facilities must be reviewed by the RPD during the preliminary
planning stages, and requirements specified by the RPD must be followed. A radiation survey of all new and remodeled facilities must be made before use.

6. A radiation safety checklist should be posted by each X-ray unit and include the following:
   a. The correct kVp, mA and exposure time
   b. Direction to evaluate stability of the PID (position indicating device; cone) and tubehead before making exposures
   c. Direction to use required leaded apron and thyroid shield
   d. A description of the required operator position during exposure

7. A description of the film processing techniques should be posted in each processing area and include the following:
   a. The correct time and temperature
   b. Appropriate lighting conditions
   c. Film feed instructions
   d. Washing, rinsing and drying conditions
   e. Replenishing regimen
   f. Film loading

8. In case of film based imaging, student's access to radiographic film should be controlled. Correct number of film packets should be provided and only when a prescription for specific radiographs has been signed by a licensed dentist.

9. Digital sensors will be secured by the clinic staffs, and will be issued to students only when a prescription for specific radiographs has been signed by a licensed dentist.

10. Radiographic viewing should be accomplished under ideal conditions with equipment such as dim background lighting, masked viewboxes of adequate and uniform intensity, opaque film mounts and magnifying glasses. All viewboxes must be kept clean, be of the same intensity and the same color. For viewing digital radiographs, the monitors should preferably housed in a dimly lit area. For diagnosis purpose, the images preferably should be viewed on a computer screen instead of a print.

III. CRITERIA FOR EXPOSURE

1. All radiographs shall be prescribed in writing on the Radiographic Request form or in axiUm and signed/digitally signed by a licensed dentist. The request must include clearly stated reason for the examination, prior to the procedure being done and entered in the Progress Notes sheet or in axiUm.

2. Radiographs for all patients shall be ordered only after clinical examination to determine the need and desirability of specific radiographs. Radiographs ordered merely on the basis of routine or for screening purposes shall not be permitted.

3. Radiographs shall be limited to the minimum number needed for a complete diagnostic work-up of the patient's dental need. The limits on exposure in each case will be determined by the professional judgment of a faculty dentist.
4. There can be no set frequency for radiographic examinations. The procedure to be employed and the frequency of the examination shall be determined by the professional judgment of the dentist ordering the radiographs.

5. If prior radiographs are available from a private dentist or another institution, they must be evaluated before new radiographs are prescribed. Only those additional views needed to complete diagnosis and treatment planning shall be exposed. This requirement does not preclude making a new complete intraoral survey if it is appropriate to the diagnosis.

6. Radiographs should not be used merely to document clinically apparent lesions.

7. Radiographs obtained for administrative purposes only, including those for insurance claims or legal proceedings, should not be made. However, diagnostic radiographs already made may be used for administrative purposes.

8. Demonstrations or training on X-ray equipment must be performed with proper protection of the observers and operator(s). Phantoms (mannequins), not humans, must be used for demonstration.

9. Deliberate exposure of an individual to radiographic procedure for training or demonstration purposes shall not be permitted, unless there is a diagnostic need for the exposure.

10. Individuals exposed for other than diagnostic reasons shall have the approval of the Human Use Subcommittee and All-University Radiation Protection Committee of the University of Minnesota.

11. Students should be assisted with all patients requiring three or more retake radiographs on a complete intraoral radiograph survey.

12. Patients should not be subjected to retakes to satisfy technical perfection. A minimally acceptable complete mouth radiographic survey should demonstrate, at least one time, each tooth in entirety and each interproximal space without overlapping and with clarity and accuracy.

13. Discretionary radiographic examination of patients who are known to be pregnant should be delayed until after delivery. Specific emergency radiographs may be obtained as needed.

14. No individual under 18 years of age shall be allowed to receive any occupational radiation dose except for training purposes.

IV. EXPOSURE PROCEDURE

1. For film based radiography, only American National Standards Institute Speed Group E film or faster (i.e. Kodak Insight), shall be used for all intra-oral radiographic procedures.

2. For introral radiography, rectangular collimation should be achieved, either by using a rectangular tube or a rectangular collimation.

3. No operator shall be permitted to hold patients or films/sensors during exposure. If assistance is
required for children or handicapped patients, an adult member of the patient's family may assist. The hands and body of the assisting person should be positioned in a manner to prevent primary beam exposure, and a protective lead apron and gloves of 0.5 mm lead equivalence should be provided for the assistant.

4. Only the patient shall be in the operatory during radiation exposure. All other individuals shall be required to leave the area.

5. During each exposure, the operator shall stand behind the barrier provided for each operatory.

6. Leaded rubber aprons and thyroid shields shall be used for all intra-oral procedures as an additional precaution to minimize scatter radiation exposure to the body of the patient.

7. Leaded rubber aprons should be used for all extra-oral procedures, when feasible.

8. The patient should be observed through a lead-glass window, if possible, during each exposure.

9. The patient record must accompany each patient before exposures can be made. The operator must review the history of previous patient exposure and status in regard to any infectious disease.

10. If a malfunction is detected in an X-ray machine, it should be corrected immediately or the machine shall be "closed down" until the necessary corrections have been made and the equipment recalibrated. All repairs/adjustments must be documented.

11. Mechanical support of the tube head and cone shall maintain the exposure position without drift or vibration. These shall not be hand held during exposure.

12. Intraoral film/sensor holding devices must be used except when endodontic procedures do not permit doing so. In those cases where the patient must hold the extraoral film cassette, the patient must wear 0.5 mm lead equivalent gloves on the hand that holds the cassette. In addition, any portion of the body, other than the area of interest must be covered by 0.5 mm lead equivalent material.

13. All intraoral film/sensor holding devices must be sterilized according to SOD Infection Control Policy.

14. Extra-oral exposures should employ screen-film combinations of the highest speed consistent with their diagnostic objectives. Direct exposure X-ray film (without intensifying screens in a cassette) shall not be permitted for extraoral radiography.

15. Intra-oral fluoroscopy shall not be used for intra-oral radiographic examinations.

16. The target to skin distance for intra-oral radiographs shall not be less than 7.1 inches, and preferably should be a minimum of 12 inches or longer. The target to skin distance for extra-oral radiography shall not be less than 11.8 inches.

17. The exposure control switch shall be of "dead-man" type, i.e., it requires continuous pressure by the operator to complete the circuit. This switch must be positioned behind a protective barrier.

18. All intra-oral X-ray machines shall be equipped with open-ended, shielded cones limiting the beam
diameter to 2.76 inches at the patient's face. When using rectangular collimation, the longer side of the rectangular beam at the patient's face should not exceed 2 inches.

19. Extra-oral X-ray machines shall be collimated so that the beam size does not exceed the area of interest and/or the film cassette size.

20. The half-value layer (HVL, beam quality) for a given kVp should not be less than the values prescribed by the Minnesota Department of Health.

21. X-ray machines designed to use kilovoltage of less than 50 shall not be used for diagnostic purposes.

V. INSTRUCTIONAL/TEACHING SUPPORT

1. Students must be closely supervised by teaching staff during all radiographic procedures conducted on patients.

VI. RADIATION MONITORING

1. Film badges shall be worn during working hours by all (faculty and staff) occupationally exposed personnel who regularly use X-ray equipment and all other individuals who are likely to be exposed to ionizing radiation regularly.

2. The film badge device shall not be stored in the radiation area to avoid exposure.

3. The film badge shall not be worn by the individual when he/she is exposed as a patient for any medical/dental reasons.

4. The personnel film badge must be obtained through the RPR. To obtain a badge, get a request card from the RPR. After the request card is returned, the RPR will make arrangements with the University Radiation Protection Division to obtain an appropriate film badge.

5. The RPR will keep on file the records of quarterly, yearly, and total cumulative exposure received by all individuals and makes these available for inspection by each employee quarterly. The RPR will review the reports on each individual for each change period. If the radiation dose is in excess of five percent of the maximum permissible dose limit for that period, or if an unusual dose is reported, the RPR will make a complete investigation of the circumstances involved in the dose received by the individual. The findings and conclusions will be made a part of the personnel monitoring record of the individual and a copy will be forwarded to the University Radiation Protection Division to be filed with the permanent radiation exposure history of the individual.

6. Records of individual exposure and the personnel monitoring records shall be preserved for the lifetime or 30 years after the termination of employment with the facility, whichever is less.

7. The records of individual exposure shall be furnished to an employee who is terminating employment. The report must be furnished within 30 days from the time of receipt of final dosimetry record.
8. If a film badge is lost or damaged, contact the RPR immediately so that arrangements can be made to replace it.

9. Pregnant workers may “declare” pregnancy in writing to the RPR who shall contact the Radiation Protection Division to arrange for the completion of specific training.

10. Operators who are pregnant shall not be exposed to more than 0.5 mSv (50 mrem) per month during pregnancy. Film badge dosimeters on these individuals shall be processed on a monthly basis.

VII. RECORDS

1. A record of radiation exposure history of every patient of the dental school will be maintained. All radiographic procedures shall be recorded on the inside cover of the patient’s chart or in axiUm. The record must include the date of radiographic image exposure, number and type of radiographs, including number of retakes, name of operator, name of the person requesting radiographs and name of clinic where radiographs/images are stored.

2. All film based intraoral radiographs exposed at the Dental School shall be mounted in University of Minnesota film mounts and labeled with the patient’s name, date exposed, and chart number. No loose, unmounted radiographs shall be permitted in the radiograph pocket of the patient’s chart. Digital radiographs will be stored in MiPACS.

3. All duplicate radiographs will be kept on file in the Oral and Maxillofacial Radiology clinic.

4. All film based radiographs shall be kept in the patient's chart. If an academic unit wishes to retain film-based radiograph for its records, a copy may be obtained by written order to the Oral and Maxillofacial Radiology Clinic

5. Interpretation of radiographs should be documented in the patient's record.

VIII. SATELLITE RADIOGRAPHIC AREAS

1. The RPR in cooperation with the University Radiation Protection Division has the complete overall responsibility and authority for controlling use of ionizing radiation for diagnostic purposes and ensuring use of good radiologic practices in other clinical disciplines.

2. The following supplies will be available at appropriate places in or near each satellite area.

   a. "Radiographic Request" forms
   b. Film dispensing forms
   c. Lead aprons
   d. Thyroid shields
   e. Film mounts
   f. XCP or other film-holders

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3. The operator shall comply with all radiation protection practices outlined in the school-wide policy.

4. All radiographs to be exposed in satellite radiographic facilities shall be prescribed in writing by a licensed dentist on the faculty and appropriately entered in the Progress Notes sheet.

5. In order to facilitate an accurate account of patient exposures, all radiographic films shall be dispensed to the students at designated areas to prevent unauthorized use. No automatic film dispensers shall be permitted in areas available for student activity.

6. Films/sensors shall be dispensed to the students only when a prescription for specific radiographs has been signed by a licensed dentist.

7. All film badge distribution and collection shall be handled by the RPR. The badges must be returned and the new ones picked up in the Oral and Maxillofacial Radiology Clinic within 4 days of each change period. The change periods are: the first working day in January, April, July, and October.

8. The Radiation Protection Division of the University has stipulated that a charge of $50.00 be assessed for a lost or unreturned film badge.

IX. DARKROOM MAINTENANCE POLICY

1. The following processor maintenance protocol shall be followed:

   a. Every cleaning cycle. To be done late afternoon on Friday or before a holiday.

   (1) Unplug processor.

   (2) Drain chemicals and water completely. Save used fixer in supplied plastic bottle for silver recovery and lawful disposal.

   (3) Remove transport system. Wash them well with soapy water and rinse thoroughly. Let them air dry over the weekend. Chemical cleaning solutions may be used as needed.

   (4) Wash out tanks with water and remove any chemical buildups. Wipe out tanks with a clean, lint-free cloth.

   (5) Fill tanks with new chemicals in the morning on Monday or after a holiday.

   (6) Fill water.

   (7) Replace transport system.

   (8) Plug in processor.

   (9) Run cleaner films through. Run at least two new unexposed periapical films through each chute.

   (10) If films come out clean and clear, the processor is ready for use. Proceed with Quality Control tests.
(11) If there are marks or residue on the films or if periapical films are dark or fogged, call the Oral Radiology Clinic supervisor at 625-1126. Do not use processor until its use has been cleared by the Oral Radiology supervisor.

(12) Check water temperature to be sure it is set to manufacturer’s recommended temperature.

(13) Make entry in the Processor Maintenance log posted in the darkroom.

(b) Daily

(1) Turn processor on. Change water daily

(2) Check chemical level. If too low, add more.

(3) Run cleaner films through as outlined in "a" above.

(4) Check temperature setting. If adequate, proceed with Q.C. film. Record temperature on log sheet.

(5) Expose and process a step wedge film and compare with standard. The step wedge film must be within one step of standard. If not, do trouble shooting. Repeat Q.C. tests until satisfactory results obtained.

(6) Turn processor and water off at the end of the day.

(7) Lift lid off slightly to allow air to circulate.

2. Film processing shall be monitored in each darkroom on a regular basis to assure film quality. Test records will be maintained by the RPR. Test films must be labeled and saved for 30 days.

3. Instructions for processing shall be posted in each darkroom.

4. All old films, lead foil film backings and used fixer must be saved for proper disposal by the Dental Engineering Department.

5. The darkrooms shall be evaluated for white light leakage and adequacy of safelights by the RPR every six months. All deficiencies must be corrected immediately.

IX. REGIONAL DENTAL BOARDS PATIENTS

1. A request for radiographs on all board examination patients shall be signed by a licensed dentist. Reason for radiographic examination must be recorded. Patients must fill out and sign Health History/Consent form.

2. All the regulations regarding radiation safety contained within this policy would apply when appropriate.
GUIDELINES
for the
Certification
Process

American Board of Prosthodontics

Revised----------December 11, 2011
Effective -----------December 11, 2011
www/prosthodontics.org/abp
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MISSION STATEMENT
The American Board of Prosthodontics

The mission of the American Board of Prosthodontics is to certify individuals who have demonstrated special knowledge and skills in prosthodontics. The Board also seeks to certify those who are committed to life-long learning and a lifetime of ethical practices, who value the doctor/patient relationship, who respect those with philosophical, cultural or physical differences and who are committed to the advancement of prosthodontics.

The American Board of Prosthodontics recognizes its responsibility to the profession and to the public and accepts this responsibility through the administration of an examination designed to identify individuals with the knowledge, skills and attributes deemed important to those who will be called Diplomates of the American Board of Prosthodontics.

GOALS
The American Board of Prosthodontics

1. Assure that Diplomates meet certain knowledge and skill criteria and issue certificates to these individuals indicating they have met the established criteria. Bylaws, Article II, Section 1 and Article VIII, Section 1.
2. Assure that Diplomates maintain continued proficiency in prosthodontics. Bylaws, Article VIII, Section 4.
3. Provide the public and profession with information regarding individuals who are Board Certified. Bylaws, Article I, Section 2; Article XII, Sections 1 and 2.
4. Encourage the specialty to advance itself through Board certification.

HISTORY
The American Board of Prosthodontics

The American Board of Prosthodontics was incorporated on February 21, 1947, in the State of Illinois. Following preliminary organizational efforts by the Academy of Denture Prosthetics (now the Academy of Prosthodontics), the Board, at the request of the American Dental Association, was established as the specialty certifying body for prosthodontics. The following nine founder board members were duly elected from the membership of the Academy of Denture Prosthetics during the annual session at Miami, Florida in October 1946: Drs. C. J. Stansbury, R. H. Kingery, O. M. Dresden, Bert L. Hooper, David McLean, F. C. Elliot, I. R. Hardy, C. O. Boucher, and R. M. Tench. There were 64 members of the Board representing the Academy of Denture Prosthetics(now the Academy of Prosthodontics), American Denture Society (now the American Prosthodontic Society), and the Pacific Coast Society of Prosthodontics.

The first Board examination was given in 1949 and included written essays and oral and clinical components during a one-week session. To be eligible for the certifying examination prior to January 1, 1964, the applicant had to present evidence either of prosthodontic training or of having spent 10 years in the practice of dentistry with special interest in prosthodontics. Thereafter, formal educational requirements included a Master of Science degree in prosthetic dentistry or the equivalent from an American Dental Association-approved or provisionally approved dental school.
In 1951, Canadian dentists became eligible for certification. After Board approval of several hospital residency and internship programs in prosthodontics during 1952, successful candidates from these programs and others established since were adjudged to have satisfied the requirements for examination. On January 1, 1954, the eligibility requirements were changed to include formal educational experiences such as a Master of Science degree in prosthetic dentistry or its equivalent from a dental school approved or provisionally approved by the American Dental Association. Minor changes in examination procedures were made in the ensuing years, and in 1957, the Board accepted the responsibility for examining candidates in fixed prosthodontics.

The written part of the examination was changed from an essay to an objective form in 1960, and consideration was given to dividing the week-long examination into two separate parts. Additional study of the phased procedure culminated in application of the concept in 1962. Also during 1962, the American Dental Association House of Delegates changed the eligibility requirements for Board candidates by making mandatory two years of formal advanced education in prosthodontics for individuals applying after January 1, 1965. From 1962 to 1987, a Phase I examination consisting of the written, oral and patient presentation parts was given each February, followed in June by Phase II which consisted of clinical and oral parts. In 1987 the Phase I oral examination was lengthened to one hour to include the patient presentation, the broad areas of prosthodontics, and the related basic and applied sciences. The Phase II oral examination was eliminated.

At the request of the Federation of Prosthodontic Organizations and the American Academy of Maxillofacial Prosthetics in 1967, the Board, with American Dental Association sanction, accepted the responsibility for including maxillofacial prosthetics as a component area of prosthodontics for competency certification. In 1974, provision was made for candidates to elect to take the clinical examination in maxillofacial prosthetics.

Recognizing the growing complexity of the prosthodontic specialty and the need for a broader Board membership base, the Academy of Denture Prosthetics (now the Academy of Prosthodontics), in 1972, relinquished sponsorship of the Board in favor of the Federation of Prosthodontic Organizations.

In 1987, the American Dental Association mandated that prosthodontics would be recognized as a single specialty including fixed, removable, and maxillofacial prosthetics and that advanced educational programs in prosthodontics must provide education and training in all of these areas. Recognizing a need for a more comprehensive examination to reflect these changes in the standards for Advanced Education in Prosthodontics, the Board, in 1990, announced significant changes in the examination format to more accurately evaluate candidates’ knowledge and clinical proficiency in all aspects of Prosthodontics (fixed prosthodontics, removable partial prosthodontics, complete denture prosthodontics, maxillofacial prosthetics, implant prosthodontics, and occlusion). Following a transition year during 1991, the Phase I examination was expanded from one half day to a full day. The oral and patient presentation parts were expanded and moved to the Phase II examination and the onsite clinical examination was discontinued. An additional written examination covering clinical prosthodontics was also incorporated into the Phase II examination.

In 1988, the Federation of Prosthodontic Organizations designated the American College of Prosthodontists as the sponsoring organization of the Board within the structure of the Federation of Prosthodontic Organizations. In 1992, the Federation of Prosthodontic Organizations designated and the ADA Council on Dental Education recognized the American College of Prosthodontists as the sponsoring organization for the specialty of prosthodontics and the sponsor of the American Board of Prosthodontics.
To simplify describing the examination, the various parts were numbered from 1 to 5 in 1993. The Part 1 examination is a half-day comprehensive written examination. Parts 2, 3 and 4 consist of evaluating 3 patient treatments that include oral examinations of the candidate. The candidate makes a slide presentation of the patient treatment for Parts 3 and 4. The Part 5 examination was a three (3) hour examination which was incorporated into the Part 1 examination in 1996 by increasing the size and scope of the Part 1 examination.

To provide more flexibility for candidates to complete the examination process, recent additional modifications have been made. In 1996 candidates were given the option of taking the Part 1 written examination during the 3rd year of their prosthodontic training program, prior to establishing board eligibility. Additionally, in 2003 candidates were given the option of performing all patient treatments (Parts 2, 3, and 4) during their training program and the possibility of taking one of the patient presentation examinations during the February examination period in their final year of training.

In 2006 computer based testing was initiated to allow candidates to take the written examination closer to their homes using one of various testing centers across the country.

In 2008 substantive changes were made to the oral examination process. To minimize confusion during the transition period the various parts of the examination were renamed. Effective for 2008, Section A remains as the former Part I written examination given in April of each year at remote testing centers near the candidate’s home. Section B includes the oral patient presentation examinations (formerly Parts 2, 3 and 4). Section C includes the Scenario Based Examinations that replace one of the oral patient presentation examinations. Candidates have the choice of whether to take all 3 parts of Section B (the former parts 2, 3 and 4) or whether to take two of the oral patient presentation examinations plus Section C (three 1/3 hour scenario based oral examinations for a total of 1 hour).

In 2011 modifications were made to the Section B oral examination patient treatment criteria to make them more relevant to current prosthodontic treatment principles.

The primary objective of the American Board of Prosthodontics continues to be the determination of the proficiency of eligible candidates who desire certification in prosthodontics.

DEFINITIONS

Prosthodontics is that branch of dentistry pertaining to the restoration and maintenance of oral function, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

Removable Prosthodontics is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are removable from the mouth.

Fixed Prosthodontics is that branch of prosthodontics concerned with the replacement and/or restoration of teeth by artificial substitutes that are not removable from the mouth.
Implant Prosthodontics is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures by artificial substitutes partially or completely supported and/or retained by alloplastic implants.

Maxillofacial Prosthetics is that branch of prosthodontics concerned with the restoration and/or replacement of stomatognathic and associated facial structures by artificial substitutes that may or may not be removed.

**GENERAL STATEMENT OF PURPOSE**

The American Board of Prosthodontics

The American Board of Prosthodontics was organized by the Academy of Denture Prosthetics at the request of the American Dental Association for the following purposes:

To advance the science and art of prosthodontics by encouraging its study and improving its practice.

To determine the eligibility of candidates within the regulations for qualification for examination.

To conduct examinations to determine the proficiency of applicants for certification as Diplomates.

To grant and issue Diplomate certificates to successful candidates.

To maintain a roster of Diplomates for the general information of the public, the dental and medical professions, dental schools, and health agencies.

**CERTIFICATION FOR THE SPECIALTY OF PROSTHODONTICS**

By the authority of the American Dental Association and its Council on Dental Education, certificates may be issued by the American Board of Prosthodontics, which will attest to an applicant’s knowledge, ability and proficiency in the specialty of prosthodontics.

Any dentist who meets the qualifications as set forth in this document may become a candidate for certification by making formal application to the American Board of Prosthodontics. The American Board of Prosthodontics will not discriminate against any person because of race, color, religion, sex, national origin, ancestry, age, marital status or handicaps. Please note that language is not a physical disability for testing purposes.

Diplomates of the American Board of Prosthodontics are expected to announce and limit their practice to prosthodontics.

Limited Practice—Dentists who have successfully completed an advanced prosthodontic education program which is accredited by the Commission on Dental Accreditation may ethically limit their practice to prosthodontics, subject to individual state guidelines.
Educationally Qualified—An individual is considered Educationally Qualified after the successful completion of an advanced educational prosthodontic program which is accredited by the Commission on Dental Accreditation. However, an individual is not Board Eligible unless his/her application has been submitted to and approved by the Board and his/her eligibility has not expired.

Board Eligible—Sometimes there is confusion regarding the use of the phrase board eligible. Individuals are not board eligible upon completion of their advanced education program in prosthodontics. Individuals are educationally qualified upon completion of a program which is accredited by the Commission on Dental Accreditation. They become board eligible only when their application for certification has been submitted to and approved by the Board.

Dentists trained in Canada are eligible for certification by the American Board of Prosthodontics under the same rules governing candidates from the United States, except that Canadian dentists must present to the Board evidence of parallel qualifications in Canada in all categories required for candidates trained in the United States.

Duration of Eligibility—The period of Board eligibility begins on the date when the individual’s application is accepted and approved by the Board and is extended to the candidate for six (6) consecutive years. However, Board eligibility status will be forfeited if the Part 1 written examination is not taken within two (2) years of eligibility. Although eligibility may be re-established by re-application, all phases of the examination must be successfully completed within six (6) years of initial eligibility. No re-applications are acceptable after this six (6) year period unless, upon consultation with the applicant, the Board determines that unusual extenuating circumstances warrant an extension of the duration of eligibility. Graduate students/residents taking Part I during a prosthodontic training program will not be considered Board eligible until formal application for eligibility is made to the Board. Board eligibility of 6 years begins only after formal application to and acceptance by the Board. Successful completion of the Section A Written Examination is not time dependent and does not expire.

Graduate students/residents wishing to take one of the patient presentation examinations (Section B-Part 2, 3, or 4) during the final year of training must apply for and receive notice of eligibility prior to taking the examination during February of the final year of training. The 6 year period of eligibility begins on the date eligibility is awarded, during the third year of training.

Diplomate—Any dentist who has successfully met the requirements of the Board for certification and remains in good standing.

ROLE OF THE BOARD AND ITS EXAMINERS IN THE EVALUATION PROCESS

An examiner has been described as one who works in examining records or people and who tests by careful questioning in order to find out the knowledge, skill and qualifications of a candidate. Since its inception, the primary objective of the Board has been, and will continue to be, the protection of the public through determination of the competency of eligible candidates who desire certification as specialists in prosthodontics. The Board is an examining and certifying body. It remains independent from political issues and is not directly responsible for the education of the candidates. It has been, and will continue to be the position of the Board, that candidates be examined by the current standards.
approved by the Commission on Dental Accreditation for advanced education programs in prosthodontics. The Board is not static or unchanging. Changes occur, however, only after a great deal of study and thought. The Board strives to be fair and objective in all its relationships with candidates. It abides by the rules which are in effect, but seeks to modify the guidelines and examining procedures whenever it appears that such changes could benefit those it serves: the public, the profession, the specialty, the certified diplomates, and the candidates seeking diplomate status.

VALIDITY AND RELIABILITY OF CRITERION BASED EXAMINATIONS

Individuals knowledgeable in testing have emphasized that any system of evaluation must be objective if it is to be considered valid and reliable. The Board has always strongly advocated eliminating subjectivity in its certification process. Its dedication to improving the examinations will be ongoing. Criterion-based evaluation has been presented as a method of increasing the validity and reliability of an examination. The Board devoted a great deal of effort during the early 1980’s to developing criterion statements for the different oral examination phases of its certification process. In February, 1985 the first criterion-based oral examination was conducted to evaluate the performance of one candidate in the Part 2 (now Section B) patient presentation. During this initial experience, both the traditional and criterion-based methods were used in the evaluation of the candidate’s performance. Using both methods the Board could make a paired comparison of the two and judge the efficacy of the new system. The criterion statements developed by the Board for the patient presentation included: records, the narrative, fixed prosthodontics, removable partial prosthodontics, maxillofacial prosthetics, and occlusion. Each member of the Board was requested to evaluate the candidate’s performance in each of the areas using the criterion statements. The criteria were written as objective descriptions of acceptable, marginal, or unacceptable levels of skill or performance. In selected areas the acceptable and unacceptable levels were further divided into two subsets. To evaluate a candidate’s performance at a specific task, the Board member selected the category (acceptable, marginal, or unacceptable) in which the criterion statement best matched the candidate’s skill at performing the examined task. The Board member then checked the appropriate numerical value on the candidate’s score sheet: (acceptable 1 or 2, marginal 3 or unacceptable 4 or 5).

In the initial evaluation of the criterion-based examination, the Board examiners experienced agreement or near agreement in almost every category. As a result of this early effort, the Board adopted the process of a criterion-based examination for use in all phases of the examination.

The specific criterion statements for the Section B Oral Presentation Examinations (formerly Parts 2, 3 and 4) of the certification process appear at the end of this document. An explanation is also provided on how the Board uses the scores received by each candidate to determine pass/fail outcomes. This document represents the Board’s efforts to date and is subject to change. The Board reserves this “right to change” as its responsibility to those it serves. The purpose in publishing this material is to better inform any and all persons who are interested in the certification process, and it is hoped that it will assist candidates in preparing for the examinations.

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REQUIRED QUALIFICATIONS FOR EXAMINATION

A candidate for examination by the American Board of Prosthodontics must:

1. Have satisfactory moral and ethical standing in the dental profession.

2. Show evidence of satisfactory completion (or anticipated completion) of advanced education in Prosthodontics as defined in the American Dental Association document entitled Requirements for Advanced Specialty Education Programs in Prosthodontics or by the Canadian Dental Association.

Advanced education in a recognized specialty area of dentistry may be offered on either a graduate or postgraduate basis.

a. A graduate program is a planned sequence of advanced courses leading to a master’s or doctoral degree granted by a recognized and accredited educational institution.

b. A postgraduate program is a planned sequence of advanced courses that leads to a certificate of completion in a specialty recognized by the American Dental Association or Canadian Dental Association. The level of specialty-area instruction in the graduate and postgraduate programs must be comparable.

3. Meet the requirements to be Board Eligible.

Upon submitting an application, (which must include certified evidence of the successful completion of an accredited program in advanced Prosthodontics) and all other certified documents required by the application and having such applications approved by the Board, a candidate for certification becomes Board eligible.

APPLICATION PROCEDURES

Requests for information or application forms should be directed to the Executive Director of the American Board of Prosthodontics (ttaylor@nso.uchc.edu).

After having answered all questions and submitted all data requested, (to include either “certified true copies” or university copies certified by the registrar of completion of advanced education in prosthodontics or a letter from the program director stating that the applicant is expected to complete the training program within the expected time frame), the applicant must mail the application form back to the Executive Director. The candidate must include the application fee with the completed form. The fee is not refundable, either in the event of acceptance or rejection by the Board.

NOTE: Incomplete forms will not be considered by the Board. If any item is left blank or is not answered completely, a clearly detailed statement should be made setting forth the reason the information is not available. All transcripts, certificates, or diplomas must be notarized copies.

After the Executive Director has reviewed the completed application, the candidate will be informed of their eligibility status and of the date and place of the next examination.
FEES

There is an application for certification fee plus a fee for each part of the examination. The appropriate fees must accompany each application. The examination fee schedule is as follows: Application for Certification fee $200, the Computer Based Section A (formerly Part1) $375, Section B (formerly Parts 2,3,4) $250 each, Section C scenario exams (1 fee for the entire Section C exam) $250. Re-examination fees will be the same for subsequent applications. The appropriate fee must be paid to the Executive Director at the time the candidate, in writing, signifies they intend to take a portion of the examination. All fees must be paid in United States currency.

THE EXAMINATION

The examination shall include the principles and procedures of fixed prosthodontics, occlusion, removable prosthodontics, implant prosthodontics, maxillofacial prosthetics, and related arts and sciences. It shall consist of a computer based examination, patient presentations, and oral examinations. The examination is conducted in three sections. Any section may be taken in any order.

The Section A Written (formerly Part 1) Examination is a computer based examination given during the month of April each year at 200 PearsonVUE professional testing centers located regionally in the 48 contiguous United States. Information on the computer based testing process can be found at www.MeasurementResearch.com. Here one can find answers to frequently asked questions about computer based testing and a demonstration test which shows the item format and how to answer questions.

The application deadline for the Section A Written Examination is 90 days in advance of the examination date. The candidate may take this examination in the third year of their prosthodontic training program, prior to establishing Board eligibility. An individual whose prosthodontic education extends beyond 3 years may take Section A in their third year. The program director must certify that the candidate is in the 3rd year of the program.

Section B Patient Presentation Oral Examinations (formerly Parts 2-4) are candidate generated patient presentations that include oral examination. Board eligible candidates may take any or all of the Section B parts in any order, at either the February or autumn examinations. The application deadline for Section B examinations is 30 days in advance of the examination date.

Graduate student/resident candidates may take one of the Section B Patient Presentation Oral Examinations (Part 2, 3, or 4) during the February examination period of the third year of training in addition to the written Section A Written Examination. Patient treatments presented may have been performed during the training program. At least one of the patient presentations Section B must include implant prosthodontics.

The candidate should be aware that the entire examination must be completed within 6 consecutive years from the date Board eligibility was initially approved.

English is the official language of the American Board of Prosthodontics.
Candidates may utilize digital photographs and radiographs provided no alterations of the images have been performed with the exception of peripheral cropping. Any alteration will result in automatic failure of the candidate. A signed statement that no alteration has occurred must be included with each patient presentation.

The use of recording devices of any kind is strictly forbidden. Cellular telephones, miniature recording devices or any instrument capable of recording/transmitting information from the examination site is strictly forbidden in the examination room at any time. Likewise, any notes taken during the examination must be turned over to the examiners upon completion of the examination segment. Should a candidate use any such device during participation or fail to relinquish such notes in any segment of the American Board of Prosthodontics examination process, that individual will be disqualified from the examination and will forfeit all opportunities to sit for future examinations. Examination security measures will be consistent with industry standards and compliance will be monitored before, during and after the examination.

**DESCRIPTION OF THE SECTION A WRITTEN EXAMINATION**

Section A is a criterion-referenced examination that is constructed through the coordinated efforts of Board Members and Psychometric Experts who provide information on the measurement characteristics of the items and/or test. The computer-based examination is given at regional testing centers. Some of the questions (items) are chosen or modified from a bank of test items catalogued by subject area. New items are written for the examination by Board members each year. Questions are also solicited from training program directors. These items are reviewed by the Board and those approved are added to the question bank.

The Criterion-referenced Examination is written to measure the knowledge and skills of qualified candidates. The items are evaluated to ascertain that they measure what they purport to measure, are appropriate for prosthodontic candidates, minimize the amount of test error and are coherent in style and format. Those questions not meeting accepted criteria are either discarded or rewritten. A test score from a criterion referenced test is a measure of how well a candidate performs in relation to the test items rather than the performance of other candidates.

The content of the examination is based upon the Standards for Advanced Specialty Education Programs in Prosthodontics and is updated to reflect changes in those standards. There are “must” statements in the didactic curriculum section of the standards that require in-depth understanding and familiarity levels of knowledge in specific areas. The distribution of knowledge levels within the standards is reflected in the number of questions from each area, weighted from in-depth to familiarity. The current standards emphasize the following didactic areas:

Instruction must be provided at the in-depth level in each of the following:

- Fixed prosthodontics
- Implant prosthodontics
- Occlusion
- Removable prosthodontics

Instruction must be provided at the understanding level in each of the following:
Applied pharmacology
Biomaterials
Craniofacial anatomy and physiology
Diagnostic radiology
Geriatrics
Infection control
Implant placement including surgical and post-surgical management
Maxillofacial prosthetics
Medical emergencies
Oral pathology
Preprosthetic surgery; including surgical principles and procedures
Prosthodontic patient classification systems such as the Prosthodontic Diagnostic Index (ACP Classification systems) for edentulous, partially edentulous and dentate patients.
Research methodology
Temporomandibular disorders and orofacial pain

Instruction must be provided at the familiarity level in each of the following:

Behavioral sciences
Biostatistics
Craniofacial growth and development
Endodontics
Ethics
Immunology
Intraoral photography
Oral microbiology
Orthodontics
Periodontics
Practice management
Risk assessment for oral disease
Sleep disorders
Scientific writing
Teaching methodology
Wound healing

In addition to these areas, questions from current prosthodontic literature and other related areas will complete the questions for the computer based examination. Candidates are given 4 hours to complete the examination.

Scoring the Computer Based Examination
The examination is constructed using standard psychometric methods. The test is designed by the Board and its measurement consultants to identify those candidates who are capable of meeting acceptable cognitive ability based on the Commission on Dental Accreditation’s Accreditation Standards for advanced Specialty Education Programs in Prosthodontics. The Board established the criterion
SECTION B

CHANGES TO AMERICAN BOARD OF PROSTHODONTICS SECTION B (Made in 2011)

NOTICE: The ABP Section B patient presentation requirements have been changed as of 2011. There is a change in the number of fixed natural tooth units in Parts 2 and 3. There is a change in the number of fixed implant restorations required overall for Section B, and the laboratory work requirement has changed. Also, a complete denture or overdenture can no longer be included for Part 2.

1) Below is the timeline/implementation dates for the changes to take effect.

TIMELINE: Section B patient presentations in the prior format (referred to as “OLD requirements”) will be acceptable for presentation through the November 2014 examination. After the examination in November 2014, all presentations must conform to the new requirements. The candidate must select either the OLD requirements for all Section B patient presentations or select the NEW 2011 requirements. Section B patient treatments may not be selected from both the OLD and NEW 2011 requirements. Therefore, candidates who have begun the Section B process under the OLD requirements must finish his/her examination of the Section B parts before or at the November 2014 examination. If a candidate has NOT presented any Part B patient presentations, as of the date of this posting (June 1, 2011), he/she MAY ELECT to employ the NEW 2011 requirements immediately. After November 2014, if the candidate has initiated but not completed the Part B presentations using the OLD requirements, he/she must repeat the Part B presentations using the NEW 2011 requirements.

2) Both NEW 2011 requirements and OLD requirements are below. The requirements related to presentation format, photographs, casts and written documentation for the examination have not changed for Section B; only the patient procedure requirements and the laboratory requirements for Section B have been changed.

DESCRIPTION OF SECTION B (NEW 2011 REQUIREMENTS)

Section B shall consist of 3 patient presentation and oral examination sessions of approximately one hour each in length. The oral presentation examinations are described as Parts 2, 3 and 4. The examinations will cover the patient presentation, general prosthodontics and related dental sciences. Successful completion of this part of the examination will require acceptable performance by the candidate in all three of these categories. The candidate may elect to take all 3 of the Section B examinations to fulfill the certification process (in addition to successful completion of Section A) or the candidate may elect to take any two of the oral patient presentation examinations plus the Section C scenario based oral examinations to complete the certification process.
DESCRIPTION OF SECTION B PARTS 2, 3 AND 4 (NEW 2011 REQUIREMENTS)

These parts consist of oral and image presentations by the candidate of patients he/she has treated. One of the presentations will consist of a combined fixed and removable partial prosthodontic treatment (Part 2). Another will consist of a fixed prosthodontic patient treatment (Part 3) and another will consist of a removable prosthodontic patient treatment (Part 4). Each presentation is scheduled for approximately one hour with the candidate being allowed an uninterrupted 20 minutes to present the patient’s treatment and the remaining time is devoted to questioning by a team of examiners. Candidates must be prepared to defend their diagnosis, prognosis, treatment planning, treatment and maintenance based upon evidence based dentistry. The candidate must complete at least four (4) dental implants supporting fixed restorations in one or any combination of the patient treatments. The laboratory work for one of the patient treatments must be performed by the candidate with the exclusion of removable partial denture framework fabrication which may be performed by a laboratory technician. Any laboratory work not completed by the candidate must have an accompanying work authorization. The candidate must declare in writing for which of the treatments the laboratory work was accomplished by the candidate.

The candidate will perform all prosthodontic and restorative procedures for all Section B patient treatments and will be responsible for the decision making and quality of all procedures performed by other dentists, (including pre-existing restorations and procedures). The candidate is responsible for and will be evaluated on the quality of diagnosis, treatment planning and treatment provided to the patient including restorative/prosthodontic procedures performed by other dentists. Candidates must be prepared to defend their diagnosis, prognosis, treatment planning, treatment and maintenance based upon evidence based dentistry.

The patient treatments will serve as the primary focus of the oral examination. However, questioning may include principles and concepts of the broad scope of prosthodontics.

Part 2: Removable Partial Prosthodontic Treatment consisting of a removable partial denture prosthesis for either arch and the fabrication of at least four (4) crowns that restore natural teeth in either arch. A partial denture obturator prosthesis may fulfill the partial denture requirement. It is not required that the fixed restorations serve as abutments for the removable partial denture prosthesis. Implants supporting overdentures will not fulfill any of the global ABP requirement of “4 implants supporting fixed restorations.” The patient treatment for the Part 2 examination cannot include a complete denture or complete overdenture as part of the treatment.

Part 3: Fixed Prosthodontic Treatment (no removable prostheses) consisting of a fixed reconstruction that includes at least fourteen (14) fixed units that restore the articulating surfaces of the teeth. At least six (6) of those units must be natural teeth. The candidate should seriously consider replacement of all foundation restorations and should be prepared to justify foundation material selected.
Part 4: Removable Prosthodontic Treatment consisting of any of the following: requires that at least one arch has either a complete denture, complete overdenture or complete denture obturator prosthesis opposing any method of restoring the opposing arch. The candidate is responsible for the quality of the opposing arch restoration(s), and will be graded on the restorations in the opposing arch he/she performs. Implants supporting overdentures will not fulfill any of the global ABP requirement of “4 implants supporting fixed restorations.”

The removable prostheses options include any of the following:

1) Complete denture opposing a complete denture
2) Complete denture or overdenture opposing an overdenture. Overdentures may be supported and/or retained by natural teeth or implant abutments. Implants functioning as overdenture abutments will not be counted towards fulfilling the global ABP requirement of “4 implants.”
3) Complete denture, overdenture, or complete obturator prosthesis opposing natural teeth or any method of restoring the opposing arch. The candidate is responsible for the quality of the opposing arch restorations, and will be graded on the restorations in the opposing arch he/she performs.
4) Complete denture prostheses in both arches fabricated for the Part 4 examination MUST demonstrate bilateral balanced articulation.

DESCRIPTION PART B (OLD REQUIREMENTS)
( will remain acceptable for presentation through the November 2014 examination period )

Section B shall consist of 3 patient presentation and oral examination sessions of approximately one hour each in length. The oral presentation examinations are described as Parts 2, 3 and 4. The examinations will cover the patient presentation, general prosthodontics and related dental sciences. Successful completion of this part of the examination will require acceptable performance by the candidate in all three of these categories. The candidate may elect to take all 3 of the Section B examinations to fulfill the certification process (in addition to successful completion of Section A) or the candidate may elect to take any two of the oral patient presentation examinations plus the Section C scenario based oral examinations to complete the certification process.

DESCRIPTION OF PARTS 2, 3 AND 4 (OLD REQUIREMENTS)

These parts consist of oral and image presentations by the candidate of patients he/she has treated. One of the presentations (Part 2) will consist of a removable partial denture treatment with 2 crowns for which all laboratory work excluding the fabrication of the RPD framework has been performed by the candidate, a fixed prosthodontic patient treatment (Part 3) and the other will consist of a removable prosthodontic patient treatment (Part 4). Each presentation is scheduled for approximately one hour with the candidate being allowed an uninterrupted 20 minutes to present the patient’s treatment and the
remaining time is devoted to questioning by a team of examiners. Candidates must be prepared to
defend their diagnosis, prognosis, treatment planning, treatment and maintenance based upon evidence
based dentistry. One of the presentations must include the use of dental implants.

If possible, a different team of examiners will evaluate each patient presentation. The Parts 3 and 4
patients cannot receive the same combination of treatment as the patient presented in Part 2.

The patient treatments will serve as the primary focus of the oral examination. However, questioning
may include principles and concepts of the broad scope of prosthodontics.

Part 2: Removable Partial Prosthodontic Treatment consisting of a removable partial denture prosthesis
for either arch and the fabrication of at least two crowns that restore either natural teeth or implants in
either arch. It is not required that the fixed restorations serve as abutments for the removable partial
denture prosthesis. If the removable partial denture prosthesis is fabricated opposing a complete denture
in the opposing arch the occlusion must be bilateral balance articulation.

Candidates are required to perform all clinical prosthodontic and laboratory procedures for the Part
2 patient (regardless of whether the treatment was performed during residency training or after
completion of residency training) with one exception: Services of a dental laboratory technician may be
employed to fabricate the removable partial denture framework, following a properly executed written
work authorization. A copy of the Part 2 work authorization form must be included with the patient
presentation. A form (provided by the Board at the time of examination) attesting to the completion of
all procedures by the candidate must be signed by the candidate. Violation of this requirement will lead
to disqualification of the candidate from this part of the examination. The candidate is responsible for
and will be evaluated on the quality of diagnosis, treatment planning and care provided to the patient
including restorative/prosthodontic procedures performed by other dentists. Candidates must be
prepared to defend their diagnosis, prognosis, treatment planning, treatment and maintenance based
upon evidence based dentistry.

Part 3: Fixed Prosthodontic Treatment (no removable prostheses) consisting of either

1) A fixed reconstruction that includes at least twenty (20) fixed units that restore the articulating
surfaces of the teeth.

2) A fixed reconstruction of both arches that includes one complete arch (the articulating surfaces of all
anterior and posterior teeth must be restored in that arch) and a minimum of six (6) fixed restored
units in the opposing arch.

Fixed partial dentures may be supported by implants, but a minimum of eight (8) natural teeth must be
restored as part of the total treatment for either option.

The candidate should seriously consider replacement of all foundation restorations and should be
prepared to justify foundation material selected.

Part 4: Removable Prosthodontic Treatment consisting of any of the following: requires that at least
one arch has either a complete denture, complete overdenture or complete denture obturator
prosthesis opposing any method of restoring the opposing arch. The candidate is responsible for the
quality of the opposing arch restoration(s), and will be graded on the restorations in the opposing arch he/she performs.

1) Complete denture opposing a complete denture

2) Complete denture or overdenture opposing an overdenture. Overdentures may be supported and/or retained by natural teeth or implant abutments.

3) Complete denture, overdenture, or complete obturator prosthesis opposing natural teeth or any method of restoring the opposing arch.

4) Complete denture prostheses in both arches fabricated for the Part 4 examination must demonstrate bilateral balanced articulation.

FORMAT FOR PARTS 2, 3 AND 4 PRESENTATIONS

A verbal and visual presentation shall be given by the candidate. A maximum of 20 minutes will be allowed for the presentation.

Aspects of therapy must be presented in the following order:

1. History and chief complaint
2. Clinical findings
3. Diagnosis
4. Treatment plan
5. Treatment
6. Completed treatment
7. Prognosis

Color images will be presented for each treatment. There is no limit to the number of slides shown but the candidate must complete the presentation within the allotted 20 minute period. Only one image may be presented per slide. Digital projection is the method of presentation. A monitor, and radiograph view box will be provided by the Board. The candidate must bring his/her own laptop computer to the examination for projection along with any connection adapters required by that computer type to make it compatible with standard flat screen monitors. It is the candidate’s responsibility to insure that their laptop computer presentation is compatible with standard commercially available monitors. Technical difficulties with projection are the responsibility of the candidate to rectify. Failure to project images satisfactorily will disqualify the candidate from taking the examination during that examination period. Candidates must provide the Board with a CD-ROM with the required images labeled as above. A set of periapical and bitewing radiographs of all post-treatment teeth and implants present in the mouth of the treated patient must be handed in upon completion of Part 2. A complete full mouth periapical series (including bitewings) of original post-treatment radiographs must also be handed in upon completion of Part 3. All radiographs may be either film or digital but must be of high resolution and quality. The CD-ROM and radiographs become the property of the Board and may be used for future examination material. If digital radiographs are submitted (pre-op and post-op) for parts 2 and/or 3, each individual digital radiographic image will be submitted as a separate digital file. Those individual images must be labeled as shown in the following illustration.
Slides for the Part 2 and 3 treatments must clearly show at least:

**Pre-treatment:**
- Teeth in maximum intercuspation (frontal and lateral views)
- Lateral views in laterotrusion and mediotrusion
- Teeth in protrusion (frontal and lateral views)
- Occlusal views of maxilla and mandible
- Complete mouth periapical and bitewing radiographs
- Panoramic radiograph (for patient treatments begun in 2007 or later)
  (For the Part 2 presentation, if the patient is edentulous in one arch the maximum intercuspation
  and laterotrusion, mediotrusion, and protrusion images should be taken with the pre-existing
  complete denture prosthesis in place. If the patient presented with no complete denture prosthesis
  these images are not required.)

**Treatment:**
- Tooth preparations (occlusal view)
- Tooth preparations (frontal and lateral view), (for patient treatments performed in 2006 and later)
- Provisional restorations (frontal and lateral views)
- Final impressions

**Post-Treatment**
- Same as pre-treatment

Slides for the removable treatment must clearly show at least:
- *Pre-Treatment:*
  - Occlusal views of maxillary and mandibular edentulous or partially edentulous ridges.
• Anterior view of maxillary and mandibular ridges at approximate occlusal vertical dimension
• Complete mouth periapical or panoramic radiographic series

Treatment:
• Border molded impression trays (tissue surface)(for patient treatments begun after February, 2008)
• Impressions (tissue surface)
• The technique and materials used to record maxillomandibular relationships (frontal and lateral views)
• Wax trial denture on articulator (5 slides)
  frontal view
  lateral views
  occlusal views

Post-Treatment:
• Occlusal views of maxillary and mandibular arches without the prosthesis, if implants or natural teeth are present
• Tissue surfaces of completed prostheses
• Prostheses in place, teeth in maximum intercuspation (frontal and lateral views)
• Lateral views in laterotrusion and mediotrusion
• Teeth in protrusion (frontal and lateral views)
• Full face frontal and full face profile views with both the existing and new prostheses in occlusion. The Patient’s eyes must be blocked out.
• Frontal view of full face smile. The patient’s eyes must be blocked out.

The following casts/dies will be presented.

Removable Partial and Fixed Treatment:
• Pre- and post-treatment mounted casts
• Articulated casts with diagnostic wax patterns
• Working casts/dies
• Duplicate master cast for RDP framework fabrication with RDP design drawn on cast

Removable Treatment:
• Pre-treatment mounted casts of edentulous or partially edentulous ridges at occlusal vertical dimension
• Post-treatment mounted casts of completed prostheses
• Duplicate master casts
• Working casts/dies for any fixed restorations used in conjunction with the removable treatment

For the removable treatment, a copy of the medical history and examination form will be presented.

Mounted periapical pre-treatment and post-treatment radiographs of the complete mouth will be presented for the Fixed Treatment. A pre-treatment panoramic radiograph must also be presented for patient treatments started in 2007 or later. The post-treatment radiographs will become property of and will be retained by the Board. Mounted periapical and/or panoramic pre-treatment radiographs of the complete mouth will be presented for the removable treatment. Post treatment radiographs of all implants associated with the Removable Treatment will be presented by the candidate and will become
property of and will be retained by the Board. Radiographs may be film or digital but must be of high resolution and diagnostic quality.

Laboratory technicians may be used to aid in fabrication of prostheses in the patient presentation sections, except the treatment the candidate declares as the presentation that he or she has completed all laboratory work. If a removable partial denture is fabricated in any presentation, a laboratory technician may fabricate the framework. Candidates must have a thorough understanding of laboratory procedures and are responsible for the outcome of laboratory procedures in the completed treatment. **Laboratory work authorization forms must be presented for both the fixed and removable treatments.**

**GRADING OF SECTION B- PARTS 2, 3 AND 4**

After all the candidates have been examined, the Board will meet in executive session to evaluate each candidate. The candidate’s names are read by the Executive Director and each Team of examiners have the opportunity to request that a particular candidate’s evaluation be deferred until later in the session for grading. Following this initial process, a written vote is taken for each candidate, except those that have been deferred. The votes are collected, tabulated and recorded for each candidate. The candidates for whom evaluation was deferred are then considered by the Board. A brief report is presented by the two Examiners of the Board who conducted the oral examination. Patient presentation materials are reviewed by each Examiner of the Board. After completing this review process, each Board Examiner judges the performance of the candidate against the criterion statements and a secret ballot vote is taken for the candidate.

It is a matter of Board policy that the successful completion of Parts 2, 3 and 4 requires acceptable performance by the candidate in all three categories: (1) patient presentation, (2) general prosthodontics, and (3) related dental sciences. After counting of the written ballots, the majority rule is applied and a candidate is judged to have passed or failed on that basis. All patient treatment presentations are graded according to the written criteria of the appropriate evaluation form. The evaluation forms have both major and minor categories. The major categories are those that can be graded on a numerical scale of 1 to 5 whereas the minor categories are those that can only receive grades between 2 and 4. A failure in the patient presentation occurs when the candidate receives any of the following grades: one (1) number 5 grade in any major category; two (2) number 4 grades in any major category; or four (4) number 4 grades in any of the categories. No candidate can be judged to have failed the examination by only one Examiner of the Board.

A candidate who presents an adequate patient treatment for the Part 2, 3, and/or 4 examinations but performs unsatisfactorily on the oral examination will be required to successfully complete a 40 minute repeat oral examination on general prosthodontics and related sciences. This examination will be given at a future examination date.

**SECTION C EXAMINATION**  
(Scenario Based Oral Examinations)
The scenario examinations consist of three 20 minute oral examinations in which two examiners present scenarios to the candidate and ask questions structured to assist in the evaluation of the candidate’s depth and breadth of knowledge in prosthodontics and related disciplines and sciences. The scenarios will be based on patient data and slide presentations supplied by the ABP. Each scenario will be divided into the themes of:

+ Diagnosis,
+ Treatment Planning,
+ Treatment
+ Prognosis

The three 20 minute examinations must be completed during a one hour period. Candidates will be scored based upon their performance in all three examinations combined. A poor performance in one of the scenario examinations will not, by itself, cause failure of the entire section.

APPLICATION RENEWAL

Board eligibility commences with the acceptance of a completed application by the Board. A graduate student or resident taking only the Section A written examination while a student/resident is not considered Board eligible until s/he has completed formal training in an accredited prosthodontic program and formally applies to the American Board for eligibility. Successful completion of Section A of the Examination as a student/resident does not by itself signify eligibility. Formal application to the Board is still required.

Graduate student/resident candidates who elect to take one of the patient presentation examinations (Part 2, 3, or 4) during February of the third year of training must have applied for and been granted eligibility prior to the examination and will continue to be eligible for a period of six years from the date of initial award of eligibility.

Approved applications are valid for two (2) years and the new applicant is Board Eligible only during this time. At least one part of the examination must be taken during this two year period or Board eligibility is forfeited. Taking one part of the examination automatically extends Board eligibility for the remainder of the total six (6) year period. For those who successfully complete Section A during their training program, eligibility commences with formal application to the Board for the remaining parts (6 years). Candidates may request consideration for an extension in writing from the Board when there are extenuating circumstances.

RE-EXAMINATION
Should a candidate fail all or any part(s) of the examination, s/he may apply at any time for re-examination and pay the appropriate fee for each part. If the candidate is unsuccessful in one or two parts, they can be reexamined in that part(s) only at a subsequent Board examination. Relative to the examination, Section B candidates that present an acceptable patient presentation but perform an unacceptable oral examination will be required to successfully complete a one hour repeat oral examination on general prosthodontics and related dental sciences. This examination will be given at a subsequent Board examination. A failure on any patient presentation will require that the candidate present a new patient treatment or retreatment of the same patient at a subsequent examination.

If the candidate fails any part of the examination three (3) times, Board eligibility is permanently forfeited and may not be re-established except under unusual extenuating circumstances which the Board may determine.

**APPEALS PROCESS**

The American Board of Prosthodontics has a formal appeals process for administrative or scoring concerns only. There are no appeals for examination content or performance. Details are available upon request from the Executive Director of the Board.

**ANNUAL FEE**

Holders of certificates from the American Board of Prosthodontics are required to pay an annual fee as determined by the Board. Annual fees are payable to the Executive Director of the Board on or before January 1 of each year.

The American Board of Prosthodontics issues time-limited certificates of eight (8) years duration.

Certification will be revoked if the annual fee is six (6) months delinquent. Payment is the responsibility of the Diplomate. Delinquent diplomates will receive a final registered letter from the executive director approximately one month prior to the six month delinquent date. Delinquent diplomates will not be listed in the roster as published in the Journal of Prosthetic Dentistry and the Journal of Prosthodontics. Nor will they be listed in the ABP website.

**REVOCATION OF CERTIFICATE**

The American Board of Prosthodontics shall have the power, jurisdiction, and right to decide or determine whether evidence or information placed before it is sufficient to constitute grounds for suspension or revocation of any certification issued by the Board.

**CONTINUED PROFICIENCY (RECERTIFICATION)**
The issuance of the original certificate shall not preclude periodic re-examination should the Board decide such procedure to be necessary to maintain desirable standards for the specialty of prosthodontics. All active diplomates will be required to undergo a process of continued proficiency (recertification). The following is an outline for the continued proficiency process.

I. Certificates of diplomate status are issued for eight (8) year periods.

II. Continued Proficiency Mechanism
   
   A. Continuing education
   
   Attainment of at least forty (40) points in an eight (8) year period will be required by all diplomates except those in a Life Diplomate status. A maximum of 10 (10) points per year will be allowed toward the total of forty (40) points. Points may be accumulated in the following ways:
   
   1. Attendance at a scientific session sponsored by a major prosthodontic organization (one point per day).
   2. Other courses, conferences and meetings applicable to prosthodontics preferably “CERP” approved (one point per day).
   3. Publications in peer reviewed journals (not to include abstracts), (two points per publication).*
   4. Prosthodontic book chapters - (one point per chapter).*
   5. Professional lectures given and study club activities related to prosthodontics (one point per day).*

   * A maximum of sixteen (16) points in an eight (8) year period may be credited from publications, lectures and study group activities. Activities of a 1/2 day will earn 1/2 point (three hours equals 1/2 point).

   Continuing education activity will be reported yearly on the registration form. All diplomates will be responsible for maintaining updated documentation of their continuing education activity. A percentage of randomly chosen diplomates will be requested to furnish documentation to the Board relating to their continuing education activities.

   B. Self Assessment

   A self assessment on recent prosthodontic advances will be prepared by the American Board of Prosthodontics. The self assessment can be requested on the annual registration form beginning in 1998. A package of questions with score card will be mailed to the diplomates requesting the self assessment. The completed score card will be mailed back to the executive director of the Board, logged and scored. The results, with correct answers and references, will be sent back to the diplomat.

   C. At least one (1) documented self assessment is required in the eight (8) year certification period.

Summary
To become recertified following the eight (8) year period of certification a diplomate must:

1. Complete 40 points of continuing education.
2. Complete at least one (1) self-assessment.
3. Monitor their progress toward continued proficiency on a yearly basis.

GENERAL INFORMATION

Inquiries concerning the activities of the American Board of Prosthodontics as well as information regarding applications and examinations for certification should be addressed to the Executive Director.

TTAYLORABPROS@COMCAST.NET.

CRITERION STATEMENTS FOR SECTION B

PATIENT PRESENTATION

PART 2

RECORDS

Preoperative Radiographs, Casts, Dies and Photographs

- Acceptable
  Preoperative radiographs are originals, properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.

- Marginal
  Radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements though with less than ideal contrast and sharpness.

- Unacceptable (any one of the following constitutes unacceptability)
  Radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty.
The mounting is not smooth and neat. Articulation instrument is inadequately programmed or inappropriately used. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

Postoperative Radiographs, Casts, Dies and Photographs

- **Acceptable**
  Postoperative radiographs are originals properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.

- **Marginal**
  Postoperative radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements with less than ideal contrast and sharpness.

- **Unacceptable (any one of following constitutes unacceptability)**
  Postoperative radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” seriously compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

**NARRATIVE**

History and Clinical Examination

- **Acceptable**
  History records chief complaint, an account of current problems, past history of dental and general health, family history, personal history and a review of systems. Clinical examination includes a general survey of patient condition, examination of the head and neck, examination of soft tissues of the mouth, and detailed information gained from a comprehensive dental examination.

- **Marginal**
  History is adequate though in depth coverage of some elements is marginal. Clinical examination is adequate though some aspects of the examination are marginally covered.

- **Unacceptable (any one of the following constitutes unacceptability)**
  History is poorly organized and fails to elicit pertinent information. Omissions compromise the formulation of an accurate diagnosis. Clinical examination is deficient resulting in a lack of needed diagnostic information.

Diagnosis/Treatment Plan

- **Acceptable**
  Diagnosis is appropriate and supported by a thorough systemic method of identifying oral disease. Treatment plan is well organized and chronologically sequenced to prevent and correct oral disease.
• **Acceptable**
  Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment plan is organized and chronologically sequenced to prevent and correct oral disease.

• **Marginal**
  Diagnosis is adequate though method used to formulate it is questionable. Treatment plan is marginally adequate but not well organized.

• **Unacceptable (any one of the following constitutes unacceptability)**
  Diagnosis is incomplete or inappropriate and is not supported by clinical findings. Treatment plan is inappropriate. Treatment plan is poorly organized and improperly sequenced.

• **Unacceptable (any one of the following constitutes unacceptability)**
  Diagnosis is clearly incomplete or inappropriate and is not supported by clinical findings. Treatment plan is grossly inappropriate or inadequate with errors in content and sequencing. Teeth have been inappropriately extracted and/or restored.

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**FIXED PROSTHODONTICS/ NATURAL TEETH**

**Overall Design Concept**

- **Acceptable**
  All basic components of accepted design concepts have been considered and optimally applied.

- **Acceptable**
  All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.

- **Marginal**
  Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Some of the basic components of accepted design concepts have not been addressed.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

**Abutment Preparation**

- **Acceptable**
  Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Finish line design and location are optimal for the preparation. Finish of the preparation displays finesse.

- **Acceptable**
  Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Finish line design and location are generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.

- **Marginal**
Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Finish line design or location is questionable. Finish of the preparations is marginally adequate.

- Unacceptable (any one of the following constitutes unacceptability)
  Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate, adjacent teeth damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

- Unacceptable (any one of the following constitutes unacceptability)
  Reduction, retention, resistance form, finish line design, and the finish of the preparations are grossly inadequate. Gross undercuts present. Teeth have been prepared that did not need restoration. Existing restorations that have obvious deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

Pontic(s)
- Acceptable
  Pontic form, tissue relationship, and axial contour are well designed.

- Marginal
  Form, contour and tissue relationship are marginally acceptable.

- Unacceptable (any one of the following constitutes unacceptability)
  Gross inadequacies in pontic form, tissue relationships and contours.

Other Restorative Procedures
- Acceptable
  Restorative material is appropriate to situation in which employed; margins as well adapted; physiologic contours achieved; and post(s) appropriate in length and design.

- Marginal
  Restorative materials, margin adaptation, contours or post length and design are marginally acceptable.

- Unacceptable (any one of the following constitutes unacceptability)
  Restorative material is inappropriate to the situation in which employed; margins are poorly placed or adapted; contours are poor and may be pathogenic; post length and design are inappropriate to situation.

Esthetics
- Acceptable
  Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved.

- Marginal
  Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable.

- Unacceptable (any one of the following constitutes unacceptability)
  Restoration is grossly different from natural teeth. Result is unnatural with undesirable appearance.
Completed Restorations

- Acceptable
  Restoration is physiologically compatible and well integrated with other elements of care.
- Acceptable
  Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- Marginal
  Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
- Unacceptable (any one of the following constitutes unacceptability)
  Future damage to surrounding tissues is likely to occur. Integration with other elements of care is lacking.
- Unacceptable (any one of the following constitutes unacceptability)
  Damage has occurred to surrounding tissues. Gross neglect of integration with other elements of care is evident.

**FIXED PROSTHODONTICS/IMPLANTS**

Overall Design Concept

- Acceptable
  All basic components of accepted design concepts have been considered and optimally applied.
- Acceptable
  All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- Marginal
  Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)
  Some of the basic components of accepted design concepts have not been addressed.
- Unacceptable (any one of the following constitutes unacceptability)
  Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

Abutments

- Acceptable
  An appropriate number of implants of proper length have been well placed in the edentulous area and appear to be physiologically compatible.
- Acceptable
  An appropriate number of implants with generally adequate length have been placed in the edentulous area and appear to be physiologically compatible.
- **Marginal**
  The number, length, placement of the implants is marginal but they appear to be physiologically compatible.
- **Unacceptable (any one of the following constitutes unacceptability)**
  The number, length, placement of the implants is unacceptable and that may affect their physiologic compatibility.
- **Unacceptable (any one of the following constitutes unacceptability)**
  The number, length, distribution of the implants is unacceptable and/or the implants appear to not be physiologically compatible.

**Pontics**
- **Acceptable**
Pontic form, tissue relationship, and axial contours are well designed. Presentation accurately shows these areas.
- **Marginal**
Form, contour, tissue relationship, presentation are marginally acceptable.
- **Unacceptable**
Gross inadequacies in pontic form, tissue relationships, contours, and presentations.

**Esthetics**
- **Acceptable**
Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved. Presentation clearly shows the required details.
- **Marginal**
Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable. Presentation marginal.
- **Unacceptable (any one of the following constitutes unacceptability)**
Restoration is grossly different from the natural teeth. Result is unnatural with undesirable appearance. Presentation unacceptable.

**Completed Restoration(s)**
- **Acceptable**
Prosthesis is properly contoured and finished and well integrated with other elements of care.
- **Acceptable**
Prosthesis is generally properly contoured, finished and integrated with other elements of care.
- **Marginal**
Prosthesis contour, finish or integration with other elements of care is marginal.
- **Unacceptable (any one of the following constitutes unacceptability)**
Prosthesis contour, finish, integration with other elements of care is unacceptable.
- **Unacceptable (any one of the following constitutes unacceptability)**
Prosthesis contour, finish, integration with other elements of care is grossly unacceptable.

**REMOVABLE PARTIAL PROSTHODONTICS**

Overall Design Concept
• Acceptable
  All basic components of accepted design concepts have been considered for both the edentulous and dentate areas.
• Acceptable
  All basic components of accepted design concepts have been addressed for both the edentulous and the dentate areas. The method in which one or more of these components have been used may be controversial.
• Marginal
  Most basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed might be justified upon oral examination.
• Unacceptable (any one of the following constitutes unacceptability)
  Some basic components of accepted design concepts have not been addressed for both the edentulous and the dentate areas.
• Unacceptable (any one of the following constitutes unacceptability)
  Most basic components of accepted design concepts have not been addressed for both the edentulous and the dentate areas. Those components not addressed cannot be justified in the light of current knowledge.

Direct Retainer Assembly Selection
• Acceptable
  An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
• Marginal
  The type, number, and placement of most direct retainer assemblies are adequate, but at least one direct retainer is inappropriate in type and/or placement.
• Unacceptable (any one of the following constitutes unacceptability)
  The type, number, size, placement of direct retainer assemblies are unacceptable.

Rest(s)
• Acceptable
  Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
• Marginal
  Most of the occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
• Unacceptable (any one of the following constitutes unacceptability)
  Most of the occlusal, cingulum, or incisal rests have been improperly prepared or improperly placed to provide optimal support for the prosthesis.

Retention/Reciprocation
• Acceptable
  Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.
• Marginal
Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.

- Unacceptable (any one of the following constitutes unacceptability)
  Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability. The size, contour, location or material used for the reciprocating and retentive components is/are unacceptable for the type of prosthesis.

Indirect Retainer(s)
- Acceptable
  An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.

- Marginal
  An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line or is less than optimal from a rest seat position/preparation standpoint.

- Unacceptable (any one of the following constitutes unacceptability)
  An indirect retainer(s) has not been placed to resist rotation of the prosthesis around the fulcrum line. The size of the indirect retainer is inadequate or is less than optimal from a rest seat position/preparation standpoint.

Major Connector Selection/Placement/Size
- Acceptable
  The major connector selection is appropriate, it is appropriately placed and appears to be rigid. It is of the type that would provide maximum stabilization and support to the prosthesis and remaining oral structures.

- Acceptable
  The major connector selection is appropriate, it is placed within the scope of acceptable principles and it appears to be rigid. It is of the type that will provide adequate stabilization and support to the prosthesis and remaining oral structures.

- Marginal
  The major connector is acceptable, it appears to be rigid, but the placement and selection are questionable.

- Unacceptable (any one of the following constitutes unacceptability)
  Aspects of major connector selection, placement and/or rigidity are inadequate.

- Unacceptable (any one of the following constitutes unacceptability)
  Aspects of major connector selection, placement and/or rigidity are grossly inadequate.

Base(s) Coverage/Contour
- Acceptable
  The denture bases are extended and contoured properly within physiologic limits in order to give maximum stability and support to the prosthesis.

- Marginal
  The extent of the bases is marginally acceptable and the contour is questionable.

- Unacceptable (any one of the following constitutes unacceptability)
  The bases are grossly over or under extended and the contour is inadequate.
Esthetics

- **Acceptable**
  The selection, color and position of the teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

- **Marginal**
  The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.

- **Unacceptable (any one of the following constitutes unacceptability)**
  - The selection, color and position of the teeth are not correct. There is poor orofacial support (in insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.

Denture Finish and Contour

- **Acceptable**
  Resin exhibits no porosity. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish.

- **Marginal**
  Resin exhibits minor areas of porosity. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonably acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished.

- **Unacceptable (any one of the following constitutes unacceptability)**
  - Resin is porous throughout. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces modified by grinding are rough. Denture or denture teeth have been fractured and not repaired or inadequately repaired.

Abutment Restoration(s)

- **Acceptable**
  The abutment restorations have good margin integrity and are of the proper material and contour to permit ideal placement of the retainer assemblies.

- **Acceptable**
  The abutment restorations have good margin integrity and are of the proper material, but the contours might be less than ideal for the chosen retainer assemblies.

- **Marginal**
  The abutment restorations lack some margin integrity and the material used and/or contours are less than ideal for proper placement of the retainer assemblies.

- **Unacceptable (any one of the following constitutes unacceptability)**
The abutment restorations lack some areas of margin integrity and the material used and/or contours are inadequate for the retainer assemblies selected.

- Unacceptable (any one of the following constitutes unacceptability)
  The abutment restorations show major areas lacking margin integrity and the material used and/or the contours are totally inadequate for the retainer assemblies chosen.

**COMPLETE DENTURE/ OVERDENTURE PROSTHODONTICS**

**Overdenture/Natural Teeth Abutment Preparations (without copings)**

- **Acceptable**
  Reduction is optimal. Contours are smooth with no undercuts. Occlusal or incisal restorations sealing the root canal and tooth surfaces are smooth and polished. Margins are supragingival with no ledging.

- **Acceptable**
  Reduction is generally adequate though not optimal. Occlusal or incisal restoration sealing the root canal are generally smooth and polished. Margins are supragingival with areas slightly roughened.

- **Marginal**
  Reduction is marginally acceptable with abutment(s) being over or under reduced. Occlusal or incisal restorations sealing the root canal and abutment surface are not smooth. Margins are mostly supragingival though some are subgingival.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Abutments have been over or under prepared to an extent that will compromise treatment outcome. Occlusal or incisal restorations and abutment surfaces are rough and poorly contoured. Significant portions of the margins are subgingival leaving marginal gingiva unsupported.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Abutments are grossly over or under reduced decidedly compromising treatment outcome. Abutment restorations and surfaces are very rough and poorly contoured. Most margins are subgingival resulting in unsupported marginal gingiva.

**Overdenture/Natural Teeth Abutment Preparations (for copings)**

- **Acceptable**
  Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Margin design is optimal for the preparation. Finish of the preparation displays finesse.

- **Acceptable**
  Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Margin design is generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.

- **Marginal**
  Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Margin design is questionable. Finish of the preparations is marginally adequate.

- **Unacceptable (any one of the following constitutes unacceptability)**
Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Margin design is inappropriate. Preparation finish is inadequate.

- Unacceptable (any one of the following constitutes unacceptability)
  Reduction, retention, resistance form, margin design, finish of the preparations.

Completed Overdenture Abutment Restorations
- Acceptable
  Restoration is physiologically compatible and well integrated with other elements of care.
- Acceptable
  Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- Marginal
  Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
- Unacceptable (any one of the following constitutes unacceptability)
  Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.
- Unacceptable (any one of the following constitutes unacceptability)
  Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

Occlusal Scheme
- Acceptable
  The occlusal scheme developed conforms to and demonstrates an acceptable technique.
- Marginal
  The occlusal scheme developed follows an acceptable technique. The candidate’s understanding of the principles and concepts of the technique is marginal.
- Unacceptable (any one of the following constitutes unacceptability)
  The occlusal scheme developed does not follow an acceptable technique.

Centric Relation/Maximum Intercuspation
- Acceptable
  Centric occlusion position and maximum intercuspidation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed in centric occlusion.
- Acceptable
  Centric occlusion contacts demonstrate minor variations which could be improved with minor occlusal adjustment.
- Marginal
  Centric occlusion contacts show minor variations which are within the range of occlusal adjustment but will require a remount to correct.
- Unacceptable (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspidation are not coincidental. Occlusal variations are present that cannot be corrected by conservative means.
- Unacceptable (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspidation are not coincidental. Gross occlusal variations exist. Discrepancies cannot be corrected by conservative means.
Esthetics

- Acceptable
  The selection, color and position of the anterior teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

- Acceptable
  The selection, color and position of the anterior teeth could be improved esthetically. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

- Marginal
  The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.

- Unacceptable (any one of the following constitutes unacceptability)
  The selection, color and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.

Denture Finish and Contour

- Acceptable
  Dentures exhibit no porosity. Tissue surfaces are free of sharp edges, nodules, and voids. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish. Thickness of the palate of the maxillary denture is uniform and approximately 2.5 mm.

- Marginal
  Dentures demonstrate minor areas of porosity. Tissue surfaces are mostly free of sharp edges but some nodules are apparent. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonably acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished. Thickness of maxillary denture palate is not uniform and is too thick or too thin.

- Unacceptable (any one of the following constitutes unacceptability)
  Dentures contain porosity throughout. Tissue surfaces contain many resin nodules or sharp resin fins. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces modified by grinding are rough. Maxillary denture palate is grossly too thick or too thin or palate is irregular with thin and thick areas. Denture or denture teeth have been fractured and not repaired or inadequately repaired.
OCCLUSION

- **Acceptable**
  Centric relation and maximum intercusption are coincident. Occlusal contacts are harmonious in centric relation and eccentric positions. The occlusal plane and type of teeth selected (material and cusp form) enhance the stability of the prosthesis.

- **Acceptable**
  Occlusal contacts are generally harmonious in centric relation and eccentric positions, but minor discrepancies exist.

- **Marginal**
  Occlusal contacts are compromised in either centric relation or eccentric positions. The choice of teeth and position of the occlusal plane is questionable.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Centric relation and maximum intercusption may not coincide. Occlusion has major discrepancies. Occlusal contacts may be lacking in centric relation. Undesirable eccentric contacts may be present. Occlusion is likely to be a pathogenic factor or create instability.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Centric relation and maximum intercusption do not coincide. Occlusion has gross discrepancies. Numerous occlusal errors in centric relation/eccentric positions would likely create major instability.

PROGNOSIS

- **Acceptable**
  Prognosis is realistic, based on an appropriate diagnosis, a well organized treatment plan and appropriate treatment.

- **Marginal**
  Prognosis is reasonable though slightly optimistic.

- **Unacceptable**
  Prognosis is not realistic.

WORK AUTHORIZATION FORM(S)

- **Acceptable**
  All pertinent information is present and clearly described.

- **Marginal**
  Information is generally adequate but some aspects are marginally covered.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Pertinent information has not been written, information is confusing, incomplete or no form was used.

CRITERION STATEMENTS FOR
PATIENT PRESENTATION
PARTS 3 AND 4

RECORDS

Preoperative Radiographs, Casts, Dies, Slides
- **Acceptable**
  Preoperative radiographs are originals, properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical “cut off.” Casts are clean, securely mounted and accurately reproduce the oral structures. Casts are free of any elements which would introduce error. Slides are properly exposed and exhibit the required information. All required views are present.
- **Marginal**
  Radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Slides are adequate but exposure and portrayal of required information could be improved. All required views are present.
- **Unacceptable** (any one of the following constitutes unacceptability)
  Radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement and apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Articulation instrument inadequately programmed or inappropriately used. Slides are improperly exposed or fail to exhibit the required information. Required views are missing.

Postoperative Radiographs, Casts, Dies, Slides
- **Acceptable**
  Postoperative radiographs are originals properly mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted, and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Slides are properly exposed and exhibit the required information. All required views are present.
- **Marginal**
  Postoperative radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Slides are adequate but exposure and portrayal of required information could be improved. All required views are present.
- **Unacceptable** (any one of the following constitutes unacceptability)
  Postoperative radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement and apical “cut off” seriously compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Slides are improperly exposed or fail to exhibit the required information. Required views are missing.
MEDICAL HISTORY/EXAMINATION FORM USED FOR REMOVABLE PROSTHODONTIC TREATMENT

- **Acceptable**
  All pertinent information has been collected and recorded accurately.

- **Marginal**
  Information is generally adequate but some aspects are marginally covered.

- **Unacceptable** (any one of the following constitutes unacceptability)
  Pertinent information has not been collected, not recorded accurately or no form was used.

PATIENT PRESENTATION

History and Clinical Examination

- **Acceptable**
  History records chief complaint, and account of current problems, past history of dental and general health, family history, personal history, and a review of systems. Clinical examination includes a general survey of patient condition, examination of the head and neck, examination of the soft tissues of the mouth, and detailed information gained from a comprehensive dental examination.

- **Marginal**
  History is adequate though in depth coverage of some elements is marginal. Clinical examination is adequate though some aspects of the examination are marginally covered.

- **Unacceptable** (any one of the following constitutes unacceptability)
  History is poorly organized and fails to elicit pertinent information. Omissions compromise the formulation of an accurate diagnosis. Clinical examination is deficient resulting in a lack of needed diagnostic information.

Diagnosis and Treatment Planning

- **Acceptable**
  Diagnosis is appropriate and supported by a thorough, systematic method of identifying oral disease. Treatment Plan is well organized and chronologically sequenced to prevent and correct oral disease.

- **Acceptable**
  Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment Plan is organized and chronologically sequenced to prevent and correct oral disease.

- **Marginal**
  Diagnosis is adequate though method used for formulating it is questionable. Treatment Plan is marginally adequate but not well organized.

- **Unacceptable** (any one of the following constitutes unacceptability)
  Diagnosis is inappropriate and is not supported by clinical findings. Treatment Plan is poorly organized and improperly sequenced. Patient could benefit by referral to another specialist.

- **Unacceptable** (any one of the following constitutes unacceptability)
  Diagnosis is clearly inappropriate and is not supported by clinical findings. Treatment Plan is grossly inadequate with errors in content and/or sequencing. Teeth have been inappropriately prepared, restored and/or extracted. Teeth that should have been treated were not. Patient should have been referred to another specialist.
FIXED PROSTHODONTICS

Overall Design Concept
- Acceptable
  All basic components of accepted design concepts have been considered and optimally applied.
- Acceptable
  All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- Marginal
  Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)
  Some of the basic components of accepted design concepts have not been addressed.
- Unacceptable (any one of the following constitutes unacceptability)
  Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

Abutment Preparation
- Acceptable
  Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Finish line design and location are optimal for the preparation. Finish of the preparation displays finesse.
- Acceptable
  Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Finish line design and location are generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.
- Marginal
  Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Finish line design or location is questionable. Finish of the preparations is marginally adequate.
- Unacceptable (any one of the following constitutes unacceptability)
  Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate, adjacent teeth damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.
- Unacceptable (any one of the following constitutes unacceptability)
  Reduction, retention, resistance form, finish line design, and the finish of the preparations are grossly inadequate. Gross undercuts present. Teeth have been prepared that did not need restoration. Existing restorations that have obvious deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

Other Restorative Procedures
- Acceptable
Restorative material is appropriate to situation in which employed; margins are well adapted; physiologic contours achieved; and post appropriate in length and design (if employed).

- Marginal
  Restorative materials, marginal adaptation, contours, post length and design, are marginally acceptable.
- Unacceptable (any one of the following constitutes unacceptability)
  Restorative material is inappropriate to the situation in which employed; margins are poorly placed or adapted; contours are poor and may be pathogenic; post length and design are inappropriate to the situation.

Provisional Restorations
- Acceptable
  The provisional restorations are esthetic, well contoured, show proper fit, show proper occlusion, and are not irritating to the tissues.
- Marginal
  The provisional restorations are generally acceptable but differences exist in esthetics, occlusion, contour, and tissue reaction.
- Unacceptable (any one of the following constitutes unacceptability)
  The provisional restorations are poorly contoured, unesthetic, lack proper fit, are irritating to the tissues, and lack adequate occlusion.

Pontics
- Acceptable
  Pontic form, tissue relationship, and axial contours are well designed.
- Marginal
  Form, contour, tissue relationship, are marginally acceptable.
- Unacceptable
  Gross inadequacies in pontic form, tissue relationships, contours.

Esthetics
- Acceptable
  Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved.
- Marginal
  Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable.
- Unacceptable (any one of the following constitutes unacceptability)
  Restoration is grossly different from the natural teeth. Result is unnatural with undesirable appearance.

Completed Restorations
- Acceptable
  Restoration is physiologically compatible and well integrated with other elements of care.
- Acceptable
  Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
• Marginal
  Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.

• Unacceptable (any one of the following constitutes unacceptability)
  Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.

• Unacceptable (any one of the following constitutes unacceptability)
  Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

REMovable PARTial PROSTHodontics

Overall Design Concept
  • Acceptable
    All basic components of accepted design concepts have been considered for both the edentulous and dentate areas.
  • Acceptable
    All basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. The method in which one or more of these components have been used may be controversial.
  • Marginal
    Most basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed have been justified upon oral examination.
  • Unacceptable (any one of the following constitutes unacceptability)
    Some basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed cannot be justified in the light of current knowledge.
  • Unacceptable (any one of the following constitutes unacceptability)
    Most basic components of accepted design concepts have not been addressed for both the edentulous and dentate areas.

Direct Retainer Assembly Selection
  • Acceptable
    An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
  • Marginal
    The type, number, and placement of most direct retainer assemblies are acceptable, but at least one direct retainer is unacceptable in type and/or placement.
  • Unacceptable (any one of the following constitutes unacceptability)
    The type, number, and placement of most direct retainer assemblies are unacceptable.

Rest(s)
  • Acceptable
    Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
Marginal
Most of the occlusal, cingulum, and incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.

Unacceptable (any one of the following constitutes unacceptability)
Most of the occlusal, cingulum, or incisal rests have been improperly placed to provide optimal support for the prosthesis.

Retention/Reciprocation
Acceptable
Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.

Marginal
Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.

Unacceptable (any one of the following constitutes unacceptability)
Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components is unacceptable for the type of prosthesis.

Indirect Retainer(s)
Acceptable
An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.

Marginal
An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation.

Unacceptable (any one of the following constitutes unacceptability)
An indirect retainer(s) has not been placed to resist rotation of the prosthesis around the fulcrum line.

Major Connector Selection/Placement/Size
Acceptable
The major connector selection is appropriate, it is appropriately placed and appears to be rigid. It is of the type that would provide maximum stabilization and support to the prosthesis and remaining oral structures.

Acceptable
The major connector selection is appropriate, it is placed within the scope of acceptable principles and it appears to be rigid. It is of the type that will provide adequate stabilization and support to the prosthesis and remaining oral structures.

Marginal
The major connector selection is appropriate, it appears to be rigid, but the placement and selection are questionable.

Unacceptable (any one of the following constitutes unacceptability)
Aspects of major connector selection, placement and/or rigidity are not adequate.
• Unacceptable (any one of the following constitutes unacceptability)
  Aspects of major connector selection, placement and/or rigidity are grossly inadequate.

Base(s) Coverage/Contour
• Acceptable
  The denture bases are extended and contoured properly within physiologic limits in order to give
  maximum stability and support to the prosthesis.
• Marginal
  The extent of the bases is marginally acceptable and the contour is questionable.
• Unacceptable
  The bases are grossly over or under extended and the contour is inadequate.

Abutment Restoration(s)
• Acceptable
  The abutment restorations have good marginal integrity and of the proper material and contour to
  permit ideal placement of the retainer assemblies.
• Acceptable
  The abutment restorations have good marginal integrity and are of proper material, but the
  contours might be less than ideal for the chosen retainer assemblies.
• Marginal
  The abutment restorations lack some marginal integrity and the material used and/or contours are
  less than ideal for proper placement of the retainer assemblies.
• Unacceptable (any one of the following constitutes unacceptability)
  The abutment restorations lack some areas of marginal integrity and the material used and/or
  contours are inadequate for the retainer assemblies selected.
• Unacceptable (any one of the following constitutes unacceptability)
  The abutment restorations show major areas lacking in marginal integrity and the material used
  and/or the contours are totally inadequate for the retainer assemblies chosen.

IMPLANT PROSTHODONTICS

Abutments
• Acceptable
  An adequate number of implants of proper length have been well distributed in the edentulous
  area and they appear to be physiologically compatible.
• Acceptable
  An adequate number of implants with generally adequate length have been distributed in the
  edentulous area and they appear to be physiologically compatible.
• Marginal
  The number, length, distribution of the implants is marginal but they appear to be physiologically compatible.

• Unacceptable (any one of the following constitutes unacceptability)
  The number, length, distribution of the implants is unacceptable and that may affect their physiologic compatibility.

• Unacceptable (any one of the following constitutes unacceptability)
  The number, length, distribution of the implants is unacceptable and the implants appear to not be physiologically compatible.

Overall Design Concept
• Acceptable
  All basic components of accepted design concepts have been considered and optimally applied.

• Acceptable
  All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.

• Marginal
  Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.

• Unacceptable (any one of the following constitutes unacceptability)
  Some of the basic components of accepted design concepts have been addressed. Those components not addressed cannot be justified in the light of current knowledge.

• Unacceptable (any one of the following constitutes unacceptability)
  Most basic components of accepted design concepts have not been addressed.

Complete Prosthesis
• Acceptable
  Prosthesis is properly contoured and finished and well integrated with other elements of care.

• Acceptable
  Prosthesis is generally properly contoured, finished and integrated with other elements of care.

• Marginal
  Prosthesis contour, finish or integration with other elements of care is marginal.

• Unacceptable (any one of the following constitutes unacceptability)
  Prosthesis contour, finish, integration with other elements of care is unacceptable.

• Unacceptable (any one of the following constitutes unacceptability)
  Prosthesis contour, finish, integration with other elements of care is grossly unacceptable.

COMPLETE DENTURES/OVERDENTURES

Overdenture/Natural Teeth Abutment Preparations (without copings)
• Acceptable
  Reduction is optimal. Contours are smooth with no undercuts. Occlusal or incisal restorations sealing the root canal and tooth surfaces are smooth and polished. Margins are supragingival with no ledging. Casts clearly document all of these requirements.

• Acceptable
Reduction is generally adequate though not optimal. Occlusal or incisal restoration sealing the root canal are generally smooth and polished. Margins are supragingival with areas slightly roughened. Casts clearly document these requirements.

- Marginal
  Reduction is marginally acceptable with abutment(s) being over or under reduced. Occlusal or incisal restorations sealing the root canal and abutment surface are not smooth. Margins are mostly supragingival though some are subgingival. Casts marginally document requirements.

- Unacceptable (any one of the following constitutes unacceptability)
  Abutments have been over or under prepared to an extent that will compromise treatment outcome. Occlusal or incisal restorations and abutment surfaces are rough and poorly contoured. Significant portions of the margins are subgingival leaving marginal gingiva unsupported. Casts do not document requirements.

- Unacceptable (any one of the following constitutes unacceptability)
  Abutments are grossly over or under reduced decidedly compromising treatment outcome. Abutment restorations and surfaces are very rough and poorly contoured. Most margins are subgingival resulting in unsupported marginal gingiva.

Overdenture/Natural Teeth Abutment Preparations (for copings)

- Acceptable
  Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Margin design is optimal for the preparation. Finish of the preparation displays finesse.

- Acceptable
  Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Margin design is generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.

- Marginal
  Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Margin design is questionable. Finish of the preparations is marginally adequate.

- Unacceptable (any one of the following constitutes unacceptability)
  Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Margin design is inappropriate. Preparation finish is inadequate.

- Unacceptable (any one of the following constitutes unacceptability)
  Reduction, retention, resistance form, margin design, and/or finish of the preparations are grossly inadequate.

Completed Overdenture Abutment Restorations

- Acceptable
  Restoration is physiologically compatible and well integrated with other elements of care.

- Acceptable
  Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.

- Marginal
  Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
• Unacceptable (any one of the following constitutes unacceptability)
Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.

• Unacceptable (any one of the following constitutes unacceptability)
Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

Maxillary Impression
• Acceptable
The flanges extend into the vestibule without impinging on movable tissue. The surface of the impression accurately reproduces the anatomy of the supporting tissues. The posterior extension of the impression includes the hamular notches and the posterior junction of the hard and soft palate.

• Acceptable
The border extensions are generally acceptable. There are some localized areas of over extension that can be corrected. The impression records the anatomy of the supporting tissues. The posterior extension includes the anatomic guides.

• Marginal
Some of the border extensions are generally acceptable with local areas of over or under extension. The impression records the anatomy of the tissues. The posterior extension of the impression includes the anatomic guides. Some voids present in impression. The border extensions are generally acceptable, with localized areas of over- or under extension. The impression records the anatomy of the tissues. There are some voids.

• Unacceptable (any one of the following constitutes unacceptability)
The border extensions are generally over- or under extended with the potential for loss of stability and/or retention. The impression lacks detail, and there are several voids.

• Unacceptable (any one of the following constitutes unacceptability)
The border extensions are grossly under- or overextended. The tissue registered by the impression lacks detail. There are voids and/or distortions evident.

Mandibular Impression
• Acceptable
The flanges extend into the vestibule without impinging on movable tissue. The tray covers, but does not extend beyond the retromolar pads. The surface of the impression contacting the supporting oral mucosa accurately reproduces the anatomy of these tissues. The impression material is evenly distributed in the impression tray.

• Acceptable
The border extensions are generally acceptable. There are also some localized areas that are overextended, but the conditions are correctable with minor alterations. The impression records the anatomy of the tissues. The impression material is evenly distributed in the impression tray.

• Marginal
The border extensions are generally acceptable, with local areas of over or under extension. The retromolar pads are only partially covered. The impression records the anatomy of the tissues. The impression material is evenly distributed in the impression tray; however, there are a few small voids.
• Unacceptable (any one of the following constitutes unacceptability)
The border extensions are generally over or under extended, with the potential for loss of
stability and/or retention. The tray does not contact the retromolar pads. The impression lacks
tissue detail, and there are several voids. The impression material is unevenly distributed in the
impression tray.
• Unacceptable (any one of the following constitutes unacceptability)
The border extensions are grossly under or overextended. The tissues registered lack detail. The
impression material is unevenly distributed in the impression tray, and there are several areas
where the tray has distorted tissue.

Maxillomandibular Relationship Records
• Acceptable
The methods used to establish centric relation records follow acceptable techniques. Casts are
properly poured, trimmed, and mounted. Record bases properly contoured. Mounted casts
clearly show these requirements.
• Marginal
The methods used to establish centric relation records follow acceptable techniques. Casts show
minor discrepancies which would be correctable with minor adjustments on the finished denture.
• Unacceptable (any one of the following constitutes unacceptability)
The methods used to establish centric relation records do not follow acceptable technique. Casts
show major discrepancies. Record bases are unacceptable.

Wax Trial Dentures
• Acceptable
The prosthetic teeth have been optimally arranged for function and esthetics and the wax is
nicely contoured and very smooth.
• Acceptable
The prosthetic teeth are arranged for good function and esthetics and the wax is properly
contoured and smooth.
• Marginal
The tooth arrangement is marginal and/or the wax contours and smoothness lack finesse.
• Unacceptable (any one of the following constitutes unacceptability)
The teeth are not acceptably arranged for function, esthetics. The wax contours, smoothness are
unacceptable.
• Unacceptable (any one of the following constitutes unacceptability)
There are gross discrepancies in tooth arrangement, waxing.

Cuspless Tooth Arrangements
Centric Occlusion/Maximum Intercuspatation
• Acceptable
Centric occlusion and maximum intercuspatation are coincidental. Occlusal contacts of the
posterior teeth are bilateral and simultaneous when closing the articulator in the centric occlusion
position. Similar relationships are demonstrated in the mouth.
• Marginal
Centric occlusion and maximum intercuspation are quite close to being coincidental. The occlusal contacts observed in centric occlusion demonstrate minor deflections which are within the correctable range. Similar relationships are shown in the mouth.

- **Unacceptable** (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspation are not coincidental. The occlusal contacts are grossly deflective. Correction will require resetting the teeth.

### Bilateral Cross-Tooth, Cross-Arch
**Balanced Articulation**
**Centric Occlusion/Maximum Intercuspation**
- **Acceptable**
  Centric occlusion and maximum intercuspation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed on the articulator in centric occlusion. A similar relationship is also shown in the mouth.
- **Marginal**
  Centric occlusion and maximum intercuspation are coincidental. The occlusal contacts demonstrate minor deflections which are within the correctable range. A similar relationship is shown in the mouth.
- **Unacceptable** (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspation are not coincidental. The occlusal contacts are grossly deflective. Correction will require resetting the teeth.

### Occlusal Vertical Dimension
- **Acceptable**
  The patient demonstrates an acceptable interocclusal distance in a closed position and a normal physiologic rest position.
- **Acceptable**
  The patient demonstrates an interocclusal distance that is less than ideal (slightly open with interocclusal space remaining or slightly closed).
- **Marginal**
  The patient demonstrates an interocclusal space that is considered to be closed 2 to 3 millimeters anteriorly.
- **Unacceptable** (any one of the following constitutes unacceptability)
  No interocclusal space or open occluding vertical dimension.
- **Unacceptable** (any one of the following constitutes unacceptability)
  Patient is excessively open or excessively closed.

### Centric Relation/Maximum Intercuspation
- **Acceptable**
  Centric occlusion position and maximum intercuspation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed in centric occlusion.
- **Acceptable**
  Centric occlusion contacts demonstrate minor variations which could be improved with minor occlusal adjustment.
• Marginal
Centric occlusion contacts show minor variations which are within the range of occlusal adjustment but will require a remount to correct.

• Unacceptable (any one of the following constitutes unacceptability)
Centric occlusion and maximum intercuspation are not coincidental. Occlusal variations are present that cannot be corrected by conventional means.

• Unacceptable (any one of the following constitutes unacceptability)
Centric occlusion and maximum intercuspation are not coincidental. Gross occlusal variations exist. Discrepancies cannot be corrected by conventional means.

Esthetics
• Acceptable
The selection, color and position of the anterior teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

• Acceptable
The selection, color and position of the anterior teeth could be improved esthetically. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

• Marginal
The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.

• Unacceptable (any one of the following constitutes unacceptability)
The selection, color and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.

• Unacceptable (any one of the following constitutes unacceptability)
The selection, color, and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics created are poor.

Denture Finish and Contour
• Acceptable
Dentures exhibit no porosity. Tissue surfaces are free of sharp edges, nodules, and voids. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish. Thickness of the palate of the maxillary denture is uniform and approximately 2.5 mm.

• Marginal
Dentures demonstrate minor areas of porosity. Tissue surfaces are mostly free of sharp edges but some nodules are apparent. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonable acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished. Thickness of maxillary denture palate is not uniform and is too thick or too thin.
Unacceptable (any one of the following constitutes unacceptability)
Dentures contain porosity throughout. Tissue surfaces contain many resin nodules or sharp resin fins. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces modified by grinding are rough. Maxillary denture palate is grossly too thick or too thin or palate is irregular with thin and thick areas. Denture or denture teeth have been fractured and not repaired or inadequately repaired.

MAXILLOFACIAL PROSTHETICS

Overall Design Concept
- Acceptable
  All basic components of accepted design concepts have been considered for both the defect and the non-defect areas.
- Acceptable
  All basic components of accepted design concepts have been addressed for both the defect and the non-defect areas. The method in which one or more of these components have been used may be controversial.
- Marginal
  Most basic components of accepted design concepts have been addressed for both the defect and the non-defect area. Those components not addressed might be justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)
  Some basic components of accepted design concepts have been addressed for both the defect and the non-defect areas. Those components not addressed cannot be justified in the light of current knowledge.
- Unacceptable (any one of the following constitutes unacceptability)
  All basic components of accepted design concepts have not been addressed for both the defect and the non-defect areas.

Direct Retainer Assembly Section
- Acceptable
  An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
- Marginal
  The type, number, and placement of most direct retainer assemblies are acceptable, but at least one direct retainer is unacceptable in type and/or placement.
- Unacceptable (any one of the following constitutes unacceptability)
  The type, number, and placement of most direct retainer assemblies is unacceptable.

Rest(s)
- Acceptable
  Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- Marginal
Most of the occlusal, cingulum, and incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.

- Unacceptable (any one of the following constitutes unacceptability)
  Most of the occlusal, cingulum, or incisal rests have been improperly placed to provide optimal support for the prosthesis.
Retention/Reciprocation

- **Acceptable**
  Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.

- **Marginal**
  Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.

- **Unacceptable (any one of the following constitutes unacceptability)**
  Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components is unacceptable for the type of prosthesis.

Indirect Retainer(s)

- **Acceptable**
  An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.

- **Marginal**
  An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line.

- **Unacceptable (any one of the following constitutes unacceptability)**
  An indirect retainer(s) has not been placed to resist rotation around the fulcrum line.

Major Connector Selection/Placement

- **Acceptable**
  The major connector appears to be rigid and appropriately placed. It is of the type that would give maximum stabilization and support to the prosthesis and remaining oral structures.

- **Marginal**
  The major connector is marginally acceptable. It appears to be rigid, but the placement and selection are questionable.

- **Unacceptable (any one of the following constitutes unacceptability)**
  The major connector appears not to be rigid and its placement and selection are questionable.

Base(s) Coverage/Contour (Non-defect area, if present)

- **Acceptable**
  The bases in the non-defect area/areas are extended and contoured properly within physiological limits in order to give maximum stability and support to the prosthesis.

- **Marginal**
  The extent of the bases in the non-defect area or areas is marginally acceptable and the contour is questionable.

- **Unacceptable (any one of the following constitutes unacceptability)**
  The bases are grossly over or under extended and the contour is inadequate.
Obturator Extension/Contour

- **Acceptable**
The extent and contour of the bases in the defect areas are appropriate.

- **Marginal**
The extent of the bases in the non-defect area or areas is marginally acceptable and the contour is questionable.

- **Unacceptable** (any one of the following constitutes unacceptability)
The extent and contour of the bases are inadequate.

Design

- **Acceptable**
The design and materials used are appropriate for the type of defect to be obturated.

- **Acceptable**
The design and materials used are generally adequate but not optimal for the type of defect to be obturated.

- **Marginal**
The design and materials used are marginally acceptable for the type of defect to be obturated.

- **Unacceptable** (any one of the following constitutes unacceptability)
The design is overly or under simplified and the materials used are inappropriate for the type of defect to be obturated.

- **Unacceptable** (any one of the following constitutes unacceptability)
The design and materials used are grossly inadequate for the type of defect to be obturated.

Abutment Restoration(s)

- **Acceptable**
The abutment restorations have good marginal integrity and are of the proper material and contour to permit ideal placement of the retainer assemblies.

- **Acceptable**
The abutment restorations have good marginal integrity and are of proper material, but the contours might be less than ideal for the chosen retainer assemblies.

- **Marginal**
The abutment restorations lack some marginal integrity and the material used and/or contours are less than ideal for proper placement of the retainer assemblies.

- **Unacceptable** (any one of the following constitutes unacceptability)
The abutment restorations lack some areas of marginal integrity and the material used and/or the contours are inadequate for the retainer assemblies selected.

- **Unacceptable** (any one of the following constitutes unacceptability)
The abutment restorations show major areas lacking in marginal integrity and the material used and/or the contours are totally inadequate for the retainer assemblies chosen.
OCCLUSION

- Acceptable
  Centric occlusion and maximum intercuspation are coincident. Occlusal contacts are harmonious in centric occlusion and eccentric positions. The occlusal plane and type of teeth selected (material and cusp form) enhance the stability of the prosthesis.
- Acceptable
  Occlusal contacts are generally harmonious in centric occlusion and eccentric positions, but minor discrepancies exist.
- Marginal
  Occlusal contacts are compromised in either centric occlusion or eccentric positions. The choice of teeth and position of the occlusal plane is questionable.
- Unacceptable (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspation may not coincide. Occlusion has major discrepancies. Occlusal contacts may be lacking in centric occlusion. Undesirable eccentric contacts may be present. Occlusion may create instability for the prosthesis.
- Unacceptable (any one of the following constitutes unacceptability)
  Centric occlusion and maximum intercuspation do not coincide. Occlusion has gross discrepancies. Numerous occlusal errors in centric occlusion and eccentric positions would likely create major instability for the prosthesis(es).

PROGNOSIS

- Acceptable
  Prognosis is realistic, based on an appropriate diagnosis, a well organized treatment plan and appropriate treatment.
- Marginal
  Prognosis is reasonable though optimistic.
- Unacceptable
  Prognosis is not realistic.

WORK AUTHORIZATION FORM(S)

- Acceptable
  All pertinent information is present and clearly described.
- Marginal
  Information is generally adequate but some aspects are marginally covered.
- Unacceptable (any one of the following constitutes unacceptability)
  Pertinent information has not been written, information is confusing, incomplete or no form was used.
CRITERION STATEMENTS FOR
ORAL EXAMINATION
PARTS 2, 3 AND 4

- Acceptable
  The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates a superior understanding of the broad scope of Prosthodontics.

- Acceptable
  The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates an adequate understanding of the broad scope of Prosthodontics.

- Marginal
  The candidate responds adequately to questioning associated with the patient presentation. The candidate understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate’s understanding of the broad scope of Prosthodontics is marginal.

- Unacceptable (any one of the following constitutes unacceptability)
  The candidate’s response to questioning associated with the patient presentation is not adequate. Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate’s understanding of the broad scope of Prosthodontics is not adequate.

- Unacceptable (any one of the following constitutes unacceptability)
  The candidate’s response to questioning associated with the patient presentation is not adequate. The candidate’s patient presentation is technically poor and he/she cannot justify the rationale for the specific treatment provided. The candidate’s understanding of the broad scope of Prosthodontics is not adequate.
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<th>Year</th>
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<tr>
<td>1994-95</td>
<td>Dr. Ronald D. Woody</td>
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<td>1995-96</td>
<td>Dr. Howard M. Landesman</td>
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<td>1996-97</td>
<td>*Dr. Robert Staffanou</td>
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<td>Dr. Richard J. Grisius</td>
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<td>Dr. Charles J. Goodacre</td>
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<td>Dr. Edward J. Plekavich</td>
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<td>2000-2001</td>
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<td>2002-2003</td>
<td>Dr. Robert J. Cronin</td>
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<td>2003-2004</td>
<td>Dr. Steven A. Aquilino</td>
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<td>2004-2005</td>
<td>* Dr. Carl J. Andres</td>
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<td>2005-2006</td>
<td>Dr. Stephen D. Campbell</td>
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<td>2006-2007</td>
<td>Dr. John R. Agar</td>
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<td>2007-2008</td>
<td>Dr. Roy Yanase</td>
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<td>2008-2009</td>
<td>Dr. Kenneth A. Malament</td>
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<td>2009-2010</td>
<td>Dr. Stephen M. Parel</td>
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<td>2010-2011</td>
<td>Dr. Rhonda F. Jacob</td>
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* Deceased
Board Certification in Prosthodontics
Heather J. Conrad DMD, MS, FACP, FRCD(C)
Diplomate American Board of Prosthodontics
2012 Update

What does Board Certification mean?
- Wikipedia
  The process by which a physician, dentist, pharmacist, or podiatrist, demonstrates through either written, practical, and/or simulator based testing, a mastery of the basic knowledge and skills that define an area of medical specialization.

- American Board of Family Medicine
  "Demonstrates exceptional expertise in a particular specialty of practice.
  "Involves a rigorous process of testing and peer evaluation that is designed and administered by specialists in the specific area of medicine.
  "Exhibits dedication to providing exceptional patient care through a rigorous, voluntary commitment to lifelong learning.

ABP Mission Statement
- To certify individuals who
  - Have demonstrated special knowledge and skills in prosthodontics
  - are committed to life-long learning and a lifetime of ethical practices
  - value the doctor/patient relationship
  - respect those with philosophical, cultural or physical differences
  - are committed to the advancement of prosthodontics

Board Eligible
- After successful completion of an advanced educational prosthodontic program accredited by CODA, an individual is considered Educationally Qualified
- An individual is not Board Eligible unless your application has been submitted to and approved by the Board
- All phases of the examination must be successfully completed within 6 years of initial eligibility
- Graduate residents who take the written examination in their 3rd year do not have to apply for eligibility unless they also wish to take one of the patient presentation examinations
- Successful completion of the written examination is not time dependent and does not expire

Changes to the ABP Process
- Most recent changes:
  - Section A – 2006 – computer-based testing was initiated
  - Section C – 2008 – substantive changes were made to the oral examination process – scenario-based examinations
  - Section B – 2011 – modifications were made to the oral patient presentation examinations to make them more relevant to current prosthodontic treatment principles
Section A Examination

- Former Part I
- Computer-based written examination given during the month of April each year at 200 Pearson VUE professional testing centers located regionally in the 48 contiguous United States
- Application deadline is 90 days prior to the examination date
- May take in the third year of prosthodontic training prior to establishing Board eligibility

Section A Examination

- Criterion-referenced examination
- Written to measure the knowledge and skills of qualified candidates
- Fixed, implant, and removable prosthodontics, occlusion
- Pharmacology, biomaterials, craniofacial anatomy and physiology, radiology, geriatrics, infection control, implant placement, MFP, medical emergencies, oral pathology, preprosthetic surgery, research methodology, TMD and orofacial pain
- Current prosthodontic literature
- 175 multiple choice questions
- 4.5 hours

Section B Examination

- Formerly Parts 2, 3, and 4
- Candidate-generated patient presentations taken in any order that include oral examinations
- May take one patient presentation examination during the February examination period while in the third year of training in addition to Section A
- All patient treatments may have been performed during the training program
- At least one treatment must include implant prosthodontics
- Documentation and presentation are more important than an overly difficult treatment – select cases that are not controversial
- Application deadline is 30 days prior to the examination date

Section B Examination

- Formerly Parts 2, 3, and 4
- "Part 2 – Fixed/Removable"
- "Part 3 – Fixed"
- "Part 4 – Removable"

Section B Examination Changes

- Formerly Parts 2, 3, and 4 – Changes in the:
  - Number of fixed natural tooth units in Parts 2 & 3
    - Part 2 – increase from 2 to 4
    - Part 3 – decrease from 20 to 14
  - Number of fixed implant restorations required overall for Section B
    - OLD – one of the presentations must include the use of dental implants
    - NEW – Must complete at least 4 dental implants supporting fixed restorations in one or any combination of patient treatments
  - Requirements for the opposing occlusion for Part 2 – can no longer be a CD or overdenture
Section B Examination Changes

- Formerly Parts 2, 3, and 4 – Changes in the:
  - Laboratory work requirements
    - Laboratory work for one of the patient treatments (OLD was limited to Part 2) must be performed by the candidate with the exclusion of removable partial dentures framework fabrication which may be performed by a laboratory technician.
    - Any laboratory work not completed by the candidate must have an accompanying work authorization
    - Candidate must declare in writing for which of the treatments the laboratory work was accomplished by the candidate.

- ‘OLD Requirements’ – acceptable for presentation through November 2014
- Must select either the OLD requirements for all Section B or select the NEW 2011 requirements
- Candidates who have begun the Section B process under the OLD requirements must finish the Section B parts by November 2014 or else the candidate would have to repeat the Part B presentations using the NEW 2011 requirements.
- If a candidate has not presented any Part B patient presentations as of June 2011, he/she may elect to employ the NEW 2011 requirements immediately.

Format for Section B Presentations

- Aspects of therapy must be presented in the following order:
  - History and chief complaint
  - Clinical findings
  - Diagnosis
  - Treatment plan
  - Treatment
  - Completed treatment
  - Prognosis

- No limit to the number of slides shown as long as presentation is completed within 20 minutes – only one image may be presented per slide.
- Candidate is responsible for bringing laptop and connection adapters and for any technical difficulties with projection.
- Candidate must provide Board with a CD-ROM of required labeled images.
- An original post-treatment full mouth series of radiographs must be handed in upon completion and become the property of the Board.
- Specific requirements for pre-treatment, treatment, and post-treatment:
  - Radiographs, casts, and color photographs.

Section C Examination

- New since 2008
- Includes three 20 minute scenario-based examinations for a total of 1 hour.
- Section C may replace one of the oral patient presentation examinations in Section B.
- Candidates may either
  - Take all 3 parts of Section B or
  - Take any 2 parts of Section B plus Section C.

Fees

- Application fee $200
- Section A computer-based written exam $375
- Section B patient exams $250 each
- Section C scenario exam $250
- Total $1325
- Application forms and fees are submitted to the Executive Director of the ABP
  - Thomas Taylor
Section B Case Presentation

Part 2
Fixed/Removable

Section B – Part 2

OLD Requirements
- Must submit a patient history and treatment record of a patient whose treatment included at least one RPD and 2 crowns
- Crowns may restore natural teeth or implants and may be in either arch
- If all the required prostheses are in the same arch, the opposing arch may include an appropriately restored natural or artificial dentition

NEW Requirements
- Treatment consists of a removable partial denture prosthesis for either arch and the fabrication of at least 4 crowns that restore natural teeth in either arch
- It is not required that the fixed restorations serve as abutments for the RPD
- Treatment cannot include a complete denture or complete overdenture as part of the treatment

Frontal Smiling
- 48 years of age
- Female
- Caucasian
- CC: “After a bike crash in September 2003, I had joint pain which has healed; however, I still have pain in #21. My partial denture was broken and I can’t wear it anymore.”

Rest Position

- Medical History
  - NSF
  - No medications
  - No known allergies
- Vital signs
  - BP 128/80 mm Hg
  - HR 72 beats/minute
  - Respiration 14/minute
- Non-smoker

Profile

- Dental History
  - Bike accident in 09/03 caused the fracture of her existing mandibular RPD and #21
  - #21 was unsuccessfully treated with a crown and then RCT
Occlusal Views

Maximum Intercuspation

Right Working/Left Non-Working

Left Working/Right Non-Working

Protrusion

Panoramic Radiograph
Pre-Treatment
Complete Periapical Radiographic Series

Periodontal Charting

Diagnosis
- Maxillary and mandibular partial edentulism.
- Defective metal-ceramic restoration and failed root canal therapy #21.
- Generalized mild gingivitis and bleeding on probing.
- Defective composite restorations #24 and 25.
- Slight mobility, distal drifting, and working side contact #28.
- Altered occlusal plane due to missing teeth.
- Porcelain wear #5.
- Mesial drift of #2 and 3 to narrow space for #4.

Treatment Plan
- Preventive Procedures – Oral hygiene instruction and oral prophylaxis
- Surgical Procedures – Extraction of #21
- Operative Procedures – Class III metal composite restorations on #24 and 25
- Fixed Prosthodontic Procedures
  - #27 – A surveyed metal-ceramic crown with a porcelain shoulder margin, facial veneer of porcelain, distal guide plane, cingulum rest, and a mesial-buccal undercut of 0.02.
  - #27 – A surveyed metal-ceramic crown splinted to #26 with a porcelain shoulder margin, facial veneer of porcelain, and a mesial-buccal undercut of 0.02.
- Removable Prosthodontic Procedures
  - #22 – A surveyed metal-ceramic crown with a porcelain shoulder margin, facial veneer of porcelain, cingulum rest, and a mesial-buccal undercut of 0.02.
  - #27 – A surveyed metal-ceramic crown splinted to #28 with a porcelain shoulder margin, facial veneer of porcelain, distal guide plane, cingulum rest, and a mesial-buccal undercut of 0.02.
- #22 – A surveyed metal-ceramic crown splinted to #28 with a porcelain shoulder margin, facial veneer of porcelain, distal guide plane, cingulum rest, and a mesial-buccal undercut of 0.02.
- #28 – A surveyed metal-ceramic crown splinted to #27 with a porcelain shoulder margin, facial veneer of porcelain, distal guide plane, cingulum rest, and a mesial-buccal undercut of 0.02.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
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- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Indirect retainer - #27 cingulum rest.
- Mounted Diagnostic Casts
- Diagnostic Casts
Diagnostic Wax-Up

Occlusal View of Preparations
- Preparation Design
  - Garguilo – biologic width
    - Combined CT-EE attachment from the crest of the alveolar bone to the base of the gingival sulcus
  - Gilboe – fundamentals of extracoronal tooth preparation
  - Guyer – four elements of tooth preparation
  - Eissmann – margins should be fully exposed to cleansing action and have a smooth transition from restoration to tooth

Final Impression
- Benson – tissue displacement methods
  - Mechanical methods
    - Knitted retraction cord (non-impregnated)
  - Mechanicochemical methods
    - Ferric sulfate – good tissue response, compatible with aluminum chloride, extended working time, good displacement; not compatible with E (massive blue precipitate develops); transient tissue discoloration, unpleasant taste
  - Rotary gingival curettage – using rotary diamond instruments to enlarge sulcus
  - Electrosurgical methods – fully rectified surgical current

Temporary Restorations

Mounting Mandibular Cast
Full Contour Wax-Up and Matrices

- Splinting
- Applegate – recommends splinting adjacent teeth so that traumatized teeth are effectively stabilized to achieve bone regeneration
- Steffel – teeth splinted together by fixed restorations provide strong abutments
- Praden – splint weak teeth to prolong their life

Cut Back & Investing

- Investment
  - GC Fujivest II – phosphate bonded
  - Greater flexibility in controlling expansion
- Ceramic Alloy
  - Eclipse – 92% Gold, 7.5% Palladium
  - Substituting Palladium for Gold
  - Lenses the thermal coefficient of expansion
- Indium, Tin, Iron
- Oxides
- Rhenium, Ruthenium
- Grain refining
- Castability
- Extremely high melting temperatures

Prepare Casting

- Hobo – metal design
  - Labial surface reduced in two planes, shallower lingual reduction, incisal reduction paralleling incisal edge, round corners
  - Occlusal contacts in metal and away from P-M finish line by 2mm, junction should not extend too far incisally

Margins Trimmed for Porcelain

- Vita Omega 900
  - Firing temperature 900°C
  - Leucite
  - Reinforcing phase
  - Increases CTE to match that of the alloy
- Feldspar
  - Main raw ingredient
  - Potassium aluminum silicate

Oxidation

- Bonding mechanisms
  - Mechanical entrapment
  - Compressive forces
  - Van der Waal’s forces
  - Chemical bonding

Wash Opaque, Opaque, & Porcelain Margins
Dentin & Enamel

Finish Metal

Survey Crowns

Ready for Delivery

Maximum Intercuspation

Right Working/Left Non-Working
Occlusal View

- McCracken’s
  - Design of occlusal rest
    - Rounded triangular shape
    - Reduction of marginal ridge by 1.5mm
    - Floor should be apical to marginal ridge
    - Angle formed by occlusal rest and vertical minor connector should be less than 90°
  - Design of cingulum rest
    - Lingual slope of mandibular canine usually too steep
    - Slightly rounded ‘V’
    - Wall must provide a definite seat
      - Located closer to the marginal ridge
      - Does not tend to tip the tooth

Framework Final Impression & Master Cast

- Henderson – lingual plate
  - All the remaining teeth contribute to resisting destructive horizontal forces
- Applegate – combination clasp
  - Omni-directional flexure
  - More esthetic
  - Decreased tooth coverage
- Steffel – elastic clasps
  - More efficient for retention
  - Less traumatizing to abutment teeth than clasps
- Kratochvil, Krol, & Demer – proximal plates

Survey Master Cast

Framework Design
Framework

- Alloy – Vitallium 2000
  - 63.8% cobalt – increases elastic modulus, strength, hardness
  - 28.5% chromium – corrosion resistance
  - 8% molybdenum – strength
  - ≤1% carbon – hardness
  - ≤1% silicon/manganese – aids castability
  - Highest elastic modulus and hardness
  - Casting temperature 1400-1500°C
  - Phosphate bonded investment

Advantages
- Lower density, high modulus of elasticity, low cost, resistance to tarnish

Stress-Strain Curve

- Elastic modulus (rigid vs flexible)
- Proportional Limit
- *Yield Strength
- *Ultimate Tensile Strength
- Ductility/Elongation
- Area 1 - elastic region/resilience
- Area 2 - plastic region
- Area 1 & 2 - toughness

Altered Cast Impression

- Holmes – alerted cast
  - Dual nature of available support – rigid teeth, resilient mucosa, and underlying bone
  - Least amount of movement from occlusal loading

- Taylor – good adaptation of the base far outweighs the importance of clasp design on a well-fitting framework

- Boucher – selective pressure impression technique
  - Uses supporting tissues that are anatomically favorable to withstanding pressure

Prepare Altered Cast

Completed Altered Cast

Wax Rim
Mount Mandibular Cast

Protrusive Record

Wax Set-Up & Try-In

Flasking & Processing

Pick-Up Impression & Clinical Remount

Clinical Remount

- Pick-Up Impression & Clinical Remount
  - Weinberg – semi-adjustable articulator
  - Hanau – `realfeel` – resiliency and life effect of the soft tissue
  - Hanau Wide-Vue Artesen
  - Adjustable OVP, LCP, reciprocating guide table
  - Protrusive record used to determine protrusive inclination
  - Bennett angle calculated by formula
    \[ \frac{H}{8} + 12 \]
  - Balancing condylar movement is downward, forward, and medial
  - Working condylar movement is built into the machine and varies only in amount

- Clinical Remount
  - Colman – occlusal requirements for RPD
  - When the anterior teeth in the opposing arches supply the guiding factors to the occlusal scheme, the extension base should have only centric occlusal contact.
  - The support for an extension base must be distributed between both the residual ridge and the remaining teeth so that neither is individually overloaded.
Part 3 Case Presentation

Fixed

Part 3 Fixed Prosthodontic Treatment

OLD Requirements
- Fixed reconstruction that includes at least 20 units
  - Must include one complete arch and a minimum of 6 units in the opposing arch
  - Units may be implant supported but there must be a minimum of 8 natural teeth restored

NEW Requirements
- No removable prosthesis included
- Fixed reconstruction that includes at least 14 units that restore the articulating surfaces of the teeth
  - Units may be implant supported but there must be a minimum of 6 natural teeth restored
  - Candidate should seriously consider replacement of all foundation restorations and should be prepared to justify foundation material selected

CC: “My teeth are literally beginning to fall apart. All of the teeth in my lower jaw and half of the teeth in my upper jaw are now chipped and my upper incisors are cracked.”
Frontal Smiling

- Medical History
- BP 125/72 mm Hg, Pulse 72 beats/min
- Depression (since 1989)
  - Depakote 1500 mg/day
  - Antidepressant used for manic episodes in bipolar disorder
- Wellbutrin 1500 mg/day
  - Antidepressant and NE reuptake inhibitor
- Zoloft 50 mg/day
  - Serotonin reuptake inhibitor
- Gastroesophageal Reflux Disease (1984-2002)
  - Nonprescription
  - Antacid (Pepto-Bismol)
  - H2 receptor antagonist (Zantac)
- Prescription
  - Proton Pump Inhibitor (Nexium)
- Alternative healer

Profile

- Dental History
- Facial pain associated with nocturnal bruxism & diurnal clenching
  - Mandibular splint made in 1993 decreased symptoms
- Generalized erosion, attrition, and abrasion
- Dental sensitivity to acidic and cold foods: apples, oranges, tangerines, pineapple, salad dressings containing vinegar, iced drinks, ice cream
- #19 sensitive to pressure

Occlusal Views

Maximum Intercuspaition

Right Working/Left Non-Working

Left Working/Right Non-Working
Protrusive

Periodontal Charting

Treatment Plan

- Preventive Procedures
- Oral hygiene instruction and oral prophylaxis
- Surgical Procedures
- Extraction of #19
- Endodontic Procedures
  - Prophylactic root canal therapy #6, 8, 21, 22, 27, and 28, due to a lack of coronal tooth structure
- Periodontal Procedures
  - Connective tissue graft buccal #3-5
- Fixed Prosthodontic Procedures
  - Cast post & core #6, 8, 21, 22, 27, and 28, and replacement of core restorations
  - Full coverage metal ceramic crowns to restore a mutually protected articulation
  - Contact points #6, 15, 11-13
  - IPS e.max crowns on anterior teeth and teeth with extensive subgingival caries on posterior teeth
- Post Treatment Procedures
  - Instructions to the patient on proper maintenance of restorations, and establishment of a recall schedule.
  - Occlusal device constructed of heat processed acrylic resin for use during the day or night
  - Post treatment records

Pre-Treatment
Complete Periapical Radiographic Series

Diagnosis
- Bruxism leading to attrition and stress induced cervical lesions
- Erosion resulting from history of GERD
- Working side contacts bilaterally and right side balancing contacts
- Compromised esthetics with chipped and uneven incisal edges, discolored crowns, and minimal tooth display
- Dental sensitivity to acidic and cold foods
- Failed RCT #19 due to a cracked root diagnosed at an endodontic consult
- Periodontal concerns included:
  - Generalized mild gingivitis
  - Furcation involvement
  - Attachment loss #3-5
  - Depression

Preliminary Casts
Denar® Cadiax® Compact
TMJ Movement Recording

 Mounted Diagnostic Casts

 Diagnostic Wax Up

 Maxillary Occlusal View

 Mandibular Occlusal View

 Maxillary CP&C
Mandibular CP&C

Delivery Mandibular CP&C

Occlusal Views of Tooth Preparations

Provisional Restorations

Final Impressions

Master Casts
Mounted Master Casts

Stained, Glazed, & Polished

Frontal and Profile in Occlusion

Rest Position & Full Smile

Occlusal Views

Maximum Intercuspation
Right Working/Left Non-Working

Left Working/Right Non-Working

Protrusion

Post-Treatment Complete Periapical Radiographic Series

Final Prosthesis Impressions

Mandibular Splint
Final Prosthesis

Part 4 Case Presentation

Removable

Part 4 Removable Prosthodontic Treatment

OLD Requirements
May consist of any of the following:
- CD/CD
- CD or overdenture/overdenture – supported by natural teeth or implants
- CD or overdenture/RPD, implant supported fixed complete denture, or implant supported fixed partial denture
- Obturator/CD, RPD, or implant prosthesis

NEW Requirements
May consist of any of the following:
- CD/CD
- CD or overdenture opposing an overdenture – supported by natural teeth or implants
  - Implants functioning as overdenture abutments will not be counted towards fulfilling the global ABP requirement of 4 implants
- CD, overdenture, or complete obturator prosthesis opposing natural teeth or any method of restoring the opposing arch
- CD/CD MUST demonstrate bilateral balanced articulation

Full Face Frontal

64 years of age
Male
Caucasian
CC: “I would like to have implants in my bottom jaw to help hold my denture in.”

Frontal Smiling

Medical History
- BP 136/85 mm Hg, Pulse 72 beats/min
- Diabetes II
  - Metformin 500mg – oral hypoglycemic
  - Controlled with diet & exercise
- Hypertension
  - Lisinopril 5mg – ACE inhibitor
- Hypercholesterolemia
  - Lovastatin 10mg – cholesterol-lowering agent
- Arthritis
  - Naprosyn – nonsteroidal anti-inflammatory
- No known allergies
Full Face Profile
- Dental History
- Extraction of periodontally hopeless and decayed teeth in December 2004
- Delivery of immediate CUD/CLD

Anterior View of Ridges at OVD

Occlusal Views of Edentulous Ridges

Panoramic Radiograph

Occlusal View of Pre-Treatment Casts

Mounted Diagnostic Casts of Ridges at OVD
Diagnosis

- Maxillary and mandibular edentulism
- Need for replacement of immediate CUD/CLD
- Patient desire for mandibular implant supported overdenture

Treatment Plan

- Pre-Treatment
  - Duplication of CLD and surgical guide fabrication
- Surgical Procedures
  - Mandibular alveoplasty of 7 mm to increase the interocclusal space and lingually to further reduce the tori
  - Placement of 3 implants at sites 21, 22, 24, 27, 28
    - Lifecore external hex
      - 3 central implants 3.75*15 mm
      - 2 distal implants 3.75*13 mm
- Removable Prosthetic Procedures
  - Relining of existing CDs as required
  - Fabrication of a standard CUD
  - Fabrication of an implant supported CLD with a bar and Locator attachments
- Post Treatment Procedures
  - Instructions to the patient on proper maintenance of prosthesis and establishment of a recall schedule
  - Prosthesis adjustments
  - Post treatment records

Surgery

Stage 1

Stage 2

Healing Abutments
<table>
<thead>
<tr>
<th>Stabilized Record Bases</th>
<th>Maxillary Relations</th>
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<tbody>
<tr>
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<td><img src="image2.png" alt="Maxillary Relations" /></td>
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<tr>
<th>Mandibular Relations</th>
<th>Centric Relation</th>
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<td><img src="image3.png" alt="Mandibular Relations" /></td>
<td><img src="image4.png" alt="Centric Relation" /></td>
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<th>Initial Wax Try-In</th>
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<td><img src="image5.png" alt="Verify Centric Relation" /></td>
<td><img src="image6.png" alt="Initial Wax Try-In" /></td>
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</table>
Occlusal Views

A-P Spread

Implant Bar Wax-Up

Implant Bar Try-In

Locator Attachments

Final Wax Set-Up
Occlusal Views

Remount Jig

Flanking

Boil Out

Block Out with Plaster

Separate Bar from Denture
Intaglio Surface

Prepare for Clinical Remount

Verify Centric Relation

Polished Surfaces

Centric Relation Record

Clinical Remount
Lingualized Balanced Occlusion

Maximum Intercuspation

Right Working/Left Non-Working

Left Working/Right Non-Working

Protrusion

Final Prosthesis
Final Prosthesis

Frontal and Profile in Occlusion

Frontal Full Face Smile

Thank you
Accreditation Standards for
Advanced Specialty Education Programs in
Prosthodontics

Commission on Dental Accreditation
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611-2678
(312) 440-4653
www.ada.org

Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes. (Adopted April 2003)

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American Dental Association
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### Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics

#### Document Revision History

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<tr>
<th>Date</th>
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<tr>
<td>July 31, 2008</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics</td>
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<tr>
<td>January 1, 2009</td>
<td>Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics</td>
<td>Implemented</td>
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<td>August 5, 2011</td>
<td>Revised Policy on Program Changes</td>
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<td>February 3, 2012</td>
<td>Revised Policy on Program Changes</td>
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<tr>
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<td>Revised Policy on Off-Campus Sites</td>
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Mission Statement of the Commission on Dental Accreditation

The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs.

Commission on Dental Accreditation
Revised: January 30, 2001
Accreditation Status Definitions

Programs That Are Fully Operational:

**Approval (without reporting requirements):** An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

**Approval (with reporting requirements):** An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

Programs That Are Not Fully Operational:

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

**Initial Accreditation** is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).
Preface

Maintaining and improving the quality of advanced education in the nationally recognized specialty areas of dentistry is a primary aim of the Commission on Dental Accreditation. The Commission is recognized by the public, the profession, and the United States Department of Education as the specialized accrediting agency in dentistry.

Accreditation of advanced specialty education programs is a voluntary effort of all parties involved. The process of accreditation assures students/residents, specialty boards and the public that accredited training programs are in compliance with published standards.

Accreditation is extended to institutions offering acceptable programs in the following recognized specialty areas of dental practice: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics. Program accreditation will be withdrawn when the training program no longer conforms to the standards as specified in this document, when all first-year positions remain vacant for a period of two years or when a program fails to respond to requests for program information. Exceptions for non-enrollment may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from an institution stating reasons why the status of the program should not be withdrawn.

Advanced education in a recognized specialty area of dentistry may be offered on either a certificate-only or certificate and degree-granting basis.

Accreditation actions by the Commission on Dental Accreditation are based upon information gained through written submissions by program directors and evaluations made on site by assigned consultants. The Commission has established review committees in each of the recognized specialties to review site visit and progress reports and make recommendations to the Commission. Review committees are composed of representatives selected by the specialties and their certifying boards. The Commission has the ultimate responsibility for determining a program’s accreditation status. The Commission is also responsible for adjudication of appeals of adverse decisions and has established policies and procedures for appeal. A copy of policies and procedures may be obtained from the Director, Commission on Dental Accreditation, 211 East Chicago Avenue, Chicago, Illinois 60611.

This document constitutes the standards by which the Commission on Dental Accreditation and its consultants will evaluate advanced programs in each specialty for accreditation purposes. The Commission on Dental Accreditation establishes general standards which are common to all dental specialties, institutions and programs regardless of specialty. Each specialty develops specialty-specific standards for education programs in its specialty. The general and specialty-specific standards, subsequent to approval by the Commission on Dental Accreditation, set forth the standards for the education content, instructional activities, patient care responsibilities, supervision and facilities that should be provided by programs in the particular specialty.

General standards are identified by the use of a single numerical listing (e.g., 1). Specialty-specific standards are identified by the use of multiple numerical listings (e.g. 1-1, 1-1.2, 1-2).
REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program’s potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. Reporting changes in the Annual Survey does not preclude the requirement to report changes to the Commission. Failure to report and receive approval in advance of any increase in enrollment or other change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program’s accreditation status. Advanced specialty education programs must adhere to the Policy on Enrollment Increases in Advanced Specialty Programs.

The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breech of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

When a change is planned, Commission staff should be consulted to determine reporting requirements. This report must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the ADA website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported at least thirty (30) days prior to a regularly scheduled, semi-annual Review Committee meeting and must be reviewed by the appropriate Review Committee and approved by the Commission to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites
- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another;
- Program director qualifications not being in compliance with the standards;
- Substantial increase in program enrollment beyond the apparent resources of the program. (Specialty programs see Policy on Enrollment Increases In Advanced Specialty Programs);
- Significant change in the nature of the program’s financial support;
- Curriculum changes that eliminate content areas required by the standards;
- Modification or reduction in faculty or support staff;
- Increase in the required length of the program; and/or

Prosthodontics Standards  
-8-
Prosthodontics Standards

-9-

- Significant reduction of program dental facilities and
- Expansion of an existing dental hygiene program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected, changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster. Failure to proactively plan for change will not be considered unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:
- Adding content to individual courses;
- Updating or replacing laboratory/clinical equipment;
- Expansion or relocation of dental facilities within the same institution;
- Re-sequencing specific courses within the curriculum; and/or
- Change in program director. A copy of the new or acting program director’s curriculum vitae should be provided to Commission staff.

Revised: 2/12, 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11
POLICY ON ENROLLMENT INCREASES IN ADVANCED DENTAL SPECIALTY PROGRAMS

A program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program’s planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change on the accreditation status and the procedures to be followed. A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission one (1) month prior to a regularly scheduled semiannual Review Committee meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents.

The Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis, including, but not limited to:

- Student/Resident extending program length due to illness, incomplete projects/clinical assignments, or concurrent enrollment in another program;
- Unexpected loss of an enrollee and need to maintain balance of manpower needs;
- Urgent manpower needs demanded by U.S. armed forces; and
- Natural disasters.

Failure to comply with this policy will jeopardize the program’s accreditation status, up to and including withdrawal of accreditation. If a program has enrolled beyond the approved number of students/residents without prior approval by the Commission, a special focused site visit will be required at the program’s expense.

If the focused visit determines that the program does not have the resources to support the additional student(s)/resident(s), the program will be placed on “intent to withdraw” status and no additional student(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Student(s)/Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.
Definitions of Terms Used in Prosthodontics Accreditation Standards

The terms used in this document (i.e. shall, must, should, can and may) were selected carefully and indicate the relative weight that the Commission attaches to each statement. The definitions of these words used in the Standards are as follows:

**Must** or Shall: Indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

**Intent**: Intent statements are presented to provide clarification to the advanced specialty education programs in prosthodontics in the application of and in connection with compliance with the Accreditation Standards for Advanced Specialty Education Programs in Prosthodontics. The statements of intent set forth some of the reasons and purposes for the particular Standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

**Examples of evidence to demonstrate compliance include**: Desirable condition, practice or documentation indicating the freedom or liberty to follow a suggested alternative.

Should: Indicates a method to achieve the standards.

May or Could: Indicates freedom or liberty to follow a suggested alternative.

Levels of Knowledge:

- **In-depth**: A thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding.

- **Understanding**: Adequate knowledge with the ability to apply.

- **Familiarity**: A simplified knowledge for the purpose of orientation and recognition of general principles.

Levels of Skills:

- **Proficient**: The level of skill beyond competency. It is that level of skill acquired through advanced training or the level of skill attained when a particular activity is accomplished with repeated quality and a more efficient utilization of time.

- **Competent**: The level of skill displaying special ability or knowledge derived from training and experience.

- **Exposed**: The level of skill attained by observation of or participation in a particular activity.
Other Terms:

Institution (or organizational unit of an institution): a dental, medical or public health school, patient care facility, or other entity that engages in advanced specialty education.

Sponsoring institution: primary responsibility for advanced specialty education programs.

Affiliated institution: support responsibility for advanced specialty education programs.

Advanced specialty education student/resident: a student/resident enrolled in an accredited advanced specialty education program.

A degree-granting program is a planned sequence of advanced courses leading to a master’s or doctoral degree granted by a recognized and accredited educational institution.

A certificate program is a planned sequence of advanced courses that leads to a certificate of completion in a specialty recognized by the American Dental Association.

Student/Resident: The individual enrolled in an accredited advanced education program.

International Dental School: A dental school located outside the United States and Canada.

Prosthodontic Specific Terms:

Removable Prosthodontics – is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are removable from the mouth.

Fixed Prosthodontics – is that branch of prosthodontics concerned with the replacement and/or restoration of teeth by artificial substitutes that are not removable from the mouth.

Implant Prosthodontics – is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures by artificial substitutes partially or completely supported and/or retained by alloplastic implants.

Maxillofacial Prosthetics – is that branch of prosthodontics concerned with the restoration and/or replacement of stomatognathic and associated craniofacial structures by artificial substitutes.

Educationally Qualified: An individual is considered Educationally Qualified after the successful completion of an advanced educational prosthodontics program, which is accredited by the Commission on Dental Accreditation.

Board Eligible: An individual is Board Eligible when his/her application has been submitted to and approved by the Board and his/her eligibility has not expired.

Diplomate: Any dentist who has successfully met the requirements of the Board for certification and remains in good standing.

Prosthodontics Standards
STANDARD 1 - INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS

The program must develop clearly stated goals and objectives appropriate to advanced specialty education, addressing education, patient care, research and service. Planning for, evaluation of and improvement of educational quality for the program must be broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service.

The program must document its effectiveness using a formal and ongoing outcomes assessment process to include measures of advanced education student/resident achievement.

Intent: The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of prosthodontics and that one of the program goals is to comprehensively prepare competent individuals to initially practice prosthodontics. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program’s purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f) review the assessment plan, revise as appropriate, and continue the cyclical process.

The financial resources must be sufficient to support the program’s stated goals and objectives.

Intent: The institution should have the financial resources required to develop and sustain the program on a continuing basis. The program should have the ability to employ an adequate number of full-time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced specialty discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.

The sponsoring institution must ensure that support from entities outside of the institution does not compromise the teaching, clinical and research components of the program.

Examples of evidence to demonstrate compliance may include:

- Written agreement(s)
- Contract(s)/Agreement(s) between the institution/program and sponsor(s) related to facilities, funding, and faculty financial support

Prosthodontics Standards
-13-
Advanced specialty education programs must be sponsored by institutions, which are properly chartered, and licensed to operate and offer instruction leading to degrees, diplomas or certificates with recognized education validity. Hospitals that sponsor advanced specialty education programs must be accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS). Educational institutions that sponsor advanced specialty education programs must be accredited by an agency recognized by the United States Department of Education. The bylaws, rules and regulations of hospitals that sponsor or provide a substantial portion of advanced specialty education programs must ensure that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients.

The authority and final responsibility for curriculum development and approval, student/resident selection, faculty selection and administrative matters must rest within the sponsoring institution.

The position of the program in the administrative structure must be consistent with that of other parallel programs within the institution and the program director must have the authority responsibility, and privileges necessary to manage the program.

**AFFILIATIONS**

The primary sponsor of the educational program must accept full responsibility for the quality of education provided in all affiliated institutions.

Documentary evidence of agreements, approved by the sponsoring and relevant affiliated institutions, must be available. The following items must be covered in such inter-institutional agreements:

a. Designation of a single program director;
b. The teaching staff;
c. The educational objectives of the program;
d. The period of assignment of students/residents; and
e. Each institution’s financial commitment.

*Intent:* The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).

**POLICY STATEMENT ON ACCREDITATION OF OFF-CAMPUS SITES**

The Commission on Dental Accreditation must be informed when a program accredited by the Commission plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). The Commission must be informed in writing at least thirty (30) days prior to a regularly
scheduled semi-annual Review Committee meeting. A program must receive Commission on Dental Accreditation approval of the off-campus site prior to initiating use of the site.

Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites. The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. When the Commission has received notification that an institution plans to offer its accredited program at an off-campus site, the Commission will conduct a special focused site visit to each off-campus location where a significant portion of each student’s/resident’s educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission. After the initial visit, each site will continue to be visited during the regularly scheduled site visit to the program.

The Commission recognizes that dental assisting and dental laboratory technology programs utilize numerous extramural dental offices and laboratories to provide students with clinical/laboratory practice experience. In this instance, the Commission will randomly select and visit several facilities during the site visit to a program.

Expansion of an existing dental hygiene program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to on and off-campus locations. The Commission office should be contacted for current information on fees.

Revised: 2/12, 8/10, 7/09, 7/07; Reaffirmed: 2/02, 1/06; Adopted: 07/98
STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF

The program must be administered by a director who is board certified in the respective specialty of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, must be board certified.)

**Intent:** The director of an advanced specialty education program is to be certified by an ADA-recognized certifying board in the specialty. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified, but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance may include:
- For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification
- (For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation or Commission on Dental Accreditation of Canada-accredited advanced specialty program in the respective discipline; letter from the previous employing institution verifying service)

The program director must be appointed to the sponsoring institution and have sufficient authority and time to achieve the educational goals of the program and assess the program’s effectiveness in meeting its goals.

2-1 The program director must have primary responsibility for the organization and execution of the educational and administrative components to the program.

2-1.1 The program director must devote sufficient time to:
- a. Participate in the student/resident selection process, unless the program is sponsored by federal services utilizing a centralized student/resident selection process;
- b. Develop and implement the curriculum plan to provide a diverse educational experience in biomedical and clinical sciences;
- c. Maintain a current copy of the curriculum’s goals, objectives, and content outlines;
- d. Maintain a record of the number and variety of clinical experiences accomplished by each student/resident;
- e. Ensure that the majority of faculty assigned to the program are educationally qualified prosthodontists;
- f. Provide written faculty evaluations at least annually to determine the effectiveness of the faculty in the educational program;
- g. Conduct periodic staff meetings for the proper administration of the educational program; and
- h. Maintain adequate records of clinical supervision.
2-2 The program director must encourage students/residents to seek certification by the American Board of Prosthodontics.

2-3 The number and time commitment of the teaching staff must be sufficient to
a. Provide didactic and clinical instruction to meet curriculum goals and objectives; and
b. Provide supervision of all treatment provided by students/residents through specific and regularly scheduled clinic assignments.
STANDARD 3 - FACILITIES AND RESOURCES

Institutional facilities and resources must be adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. Equipment and supplies for use in managing medical emergencies must be readily accessible and functional.

**Intent:** The facilities and resources (e.g.; support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, students/residents, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.

The program must document its compliance with the institution’s policy and applicable regulations of local, state and federal agencies, including but not limited to radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. Policies must be provided to all students/residents faculty and appropriate support staff and continuously monitored for compliance. Additionally, policies on bloodborne and infectious diseases must be made available to applicants for admission and patients.

**Intent:** The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the students/residents faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.

Students/Residents, faculty and appropriate support staff must be encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and dental personnel.

**Intent:** The program should have written policy that encourages (e.g., delineates the advantages of) immunization of students/residents, faculty and appropriate support staff.

All students/residents, faculty and support staff involved in the direct provision of patient care must be continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation.

**Intent:** Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.

The use of private office facilities as a means of providing clinical experiences in advanced specialty education is not approved, unless the specialty has included language that defines the use of such facilities in its specialty-specific standards.

**Intent:** Required clinical experiences do not occur in private office facilities. Practice management and elective experiences may be undertaken in private office facilities.
3-1 Physical facilities must permit students/residents to operate under circumstances prevailing in the practice of prosthodontics.

3-1.1 The clinical facilities must be specifically identified for the advanced education program in prosthodontics.

3-1.2 There must be sufficient number of completely equipped operatories to accommodate the number of students/residents enrolled.

3-1.3 Laboratory facilities must be specifically identified for the advanced education program in prosthodontics.

3-1.4 The laboratory must be equipped to support the fabrication of most prostheses required in the program.

3-1.5 There must be sufficient laboratory space to accommodate the number of students/residents enrolled in the program, including provisions for storage of personal and laboratory armamentaria.

3-2 Radiographic equipment for extra-and intraoral radiographs must be accessible to the student/resident.

3-3 Lecture, seminar, study space and administrative office space must be available for the conduct of the educational program.

3-4 Library resources must include access to a diversified selection of current dental, biomedical, and other pertinent reference material.

3-4.1 Library resources must also include access to appropriate current and back issues of major scientific journals as well as equipment for retrieval and duplication of information.

3-5 Facilities must include access to computer, photographic, and audiovisual resources for educational, administrative, and research support.

3-6 Adequate allied dental personnel must be assigned to the program to ensure clinical and laboratory technical support.

3-7 Secretarial and clerical assistance must be sufficient to meet the educational and administrative needs of the program.

3-8 Laboratory technical support must be sufficient to ensure efficient operation of the clinical program and meet the educational needs of the program.
STANDARD 4 – CURRICULUM AND PROGRAM DURATION

The advanced specialty education program must be designed to provide special knowledge and skills beyond the D.D.S. or D.M.D. training and be oriented to the accepted standards of specialty practice as set forth in specific standards contained in this document.

**Intent:** The intent is to ensure that the didactic rigor and extent of clinical experience exceeds pre-doctoral, entry level dental training or continuing education requirements and the material and experience satisfies standards for the specialty.

The level of specialty area instruction in certificate and degree-granting programs must be comparable.

**Intent:** The intent is to ensure that the students/residents of these programs receive the same educational requirements as set forth in these Standards.

Documentation of all program activities must be ensured by the program director and available for review.

If an institution and/or program enrolls part-time students/residents, the institution must have guidelines regarding enrollment of part-time students/residents. Part-time students/residents must start and complete the program within a single institution, except when the program is discontinued. The director of an accredited program who enrolls students/residents on a part-time basis must ensure that: (1) the educational experiences, including the clinical experiences and responsibilities, are the same as required by full-time students/residents; and (2) there are an equivalent number of months spent in the program.

PROGRAM DURATION

4-1 A postdoctoral program in prosthodontics must encompass a minimum of 33 months.

4-2 A postdoctoral program in prosthodontics that includes integrated maxillofacial training must encompass a minimum of 45 months.

4-3 A 12-month postdoctoral program in maxillofacial prosthetics must be preceded by successful completion of an accredited prosthodontics program.

CURRICULUM

4-4 The curriculum must be designed to enable the student/resident to attain skills representative of a clinician proficient in the theoretical and practical aspects of prosthodontics. Advanced level instruction may be provided through the following: formal courses, seminars, lectures, self-instructional modules, clinical assignments and laboratory assignments.
4-4.1 Written goals and objectives must be developed for all instruction included in this curriculum.
4-4.2 Content outlines must be developed for all didactic portions of the program.
4-4.3 Students/Residents must prepare and present diagnostic data, treatment plans and the results of patient treatment.
4-4.4 The amount of time devoted to didactic instruction and research must be at least 30% of the total educational experience.
4-4.5 A minimum of 60% of the total program time must be devoted to providing patient services, including direct patient care and laboratory procedures.
4-4.6 The program may include organized teaching experience. If time is devoted to this activity, it should be carefully evaluated in relation to the goals and objectives of the overall program and the interests of the individual student/resident.

DIDACTIC PROGRAM: BIOMEDICAL SCIENCES

4-5 Instruction must be provided at the understanding level in each of the following:
   a. Oral pathology;
   b. Applied pharmacology;
   c. Craniofacial anatomy and physiology;
   d. Risk assessment for oral disease;
   e. Infection control; and
   f. Wound healing.

4-6 Instruction must be provided at the familiarity level in each of the following:
   a. Craniofacial growth and development;
   b. Immunology; and
   c. Oral microbiology.

Intent: Students/Residents will have the didactic background that supports the various aspects of comprehensive prosthodontic therapy they provide or guide during their clinical experiences with dentate, partially edentulous and completely edentulous patients. This fundamental didactic background is necessary whether the student provides therapy or serves as the referral source to other providers. It is expected that such learning would be directly supportive of requisite clinical curriculum proficiencies and competencies.

DIDACTIC PROGRAM: PROSTHODONTICS AND RELATED DISCIPLINES

4-7 Instruction must be provided at the in-depth level in each of the following:
   a. Fixed prosthodontics;
   b. Implant prosthodontics;
   c. Removable prosthodontics, and
   d. Occlusion.
**Intent:** Students/Residents will have in depth knowledge in all aspects of prosthodontic therapy to serve their leading role in the management of patients from various classification systems such as the Prosthodontic Diagnostic Index for edentulous, partially edentulous and dentate patients. This includes surgical and post-surgical management of the implant patient.

4-8 **Instruction must be provided at the understanding level in each of the following:**
   a. Biomaterials;
   b. Geriatric dentistry;
   c. Maxillofacial prosthetics;
   d. Preprosthetic surgery; including surgical principles and procedures;
   e. Evidence-based decision-making
   f. Temporomandibular disorders and orofacial pain;
   g. Medical emergencies;
   h. Diagnostic radiology;
   i. Research methodology; and
   j. Emerging science and technology.

4-9 **Instruction must be provided at the familiarity level in each of the following:**
   a. Endodontics;
   b. Periodontics;
   c. Orthodontics;
   d. Sleep disorders;
   e. Sedation;
   f. Intraoral photography;
   g. Practice management;
   h. Ethics;
   i. Biostatistics;
   j. Scientific writing; and
   k. Teaching methodology.

**CLINICAL PROGRAM**

4-10 The program must provide sufficient clinical experiences for the student/resident to be proficient in the comprehensive treatment of a wide range of complex prosthodontic patients with various categories of need.

4-11 The program must provide sufficient clinical experiences for the student/resident to be proficient in:
   a. Collecting, organizing, analyzing, and interpreting diagnostic data;
   b. Determining a diagnosis;
   c. Developing a comprehensive treatment plan and prognosis;
   d. Critically evaluating the results of treatment; and
e. Effectively utilizing the professional services of allied dental personnel, including
but not limited to, dental laboratory technicians, dental assistants, and dental
hygienists.

4-12 The program must provide sufficient clinical experiences for the student/resident to be
proficient in the comprehensive diagnosis, treatment planning and rehabilitation of
edentulous, partially edentulous and dentate patients.

  a. Clinical experiences must include a variety of patients within a range of
     prosthodontic classifications, such as in the Prosthodontic Diagnostic Index for
edentulous, partially edentulous and dentate patients.
  b. Clinical experiences must include rehabilitative and esthetic procedures of
     varying complexity.
  c. Clinical experiences must include treatment of geriatric patients, including
     patients with varying degrees of cognitive and physical impairments.
  d. This may include defects, which are due to genetic, functional, parafunctional,
microbial or traumatic causes.

Intent: Students/Residents will be proficient in the use of adjustable articulators to develop
an integrated occlusion for opposing arches; complete and partial coverage restorations,
restoration of endodontically treated teeth, fixed prosthodontics, removable partial dentures,
complete dentures, implant supported and/or retained prostheses, and continual care and
maintenance of restorations. Students/Residents will diagnose and treat patients using
advances in science and technology.

4-13 The program must provide sufficient dental laboratory experience for the
student/resident to be competent in the laboratory aspects of treatment of complete
edentulism, partial edentulism and dentate patients.

4-14 Students/Residents must be competent in the prosthodontic management of patients
with temporomandibular disorders and/or orofacial pain.

4-15 Students/Residents must be exposed to patients requiring various maxillofacial
prosthetic services.

4-16 Students/Residents must participate in all phases of implant treatment including
implant placement.

4-17 Students/Residents must be exposed to preprosthetic surgical procedures.

Intent: Surgical procedures should include contouring of residual ridges, gingival
recontouring, placement of dental implants, and removal of teeth.

4-18 Students/Residents must be exposed to patient management through sedation.

Intent: Students/Residents will observe procedures for patients who are sedated.
4-19 Students/Residents must be competent in oral/head/neck cancer screening and patient education for prevention.

Intent: Students/Residents will be competent in clinical identification of potential pathosis and referral to a specialist. Students/Residents will also educate patients to promote oral/head/neck cancer prevention.

MAXILLOFACIAL PROSTHETICS

Note: Application of these Standards to programs of various scope/length is as follows:
   a. Prosthodontic programs that encompass a minimum of forty-five months that include integrated maxillofacial prosthetic training: all sections of these Standards apply;
   b. Prosthodontic programs that encompass a minimum of thirty-three months: all sections of these Standards apply except sections 4-20 through 4-26 inclusive; and
   c. Twelve-month maxillofacial prosthetic programs: all sections of these Standards apply except sections 4-5 through 4-19, inclusive.

PROGRAM DURATION

4-20 An advanced education program in maxillofacial prosthetics must be provided with a forty-five month integrated prosthodontic program which includes fixed prosthodontic, removable prosthodontic, implant prosthodontic and maxillofacial prosthetic experiences; or a one-year program devoted specifically to maxillofacial prosthetics which follows completion of a prosthodontic program.

DIDACTIC PROGRAM

4-21 Instruction must be provided at the in-depth level in each of the following:
   a. Maxillary defects and soft palate defects, which are the result of disease or trauma (acquired defects);
   b. Mandibular defects, which are the result of disease or trauma (acquired defects);
   c. Maxillary defects, which are naturally acquired (congenital or developmental defects);
   d. Mandibular defects, which are naturally acquired (congenital or developmental defects);
   e. Facial defects, which are the result of disease or trauma or are naturally acquired;
   f. The use of implants to restore intraoral and extraoral defects;
   g. Maxillofacial prosthetic management of the radiation therapy patient; and
   h. Maxillofacial prosthetic management of the chemotherapy patient.
4-22 Instruction must be provided at the familiarity level in each of the following:
   a. Medical oncology;
   b. Principles of head and neck surgery;
   c. Radiation oncology;
   d. Speech and deglutation; and
   e. Cranial defects.

CLINICAL PROGRAM

4-23 Students/Residents must be competent to perform maxillofacial prosthetic treatment procedures performed in the hospital operation room.

4-24 Students/Residents must gain clinical experience to become proficient in the pre-prosthetic, prosthetic and post-prosthetic management and treatment of patients with defects of the maxilla and mandible. Clinical experience regarding management and treatment should include:
   a. Patients who are partially dentate and for patients who are edentulous;
   b. Patients who have undergone radiation therapy to the head and neck region;
   c. Maxillary defects of the hard palate, soft palate and alveolus;
   d. Mandibular continuity and discontinuity defects; and
   e. Acquired, congenital and developmental defects.

4-25 Students/Residents must gain clinical experience to become competent in the pre-prosthetic, prosthetic and post-prosthetic management and treatment of patients with defects of facial structures.

4-26 Students/Residents must demonstrate competency in interdisciplinary diagnostic and treatment planning conferences relevant to maxillofacial prosthetics, which may include:
   a. Cleft palate and craniofacial conferences;
   b. Clinical pathology conferences;
   c. Head and neck diagnostic conferences;
   d. Medical oncology treatment planning conferences;
   e. Radiation therapy diagnosis and treatment planning conferences;
   f. Reconstructive surgery conferences; and
   g. Tumor boards.
STANDARD 5 - ADVANCED EDUCATION STUDENTS/RESIDENTS

ELIGIBILITY AND SELECTION

Dentists with the following qualifications are eligible to enter advanced specialty education programs accredited by the Commission on Dental Accreditation:

a. Graduates from institutions in the U.S. accredited by the Commission on Dental Accreditation;
b. Graduates from institutions in Canada accredited by the Commission on Dental Accreditation of Canada; and
c. Graduates of international dental schools who possess equivalent educational background and standing as determined by the institution and program.

Specific written criteria, policies and procedures must be followed when admitting students/residents.

Intent: Written non-discriminatory policies are to be followed in selecting students/residents. These policies should make clear the methods and criteria used in recruiting and selecting students/residents and how applicants are informed of their status throughout the selection process.

Admission of students/residents with advanced standing must be based on the same standards of achievement required by students/residents regularly enrolled in the program. Transfer students/residents with advanced standing must receive an appropriate curriculum that results in the same standards of competence required by students/residents regularly enrolled in the program.

Examples of evidence to demonstrate compliance may include:
- policies and procedures on advanced standing
- results of appropriate qualifying examinations
- course equivalency or other measures to demonstrate equal scope and level of knowledge
EVALUATION

A system of ongoing evaluation and advancement must ensure that, through the director and faculty, each program:

a. Periodically, but at least semiannually, evaluates the knowledge, skills, ethical conduct and professional growth of its students/residents, using appropriate written criteria and procedures;

b. Provides to students/residents an assessment of their performance, at least semiannually;

c. Advances students/residents to positions of higher responsibility only on the basis of an evaluation of their readiness for advancement; and

d. Maintains a personal record of evaluation for each student/resident which is accessible to the student/resident and available for review during site visits.

Intent: (b) Student/Resident evaluations should be recorded and available in written form
(c) Deficiencies should be identified in order to institute corrective measures
(d) Student/Resident evaluation is documented in writing and is shared with the student/resident

DUE PROCESS

There must be specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution.

RIGHTS AND RESPONSIBILITIES

At the time of enrollment, the advanced specialty education students/residents must be apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. Additionally, all advanced specialty education students/residents must be provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty.

Intent: Adjudication procedures should include institutional policy which provides due process for all individuals who may potentially be involved when actions are contemplated or initiated which could result in disciplinary actions, including dismissal of a student/resident (for academic or disciplinary reasons). In addition to information on the program, students/residents should also be provided with written information which affirms their obligations and responsibilities to the institution, the program, and the faculty. The program information provided to the students/residents should include, but not necessarily be limited to, information about tuition, stipend or other compensation; vacation and sick leave; practice privileges and other activity outside the educational program; professional liability coverage; and due process policy and current accreditation status of the program.
STANDARD 6 - RESEARCH

Advanced specialty education students/residents must engage in scholarly activity.
V. COMPLAINTS

A. DEFINITION

A complaint is defined by the Commission on Dental Accreditation as one alleging that a Commission-accredited educational program, a program which has an application for initial accreditation pending, or the Commission may not be in substantial compliance with Commission standards or required accreditation procedures.

B. PROGRAM REQUIREMENTS AND PROCEDURES

NOTICE OF OPPORTUNITY TO FILE COMPLAINTS: In accord with the U.S. Department of Education’s Criteria and Procedures for Recognition of Accrediting Agencies, the Commission requires accredited programs to notify students of an opportunity to file complaints with the Commission.

Each program accredited by the Commission on Dental Accreditation must develop and implement a procedure to inform students of the mailing address and telephone number of the Commission on Dental Accreditation. The notice, to be distributed at regular intervals, but at least annually, must include but is not necessarily limited to the following language:

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.

The accredited program must retain in its files information to document compliance with this policy so that it is available for review during the Commission's on-site reviews of the program.

REQUIRED RECORD OF COMPLAINTS: The program must maintain a record of student complaints related to the Commission’s accreditation standards and/or policy received since the Commission’s last comprehensive review of the program.

At the time of a program’s regularly scheduled on-site evaluation, visiting committees evaluate the program’s compliance with the Commission’s policy on the Required Record of Complaints. The team reviews the areas during the site visit and include findings in the draft site visit report and note at the final conference.

Reaffirmed: 8/10, 7/09, 7/08, 7/07, 7/04, 7/01, 7/96; Revised: 8/02, 1/9; CODA: 01/94:6 4
C. COMMISSION LOG OF COMPLAINTS

A log is maintained of all complaints received by the Commission. A central log related to each complaint is maintained in an electronic database. Detailed notes of each complaint and its disposition are also maintained in individual program files.

Revised: 8/10, 7/06, 7/02, 7/00, 7/96; CODA: 01/95:5

D. POLICY AND PROCEDURE REGARDING INVESTIGATION OF COMPLAINTS AGAINST EDUCATIONAL PROGRAMS

The following policy and procedures have been developed to handle the investigation of complaints about an accredited program, or a program which has a current application for initial accreditation pending, which may not be in substantial compliance with Commission standards or established accreditation policies.

1. Investigative Procedures: Students, faculty, constituent dental societies, state boards of dentistry, and other interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding any Commission accredited dental, allied dental or advanced dental education program, or a program that has an application for initial accreditation pending. An appropriate complaint is one that directly addresses a program’s compliance with the Commission’s standards, policies and procedures. The Commission is interested in the continued improvement and sustained quality of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

In accord with its responsibilities to determine compliance with accreditation standards, policies, and procedures, the Commission does not intervene in complaints as a mediator but maintains, at all times, an investigative role. This investigative approach to complaints does not require that the complainant be identified to the program.

The Commission, upon request, will take every reasonable precaution to prevent the identity of the complainant from being revealed to the program; however, the Commission cannot guarantee the confidentiality of the complainant.

Only written, signed complaints will be considered by the Commission; oral and unsigned complaints will not be considered. The Commission strongly encourages attempts at informal or formal resolution through the program's or sponsoring institution's internal processes prior to initiating a formal complaint with the Commission. The following procedures have been established to manage complaints:

When an inquiry about filing a complaint is received by the Commission office, the inquirer is provided a copy of the Commission’s Evaluation and Operational Policies and Procedures Manual which includes the policies and procedures for filing a complaint and the appropriate accreditation standards document.

The initial screening is usually completed within thirty (30) days and is intended to ascertain that the potential complaint relates to a required accreditation policy or procedure (i.e. one contained in the Commission’s Evaluation and Operational Policies and Procedure Manual) or to one or more accreditation standard(s) or portion of a standard which have been or can be specifically identified by the complainant.
Written correspondence clearly outlines the options available to the individual. It is noted that the burden rests on the complainant to keep his/her identity confidential. If the complainant does not wish to reveal his/her identity to the accredited program, he/she must develop the complaint in such a manner as to prevent the identity from being evident. The complaint must be based on the accreditation standards or required accreditation procedures. Submission of documentation which supports the noncompliance is strongly encouraged.

When a complainant submits a written, signed statement describing the program’s noncompliance with specifically identified policy(ies), procedure(s) or standard(s), along with the appropriate documentation, the following procedure is followed:
1. The materials submitted are entered in the Commission’s database and the program’s file and reviewed by Commission staff.
2. Legal counsel, the Chairperson of the appropriate Review Committee, and the applicable Review Committee members may be consulted to assist in determining whether there is sufficient information to proceed.
3. If the complaint provides sufficient evidence of probable cause of noncompliance with the standards or required accreditation procedures, the complainant is so advised and the complaint is investigated using the procedures in the following section, formal complaints.
4. If the complaint does not provide sufficient evidence of probable cause of noncompliance with the standard(s) or required accreditation policy(ies), or procedure(s), the complainant is so advised. The complainant may elect:
   a. to revise and submit sufficient information to pursue a formal complaint; or
   b. not to pursue the complaint. In that event, the decision will be so noted and no further action will be taken.

Initial investigation of a complaint may reveal that the Commission is already aware of the program’s noncompliance and is monitoring the program’s progress to demonstrate compliance. In this case, the complainant is notified that the Commission is currently addressing the noncompliance issues noted in the complaint. The complainant is informed of the program’s accreditation status and how long the program has been given to demonstrate compliance with the accreditation standards.

Reaffirmed: 8/10

2. Formal Complaints: Formal complaints (as defined above) are investigated as follows:
1. The complainant is informed in writing of the anticipated review schedule.
2. The Commission informs the chief administrative officer (CAO) of the institution sponsoring the accredited program that the Commission has received information indicating that the program’s compliance with specific required accreditation policy(ies), procedure(s) or designated standard(s) has been questioned.
3. Program officials are asked to report on the program’s compliance with the required policy(ies), procedure(s) or standard(s) in question by a specific date, usually within thirty (30) days.
   a. For standard(s)-related complaints, the Commission uses the questions contained in the appropriate sections of the self-study to provide guidance on the compliance issues to be addressed in the report and on any documentation required to demonstrate compliance.
   b. For policy(ies) or procedure(s)-related complaints, the Commission provides the program with the appropriate policy or procedural statement from the Commission’s Evaluation and Operational Policies and Procedures Manual. Additional guidance on how to best demonstrate compliance will be provided to the program. The Chairperson of the appropriate Review Committee and/or legal counsel may assist in developing this guidance.

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4. Receipt of the program’s written compliance report, including documentation, is acknowledged.

5. The appropriate Review Committee and the Commission will investigate the issue(s) raised in the complaint and review the program’s written compliance report at the next regularly scheduled meeting. In the event that waiting until the next meeting would preclude a timely review, the appropriate Review Committee(s) will review the compliance report in a telephone conference call(s). The action recommended by the Review Committee(s) will be forwarded to the Commission for mail ballot approval in this later case.

6. The Commission may act on the compliance question(s) raised by the complaint by:
   a. determining that the program continues to comply with the policy(ies), procedure(s) or standard(s) in question and that no further action is required.
   b. determining that the program may not continue to comply with the policy(ies), procedure(s) or standard(s) in question and going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require an on-site review.
      i. If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
      ii. If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted. If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.
   c. determining that a program does not comply with the policy(ies), procedure(s) or standards(s) in question and:
      i. changing a fully-operational program’s accreditation status to “approval with reporting requirements”
      ii. going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require an on-site review.
         • If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
         • If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted. If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.

7. Within two weeks of its action on the results of its investigation, the Commission will also:
   a. notify the program of the results of the investigation.
   b. notify the complainant of the results of the investigation.
   c. record the action.
8. The compliance of programs applying for initial accreditation is assessed through a combination of written reports and on-site reviews.
   a. When the Commission receives a complaint regarding a program which has an application for initial accreditation pending, the Commission will satisfy itself about all issues of compliance addressed in the complaint as part of its process of reviewing the applicant program for initial accreditation.
   b. Complainants will be informed that the Commission does provide developing programs with a reasonable amount of time to come into full compliance with standards that are based on a certain amount of operational experience.

   Reaffirmed: 8/10; Revised: 7/07, 7/06, 8/02, 7/00, 7/96; Adopted: 1/95

E. POLICY AND PROCEDURES ON COMPLAINTS DIRECTED AT THE COMMISSION ON DENTAL ACCREDITATION

Interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding Commission policy(ies), procedure(s) or the implementation thereof. The Commission will determine whether the information submitted constitutes an appropriate complaint and will follow up according to the established procedures.

Procedures:
1. Within two (2) weeks of receipt, the Commission will acknowledge the received information and provide the complainant with the policy(ies) and procedure(s).
2. The Commission will collect additional information internally, if necessary, and then conduct an initial screening to determine whether the complaint is appropriate. The initial screening is completed within thirty (30) days.
3. The Commission will inform the complainant of the results of the initial screening.
4. If the complaint is determined to be appropriate, the Commission and appropriate committees will consider the complaint at its next regularly scheduled meeting. The complaint will be considered in closed session if the discussion will involve specific programs or institutions; otherwise, consideration of the complaint will occur in open session. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the complaint in a telephone conference call(s). The action recommended by the committees will be forwarded to the Commission for mail ballot approval in this later case.
5. The Commission will consider changes in its policies and procedures, if indicated.
6. The Commission will inform the complainant of the results of consideration of the complaint within two (2) weeks following the meeting or mail balloting of the Commission.

   Reaffirmed: 8/10, 7/09, 7/04; Revised: 1/98; Adopted: 7/96
Evaluation & Operational Policies & Procedures
# COMMISSION ON DENTAL ACCREDITATION

## EVALUATION AND OPERATIONAL POLICIES AND PROCEDURES MANUAL

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I. INTRODUCTION AND GENERAL INFORMATION

A. PURPOSE OF THIS MANUAL

This manual provides information about the Commission on Dental Accreditation’s accreditation policies and procedures for all institutions sponsoring dental, allied dental and advanced dental education programs. It contains background information on the Commission and its accreditation policies, as well as specific information to assist programs in attaining accreditation and in preparing for on-site reviews. The information in this manual applies to all dental education programs (predoctoral dental, advanced dental specialty, advanced general dentistry, dental assisting, dental hygiene and dental laboratory technology) except where specifically noted. Dates following each policy refer to the date of the Commission action to Adopt, Revise or Reaffirm the policy. A reference noted as CODA: 7/00:4 indicates that additional information can be found on page four (4) of the Commission’s July 2000 minutes.

B. HISTORY AND AUTHORITY OF THIS COMMISSION

The Commission on Dental Accreditation, the successor of the Council on Dental Education which had conducted the accreditation program since 1937, began operating in 1975. Although the Commission has conducted all accreditation activities since it was formed in 1975, the Council on Dental Education (now known as the Council on Dental Education and Licensure) was the first accrediting body for dentistry and the related dental disciplines. All accreditation policy that had been used by the Council was adopted by the Commission in 1975 and became Commission policy even though some pre-1975 policy continues to be referenced in Council action and minutes. The Commission serves as the only nationally-recognized accrediting body for dentistry and the related dental fields. The Commission receives its accreditation authority from the acceptance of the dental community and by being recognized by the United States Department of Education (USDE), a governmental agency.

The Commission has participated in governmental recognition since 1952 when the U. S. Commissioner of Education was first required to publish a list of “nationally recognized accrediting agencies.” USDE has established recognition requirements that an accrediting agency must meet in order to be recognized and conducts reviews for continued recognition at five-year intervals.

1. American Dental Association Bylaws, Section 130 Duties: The ADA Bylaws describe the duties of the Commission on Dental Accreditation as follows:
   a. To formulate and adopt requirements and guidelines for the accreditation of dental educational and dental auxiliary educational programs.
   b. To accredit dental educational and dental auxiliary educational programs.
   c. To provide a means for appeal from an adverse decision of the accrediting body of the Commission to a separate and distinct body of the Commission whose membership shall be totally different from that of the accrediting body of the Commission.
   d. To submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission’s annual budget to the Board of Trustees of the Association.
   e. To submit the Commission’s articles of incorporation and rules and amendments thereto to this Association’s House of Delegates for approval by vote either through or in cooperation with the Council on Dental Education and Licensure.
2. Rules Of The Commission On Dental Accreditation:

Article I. MISSION

The Commission on Dental Accreditation serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental related educational programs.

Article II. BOARD OF COMMISSIONERS

Section 1. LEGISLATIVE AND MANAGEMENT BODY: The legislative and management body of the Commission shall be the Board of Commissioners.

Section 2. COMPOSITION: The Board of Commissioners shall consist of:

Four (4) members shall be selected from nominations open to all trustee districts from the active, life or retired members of this association, no one of whom shall be a faculty member working more than one day per week of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the American Dental Association House of Delegates.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Association of Dental Boards from the active membership of that body, no one of whom shall be a member of a faculty of a school of dentistry.

Four (4) members who are active, life or retired members of the American Dental Association shall be selected by the American Dental Education Association from its active membership. These members shall hold positions of professorial rank in dental schools accredited by the Commission on Dental Accreditation and shall not be members of any state board of dental examiners.

The remaining Commissioners shall be selected as follows: one (1) certified dental assistant selected by the American Dental Assistants Association from its active or life membership, one (1) licensed dental hygienist selected by the American Dental Hygienists’ Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association, one (1) dentist for each ADA recognized dental specialty who is board certified in the respective special area of practice and is selected by the respective specialty sponsoring organization, one (1) dentist representing postdoctoral general dentistry who is jointly appointed by the American Dental Education Association and the American Association of Hospital Dentists and four (4) consumers who are neither dentists nor allied dental personnel nor teaching in a dental or allied dental education institution and who are selected by the Commission, based on established and publicized criteria. In the event a Commission member sponsoring organization fails to select a Commissioner, it shall be the responsibility of the Commission to select an appropriate representative to serve as a Commissioner. A member of the Standing Committee on the New Dentist (when assigned by the ADA Board of Trustees) and the Director of the Commission shall be ex-officio members of the Board without the right to vote.

Section 3. TERM OF OFFICE: The term of office of the members of the Board of Commissioners shall be one four (4) year term except that the member jointly selected by the American Dental Education
Section 4. **POWERS:**

A. The Board of Commissioners shall be vested with full power to conduct all business of the Commission subject to the laws of the State of Illinois, these *Rules* and the *Constitution and Bylaws* of the American Dental Association.

B. The Board of Commissioners shall have the power to establish rules and regulations not inconsistent with these *Rules* to govern its organization and procedures.

Section 5. **DUTIES:**

A. The Board of Commissioners shall prepare a budget at its winter meeting each year for carrying on the activities of the Commission for the ensuing fiscal year and shall submit said budget to the Board of Trustees of the American Dental Association for funding in accordance with Chapter XIV of the *Bylaws* of the American Dental Association.

B. The Board of Commissioners shall submit an annual report of the Commission's activities to the House of Delegates of the American Dental Association and interim reports, on request, to the Board of Trustees of the American Dental Association.

C. The Board of Commissioners shall appoint special committees of the Commission for the purpose of performing duties not otherwise assigned by these *Rules*.

D. The Board of Commissioners shall appoint consultants to assist in developing accreditation standards and conducting accreditation evaluations, including on-site reviews of predoctoral, advanced dental educational and allied dental educational programs and to assist with other duties of the Commission from time to time as needed.

Section 6. **MEETINGS:**

A. **REGULAR MEETINGS:** There shall be two (2) regular meetings of the Board of Commissioners each year.

B. **SPECIAL MEETINGS:** Special meetings of the Board of Commissioners may be called at any time by the Chairman of the Commission. The Chairman shall call such meetings on request of a majority of the voting members of the Board provided at least ten (10) days notice is given to each member of the Board in advance of the meeting. No business shall be considered except that provided in the call unless by unanimous consent of the members of the Board present and voting.

C. **LIMITATION OF ATTENDANCE DURING MEETINGS:** In keeping with the confidential nature of the deliberations regarding the accreditation status of individual educational programs, a portion of the meetings of the Commission, and its committees shall be designated as confidential, with attendance limited to members, the American Dental Association Trustee Liaison, selected staff of the Commission and affiliated accreditors. During this part of the meeting, only confidential accreditation actions may be considered.
Section 7. QUORUM: A majority of the voting members of the Board of Commissioners shall constitute a quorum.

Article III. APPEAL BOARD

Section 1. APPEAL BOARD: The appellate body of the Commission shall be the Appeal Board which shall have the authority to hear and decide appeals filed by predoctoral and advanced dental educational and allied dental educational programs from decisions rendered by the Board of Commissioners of the Commission denying or revoking accreditation.

Section 2. COMPOSITION: The Appeal Board shall consist of four (4) permanent members. The four (4) permanent members of the Appeal Board shall be selected as follows: one (1) selected by the Board of Trustees of the American Dental Association from the active, life or retired membership of the American Dental Association giving special consideration whenever possible to former members of the Council on Dental Education and Licensure, one (1) member selected by the American Association of Dental Boards from the active membership of that body, one (1) member selected by the American Dental Education Association from the active membership of that body and one (1) consumer member who is neither a dentist nor an allied dental personnel nor teaching in a dental or allied dental educational program and who is selected by the Commission, based on established and publicized criteria. In addition, a representative from either an allied or advanced education discipline would be included on the Appeal Board depending upon the type and character of the appeal. Such special members shall be selected by the appropriate allied or specialty organization. Since there is no national organization for general practice residencies and advanced education programs in general dentistry, representatives of these areas shall be selected by the American Dental Education Association and the American Association of Hospital Dentists. One (1) member of the Appeal Board shall be appointed annually by the Chairman of the Commission to serve as the Chairman and shall preside at all meetings of the Appeal Board. If the Chairman is unable to attend any given meeting of the Appeal Board, the other members of the Appeal Board present and voting shall elect by majority vote an acting Chairman for that meeting only. The Director of the Commission shall provide assistance to the Appeal Board.

Section 3. TERM OF OFFICE: The term of office of members on the Appeal Board shall be one four (4) year term.

Section 4. MEETINGS: The Appeal Board shall meet at the call of the Director of the Commission, provided at least ten (10) days notice is given to each member of the Appeal Board in advance of the meeting. Such meetings shall be called by the Director only when an appeal to the appellate body has been duly filed by a predoctoral or advanced dental educational or allied dental educational program.

Section 5. QUORUM: A majority of the voting members of the Appeal Board shall constitute a quorum.

Section 6. VACANCIES:

A. In the event of a vacancy in the membership of the Appeal Board of the Commission, the Chairman of the Commission shall appoint a member of the same organization, or in the case of a consumer of the general public, possessing the same qualifications as established by these Rules, to fill such vacancy until a successor is selected by the respective representative organization.

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B. If the term of the vacated position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for a new, consecutive four-year term. If fifty percent (50%) of more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

Article IV. ACCREDITATION PROGRAM

Section 1. ACCREDITATION STANDARDS: The Commission, acting through the Board of Commissioners, shall establish and publish specific accreditation standards for the accreditation of predoctoral and advanced dental educational and allied dental educational programs.

Section 2. EVALUATION: Predoctoral and advanced dental educational and allied dental educational programs shall be evaluated for accreditation status by the Board of Commissioners on the basis of the information and data provided on survey forms and secured by the members of, and consultants to, the Board of Commissioners during site evaluations.

If the Board of Commissioners decides to deny, for the first time, accreditation to a new educational program or to withdraw accreditation from an existing program, the Board of Commissioners shall first notify the educational program of its intent to deny or withdraw accreditation. Such notice, together with announcement of the date of the next meeting of the Board of Commissioners, shall be sent to the educational program by certified mail, return receipt requested, within fourteen (14) days following the intent to deny or withdraw decision of the Board of Commissioners. Within thirty (30) days after receipt of such notice, the educational program may, in writing, request a hearing before the Board of Commissioners at its next meeting. Within fifteen (15) days after receipt of the request, the Board of Commissioners shall schedule a hearing and notify the educational program of the date, time and place of such hearing. A request for a hearing due to the Board of Commissioner’s decision to deny for the first time, accreditation to a new program, shall automatically stay the decision to deny accreditation. In the event the educational program that has been denied initial accreditation for the first time does not make a timely request for a hearing, the Board of Commissioners’ findings and proposed decision to deny accreditation shall become final.

Section 3. HEARING: Upon completion of an evaluation for accreditation status, the Board of Commissioners shall notify the predoctoral, advanced or allied dental educational program (hereinafter called “educational program”) of its findings and decision regarding the program’s accreditation status. Two types of hearings can be held to review the appropriateness of the decision made by the Commission:

A. CHALLENGE: This type of hearing is available to a program/institution that wishes to challenge the decision of the Commission to change its accreditation status or to a new program that wishes to challenge the decision of the Commission to deny, for the first time, initial accreditation. When an institution/program believes that the Commission has made an error in judgment, a hearing may be requested. The hearing before the Commission would be held at the next regularly scheduled meeting. Representatives of the institution/program may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. The educational program need not appear in person or by its representatives at the hearing. Legal counsel may represent the educational program at the hearing. During the hearing, the educational program may offer evidence and argument in writing or orally or both tending to
refute or overcome the factual findings of the Board of Commissioners. The Director of the Board of Commissioners must receive any written evidence or argument at least thirty (30) days prior to the hearing. No new information regarding correction of the deficiencies may be presented.

B. SUPPLEMENT: An institution/program may request a hearing in order to supplement written information, which has already been submitted to the Commission. A representative of the institution would be permitted to appear in person before the Commission to present this additional information.

When a hearing to provide supplemental information is desired, a written request is to be made to the Director of the Commission thirty (30) days prior to the meeting. The chairman and the Director of the Commission determine the disposition of the request and inform the requestor of the date, hour and amount of time which will be allocated for the hearing.

Section 4. APPEAL: In the event the final decision of the Board of Commissioners is a denial or withdrawal of accreditation, the educational program shall be informed of this decision within fourteen (14) days following the Commission meeting. Within fourteen (14) days after receipt of the final decision of the Board of Commissioners, the educational program may appeal the decision of the Board of Commissioners by filing a written appeal with the Director of the Board of Commissioners. The filing of an appeal shall automatically stay the final decision of the Board of Commissioners. The Appeal Board of the Commission shall convene and hold its hearing within sixty (60) days after the appeal is filed. The educational program filing the appeal may be represented by legal counsel and shall be given the opportunity at such hearing to offer evidence and argument in writing or orally or both tending to refute or overcome the findings and decision of the Board of Commissioners. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution’s or program’s failure to meet the Commission’s standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal. The educational program need not appear in person or by its representative at the appellate hearing. The Appeal Board may make the following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A decision to affirm, amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal Board’s decisions or instructions. The Appeal Board shall advise the appellant educational program of the Appeal Board's decision in writing by registered or certified mail. The decision rendered by the Appeal Board shall be final and binding. In the event the educational program does not file a timely appeal of the Board of Commissioners' findings and decision, the Board of Commissioners' decision shall become final.

Section 5. HEARING AND APPEAL COSTS: If a hearing is held before the Board of Commissioners, the costs of the Commission respecting such hearing shall be borne by the Commission. If an appeal is heard by the Appeal Board, the costs of the Commission respecting such appeal shall be shared equally by the Commission and the appellant educational program filing the appeal except in those
instances where equal sharing would cause a financial hardship to the appellant. However, each educational program shall bear the cost of its representatives for any such hearing or appeal.

Article V. OFFICERS

Section 1. OFFICERS: The officers of the Commission shall be a Chair, Vice-Chair and a Director and such other officers as the Board of Commissioners may authorize. The Chair and Vice-Chair shall be elected by the members of the Commission. The Chair and Vice-Chair shall be active, life or retired member of the American Dental Association.

Section 2. DUTIES: The duties of the officers are as follows:

A. CHAIR: The Chair shall preside at all meetings of the Board of Commissioners.

B. VICE-CHAIR: If the Chair is unable to attend any given meeting of the Board of Commissioners, the Vice-Chair shall preside at the meeting. If the Vice-chair is unable to attend the meeting, the other members of the Board of Commissioners present and voting shall elect by majority vote an acting chair for the purpose of presiding at that meeting only.

C. DIRECTOR: The Director shall keep the minutes of the meetings of the Board of Commissioners, prepare an agenda for each meeting, see that all notices are duly given in accordance with the provisions of these Rules or as required by law, be the custodian of the Commission's records, and in general shall perform all duties incident to the office of Director.

Article VI. MISCELLANEOUS

The rules contained in the current edition of "Sturgis Standard Code of Parliamentary Procedures" shall govern the deliberations of the Board of Commissioners and Appeal Board in all instances where they are applicable and not in conflict with the Rules or the previously established rules and regulations of the Board of Commissioners.

Article VII. AMENDMENTS

These Rules may be amended at any meeting of the Board of Commissioners by majority vote of the members of the Board present and voting subject to the subsequent approval of the House of Delegates of the American Dental Association.

Reaffirmed: 8/12; Revised: 8/10, 10/02, 10/97, 10/87, 11/82


3. Governing Law And Venue Policy: Any court action challenging an adverse accreditation decision made by the Commission or otherwise pertaining to these Evaluation and Operational Policies and Procedures (EOPP) shall be governed by and construed in accordance with the laws of Illinois, without regard to where the challenge arises and without regard to conflict of laws principles. Any suit pertaining to EOPP shall be brought in the state or federal courts sitting in Chicago, Illinois, each party subject to the
EOPP waiving any claim or defense that such forum is not convenient or proper. Each such party further agrees that any such court shall have *in personam* jurisdiction over it and consents to service of process in any manner authorized by Illinois law.

Reaffirmed: 8/12; Revised: 8/10; Adopted: 7/07

C. SCOPE AND DECISIONS

The Commission on Dental Accreditation is concerned with the educational quality of dental, allied dental and advanced and specialty dental education programs in the United States. The Commission accredits more than 1300 programs in the disciplines within its purview, conducting all aspects of the accreditation process. Through its accreditation activities, the Commission attempts to foster educational excellence, supports programmatic self-improvement and assures the general public of the ongoing availability of quality dental care. These goals are an integral part of a process of evaluation which combines on-site visits with regular review of written and quantitative data. Decisions on accreditation status are the sole responsibility of the Commission. Neither Commission staff, consultants/site visitors, other consultants, individual members of the Commission, nor any other agents of the Commission are empowered to make or modify accreditation decisions.

The Commission formulates and adopts accreditation standards for the accreditation of predoctoral dental education programs, advanced and specialty dental education programs and allied dental education programs.

The Commission, in fulfilling its accreditation responsibilities, focuses on the educational results or outcomes of the programs for which it has authority, as well as on the process used to obtain these results. During its review process, the Commission evaluates programs in relation to predetermined standards. These accreditation standards afford educational institutions latitude and flexibility in program development and implementation. In evaluating the educational process, the Commission applies the established accreditation standards for each discipline uniformly to all programs. All accreditation actions are based on and directly linked to the educational standards or required accreditation policies.

The Commission shares routinely with other accrediting agencies and state licensing agencies information about the status of and any adverse actions taken against any accredited program. Likewise, the Commission receives information about the accreditation actions taken by other accrediting agencies. In accord with established procedure, staff reviews that information and makes note of actions taken at those institutions that also sponsor a Commission-accredited program. When a new program seeks initial accreditation, information regarding the sponsoring institution’s accreditation status must be provided. If any potential problems are revealed, staff seeks additional clarifying information and presents that information to the Commission, usually at its next regularly scheduled meeting. If the Commission were notified by the Department of Education of a potential problem at an institution sponsoring an education program accredited by the Commission on Dental Accreditation, that issue would be addressed immediately.

Reaffirmed: 8/12, 8/10

D. UNITED STATES DEPARTMENT OF EDUCATION

The United States Department of Education (USDE) periodically publishes a list of Nationally Recognized Accrediting Agencies and Associations, which is used to determine eligibility for U.S. federal funding or government assistance under certain legislation. Agencies and associations included on the USDE list are those determined to be the reliable authorities in evaluating the quality of education offered

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by educational institutions or programs. In order for institutions to become eligible for federal funds, the accredit ing agency for that institution must be recognized by USDE. The authority and recognition responsibility of USDE is governed by the Higher Education Act (HEA) of 1965, as amended. This legislation is periodically reauthorized, usually at five-year intervals. Following each reauthorization, the Department promulgates new Procedures and Criteria for Recognition of Accrediting Agencies. The Secretary of Education requires the Commission on Dental Accreditation to submit to USDE the standards, policies and procedures used in its evaluation program. Periodic reviews by USDE are conducted to determine the Commission’s continued eligibility for recognition. The Commission on Dental Accreditation has been recognized since the first recognition list was published in 1952.

**Policy On Communication With The United States Department Of Education (USDE):** As required by the USDE, the Commission will forward to the USDE Secretary annually the following:

- Copies of all Annual Report(s);
- Copies, updated annually, of its directory of accredited programs;
- A summary of the Commission’s major accrediting activities during the previous year, if requested by the Secretary of Education; and
- Any proposed changes in the Commission’s policies, procedures, or accreditation standards that might alter the Commission’s scope of recognition or compliance with the requirements of this part of the USDE recognition criteria.

Revised: 8/10; Reaffirmed: 8/12. 7/07, 7/01; CODA: 7/96:23

**E. PHILOSOPHY OF ACCREDITATION**

The Commission believes that its first responsibility is accountability to the public. The Commission fulfills its responsibility to the public by ensuring that the programs under its purview meet the established educational standards, that Commission policies are applied impartially, and that the Commission follows established procedures to obtain input from a broad constituency and allow for due process. Further, representatives from the public are members of the Commission and its Review Committees, and public comment is regularly solicited on the accreditation standards as well as the educational programs accredited by the Commission.

Reaffirmed: 8/12; Adopted: 8/10

1. **Accreditation Standards:** The Commission on Dental Accreditation evaluates the educational quality of dental and dental-related programs in the United States. All 50 states plus Puerto Rico and the District of Columbia recognize the Commission’s authority to accredit dental and dental-related education programs in the dental and dental-related disciplines. The Commission on Dental Accreditation has developed accreditation standards for each of the disciplines within its purview. The standards, which are the basis for accreditation actions, are reviewed periodically and revised as necessary (see Policy and Procedures for Development and Revision of Accreditation Standards). Documents for each discipline are available from the Commission office upon request. In addition, each dental and dental-related educational program defines its own goals and objectives for preparing members of the dental team. The extent to which a program meets its own goals and objectives is also considered by the Commission.

Reaffirmed: 8/10

2. **Accreditation Cycle:** The Commission on Dental Accreditation formally evaluates programs at regular intervals. Comprehensive site visits based on a self-study are routinely conducted every seven years. Programs in the specialty of oral and maxillofacial surgery are site visited at five-year intervals.
Programs found to be in full compliance with the accreditation standards are awarded the accreditation classification of Approval Without Reporting Requirements. Programs not in full compliance with the accreditation standards are awarded the accreditation classification of Approval With Reporting Requirements.

Reaffirmed: 8/12, 8/10, 7/05; Revised: 1/98, 1/99; Adopted: 7/97, 7/96

F. RECIPROCAL AGREEMENT WITH THE COMMISSION ON DENTAL ACCREDITATION OF CANADA

The reciprocal accreditation arrangement between the Commission on Dental Accreditation and the Commission on Dental Accreditation of Canada (CDAC) has been maintained and expanded since its adoption in 1956. Under the reciprocal agreement, each Commission recognizes the accreditation of educational programs in specified categories accredited by the other agency. Under this arrangement, the Commissions agree that the educational programs accredited by the other agency are equivalent to their own and no further education is required for eligibility for licensure. Commissioners and staff of the accrediting agencies will regularly attend the meetings of the other agency and its standing committees. In addition, Commissioners and/or staff will participate annually in at least one site visit conducted by the other agency. The Commissions believe that this cross-participation is important in maintaining an understanding of the accreditation processes in each country and in ensuring that the accreditation processes in each country continue to be equivalent.

The following educational programs are included in the scope of the reciprocal agreement.

- Predoctoral dental education
- Dental hygiene
- Level II dental assisting
- All nine (9) ADA recognized advanced specialty education programs

The following statement is used in each issue of the List of Accredited Advanced Education Programs and in each issue of the List of Accredited Dental Education Programs:

Canadian Programs

By reciprocal agreement, programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association. However, individuals attending dental programs in one country and planning to practice in another country should carefully investigate the requirements of the licensing jurisdiction where they wish to practice.

By reciprocal agreement, Level II Dental Assisting and Dental Hygiene programs that are accredited by the Commission on Dental Accreditation of Canada are recognized by the Commission on Dental Accreditation of the American Dental Association.

Reaffirmed: 8/12, 8/10, 7/07, 1/03, 7/01; Updated: 7/91; CODA: 1/97:03, 1/94:4-5

G. INTEGRITY

Integrity is expected. In its relationships with the Commission, a program shall demonstrate honesty and integrity. By seeking accreditation or re-accreditation, the program agrees to comply with Commission requirements, policies, guidelines, self-study requirements, decisions and requests.

- In the accreditation process, the program shall be completely candid, providing all pertinent information; and
With due regard for the rights of individual privacy, the program shall provide the Commission with access to all parts of its operations, and with complete and accurate information about the program’s affairs, including reports of other accrediting, licensing and auditing agencies, as requested.

The program’s failure to report honestly, by presenting false information, by omission of essential information or by distortion of information with the intent to mislead, constitutes a breach of integrity, in and of itself. If it appears to the Commission that the program has violated the principles of integrity in the materials submitted to the Commission or in any other manner that requires immediate attention, an investigation will be made, and the program will be offered an opportunity to respond to suspected violations. The Commission will ordinarily withdraw accreditation from a program, after due notice, if:

- The Commission concludes that the program has engaged in illegal conduct or is deliberately misrepresenting itself or presenting false information to the faculty, staff, students, the public or the Commission; or
- The program fails to provide fully and truthfully all pertinent information and materials requested by the Commission.

The Commission may immediately withdraw accreditation if it deems that action to be the most appropriate way to address the issue.

Reaffirmed: 8/12, 8/10; Adopted: 7/08

H. DEVELOPMENT OF ADMINISTRATIVE AND OPERATIONAL POLICY STATEMENTS

The purpose of the Commission on Dental Accreditation as described in its Rules and in the American Dental Association (ADA) Bylaws is (1) to formulate and adopt requirements and guidelines for the accreditation of predoctoral and advanced dental educational and allied dental education programs and (2) to accredit predoctoral and advanced dental educational and allied dental education programs. It is frequently necessary for the Commission to develop policy statements in the process of conducting its business. Such policy may be accreditation related, administrative or operational. The intended audience of a policy statement may be the accredited programs, the broader educational community, the dental community, the general public or some other more specialized audience.

Although policy statements adopted by the Commission may serve a variety of purposes, the procedures which precede adoption are very similar. Comment from all potentially affected communities will generally be obtained by circulating the proposed policy to the appropriate discipline-related Review Committees and, on occasion, to those organizations traditionally viewed as partners in the accreditation process. Some circumstances dictate even wider circulation to a broader community to provide the Commission with the information it needs in order to take action. Although the issue may have come from a specific discipline, the Commission may determine that the issue may affect a broader community and provide guidance to staff for further development of the issue. While the Commission may elect to circulate policy for comment, it is not required to do so. Operational policy, such as that related to Commission and Review Committee meetings or policies and procedures related to the accreditation of programs, are the purview of the Commission’s standing committee on Outcome Assessment, and may not be sent out for comment.

Reaffirmed: 8/12, 8/10

1. Procedure: The following procedure is used when basic policy statements are developed:
   1. An issue or concern surfaces during or between meetings and is placed on the agenda for the next meeting of the Commission.
   2. If an issue surfaces between meetings, it is automatically placed on the next agenda.
3. If an issue surfaces during a meeting, the Commission determines whether or not the issue will be considered further at the next meeting.

4. Staff studies the issue, gathers information from appropriate sources and develops a draft policy statement for circulation to all potentially affected Review Committees.

5. The recommendations of each affected Review Committee on the draft policy statement are forwarded to the Commission. The Commission may take action on the statement in one of the following ways:
   - The statement may be ruled unnecessary and rejected;
   - The statement may be referred back to staff for further work (additional study or redrafting) which should be clearly specified; or
   - The statement may be adopted, with or without amendments.

If adopted, the policy statement is included in the appropriate compilation of Commission policy statements. In general, the following occurs:

   - Accreditation-related policies are included in the Commission’s *Evaluation and Operational Policies and Procedures Manual*.
   - Accredited programs will be informed of the new policy, usually through an article posted in the Accreditation Area of the ADA website.

Reaffirmed: 8/12, 8/10

2. **Staff Protocol For Drafting Policy Reports:** The staff member:
   1. Receives writing assignment and determines which staff should be involved in the assignment;
   2. Conducts preliminary planning meeting;
   3. Develops framework (e.g., outline, notes) for report;
   4. Prepares an executive summary that clearly delineates the exact charge to the Review Committee(s). This approach will be taken on policies considered by more than one Review Committee (1500’s);
   5. Circulates the framework to the Director and managers (those determined at time of assignment);
   6. Conducts staff meeting to resolve substantive differences, if necessary;
   7. Drafts report;
   8. Circulates draft report to the Director and managers for review & comment; requests reviewers to highlight strong concerns; and
   9. Conducts staff meeting to resolve any substantive differences in comments received (if necessary).

Reaffirmed: 8/12, 8/10, 7/07, 7/01; Revised: 7/06; 7/97; CODA: 5/88:5

**II. GENERAL COMMISSION POLICIES AND PROCEDURES**

**A. POLICY AND PROCEDURE FOR DEVELOPMENT AND REVISION OF ACCREDITATION STANDARDS**

The Commission on Dental Accreditation has authority to formulate and adopt educational requirements and guidelines, i.e. standards, for the accreditation of dental educational programs within its purview. These include the predoctoral programs, as well as advanced and allied dental education programs.

In developing and revising accreditation standards, the appropriate communities of interest are substantially involved in all stages of the process. The process culminates in the adoption of accreditation standards.

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standards which become the property of the Commission. Any individual who assists in developing or revising a standards document must sign a release giving the Commission the right to copyright such documents. During the initial step of the process, representatives from the discipline involved are invited to participate in the development of the preliminary document. These representatives are selected in cooperation with the organizations(s) nationally recognized in the discipline whose membership is reflective of the discipline.

The communities of interest (COI) include, but are not limited to, the following: sponsoring organizations and certifying boards of all dental and dental related disciplines under the purview of the Commission, program directors, dental school deans, administrators of non-dental school institutions offering dental programs, and constituent societies of the American Dental Association.

The Commission uses consistent definitions and terms in its standards documents. The Commission monitors the consistency of the definitions of terms used in the accreditation standards documents and lists a glossary of terms and approved definitions to be used by appropriate audiences when the revision of the accreditation standards for a discipline is initiated.

The following language is used when draft revisions of standards are circulated:

The Commission directed that the proposed revision of the (discipline) Standards be distributed to the appropriate communities of interest for review and comment. The Commission also directed that the proposed revised standards be presented in an open hearing to be held....

Based on current word processing programs, the Commission now indicates a proposed deletion with a strikethrough and recommended additions are underlined. When more than one cycle of revisions has occurred, multiple versions of the documents will be provided with the date of the revision or the version number clearly indicated.

The following is a summary of the standards development and revision process:

Step 1. Development of a preliminary document by staff and selected representatives of the discipline involved.

Step 2.

i. Consideration of preliminary document by appropriate Review Committee
ii. Recommendation by Review Committee for circulation of document to COI by the Commission
iii. Commission authorizes circulation

Step 3.

i. Circulation of preliminary document to COI for review and comment
ii. Open hearing at ADA Annual Session and ADEA Annual Meeting and additional communities of interest as appropriate

Step 4.

i. Comments from COI compiled by staff
ii. Comments reviewed by appropriate review committee and appropriate changes made
iii. Recommendation by Review Committee to implement changes, or to recirculate for further comment if changes are significant
iv. Commission approves changes and authorizes implementation timeframe or recirculation to COI
for comments

v. Steps 3 and 4 can be repeated, depending upon significance of changes

Step 5. Commission notifies all appropriate individuals and programs of implementation timeframe

Reaffirmed: 8/12, 8/10, 7/07, 7/01; Revised: 7/09, 1/04 5/89; 12/89; Adopted: 4/83; CODA: 12/91:15, 12/90:2, 12

1. Frequency Of Citings: Each of the Review Committees and the Commission regularly review an updated analysis of the number of “must” statement citings and their distribution among the “must” statements in the accreditation standards for each discipline. These analyses are conducted at the summer meetings. Frequency of Citings Reports are provided to programs and presented at workshops. To ensure confidentiality, Frequency of Citings Reports will not be made available in disciplines where a limited number (three or less) of programs have been site visited.

Reaffirmed: 8/12, 8/10

B. POLICY ON ASSESSING THE VALIDITY AND RELIABILITY OF THE ACCREDITATION STANDARDS

The Commission on Dental Accreditation has developed accreditation standards for use in assessing, ensuring and improving the quality of the educational programs in each of the disciplines it accredits.

The Commission believes that a minimum time span should elapse between the adoption of new standards or implementation of standards that have undergone a comprehensive revision and the assessment of the validity and reliability of these standards. This minimum period of time is directly related to the academic length of the accredited programs in each discipline. The Commission believes this minimum period is essential in order to allow time for programs to implement the new standards and to gain experience in each year of the curriculum.

The Commission’s policy for assessment is based on the following formula: The validity and reliability of accreditation standards will be assessed after they have been in effect for a period of time equal to the minimum academic length of the accredited program plus three years. Thus, the validity and reliability of the new standards for a one year program will be assessed after four years while standards which apply to programs four years in length will be assessed seven years after implementation. In conducting a validity study, the Commission considers the variety of program types in each discipline and obtains data from each type in accord with good statistical practices.

The Commission’s ongoing review of its accreditation standards documents results in standards that evolve in response to changes in the educational and professional communities. Requests to consider specific revisions are received from a variety of sources and action on such revisions is based on broad input and participation of the affected constituencies. Such ongoing assessment takes two main forms, the development or revision of specific standards or a comprehensive revision of the entire standards document.

Specific issues or concerns may result in the development of new standards or the modification of existing standards, in limited areas, to address those concerns. Comprehensive revisions of standards are made to reflect significant changes in disease and practice patterns, scientific or technological advances, or in response to changing professional needs for which the Commission has documented evidence.

If none of the above circumstances prompts an earlier revision, in approximately the fifth year after the
validity and reliability of the standards has been assessed, the Commission will conduct a study to
determine whether the accreditation standards continue to be appropriate to the discipline. This study will
include input from the broad communities of interest. The communities will be surveyed and invited to
participate in some national forum, such as an invitational conference, to assist the Commission in
determining whether the standards are still relevant and appropriate or whether a comprehensive revision
should be initiated.

The following alternatives, resulting in a set of new standards, might result from the assessment of the
adequacy of the standards:

- Authorization of a comprehensive revision of the standards;
- Revision of specific sections of the standards;
- Refinement/clarification of portions of the standards; and
- No changes in the standards but use of the results of this assessment during the next revision.

The new document is developed with input from the communities of interest in accord with Commission
policies. An implementation date is specified and copyright privileges are sought when the document is
adopted. Assessment of the validity and reliability of these new standards will be scheduled in accord
with the policy specified above. Exceptions to the prescribed schedule may be approved to ensure a
consistent timetable for similar disciplines (e.g. advanced specialty education programs and/or allied
education programs.

Reaffirmed: 8/12, 8/10, 7/06; Revised: 7/07, 07/00; Adopted: 12/88

C. OPEN HEARING PROCEDURES

The Commission makes every effort to have two Commissioners attend each open hearing sponsored by
the Commission. The Commission believes that two Commissioners is an appropriate number to
routinely attend open hearings, but also believes that those in attendance are not always appropriately
visible. Thus, the Commission directed that all members of the Commission who are present during
Commission sponsored open hearings be introduced at the beginning of the open hearing and, if feasible,
be seated at a head table to ensure their visibility to those offering testimony.

The purpose of an open hearing on a proposed document is to provide individuals, institutions and
organizations that will be affected by the document with an opportunity to comment. The Commissioner
selected to chair the hearing is generally responsible for:

- Calling the hearing to order;
- Introducing him/herself, other Commission members and Commission staff present;
- Explaining the purpose of the open hearing;
- Providing brief background information on the proposed revision;
- Explaining the ground rules for the hearing;
- Listening to comments and maintaining the order and flow of the hearing; and
- Concluding the hearing.

The goal of an open hearing is to hear as many varied points of view on the proposed documents as
possible in an orderly fashion. The following ground rules facilitate achieving this goal:

- The document should be reviewed on a page-by-page basis so that comments on specific issues can
  be provided at the same time.

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General comments on the document can be considered either before or after the page-by-page review, as determined by the Chairperson.

Individuals who wish to provide comments should wait to be recognized by the Chairperson, and identify themselves by giving their name, city, state, and educational institution, if applicable.

Individuals reference the specific section of the document on which they wish to comment by indicating the page and line numbers of the section.

Comments should be as concise as possible.

Individuals should provide written comments that summarize their verbal remarks to the Chairperson by the end of the hearing.

Open hearings should be constructive. It is sometimes helpful for the Chairperson to ask an individual who is speaking at length against a section of the proposed document whether he/she has a specific suggestion for revision. This can help to clarify the speaker’s objection more precisely and to bring the comments to closure.

Occasionally, an individual or a few individuals may monopolize an open hearing. In fairness to other attendees who may wish to speak, the Chairperson should direct individuals who have had ample opportunity to express their opinions to conclude their remarks.

Commissioners are present to listen to representatives of the communities of interest and should avoid becoming involved in debates about the relative merits of specific sections of the document.

Similarly, open hearing attendees should refrain from engaging in heated debates with each other. If such debates develop, the Chairperson may wish to remind participants that the Commission is interested in considering all viewpoints on the issues and that no decision regarding any issue will be determined during an open hearing.

At the close of the hearing, the Chairperson should advise attendees of other opportunities for comment (i.e. other open hearings, if any, and the deadline for written comments) and indicate when the Commission will take the final action on the document.

Reaffirmed: 8/12, 8/10, 7/07, 7/01; CODA: 12/91:15

D. CONFLICT OF INTEREST POLICY

Evaluation policies and procedures used in the accreditation process provide a system of checks and balances regarding the fairness and impartiality in all aspects of the accreditation process. Central to the fairness of the procedural aspects of the Commission’s operations and the impartiality of its decision making process is an organizational and personal duty to avoid real or perceived conflicts of interest. The potential for a conflict of interest arises when one’s duty to make decisions in the public’s interest is compromised by competing interests of a personal or private nature, including but not limited to pecuniary interests.

Conflict of interest is considered to be: 1) any relationship with an institution or program, or 2) a partiality or bias, either of which might interfere with objectivity in the accreditation review process. Procedures for selection of representatives of the Commission who participate in the evaluation process reinforce impartiality. These representatives include: Commissioners, Review Committee members, consultants/site visitors, and Commission staff.
In addition, procedures for institutional due process, as well as strict guidelines for all written documents and accreditation decisions, further reinforce adherence to fair accreditation practices. Every effort is made to avoid conflict of interest, either from the point of view of an institution/program being reviewed or from the point of view of any person representing the Commission.

Reaffirmed: 8/12, 8/10

1. **Visiting Committee Members:** Conflicts of interest may be identified by either an institution/program, Commissioner, consultant/site visitor or Commission staff. An institution/program has the right to reject the assignment of any Commissioner, consultant/site visitor or Commission staff because of a possible or perceived conflict of interest. The Commission expects all programs, Commissioners and/or consultants/site visitors to notify the Commission office immediately if, for any reason, there may be a conflict of interest or the appearance of such a conflict. Because of the nature of their positions, a state board representative will be a resident of the state in which a program is located and may be a graduate of the institution/program being visited. These components of the policy do not apply for state board representatives, although the program retains the right to reject an individual’s assignment for other reasons.

Conflicts of interest include, but are not limited to, a consultant/site visitor who:
- is a graduate of a program at the institution;
- has served as a consultant/site visitor, consultant, employee or appointee of the institution;
- has a family member who is employed or affiliated with the institution;
- has a close professional or personal relationship with the institution/program or key personnel in the institution/program which would, from the standpoint of a reasonable person, create the appearance of a conflict;
- manifests a partiality that prevents objective consideration of a program for accreditation;
- is affiliated with an institution/program in the same state; and/or
- is a resident of the state.

If an institutional administrator, faculty member or consultant/site visitor has doubt as to whether or not a conflict of interest could exist, Commission staff should be consulted prior to the site visit. The Chairperson, Vice-Chairperson and a public member of the Commission, in consultation with Commission staff and legal counsel, may make a final determination about such conflicts.

Revised: 2/13; 8/10; Reaffirmed: 8/12

2. **Commissioners, Review Committee Members And Members Of The Appeal Board:** The Commission firmly believes that conflict of interest or the appearance of a conflict of interest must be avoided in all situations in which accreditation recommendations or decisions are being made by Commissioners, Review Committee members, or members of the Appeal Board. No Commissioner, Review Committee member, or member of the Appeal Board should participate in any way in accrediting decisions in which he or she has a financial or personal interest or, because of an institutional or program association, has divided loyalties and/or has a conflict of interest on the outcome of the decision. Areas of conflict of interest for Commissioners, Review Committee members and/or members of the Appeal Board include, but are not limited to:

- close professional or personal relationships or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as a consultant to the institution/program;
- being a graduate of the institution/program;

Revised: 2/13; 8/10; Reaffirmed: 8/12
• being a current employee or appointee of the institution/program;
• being a current student at the institution/program;
• having a family member who is employed by or affiliated with the institution;
• manifesting a professional or personal interest at odds with the institution or program;
• key personnel of the institution/program having graduated from the program of the Commissioner, Review Committee member, or member of the Appeal Board;
• having served on the program’s visiting committee; and/or
• no longer a current employee of the institution or program but having been employed there within the past five (5) years.

To safeguard the objectivity of the Commission and Review Committees, conflict of interest determinations shall be made by the Chairperson of the Commission. If the Chairperson and Vice Chairperson, in consultation with a public member, staff and legal counsel, determine that a Commissioner or Review Committee member has a conflict of interest in connection with a particular program, the report for that program will not be provided to that individual, either in an advance mailing or at the time of the meeting. Further, the individual must leave the room when they have any of the above conflicts. In cases in which the existence of a conflict of interest is less obvious, it is the responsibility of any committee member who feels that a potential conflict of interest exists to absent himself/herself from the room during the discussion of the particular accreditation report.

To safeguard the objectivity of the Appeal Board, any member who has a conflict of interest in connection with a program filing an appeal must inform the Director of the Commission. The report for that program will not be provided to that individual, either in an advance mailing or at the time of the meeting, and the individual must leave the room when the program is being discussed.

Conflicts of interest for Commissioners, Review Committee members and members of the Appeal Board may also include being from the same state, but not the same program. The Commission is aware that being from the same state may not itself be a conflict; however, when residence within the same state is in addition to any of the items listed above, a conflict would exist. This provision refers to the concept of conflict of interest in the context of accreditation decisions. The prohibitions and limitations are not intended to exclude participation and decision-making in other areas, such as policy development and standard setting.

Commissioners are expected to evaluate each accreditation action, policy decision or standard adoption for the overall good of the public. The American Dental Association (ADA) Constitution and Bylaws limits the involvement of the members of the ADA, the American Dental Education Association and the American Association of Dental Boards in areas beyond the organization that appointed them. Although Commissioners are appointed by designated communities of interest, their duty of loyalty is first and foremost to the Commission. A conflict of interest exists when a Commissioner holds appointment as an officer in another organization within the Commission’s communities of interest. Therefore, a conflict of interest exists when a Commissioner or a Commissioner-designee provides simultaneous service to the Commission and an organization within the communities of interest. (Refer to Policy on Simultaneous Service)

Reaffirmed: 8/12; Revised: 8/10

3. Commission Staff Members: Although Commission on Dental Accreditation staff does not participate directly in decisions by volunteers regarding accreditation, they are in a position to influence the outcomes of the process. On the other hand, staff provides equity and consistency among site visits

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and guidance interpreting the Commission’s policies and procedures.

For these reasons, Commission staff adheres to the guidelines for consultants/site visitors, within the time limitations listed and with the exception of the state residency, including:

- graduation from a program at the institution within the last five years;
- service as a consultant/site visitor, employee or appointee of the institution within the last five years; and/or
- close personal or familial relationships with key personnel in the institution/program.

Revised: 8/10, 7/09, 7/07, 7/00, 7/96, 1/95, 12/92; Reaffirmed: 8/12, 1/03; Adopted: 1982

E. CONFIDENTIALITY POLICY

Confidentiality of the following materials is maintained to ensure the integrity of the institution/programs and of the accreditation process. In all instances Protected Health Information must not be improperly disclosed. The Commission’s confidentiality policies apply to Commissioners, Review Committee members, members of the Appeal Board, and consultants/site visitors.

SELF-STUDY DOCUMENT: At the discretion of the institution, the administration may either release information from this document to the public or keep it confidential. The Commission will not release any information in the self-study document without the prior written approval of the institution.

SITE VISIT REPORT: The preliminary draft of a site visit report is an unofficial document and remains confidential between the Commission and the institution’s executive officers and may not, under any circumstances, be released. Members of a visiting committee who review preliminary drafts of the report must consider the report as privileged information and must not discuss it or make its contents known to anyone, under any circumstances. Reasons for assigning any non-adverse status other than full approval remain confidential between the institution and the Commission unless the institution wishes to release them.

Public release of the final draft of the site visit report that is approved by the Commission is at the sole discretion of the institution. If there is a point of contention about a specific section of the final site visit report and the institution elects to release the pertinent section to the public, the Commission reserves the right to make the entire site visit report public.

INSTITUTION’S RESPONSE TO A SITE VISIT REPORT: Release of this information is at the sole discretion of the institution. An institution’s response must not improperly disclose any Protected Health Information; however, if any such information is included in the response, such information will not be made public.

TRANSMITTAL LETTER OF ACCREDITATION NOTIFICATION: Information such as accreditation status granted and scheduled dates for submission of additional information is public information.

PROGRESS REPORT: The scheduled date for submission of progress reports is public information. Release of the content of a progress report is at the sole discretion of the institution. If there is a point of contention about a particular portion of the progress report and the institution elects to release the pertinent portion to the public, the Commission reserves the right to make public the entire progress report. Progress reports must not improperly disclose Protected Health Information. If any Protected Health Information is included in the progress report, such information will be redacted before the progress report is made public.
SURVEYS: Routinely gathered data are used in the accreditation process and also provide a national data base of information about the accredited dental and dental-related educational programs. The Commission may release to the public any portion of survey data that is collected annually unless the terms of confidentiality for a specific section are clearly indicated on the survey instrument. Subsections of each survey instrument containing data elements which are confidential are clearly marked. Any data which may be reported from confidential subsections are published in a manner which does not allow identification of an individual institution/program.

EXIT INTERVIEWS: The final conference or exit interview between the site visit committee and the chief executive officer, dental dean, chief of dental service or the program director(s) is also confidential. Additional people may be included at the discretion of the institutional administration. The interview is a confidential summation of the preliminary findings, conclusions, recommendations and suggestions which will appear in the site visit report to the institution. This is a preliminary oral report and the preliminary written report is often only in draft stage at this point; therefore, this session is not recorded on tape or by a stenographer. Note taking is permitted and encouraged.

ON-SITE ORAL COMMUNICATIONS: In order to carry out their duties as on-site evaluators, visiting committee members must communicate freely with administrators, faculty, staff and students and any other appropriate individuals affiliated with an education program. As part of their on-site accreditation duties, committee members are expected to share with other team members pertinent and relevant information obtained during interviews. All oral communications occurring on-site, however, are confidential among team members. When the site visit ends, team members may communicate orally, or in writing, only with Commission staff or other team members about any on-site interview or conversation. All questions related to any aspect of the site visit including oral communications must be referred to the Commission office.

MEETING MATERIALS/DISCUSSIONS: Background reports and informational materials related to accreditation matters are regularly prepared for review by the Commission and its Review Committees. These materials and all discussions related to accreditation matters routinely remain confidential. The Commission determines when, and the manner in which, newly adopted policy and informational reports will receive public distribution.

PROTECTED HEALTH INFORMATION: Patients’ protected health information, which includes any information that could identify an individual as a patient of the facility being site visited, may not be used by the consultants/site visitors, Review Committee members, or Commissioners for any purpose other than for evaluation of the program being reviewed on behalf of the Commission. Protected Health Information may not be disclosed to anyone other than Commissioners, Commission staff, Review Committee members or consultants/site visitors reviewing the program from which the Protected Health Information was received. Individual Protected Health Information should be redacted from Commission records whenever that information is not essential to the evaluation process. If a consultant/site visitor, Review Committee member, or Commissioner believes any Protected Health Information has been inappropriately used or disclosed, he/she should contact the Commission office.

MEETINGS: Policy portions of the Review Committee and Commission meetings are open to observers, while accreditation actions are confidential and conducted in closed session. All deliberations of the Appeal Board are confidential and conducted in closed session.

NOTICE OF REASONS FOR ADVERSE ACTION: Notice of the reasons for which an adverse
accreditation action (i.e. deny or withdraw) is taken is routinely provided to the Secretary of the U.S. Department of Education, any appropriate state agencies, and, upon request, to the public.

Reaffirmed: 8/12, 8/10; Revised: 1/05, 2/01, 7/00;  Adopted: 7/94, 5/93

1. Reminder Of Confidentiality: To be read at meetings or on site:
The Commission on Dental Accreditation reminds you that confidentiality is an integral part of the accreditation process. The Commission must have access to much sensitive information in order to conduct its review of programs. The confidentiality of this information must be protected by participants of meetings as well as by participants on accreditation site visits.

To remind you of the seriousness with which the Commission views its commitment to protect confidentiality, the Commission requires that all participants of meetings and site visits sign an Agreement of Confidentiality. In signing the Agreement which was mailed to you, you indicated your familiarity with the Commission’s policy on confidentiality and agreed to abide by it. If you have not already signed the Agreement, please arrange to do so.

Unless indicated otherwise, all meeting and site visit materials, all information obtained on site, all patient Protected Health Information, and all discussions related to the accreditation of programs are confidential. Patients’ Protected Health Information, which includes any information that could identify an individual as a patient of the facility you are visiting or reviewing, may not be used by you for any purpose other than for evaluation of the program on behalf of the Commission. If you believe any Protected Health Information has been inappropriately used or disclosed, you must contact the Commission office. And, please remember that confidentiality has no expiration date -- it lasts forever!

Reaffirmed: 8/12, 8/10, 7/01; Revised: 1/05;  Adopted: 12/85

2. The Agreement Of Confidentiality:

Agreement of Confidentiality

I am aware that, as a participant of an accreditation site visit, committee, or the Commission, I have access to accreditation information which must remain confidential. I have read and understand the Commission on Dental Accreditation’s policy on Confidentiality and Public Disclosure and agree to protect the confidentiality of all accreditation materials, all patient Protected Health Information, recommendations and suggestions and discussions before, during and after the meeting or site visit.

_______________________________________________         __________________________
Signed                                                      Date

Reaffirmed: 8/12, 8/10, 7/01; Revised: 1/05;  Adopted: 12/8

F. POLICY ON PUBLIC DISCLOSURE

Following each meeting, final accreditation actions taken with respect to all programs, are disclosed to all appropriate agencies, including the general public. The public includes other programs or institutions, faculty, students and future students, governing boards, state licensing boards, USDE, related organizations, federal and state legislators and agencies, members of the dental community, members of the accreditation community and the general public. In general, it includes everyone not directly involved in the accreditation review process at a given institution.

If the Commission, subsequent to and following the Commission’s due process procedures, withdraws or denies accreditation from a program, the action will be so noted in the Commission's lists of accredited programs. Any inquiry related to application for accreditation would be viewed as a request for public information and such information would be provided to the public. The scheduled dates of the last and
next comprehensive site visits are also published as public information.

The Commission has procedures in place to provide a brief statement summarizing the reasons for which it takes an adverse accreditation action. If initial accreditation were denied to a developing program or accreditation were withdrawn from a currently accredited program, the reasons for that denial would be provided to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and to the public. In addition, the official comments that the affected institution or program may wish to make with regard to that decision, or evidence that the affected institution has been offered the opportunity to provide official comment will also be made available to the Secretary of the U.S. Department of Education, the appropriate accrediting agencies, any appropriate state licensing or authorizing agencies, and to the public.

All documents relating to the structure, policies, procedures, and accreditation standards of the Commission are available to the public upon written request. Other official documents require varying degrees of confidentiality.

Reaffirmed: 8/12, 8/10; Revised: 1/05, 2/01, 7/00; Adopted: 7/94, 5/93

G. POLICY ON SIMULTANEOUS SERVICE

A member of the Commission on Dental Accreditation, including its standing and review committees* may not simultaneously serve as a principal officer of another organization within any of the Commission’s primary communities of interest if that organization has a role in appointing or co-appointing a member of the Commission. The Commission interprets principal officer to mean those in the position of being final decision-makers which usually includes positions such as the president, president-elect, immediate past president, secretary or treasurer of an organization, as well as members of any executive committee that has decision-making authority which does not require confirmation by a board or house. The Commission has defined primary community of interest in this context as any organizations who have a role in appointing Commissioners, including American Dental Education Association, American Association of Dental Boards and the Regional Clinical Testing Agencies, American Association of Hospital Dentists, American Dental Assistants Association, American Dental Association, American Dental Hygienists’ Association, National Association of Dental Laboratories, and the sponsoring organizations of the recognized dental specialties.

When such a conflict is revealed at the time of appointment, the appointing organization will be informed that the conflict exists and requested to select another individual for membership on the Commission.

When such a conflict arises during the term of a current Commissioner, the Commissioner will be asked to resolve the conflict by resigning from one of the conflicting appointments. In the event that the member resigns from the Commission, the appointing organization will appoint another individual to complete the unfinished term, as specified by the Rules of the Commission on Dental Accreditation.

If the term of the vacated Commission position has less than fifty percent (50%) of a full four-year term remaining at the time the successor member is appointed, the successor member shall be eligible for appointment to a new, consecutive four-year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment, the successor member shall not be eligible for another term.

*this applies to appointments made after 2013

Reaffirmed: 8/10, 7/07; Revised: 2/13, 7/09, 7/01, 7/95
H. NON-DISCRIMINATION POLICY:

The Commission on Dental Accreditation does not discriminate against any person in the conduct of its activities because of race, color, religion, gender, age, disability or national origin.

Reaffirmed: 8/10, 7/07, 7/01, 5/84, 7/95

I. POLICY ON PROFESSIONAL CONDUCT AND PROHIBITION AGAINST HARASSMENT

The American Dental Association (ADA) is proud of its professional and congenial work environment, and it will take all necessary steps to ensure that the work environment remains pleasant for all that work here. It is ADA policy that all ADA volunteers, as well as all ADA employees, are responsible for assuring that the work place is free from improper harassment. The ADA absolutely prohibits sexual harassment and harassment on the basis of race, color, religion, gender, national origin, age, disability, sexual orientation, status with respect to public assistance, or marital status. Certain discriminatory harassment is prohibited by state and federal laws, which may subject the ADA and/or the individual harasser to liability for any such unlawful conduct. With this policy, the ADA prohibits not only unlawful harassment, but also other unprofessional and discourteous actions. Derogatory racial, ethnic, religious, age, sexual orientation, sexual or other inappropriate remarks, slurs, or jokes will not be tolerated.

Sexual harassment includes unwelcome sexual advances and requests for sexual favors, and all other verbal or physical conduct of a sexual nature when:

- submission to such conduct is made either implicitly or explicitly a condition of the individual’s employment;
- submission to or rejection of such conduct is used as the basis for decisions affecting an individual’s employment; or
- such conduct is sufficiently severe or pervasive to alter the conditions of employment and to create a hostile or abusive working environment.

Sexual harassment may take many forms, including, but not limited to:

- verbal harassment or abuse of a sexual nature;
- subtle pressure or abuse of a sexual nature;
- unnecessary touching of an individual, for example, patting, pinching, hugging, repeated brushing against another employee’s body;
- offensive sexual flirtation, advances or propositioning;
- graphic verbal commentaries or jokes;
- sexually degrading words used to describe an individual; or
- the offensive display in the workplace of sexual objects, pictures or writings.

Each volunteer must exercise his or her own good judgment to avoid engaging in conduct that may be perceived by others as harassment. Forms of harassment include, but are not limited to:

- Verbal: repeated sexual innuendoes, racial or sexual epithets, derogatory slurs, off-color jokes, negative stereotyping, personally abusive remarks, propositions, threats or suggestive or insulting sounds;
- Visual/Non-verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; graphic commentaries; leering; or obscene gestures;
• Physical: unwanted physical contact including touching, interference with an individual’s normal work movement or assault; and
• Other: making or threatening reprisals as a result of a negative response to harassment.

ADA volunteers, as well as ADA employees, are responsible for keeping our work environment free of all such harassment. If you believe that you have been harassed, or if you become aware of an incident of harassment, whether by an employee or a non-employee, you should report it as soon as possible to the Executive Director and/or to the ADA Director of Human Resources, 1-800-621-8099, ext. 2755 or 312-440-2755. Do not allow an inappropriate situation to continue by not reporting it, regardless of who is creating that situation.

The ADA’s Professional Conduct Policy and Prohibition Against Harassment applies to the immediate workplace as well as to ADA related activity outside the ordinary work place, such as Annual Session and ADA-sponsored social or recreational events.

In response to every complaint, the ADA will take prompt investigatory actions and corrective and preventative actions where necessary. All ADA volunteers should be aware that the privacy of the charging party and the person accused of the harassment will be protected to the extent consistent with effective enforcement of this policy. The ADA will retain confidential documentation of all allegations and investigations.

All those involved in the accreditation process are reminded that harassment is against the law. Any consultant/site visitor or program representative who experiences or witnesses harassment in relation to the accreditation process should contact the Director of the Commission and/or the ADA Director of Human Resources, 1-800-621-8099 at once. The Commission annually reviews the American Dental Association’s Professional Conduct Policy and Prohibition Against Harassment and directs that the policy be provided routinely to all parties that participate in the accreditation review process.

Reaffirmed: 8/10; Revised: 7/09, 1/03, 7/97; CODA: 01/95:11

J. ANNUAL FEE POLICY

Programs accredited by the Commission pay an annual fee. As there is some variation in fees for different disciplines based on actual accreditation costs, programs should contact the Commission office for specific information. Site visits are conducted without any additional charge to the institution and the Commission assumes all expenses incurred by its consultants/site visitors; however, accredited programs with multiple sites which must be site visited and programs sponsored by the U.S. military in international locations are assessed a fee at the time of the site visit. The fee is established on a case-by-case basis, dependent upon the specific requirements to conduct the visit (e.g. additional consultants/site visitors, additional days, and additional travel time). Fee structures are evaluated annually by the Commission. The Commission office should be contacted for current information on fees. Expenses for representatives from the state board of dentistry or from other agencies, such as a regional accrediting agency, are not assumed by the Commission.

Failure to pay fees by the designated deadline is viewed as an institutional decision to no longer participate in the Commission’s accreditation program. Following appropriate reminder notice(s), steps to discontinue the accreditation status would be taken at the next regularly scheduled meeting of the Commission. Programs which have been discontinued or had accreditation withdrawn will not be issued a refund of accreditation fees.

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All institutions offering programs accredited by the Commission on Dental Accreditation are expected to adhere to the due date for payment of the annual accreditation fee for each accredited program sponsored by the institution.

Written requests for an extension must specify a payment date no later than thirty (30) days beyond the initial due date. If payment or a request for extension is not received by the due date, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

Reaffirmed: 8/10, 7/07, 7/01, 7/95; Revised: 7/08

K. POLICY ON ELECTRONIC SUBMISSION OF ACCREDITATION MATERIALS AND CONVERSION FEES

All institutions will provide the Commission with an electronic copy of all accreditation documents/reports and related materials. The program’s documentation for CODA must not contain any patient protected health information. If an institution nevertheless provides the Commission and/or Commission site visitors with materials containing patient protected health information (PHI), such materials must be in electronic form and encrypted as outlined by the most recent breach notification regulations related to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

These documents may include, but are not limited to, self-study, responses to site visit/progress reports, initial accreditation applications, reports of major change, and transfer of sponsorship and exhibits. Electronic submission guidelines will be provided to programs. Accreditation documents/reports and related materials must be complete and comprehensive. If the program is unable to provide a comprehensive electronic document, the Commission will assess a fee for converting the document (e.g. exhibits, tables, curriculum, report of change, progress report, transfer of sponsorship, response to site visit report) to an electronic version.

Reaffirmed: 8/10; Revised: 8/12, 8/11, 8/07, 7/06; Adopted: 1/06

L. COMMISSION POLICY AND PROCEDURE RELATED TO COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

HIPAA is the federal law that governs how “Covered Entities” handle the privacy and security of patients’ protected health information (PHI). HIPAA Covered Entities include health care providers and health plans that send certain information electronically. The Commission may be deemed a “Business Associate” of certain institutions that are HIPAA Covered Entities. A Business Associate is an individual or entity that performs a function or activity on behalf of a HIPAA Covered Entity involving the use or disclosure of individually identifiable health information. Business Associates must comply with certain HIPAA Security and Privacy rules and implement training programs. The Commission “HIPPA Policy and Procedure Manual” is updated on a yearly basis. A copy of the manual is available upon request. All Commission site visitors, Review Committee members, Commissioners, and staff are required to attend a HIPAA training session on a yearly basis.

Adopted: 8/11

M. GUIDELINES FOR MANAGING PROGRAM FILES

All correspondence is maintained and documentation related to one accreditation cycle will be stored
electronically. Electronic documents/correspondence do not need signatures (per Commission legal counsel). Transmittal letters can be saved to the accredited program’s FileWeb space without a signature.

Accredited programs
- All correspondence;
- The most recent site visit report (including the institution’s response);
- Most recent self-study (with the hospital’s bylaws, and course outlines appendix);
- Second most recent self-study (without hospital bylaws or course outlines appendix);
- All previous site visit reports (including institution’s responses);
- Progress reports related to the two (2) most recent site visit reports (without course outlines); and
- Special Reports: (e.g. interim review, major change, transfer of sponsorship) occurring during time period of the two most recent site visit reports.

Discontinued programs
- All correspondence and site visit reports.

Programs with accreditation withdrawn
- All correspondence;
- Two (2) most recent site visit reports (with institutional responses);
- Two (2) most recent self-studies (without hospital bylaws or course outlines); and
- Progress reports related to the two (2) most recent site visit reports.

Reaffirmed: 8/10, 7/09; Revised: 8/02, 8/03, 8/99; Adopted: 9/92

III. POLICIES AND PROCEDURES RELATED TO ACCREDITATION OF PROGRAMS

A. ACCREDITATION STATUS DEFINITIONS

1. Programs That Are Fully Operational:
Approval (without reporting requirements): An accreditation classification granted to an educational program indicating that the program achieves or exceeds the basic requirements for accreditation.

Approval (with reporting requirements): An accreditation classification granted to an educational program indicating that specific deficiencies or weaknesses exist in one or more areas of the program. Evidence of compliance with the cited standards must be demonstrated within eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length. If the deficiencies are not corrected within the specified time period, accreditation will be withdrawn, unless the Commission extends the period for achieving compliance for good cause. Circumstances under which an extension for good cause would be granted include, but are not limited to:
- sudden changes in institutional commitment;
- natural disaster which affects affiliated agreements between institutions; faculty support; or facilities;
- changes in institutional accreditation;
- interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program.

Revised: 5/12; Reaffirmed: 8/10, 7/05; Revised: 1/99; Adopted: 1/98
2. **Programs That Are Not Fully Operational**: A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The accreditation classification granted by the Commission on Dental Accreditation to programs which are not fully operational is “initial accreditation.” When initial accreditation status is granted to a developing education program, it is in effect through the projected enrollment date. However, if enrollment of the first class is delayed for two consecutive years following the projected enrollment date, the program’s accreditation will be discontinued, and the institution must reapply for initial accreditation and update pertinent information on program development. Following this, the Commission will reconsider granting initial accreditation status.

**Initial Accreditation** is the accreditation classification granted to any dental, advanced dental or allied dental education program which is not yet fully operational. This accreditation classification provides evidence to educational institutions, licensing bodies, government or other granting agencies that, at the time of initial evaluation(s), the developing education program has the potential for meeting the standards set forth in the requirements for an accredited educational program for the specific occupational area. The classification “initial accreditation” is granted based upon one or more site evaluation visit(s).

Reaffirmed: 8/10; Revised: 7/08; Adopted: 2/02

3. **Other Accreditation Actions**:

**Discontinued**: An action taken by the Commission on Dental Accreditation when a program voluntarily discontinues its participation in the accreditation program and no longer enrolls a first year class.

**Intent to Withdraw**: A formal warning utilized by the Commission on Dental Accreditation to notify an accredited program and the communities of interest that the program’s accreditation will be withdrawn if compliance with accreditation standards or policies cannot be demonstrated by a specified date. The warning is usually for a six-month period, unless the Commission extends for good cause. The Commission advises programs that the intent to withdraw accreditation may have legal implications for the program and suggests that the institution’s legal counsel be consulted regarding how and when to advise applicants and students of the Commission’s accreditation actions.

**Withdraw**: An action taken by the Commission when a program has been unable to demonstrate compliance with the accreditation standards or policies within the time period specified. A final action to withdraw accreditation is communicated to the program and announced to the communities of interest. A statement summarizing the reasons for the Commission’s decision and comments, if any, that the affected program has made with regard to this decision, is available upon request from the Commission office. In the event the Commission withdraws accreditation from a program, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program, will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission accredited program. Such graduates may be ineligible for certification/licensure examinations.

Reaffirmed: 8/10, 7/07, 7/01; CODA: 12/87:9

**Denial**: An action by the Commission that denies accreditation to a developing program (without enrollment) or to a fully operational program (with enrollment) that has applied for accreditation. Reasons for the denial are provided. Denial of accreditation is considered an adverse action.

Adopted: 8/11
B. APPLICATION FOR ACCREDITATION FOR FULLY OPERATIONAL PROGRAMS WITH ENROLLMENT AND WITHOUT ACCREDITATION

Those programs that have graduated at least one class of students/residents and are enrolling students/residents in every year of the program are considered fully operational. These programs will complete the self-study document and will be considered for the accreditation status of “approval with reporting requirements” or “approval without reporting requirements” following a comprehensive site visit (Please see procedures for the conduct of a comprehensive site visit). The following steps apply:

1. An application for accreditation is completed by the program and submitted to the Commission on Dental Accreditation, along with appropriate documentation and application fee. A program with an application submitted to the Commission between April 2nd and October 1st may be site visited in late spring of the following year and reviewed at the July Commission meeting. Programs with applications submitted to the Commission between October 2nd and April 1st may be site visited in late fall of the same year and reviewed at the January Commission meeting. Typically, the first opportunity for the Commission to consider the program, provided that the application is in order, would be approximately nine (9) to ten (10) months following the application submission date.

2. The completed application for accreditation is reviewed to determine whether the program, as proposed, appears to have the potential to meet minimum requirements. The application is considered complete when the Criteria for Granting Accreditation have been addressed as part of the application process.

3. If it is determined that the Criteria for Granting Accreditation have been addressed, a site visit is scheduled four (4) to seven (7) months following receipt of the application.

4. If changes occur within the program between the date of submission of the application and scheduled site visit, the site visit may be delayed.

5. After the site visit has been conducted, the visiting committee submits a draft report to the Commission office.

6. Within four (4) to six (6) weeks following the site visit, the preliminary draft of the site visit report is transmitted to the institution for consideration and comment prior to review by the discipline-specific Review Committee and the Commission.

7. The visiting committee’s report and the institution’s response to the preliminary report are transmitted to the discipline-specific Review Committee for consideration at its meeting prior to the Commission meeting.

8. The Commission then considers the Review Committee’s report and takes action on the accreditation status.

9. The Commission’s action regarding accreditation status and the final site visit report are transmitted to the institution within thirty (30) days of the Commission’s meeting.

Reaffirmed: 8/10; Revised: 7/08; Adopted: 8/02

C. APPLICATION FOR INITIAL ACCREDITATION FOR DEVELOPING PROGRAMS

A program which has not enrolled and graduated at least one class of students/residents and does not have students/residents enrolled in each year of the program is defined by the Commission as not fully operational. The same review steps that apply for Application for Accreditation for Fully Operational Programs with Enrollment and Without Accreditation apply to Application for Initial Accreditation for Developing Programs.

The developing program must not enroll students/residents until initial accreditation status has been
obtained. Once a program is granted “initial accreditation” status, a site visit will be conducted in the second year of programs that are four or more years in duration and again prior to the first class of students/residents graduating. Programs that are less than four (4) years in duration will be site visited again prior to the first class of students/residents graduating.

An institution which has made the decision to initiate and seek accreditation for a program that falls within the Commission on Dental Accreditation’s purview is required to submit an application for accreditation. “Initial accreditation” status may then be granted to programs which are not fully operational and are developing, according to the accreditation standards.

Because accreditation is voluntary, a program may withdraw its application for initial accreditation at any time prior to the Commission conducting the first on-site evaluation. The initial accreditation status is granted based upon one or more site evaluation visit(s) and until the program is fully operational. When an accreditation status has been granted, the program has the right to ask that the status be discontinued at any time for any reason.

Upon request, the Commission office will provide more specific information about types of programs, application forms, deadlines for submission and accreditation standards. Program administrators and faculty are encouraged to consult with Commission staff during this initial process.

An application fee must be submitted with a program’s application for initial accreditation. Programs should contact the Commission office for the current fee schedule.

Reaffirmed: 8/11, 8/10; Revised: 7/08, 8/02, 7/01

1. Enrollment Of Students In A Developing (Not Fully Operational) Program Prior To Granting Of Initial Accreditation Status: An additional purpose of accreditation recognized by the United States Department of Education (USDE) is the protection of the public through the identification of qualified personnel to staff the health care system. Therefore, the Commission on Dental Accreditation established accreditation classifications, which have proven to be acceptable to educational institutions. Published definitions are a widely recognized means for carrying out accreditation functions.

“Initial accreditation” status is an accreditation classification that is applicable to developing programs. It is granted when a proposed or developing program demonstrates that it has the potential to meet the accreditation standards.

For this reason, the Commission is firm in its policy that the developing program must not enroll students/residents until “initial accreditation” status has been obtained. If a program enrolls students/residents without first having been granted “initial accreditation” status, the Commission will not accept the application for accreditation until after the first enrolled class has graduated. In addition, the Commission expects that the program will notify all students/residents enrolled of the possible ramifications of enrollment in a program operating without accreditation. The Commission will also notify the applicable state board of dentistry.

When “initial accreditation” status is denied and the program wishes to reapply, it is the responsibility of the institution to make use of all possible resources, including consultation with the Commission on Dental Accreditation. (Refer to the Policy on Public Disclosure and Confidentiality for additional information regarding the announcement of an action to deny accreditation).

Reaffirmed: 8/10, 7/07, 7/01; Revised: 7/08, 8/02, 7/96; CDE: 12/74:19
2. **Time Limitation For Initial Accreditation:** The classification of “initial accreditation” granted to dental and dental-related educational programs will be terminated at the end of two (2) years following the projected enrollment date if students/residents have not been enrolled. (See the Commission’s Policy on Non-Enrollment of First Year Students for further information).

Reaffirmed: 8/10; Revised: 8/02; CODA: 05/80:12

**D. CRITERIA FOR GRANTING ACCREDITATION**

The application for accreditation of a dental or dental-related program is considered complete when the following criteria, as applicable, have been adequately addressed in the application.

a. A dean/program director/program administrator has been employed at the time the application is submitted or at least six (6) months prior to a projected accreditation site visit.

b. The program is sponsored by an institution that, at the time of the application, complies with the discipline-specific accreditation standards related to institutional accreditation.

c. A strategic plan/outcomes assessment process, which will regularly evaluate the degree to which the program’s stated goals and objectives are being met, is developed.

d. The long and short-term financial commitment of the institution to the program is documented.

e. Contractual agreements are drafted and signed providing assurance that a program dependent upon the resources of a variety of institutions and/or extramural clinics and/or other entities has adequate support.

f. A defined student/resident admission process and due process procedures are developed.

g. A projection of the number, qualifications, assignments and appointment dates of faculty is developed.

h. An explanation is included of how the curriculum was developed including who developed the curriculum and the philosophy underlying the curriculum. If curriculum materials are based on or are from an established education program, there must be documentation that permission was granted to use these materials.

i. The first-year curriculum with general course and specific instructional objectives, learning activities, evaluation instruments (including, as applicable, laboratory evaluation forms, sample tests, quizzes, and grading criteria) is developed.

j. As applicable, courses for the subsequent years of the curriculum are developed, including general and specific course objectives.

k. If the capacity of the facility does not allow all students to be in laboratory, pre-clinical laboratory and/or clinic at the same time, a plan documenting how students/residents will spend laboratory, pre-clinical and/or clinical education sessions has been developed and is included.

l. As applicable, evaluation instruments for laboratory, pre-clinical, clinical, and clinical enrichment experiences are developed.

m. As applicable, policies and procedures such as a patient recruitment system; patient classification system; an ionizing radiation policy; an infection control policy; and a student/resident tracking system are developed.

n. As applicable, the adequacy of the patient caseload in terms of size, variety and scope to support required clinical experiences is available.

o. Class schedule(s) noting how each class will utilize the facility are developed.

p. As applicable, diagrams or blueprints of the didactic, laboratory, pre-clinical laboratory and clinical facilities, and equipment needs are developed to support the anticipated enrollment date.

Revised: 8/10, 7/08, 8/03; Adopted: 8/02

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E. POLICIES AND PROCEDURES FOR ACCREDITATION OF PROGRAMS IN AREAS OF ADVANCED TRAINING IN GENERAL DENTISTRY

Advanced training programs for which an accreditation review process is initiated are considered within the realm of general dentistry education and practice. In the initiation of an accreditation review process for programs in a dental education area, the Commission on Dental Accreditation seeks only to ensure the quality of the education programs in the area.

The Commission’s accreditation process for programs in areas of advanced training in general dentistry does not confer dental specialty status. Specialty recognition is the purview of the American Dental Association, through its Council on Dental Education and Licensure, Board of Trustees and House of Delegates.

Items A through E listed below provide a framework for the Commission in determining whether a process of accreditation review should be initiated for advanced training programs in general dentistry areas. Each must be addressed in a request to establish an accreditation process for programs in an area of advanced training in general dentistry.

A. A well-defined body of established scientific dental knowledge exists that underlies the general dentistry education area – knowledge that is in large part distinct from, or more detailed than, that of other dental education areas already in accreditation review.

Elements to be addressed:
- Definition and scope of the education area;
- Educational goals and objectives of the education area;
- Competency and proficiency statements for the education area; and
- Description of how scientific dental knowledge in the education area is substantive and distinct from other education areas already under accreditation review.

B. The body of knowledge is sufficient to educate individuals in a distinct advanced education area of general dentistry, not merely one or more techniques.

Elements to be addressed:
- Identification of distinct components of biomedical, behavioral and clinical science in the advanced education area;
- Description of why this area of knowledge is a distinct education area of general dentistry, rather than a series of just one or more techniques;
- Documentation demonstrating that the body of knowledge is unique and distinct from that in any current Commission-accredited education area; and
- Documentation of the complexity of the body of knowledge of the education area by identifying specific advanced techniques and procedures, representative samples of curricula from existing programs, textbooks and journal.

C. A sufficient number of established programs exist and contain structured curricula, qualified faculty and enrolled individuals so that accreditation can be a viable method of quality assurance.

Elements to be addressed:
- Description of the historical development and evolution of educational programs in the area of advanced training in general dentistry;
- A listing of the current operational programs in the advanced general dentistry training area, identifying for each, the:
a. sponsoring institution;
b. name and qualifications of the program director;
c. number of full-time and part-time faculty (define part-time for each program);
d. curriculum (course outlines, student competencies, class schedules);
e. outcomes assessment methods;
f. minimum length of the program;
g. certificate and/or degree awarded upon completion;
h. number of enrolled individuals per year for at least the past 5 years; and number of graduates per year for at least the past 5 years. If the established education programs have been in existence less than 5 years, provide information since their founding; and
i. Documentation on how many programs in the education area would seek voluntary accreditation review, if available.

D. The education programs are the equivalent of at least one twelve-month full-time academic year in length. The programs must be academic programs sponsored by an institution accredited by an agency recognized by the United States Department of Education or accredited by the Joint Commission or its equivalent rather than a series of continuing education experiences.

Elements to be addressed:
- Evidence of the minimum length of the program for full-time students;
- Evidence that a certificate and/or degree is awarded upon completion of the program;
- Programs’ recruitment materials (e.g. bulletin, catalogue); and

E. Other evidence that the programs are bona fide higher education experiences, rather than a series of continuing education courses (e.g. academic calendars, schedule of classes, and syllabi that address scope, depth and complexity of the higher education experience, formal approval or acknowledgment by the parent institution that the courses or curricula in the education area meet the institution’s academic requirements for advanced education). The quality of the advanced educational program is important to the health care of the general public.

Elements to be addressed:
- Description of the need for accreditation review of the programs to ensure quality health care for the public;
- Description of current and emerging trends in the education area;
- Documentation that dental health care professionals currently provide health care services in the identified education area; and
- Evidence that the area of knowledge is important and significant to patient care and dentistry.

Reaffirmed: 8/10, 7/09; Updated: 7/07; Adopted: 7/04

F. PRINCIPLES AND CRITERIA ELIGIBILITY OF ALLIED DENTAL PROGRAMS FOR ACCREDITATION BY THE COMMISSION ON DENTAL ACCREDITATION

In the initiation of an accreditation review process for programs in a dental education area, the Commission on Dental Accreditation seeks to ensure the quality of the education programs, for the benefit and protection of both the public and students. Items A through E listed below provide a framework for the Commission in determining whether a process of accreditation review should be initiated for new allied dental education areas or disciplines. Each must be addressed in a request to establish an accreditation process for programs in an area of allied dentistry. If the Commission determines that appropriate documentation can be provided for each criterion, then the Commission may...
either appoint a Workgroup made of appropriate communities of interest or task the relevant standing Review Committee to develop accreditation standards.

1. Does the allied dental education area align with the accrediting agency’s mission and scope?

CODA’s mission is as follows: “The Commission on Dental Accreditation serves the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The scope of the Commission on Dental Accreditation encompasses dental, advanced dental and allied dental education programs” (Reaffirmed: 07/07; Revised: CODA: 01/01).

Elements to be addressed:

- Definition and scope of the allied dental education area.
- List the educational goals and objectives of the allied dental education area.
- Description of how the area of allied dental education aligns with the Commission on Dental Accreditation’s mission and scope.

2. Has the allied dental education area been in operation for a sufficient period of time to establish benchmarks and adequately measure performance?

Elements to be addressed:

- List the competency statements and performance measures that define competence for the discipline.
- Provide documentation that there is a body of established, substantive, scientific dental knowledge that underlies the education area.

3. Is the program part of an institution or clearly identified responsible entity encompassed under the agency’s scope, e.g., formal, postsecondary education program leading to a bona fide educational credential (certificate or degree)?

Elements to be addressed:

- A listing of the current operational programs in the allied dental education area, identifying for each, the:
  - sponsoring institution; present evidence that the sponsoring institutions are accredited by an agency recognized by the United States Department of Education.
  - documentation of the existence of an sufficient number of qualified individuals serving or available to serve as program directors;
  - documentation of the existence of a sufficient number of full-time and part-time faculty (define part-time for each program) qualified to teach in the programs;
  - documentation of existing curriculum in the area (course outlines, student competencies, class schedules);
  - evidence that the programs are bona fide higher education experiences, rather than preceptorships or a series of continuing education courses, that address scope, depth and complexity of the higher education experience;
  - outcomes assessment methods for the programs;
4. Is there sufficient level of activity and expertise in the discipline, including individuals with the academic or professional credentials, to establish standards and sustain a quality review process?

Elements to be addressed:
- Description of the historical development and evolution of educational programs in the area of allied dentistry.
- For each program, list the academic credentials required to be a full-time faculty and the academic credentials to be a part-time faculty member.
- For each program, list the academic and administrative credentials required to be a program director.
- Description of sponsoring, professional organization/association(s), if any, and (if applicable) the credentialing body, including the following information:
  - number of members
  - names and contact information of association officers
  - organization/association bylaws
  - list of sponsored continuing education programs for members
  - for credentialing body: exam criteria; number of candidates; pass rate

5. Is there evidence of need and support from the public and professional communities to sustain educational programs in the discipline?

Elements to be addressed:
- Description of the need for accreditation review of the programs to ensure quality health care for the public, including evidence of consideration of public interests in the development and operation of the programs.
- Documentation of current and emerging trends in the education area.
- Documentation of the available programs with rationale for ability to perform a robust, meaningful peer-review accreditation process.
- List of states where graduates of the allied dental education programs can be licensed and/or practice.
- Evidence that the programs in the discipline are legally authorized to operate by the relevant state or government agencies.
- Evidence that the discipline’s institutions and programs are in compliance with all applicable US Department of Education expectations including those described in the Regulations on Gainful Employment Reporting Associated with the Higher Education Opportunity Act.
- Evidence documenting (or plans to document) outcomes assessment of graduates.
- Evidence of the potential for graduates to obtain gainful employment, including:
G. SELF-STUDY GENERAL INFORMATION

In preparation for a site visit, institutions are required to complete a self-study for each program being evaluated. A self-study involves an analysis of the program in terms of the accreditation standards and an assessment of the effectiveness of the entire educational program. It includes a review of the relevance of all its activities to its stated purposes and objectives and a realistic appraisal of its achievements and deficiencies. The self-study process permits a program to measure itself qualitatively prior to evaluation by an on-site committee of peers in education and the profession. On-site evaluation assesses the degree to which the accreditation standards are met and assists the program in identifying strengths and weaknesses.

The self-study manual includes questions which require qualitative evaluation and analysis of the educational program. The intent of the self-study process is to identify program strengths and weaknesses. Latitude is permitted in interpreting questions to meet the specific needs of the program; however, Commission staff should be consulted if revisions are planned.

The sponsoring institution is required to forward a copy of the completed self-study document to each member of the visiting committee and to the Commission office no later than sixty (60) days prior to the scheduled site visit. Visiting committee members review the completed self-study documents. Any requests by committee members for additional materials relating to the on-site review are forwarded to the institution by the Commission staff or staff representative. All such requests are compiled into one official communication from the Commission office to the institution. Individual consultants/site visitors may not request additional material or information directly from an institution. The institution’s response serves as an addendum to the self-study document.

Guidelines for preparing self-study documents for each discipline, including more specific information and instructions, are available upon request from the Commission office.

H. PRE-VISIT GENERAL INFORMATION

The Commission proposes and confirms dates for the site visit, assists the institution with pre-visit plans and communicates with the visiting committee regarding transportation, hotel accommodations and the program’s accreditation history.

A site visit focuses only on the program(s) in operation at the time of the visit. The visiting committee will expect, however, to be apprised of any change in admissions, facilities, faculty, financial support or curriculum which is contemplated, but not yet implemented.

Although the Commission provides a suggested site visit schedule, the institution is responsible for preparing the actual schedule. Any necessary modifications to the schedule proposed by the institution
are made prior to the visit either by Commission staff or by the staff representative assigned to the visiting committee. The schedule is also reviewed at the beginning of the visit to determine whether any other changes are indicated. The institution notifies all individuals associated with the institution, who are participating in the review, of the time and place of their scheduled conferences with the visiting committee.

Reaffirmed: 8/10

I. POLICY ON THIRD PARTY COMMENTS

The Commission currently publishes, in its accredited lists of programs, the year of the next site visit for each program it accredits. In addition, the Commission posts its spring and fall announcements on the Accreditation News area of the ADA website for those programs being site visited January through June or July through December. Developing programs submitting applications for initial accreditation may be scheduled for site visits after the posting on the ADA website; thus, the specific dates of these site visits will not be available for publication. These programs will be listed in the Accreditation Announcements with a special notation that the developing programs have submitted applications for initial accreditation and have been scheduled for site visits. Parties interested in these specific dates (should they be established) are welcomed/encouraged to contact the Commission office.

The United States Department of Education (USDE) procedures require accrediting agencies to provide an opportunity for third-party comment, either in writing or at a public hearing (at the accrediting agencies’ discretion) with respect to institutions or programs scheduled for review. All comments must relate to accreditation standards for the discipline and required accreditation policies. In order to comply with the Department’s requirement on the use of third-party comment regarding program’s qualifications for accreditation or initial accreditation, the following procedures have been developed.

Programs with the status of initial accreditation, and programs seeking initial accreditation must solicit comment through appropriate notification of communities of interest and the public such as faculty, students, program administrators, specialty and dental-related organizations, patients, and consumers

The Commission will request written comments from interested parties in the spring and fall Accreditation Announcements on the ADA website. All comments relative to programs being visited will be due in the Commission office no later than sixty (60) days prior to each program’s site visit to allow time for the program to respond. Therefore, programs being site-visited in January through June will be listed in the fall posting of the previous year and programs scheduled for a site visit from July through December will be listed in the spring posting of the current year. Any unresolved issues related to the program’s compliance with the accreditation standards will be reviewed by the visiting committee while on-site.

Those programs scheduled for review must solicit third-party comments through appropriate notification of communities of interest and the public such as faculty, students, program administrators, specialty and dental-related organizations, patients, and consumers at least ninety (90) days prior to their site visit. The notice should indicate the deadline of sixty (60) days for receipt of third-party comments in the Commission office and should stipulate that comments must be signed, that signatures will be removed from comments prior to forwarding them to the program, and that comments must pertain only to the standards for the particular program or policies and procedures used in the Commission’s accreditation process. The announcement may include language to indicate that a copy of the appropriate accreditation standards and/or the Commission’s policy on third-party comments may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611, or by calling 1/800-621-8099, extension 4653.

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All comments submitted must pertain only to the standards relative to the particular program being reviewed or policies and procedures used in the accreditation process. Comments will be screened by Commission staff for relevancy. Only signed comments will be considered. For comments not relevant to these issues, the individual will be notified that the comment is not related to accreditation and, where appropriate, referred to the appropriate agency. For those individuals who are interested in submitting comments, requests may be made to the Commission office.

All relevant comments will have signatures removed and will then be referred to the program at least fifty (50) days prior to the site visit for review and response. A written response from the program should be provided to the Commission office and the visiting committee fifteen (15) days prior to the site visit. Adjustments may be necessary in the site visit schedule to allow discussion of comments with proper personnel. Negative comments received after the established deadline of sixty (60) days prior to the site visit will be handled as a complaint.

Revised: 8/12, 8/11, 7/09, 8/02, 1/97; Reaffirmed: 8/10, 1/03; Adopted: 7/95

J. SITE VISITS

The Commission on Dental Accreditation formally evaluates accredited programs at regular intervals. Comprehensive site visits based on a self-study are routinely conducted every seven years. Site visits of programs in the specialty of oral and maxillofacial surgery are conducted at five year intervals.

Special site visits (which may be either focused or comprehensive in scope) are conducted when it is necessary for the Commission to review information about the program that can only be obtained or documented on-site. Information on special site visits is included elsewhere in this manual.

Reaffirmed: 8/10

1. Overview And Accreditation Cycle: The Commission requires that each accredited program, or program seeking initial accreditation, conduct a self-analysis and submit a self-study report prior to its on-site review. Using the Commission’s self-study guide helps the program ensure that its self-study report addresses, assesses critically, and documents the degree of compliance with each of the accreditation standards and with the program’s own stated goals.

The Commission expects that one of the goals of a dental or dental-related educational program is to prepare qualified individuals in their respective disciplines. Accredited programs must design and implement their own outcomes measures to determine the degree to which stated goals and objectives are being met. Results of this ongoing and systematically documented assessment process must be used to evaluate the program’s effectiveness in meeting its goals, to improve program quality and to enhance student achievement.

All members of the visiting committee carefully review the self-study document prior to the on-site review. This initial assessment serves to identify areas where the program may not comply with the accreditation standards or to raise questions about information that is unclear. While on site, the visiting committee verifies the information provided in the self-study document and carefully assesses any unclear or problem areas. The verification process includes interviews with institutional personnel and review of program documentation. A recommendation is included in the report of the site visit when noncompliance with a standard is identified. If a particular standard is not addressed by the site visit report, the program is viewed as meeting that standard.

The site visit report, along with the institutional response to the report, serves as the Commission’s
primary basis for accreditation decisions. The report also guides chief executive officers and administrators of educational institutions in determining the degree of the program’s compliance with the accreditation standards. The Commission, assisted by the visiting committees, identifies specific program deficiencies or areas of noncompliance with the standards, but it is the responsibility of the program to identify specific solutions or means of improvement.

Reaffirmed: 8/10

2. Coordinated Site Visits: If an institution offers more than one dental education program, the Commission evaluates all programs during a single site visit whenever possible. Shared faculty, shared facilities and integrated curricula, as well as the time and expense involved in preparing for a visit, are among the reasons for coordinated evaluations.

The Commission encourages the coordination of its evaluations with evaluations by regional and/or other nationally recognized accrediting associations. It will make every effort to coordinate its evaluations with those of other associations if requested to do so by an institution. The Commission has conducted simultaneous evaluations with regional accrediting associations such as the Commission on Colleges of the Southern Association of Colleges and Schools and other specialized agencies such as the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or with state accrediting agencies such as the State Education Department, the University of the State of New York Division of College and University Evaluation. If an institution wishes to coordinate accreditation activities, the Commission should be contacted well in advance of the projected time of the site visit.

Reaffirmed: 8/10

3. Institutional Review Process – Reminder Statement: The Commission on Dental Accreditation is recognized by the U.S. Department of Education (USDE) as an umbrella specialized accrediting agency for dental and dental-related disciplines. As a specialized accrediting agency, the Commission is responsible for the review of all dental, allied dental, advanced dental and dental specialty educational programs. The Commission is also responsible for evaluating educational programs which are sponsored in a variety of educational settings, including hospitals. For this reason, when an institution sponsors multiple programs falling within the Commission’s accreditation purview, the institutional component is included as an integral part of the umbrella review process.

Although the Review Committees play a significant role in this broad-based review, the Commission has the final responsibility for ensuring that the impact of the programs on the sponsoring institution is considered.

Reaffirmed: 8/10, 7/09, 1/03; Updated: 7/97, 7/00; CODA: 5/91:16, 1994

4. Policy On Cooperative Site Visits With Other Accreditors: The Commission encourages the coordination of its site visits with the accreditation reviews of other specialized or regional accrediting agencies. The Commission consults with institutional and program administrators to determine whether a coordinated visit can meet the accreditation needs of each agency involved in the visit. If so, a coordinated visit is scheduled. In order to protect the confidentiality of information gathered during the review, the cooperating agencies usually specify in advance the degree of access each will have to the other’s site visit documents and reports. Each visiting committee may develop its own report or certain sections of the report may meet the needs of the cooperating agencies.

The institution that sponsors the accredited program must request that a coordinated site visit be conducted. An offer to try to work cooperatively with other agencies is routinely included in the initial letter that announces an upcoming scheduled site visit by the Commission. If a request is received from
the institution, the Commission contacts the other accrediting agencies. The agencies work together with the institution to attempt to develop a schedule or protocol that will meet the needs of both accrediting agencies and the institution.

The Commission requests the members of the visiting committees from other agencies sign the Commission’s Statement of Confidentiality in order to participate in interviews conducted by the Commission’s consultants/site visitors.

A reminder about the Commission’s willingness to conduct coordinated site visit is included periodically in the CODA Communicator e-newsletter.

Reaffirmed: 8/10, 7/07, 7/01, 10/94, 6/92; CODA: 05/92:1, 2; 12/92:5

5. **Policy On Dental Education Programs For Graduates Of International Schools:** If a dental school offers separate and distinct dental educational programs for graduates of international dental schools, these programs must complete a separate accreditation self-study report; be site visited by the core visiting committee, including an additional consultant/site visitor, if necessary; have a separate site visit report written; and be accredited separately from the core dental education program.

Reaffirmed: 8/10, 7/01, 7/95; Revised: 7/08

6. **Policy On Special Site Visits:** Special site visits are conducted when it is necessary for the Commission to review information about the program that can only be obtained or documented on-site. When necessary, special site visits are conducted to ensure the quality of the educational program, but are used selectively in order to avoid perceived harassment of programs. A special site visit may be either focused, limited to specified standards, or comprehensive, covering all accreditation standards. In making recommendations to the Commission for a special site visit, the Review Committee will indicate the specific standards or required accreditation policy in question. The Commission will communicate these concerns to the program in the letter transmitting the action related to a special site visit. If a comprehensive special visit will be conducted, the program must prepare a self-study prior to the visit. If a focused visit will be conducted, the program will be required to complete some portions of the self-study and/or to develop some other materials related to the specific standards or required policies that have been identified as areas of concern. With the exception of a special site visit due to falsification of information, all costs related to special site visits are borne by the program. The Commission may conduct a special site visit for any of the following reasons:

   a. **Failure to document compliance:** A special site visit may be directed for an accredited program when, six (6) months prior to the time period allowed to achieve compliance through progress reports (eighteen (18) months if the program is between one and two years in length or two years if the program is at least two years in length), the program has not adequately documented compliance with the accreditation standards. The special site visit will be focused on the recommendations contained in the site visit report. Recommendations for which supplemental information or documentation is submitted after the last progress report or special site visit report is reviewed by the appropriate Review Committee or the Commission and that in the Commission’s opinion requires on-site verification, shall be considered as not met for purposes of accreditation. Following the special site visit, if compliance is not demonstrated, the Commission will withdraw the program’s accreditation unless the Commission extends the period for achieving compliance for good cause.

   b. **Major change within a program:** A special site visit may be directed for an accredited program when a report of major change, review of annual survey data, or information received in other
ways, indicates that major changes in a program may have affected its ability to maintain compliance with the accreditation standards. The Commission may also request a special report from the involved program prior to conducting a special site visit. The Commission’s Policy on Reporting Major Changes in Accredited Programs provides details.

c. Investigating complaints: A special site visit may be directed for an accredited program to investigate a complaint raising questions about the program’s compliance with the accreditation standards. The Commission’s Policy on Complaints against accredited programs provides details.

d. Falsifying information: A special site visit may be directed for an accredited program to investigate the possible intentional falsification of information provided to the Commission. The Commission’s policy on Principles of Integrity provides details. The cost of such a special site visit is shared by the Commission and the program.

e. Off campus/distance sites: The Policy on Accreditation of Off-campus Sites provides details.

f. Other reasons: A special site visit may, on occasion, be directed for an accredited program to respond to a request to the Commission from the chief executive officer or program administrator. The Commission may also direct that a focused site visit is necessary for just cause if it determines that a program may be unable to maintain compliance with the accreditation standards.

Reaffirmed: 8/10, 7/06; Revised: 1/00, 1/99, 1/98; Adopted: 7/96

K. CONSULTANTS/SITE VISITORS

The Commission uses consultants/site visitors with education and practice expertise in the discipline or areas being evaluated to conduct its accreditation program. Nominations for consultants/site visitors and other consultants are requested from national dental and dental-related organizations representing the areas affected by the accreditation process. Consultants/site visitors are appointed by the Commission annually and may be re-appointed.

Prior to a site visit, a list of consultants/site visitors and other participants is reviewed by the institution/program for conflict of interest or any other potential problem. The program/institution being site visited will be permitted to remove two individuals (per discipline or area being evaluated) from the list without any written explanation or documentation. Additional consultants/site visitors or participants may be removed from the list if a conflict of interest, as described in the Commission’s Conflict of Interest Policy, can be demonstrated. Information concerning the conflict of interest must be provided in writing clearly stating the specifics of the conflict.

Consultants/site visitors are appointed by the Chairperson and approved by the institution’s administration, i.e. dental school dean or program director. The visiting committee-conducts the site visit and prepares the report of the site visit findings for Commission action. The size and composition of a visiting committee varies with the number and kinds of educational programs offered by the institution. All visiting committees will include at least one person who is not a member of the Commission, a Review Committee of the Commission or a Commission staff member. Two dental hygiene consultants/site visitors shall be assigned to dental school-sponsored dental hygiene site visits.

When appropriate, a generalist representative from a regional accrediting agency may be invited by the chief executive officer of an institution to participate in the site visit with the Commission’s visiting committee. A generalist advises, consults and participates fully in committee activities during a site visit.
The generalist’s expenses are reimbursed by the institution. The generalist can help to ensure that the overall institutional perspective is considered while the specific programs are being reviewed.

The institution is encouraged to invite the state board of dentistry to send a current member to participate in the site visit. If invited, the current member of the state board receives the same background materials as other site visit committee members and participates in all site visit conferences and executive sessions. The state board of dentistry reimburses its member for expenses incurred during the site visit.

In addition to other participants, a newly appointed consultant/site visitor and/or Commission staff member may participate on the visiting committee for training purposes. It is emphasized that consultants/site visitors are fact-finders, who report committee findings to the Commission. Only the Commission is authorized to take action affecting the accreditation status.

Reaffirmed: 8/10, 7/09, 7/07, 7/06, 7/01; Revised: 1/03, 1/00, 7/97; CODA: 07/96:10, 12/83:4

1. **Appointments:** All consultant/site visitor appointments are made annually for one year terms for a maximum of six consecutive years. Following the maximum appointment period of six consecutive years, the consultant/site visitor may reapply for appointment after one year. In exceptional circumstances the Review Committee may recommend that the Commission alter an individual’s term limits. Consultants/site visitors assist the Commission in a number of ways, including: developing accreditation standards, serving on special committees, and serving as consultants/site visitors on visits to predoctoral, advanced dental and allied dental education programs.

The Commission reviews nominations received from each specialty organization and certifying board. Individuals may also self-nominate. In addition to the mandatory subject expertise, the Commission always requests nominations of potentially under-represented ethnic groups and women, and makes every effort to achieve a pool of consultants/site visitors with broad geographic diversity to help reduce site visit travel expenses.

If a Commissioner’s term as a consultant/site visitor has expired during their term as Commissioner, he/she may continue to serve the Commission as a consultant/site visitor for a period of one year. Consultants/site visitors are appointed/reappointed annually and asked to sign the Commission’s Conflict of Interest Statement, the Agreement of Confidentiality, the Copyright Assignment, and the ADA’s Professional Conduct Policy and Prohibition Against Harassment. The Commission office stores these forms for seven (7) years.

Subsequent to appointment/reappointment by the Commission, consultants/site visitors receive an appointment letter explaining the process for appointment, training, and scheduling of Commission consultants/site visitors.

Reaffirmed: 8/10, 1/98, 8/02; Revised: 7/08; CODA: 07/94:9, 01/95:10

2. **Criteria For Nomination Of Consultants/Site Visitors:** For predoctoral dental education programs, the Commission solicits nominations for consultants/site visitors from the American Dental Education Association to serve in five of six roles on dental education program site visits. The consultant/site visitor roles are Chairperson, Basic Science, Clinical Science, Curriculum, and Finance. Nominations for the sixth role, national licensure consultant/site visitor, are submitted by the American Association of Dental Boards.

For advanced specialty education programs, the Commission solicits nominations for consultants/site visitors from the recognized dental specialty organizations and their certifying boards. Dentist consultants must be members of the ADA and their ADA-recognized specialty organizations.
For allied education programs, the American Dental Education Association is an additional source of nominations that augments, not supersedes, the nominations from the Commission’s other participating organizations, American Dental Assistants Association (ADAA), American Dental Hygienists’ Association (ADHA) and National Association of Dental Laboratories (NADL).

Revised: 8/12; Reaffirmed: 8/10, 7/07, 7/01; CODA: 05/93:6-7

A. Predoctoral Dental Education: The accreditation of predoctoral dental education programs is conducted through the mechanism of a visiting committee. Membership on such visiting committees is general dentistry oriented rather than discipline or subject matter area oriented. The composition of such committees shall be comprised, insofar as possible, of at least one Commission member, consultants/site visitors having broad expertise in dental curriculum, basic sciences, clinical sciences, finance, national licensure (practitioner) and one Commission staff member. The evaluation visit is oriented to an assessment of the educational program’s success in training competent general practitioners.

Although a basic science or clinical science consultant/site visitor may have training in a specific basic science or dental specialty area, it is expected that when serving as a member of the core committee evaluating the predoctoral program, the consultant serves as a general dentist. Further, it is expected that all findings, conclusions or recommendations that are to be included in the report must have the concurrence of the visiting committee team members to ensure that the report reflects the judgment of the entire visiting committee.

In appointing consultants/site visitors, the Commission takes into account a balance in geographic distribution as well as representation of the various types of educational settings and diversity. Because the Commission views the accreditation process as one of peer review, predoctoral dental education consultants/site visitors, with the exception of the national licensure consultant/site visitor, are affiliated with dental education programs.

All predoctoral dental education consultants/site visitors, who are eligible, must be members of the American Dental Association.

The following are criteria for the six roles of predoctoral dental education consultants/site visitors:

Chairperson:
- Must be a current dean of a dental school or have served as dean within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Basic Science:
- Must be an individual who currently teaches one or more biomedical science courses to dental education students or has done so within the previous three (3) years.
- Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Clinical Science:
- Must be a current clinical dean or an individual with extensive knowledge of and experience with the quality assurance process and overall clinic operations.
• Has served in the above capacity within the previous three (3) years.
• Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Curriculum:
• Must be a current academic affairs dean or an individual with extensive knowledge and experience in curriculum management.
• Has served in the above capacity within the previous three (3) years.
• Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

Finance:
• Must be a current financial officer of a dental school or an individual with extensive knowledge of and experience with the business, finance and administration of a dental school.
• Has served in the above capacity within the previous three (3) years.
• Should have accreditation experience through an affiliation with a dental education program being site visited or as a previous consultant/site visitor.

National Licensure:
• Should be a current clinical board examiner or have served in that capacity within the previous three (3) years.
• Should have an interest in the accreditation process.

Reaffirmed: 8/10, 7/07, 7/01; Revised: 1/99; CODA: 07/05, 05/77:4

B. Advanced Specialty Education: Specialty organizations are advised that candidates recommended to serve as consultants/site visitors be board certified and/or have completed or participated in a CODA-accredited specialty education program and must have experience in advanced education as teachers or administrators. Each specialty Review Committee will determine if board certification is required. Some specialty organizations have established additional criteria for their nominations to the Commission.

The Commission requests all agencies nominating consultants/site visitors to consider regional distribution, gender and minority representation and previous experience as a consultant/site visitor. Although consultants/site visitors are nominated by a variety of sources, the Commission carefully reviews the nominations and appoints consultants/site visitors on the basis of need in particular areas of expertise. The pool of consultants/site visitors is utilized for on-site evaluations, for special consultations and for special or Review Committees.

All consultants/site visitors are appointed for a one-year term and may be re-appointed annually for a total of six consecutive years. Appointments are made at the January Commission meeting and become effective with the close of the ADA annual session in the Fall.

Revised: 8/12, 7/09, 7/07, 7/01; Reaffirmed: 8/10; Revised: 7/09, 7/07, 7/01; Adopted: 7/98

C. Allied Education in Dental Hygiene: In appointing consultants/site visitors, the Commission takes into account a balance in geographic distribution, representation of the various types of educational settings, and diversity. Because the Commission views the accreditation process as one of peer review, the dental hygiene education consultants/site visitors are affiliated with dental hygiene education programs.

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The following are criteria for selection of dental hygiene consultants/site visitors:

- a full-time or part-time appointment with an accredited dental hygiene program;
- a baccalaureate or higher degree;
- background in educational methodology;
- accreditation experience through an affiliation with a dental hygiene education program that has completed a site visit; and
- accreditation experience within the previous three (3) years.

Reaffirmed: 8/10; Adopted: 7/09

D. Allied Education in Dental Assisting: The following are criteria for selection of dental assisting consultants/site visitors:

- certification by the Dental Assisting National Board as a dental assistant;
- full-time or part-time appointment with an accredited dental assisting program;
- equivalent of three (3) years full-time dental assisting teaching experience;
- baccalaureate or higher degree;
- demonstrated knowledge of accreditation; and
- current background in educational methodology.

Reaffirmed: 8/10, 7/08; Revised: 2/13, 1/08, 1/98, 2/02; CODA: 07/95:5

E. Allied Education in Dental Laboratory Technology: The following are criteria for selection of dental laboratory technology consultants/site visitors:

- background in all five (5) dental laboratory technology specialty areas: complete dentures, removable dentures, crown and bridge, dental ceramics, and orthodontics;
- background in educational methodology
- knowledge of the accreditation process and the Accreditation Standards for Dental Laboratory Technology Education Programs;
- Certified Dental Technician (CDT) credential through the National Board of Certification (NBC);
- and

full or part-time appointment with a dental laboratory technology education program accredited by the Commission on Dental Accreditation or previous experience as a Commission on Dental Accreditation consultant/site visitor.

Reaffirmed: 8/10; Adopted: 07/09

3. Policy Statement On Consultant/Site Visitor Training: The Commission has a long history of a strong commitment to consultant/site visitor training and requires that all program evaluators receive training. Prior to participation, consultants/site visitors must demonstrate that they are knowledgeable about the Commission’s accreditation standards and its Evaluation and Operational Policies and Procedures. Initial and ongoing training takes place in several formats.

New consultants/site visitors attend a two-day formal workshop that follows the format of an actual site visit. When consultants/site visitors cannot attend this formal workshop, they attend a site visit as trainees, accompanied by a Commission staff member or staff representative and a comparable experienced consultant/site visitor who provide ongoing training and guidance. All new consultants/site visitors are directed to the Commission’s on-line training program and are required to successfully complete the training program and consultant/site visitor final assessment.

Consultants update sessions take place at several dental-related meetings, such as the annual session of
the American Dental Education Association, the American Association of Oral and Maxillofacial Surgeons and the Allied Directors’ Conference. The Commission may entertain requests from other organizations. Components from the workshop are sometimes presented at these meetings; however, the primary purpose of the update sessions is to inform consultants/site visitors about recent Commission activities, revisions to standards and newly adopted policies and procedures.

Keeping costs in mind, the Commission continually explores new methods of providing initial training to consultants/site visitors, as well as ensuring their ongoing competence. Methods being examined include on-line materials, conference calls, broadcast e-mails and other self-instructional materials.

The Commission emphasizes its increased commitment to quality training for consultants/site visitors. While the Commission sponsors comprehensive training for new consultants/site visitors and provides updates for consultants/site visitors on a regular basis, all parent organizations are urged to provide support for training to augment the Commission’s programs. Consultants who have not been assigned on a site visit during the previous two years must re-attend the in-house training provided to new consultants, observe a site visit in the appropriate discipline, or attend the regularly scheduled update sessions at the American Dental Education Association (ADEA) Annual Meeting, before being assigned to evaluate a program on a site visit.

Revised: 8/10, 7/06, 7/00, 1/98; Reaffirmed: 7/07, 7/01, 7/96; CODA: 01/94:9

4. Job Descriptions For Predoctoral Dental Education Visiting Committee Members:

A. Chairperson:

- Will conduct a briefing session with the entire visiting committee relative to the philosophy of the Commission on the approach, purpose and methodology of the conduct of the site visit on the evening prior to the first day of the site visit;
- Will be responsible for the continual reinforcement of the above concepts during the course of the site visit and for monitoring continually the conduct of the site visit;
- Will brief visiting committee members as to their role as a fact-finding and reporting committee and the appropriate protocol during the course of the site visit; including what is expected of each member in terms of kinds of activities and relative to the report of findings and conclusions and recommendations, with adequate background rationale for making recommendations and enumerating strengths and weaknesses in the education program being evaluated;
- Will lead all assigned conferences and executive sessions;
- Will serve as liaison between the visiting committee members and the dental administration and the executive administrators of the institution;
- Will make specific and special assignments to individual visiting committee members relative to evaluating and reporting on specific matters and sections of the site visit report, e.g. administrative organization, faculty, library facilities and resources, research program, facilities and equipment, admission process, hospital program(s), student achievement;
- Will be responsible for ensuring that consultants/site visitors fully understand their responsibility for reporting adequately, but succinctly, in their area of expertise (finance, curriculum, basic sciences, clinical sciences and national licensure);
- Will consult with the dental administration at regular intervals to discuss progress of the visit;
- Will be responsible, during executive sessions with visiting committee members, for the separation of recommendations from suggestions–focusing upon the recommendations which are to be included in the site visit report which are considered to be major, critical and essential to the conduct of the education program(s); suggestions for program enhancement are to be included as part of the narrative of the report; and

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Will be responsible for the preparation of a written summary of the visiting committee’s conclusions, findings, perceptions and observations of the program(s)’ in the form of suggestions and recommendations, as appropriate, for oral presentation during the exit interview with the Dean, and for presentation of an abbreviated summary during the exit interview with the institution’s executive administrators.

Will assess institutional effectiveness including:
- Assessment of the school’s mission statement;
- Assessment and evaluation of the school’s planning, and achievement of defined goals related to education, patient care, research and service;
- Assessment of the school’s outcomes assessment process; and
- Evaluation of the school’s interaction with other components of higher education, health care education or health care delivery systems.

Will assess the effectiveness of faculty and staff including:
- Assessment of the number and distribution of faculty in meeting the school’s stated objectives;
- Assessment of the school’s faculty development process;
- Assessment of the school’s faculty governance;
- Assessment of the school’s measurement of faculty performance in teaching, patient care, scholarship and service; and
- Assessment of the school’s promotion and tenure process.

B. Financial Consultant/Site Visitor: Will confer with the sponsoring institution’s chief financial officer(s) and the dental administration and its financial manager to assess the adequacy of the full spectrum of finance as it relates to the dental school including:
- Assessment of the operating budget and budgeting process;
- Assessment of all sources of revenue (state, federal, tuition and fees, practice plans, etc.);
- Evaluation of the maintenance of the facilities and learning resources to support the school’s mission and goals;
- Assessment of the school’s compliance with applicable regulations;
- Assessment of the resources for planned and/or future renovations and/or new construction; and
- Assessment of the school’s resources as they relate to its mission and goals.

C. Curriculum Consultant/Site Visitor: Will examine the education program and the education support services including:
- Admissions
- Instruction
- Curriculum Management
- Behavioral Sciences
- Practice Management
- Ethics and Professionalism
- Information Management and Critical Thinking
- Student Services

D. Basic Science Consultant/Site Visitor: Will work closely with curriculum consultant/site visitor to ensure consistency of evaluation and assessment. During the formal and informal evaluation of the basic sciences, the consultant/site visitor will conduct personal interviews with students, faculty and departmental chairpersons and during the assessment will focus on:
• Biomedical Sciences
• Research Program

E. Clinical Sciences Consultant/Site Visitor: Within the limitations imposed by the length of the site visit, will examine and evaluate the preclinical and clinical portions of the predoctoral dental education program and activities in terms of the details of what is occurring in these areas and assess the quality of the education and experiences provided to students to prepare them for dental practice. Will work closely with curriculum consultant/site visitor to ensure consistency of evaluation and assessment. During the formal and informal evaluation of the preclinical and clinical sciences, will conduct personal interviews with students, faculty and departmental chairpersons and during the assessment will focus upon:
• Clinical Sciences
• Patient Care Services
• During the formal and informal evaluation of the clinical program, will conduct personal interviews with students, faculty and departmental chairpersons and during the assessment will focus upon:
  • stated objectives;
  • adequacy of instruction;
  • appropriateness of subject matter;
  • intra/extra-mural experiences;
  • student clinic requirements;
  • student performance evaluation mechanisms;
  • sterilization of instruments;
  • patient care policies;
  • laboratory tests for patients;
  • patient physical examinations; and
  • clinic administration.

F. National Licensure (Practitioner) Consultant/Site Visitor: Will serve in the same capacity as the clinical sciences consultant/site visitor on the visiting committee. Reaffirmed: 8/10, 7/05; Updated: 7/07; Adopted: 7/96; CODA: 01/99:

5. Job Description For Advanced Education Consultants/Site Visitors: Dental Public Health, Endodontics, Oral and Maxillofacial Pathology, Oral and Maxillofacial Radiology, Oral and Maxillofacial Surgery, Orthodontics and Dentofacial Orthopedics, Pediatric Dentistry, Periodontics, Prosthodontics (Combined and Maxillofacial), and Advanced Education in General Dentistry, General Practice Residency, Oral Medicine, Orofacial Pain, and Dental Anesthesiology.

Advanced education program consultants/site visitors will utilize the site visitors’ evaluation report form for their respective area, conduct personal interviews with Program Directors, faculty and students, and assess the advanced education program focusing upon:
• administration and staff;
• admissions procedures;
• physical facilities and equipment;
• didactic program (biomedical, lecture, seminar and conference program)
• clinical program;
• evaluation of residents;

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research activities and requirements;
library resources;
intra/extra-mural experiences;
hospital program; and
teaching conducted by residents.

An assessment of the strengths and weaknesses of the advanced education program is based upon the published accreditation standards for each respective program.
Reaffirmed: 8/10, 7/01; Revised: 7/07, 7/99, 7/00; CODA:11/87

6. Job Description For Allied Dental Education Consultants/Site Visitors:
A. Site Visit Chairperson
- Will function as chairperson/staff representative of visiting committee of consultants/site visitors evaluating the allied dental education programs in dental assisting, dental hygiene and dental laboratory technology;
- Will be responsible for the continual reinforcement of the Commission’s procedures to be used for the site visit and for monitoring continually the conduct of the visit;
- Will brief consultants/site visitors as to their role as a fact finding and reporting committee and the appropriate protocol during the course of the site visit; including what is expected of each consultant/site visitor in terms of kinds of activities and relative to the report of findings and conclusions and recommendations, with adequate background rationale for making recommendations and enumerating strengths and weaknesses in the education program being evaluated;
- Will chair all conferences and meetings of the allied dental visiting committee, as well as those which occur during the visiting committee’s executive sessions;
- Will be responsible for maintaining closely the site visit evaluation schedule;
- Will serve as liaison between the visiting committee and the allied dental visiting committee members;
- Will make specific and special assignments to individual visiting committee members relative to evaluating and reporting on specific matters and sections of the site visit report, e.g. administrative organization, faculty, library facilities and resources, research program facilities and equipment, admissions process, hospital program(s), student achievement;
- Will be responsible for ensuring that consultants/site visitors fully understand their responsibility for reporting adequately, but succinctly, in their area of expertise;
- Will consult with the allied dental administration at regular intervals to discuss progress of the visit;
- Will be responsible, during executive sessions with visiting committee members, for the separation of recommendations from suggestions – focusing upon the recommendations which are to be included in the site visit report which are considered major, critical and essential to the conduct of the education program(s). Suggestions for program enhancement are to be included as part of the narrative of the report; and
- Will be responsible for the preparation of a written summary of the visiting committee’s conclusions, finding, perceptions and observations of program(s) strengths, weaknesses, recommendations and suggestions for oral presentation during the exit interview with the dean, and for presentation of an abbreviated summary during the exit interview with the institution’s executive administrators.

B. Dentist: A dentist is also included, when at all possible, on site visits to dental assisting and
dental hygiene programs in settings other than dental schools. An additional dentist consultant/site visitor will be added to dental school visiting committees when multiple programs are to be reviewed.

The role of the dentist team member during allied site visits includes the following responsibilities:

- Take notes during conferences;
- Conduct meeting with advisory committee, when applicable;
- Ensure confidentiality by waiting to begin the meeting until all affiliated school personnel have left the room;
- Introduce the visiting committee to the advisory committee members;
- Thank the members of the committee for meeting with the team and for their interest in and commitment to the specific allied program(s);
- Explain the purpose of the site visit;
- Discuss the Commission’s policy on confidentiality as it applies to the meeting and the entire site visit;
- Begin discussion of the following topics/questions:
  a. How often the committee meets and the purpose or goals of the committee
  b. Strengths/weaknesses of the students
  c. Specific current committee activities and future goals or anticipated activities
- Ensure that all of the questions in the Site Visit Evaluation Report form under Standard 1. Institutional Effectiveness, Community Resources are answered during the meeting;
- Assist Curriculum Consultant/Site Visitor in review of science courses;
- Review clinical courses and clinical evaluation mechanisms;
- Review learning resources – library & audiovisual materials/equipment (It is usually most efficient for this review to be conducted by the dentist consultant/site visitor only.);
- Review documentation in the self-study prior to visit;
- Conduct preclinical, clinical, and/or laboratory observations (on/off campus) with Curriculum Consultant/Site Visitor;
  a. Extended campus laboratory facilities
  b. Extramural clinical facilities
- Formulate recommendations and suggestions; and
- After the visit, review and critique preliminary draft of the site visit report.

Reaffirmed: 8/10, 7/01; Revised: 7/07, 7/00, 7/99; Adopted:10/94, 11/87; CODA: 05/86:10

7. **Role Of The Consultant/Site Visitor Trainee (All Disciplines):** When a consultant/site visitor cannot attend a formal consultant/site visitor training workshop or if it is determined that additional training is warranted, s/he may be requested to attend a site visit as a trainee. The trainee is accompanied by a Commission staff member or staff representative and a comparable experienced consultant/site visitor who provide ongoing training and guidance.

The trainee must sign the Commission’s Agreement of Confidentiality prior to the site visit and must not have a conflict of interest with the institution. The consultant/site visitor trainee, if authorized to participate in the site visit by the institution, receives all self-study materials from the institution and background information from the Commission prior to the site visit.
The trainee participates during all site visit conferences and executive sessions. In the event the chairperson/staff representative of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, the trainee will be considered a non-voting member of the site visit committee.

Reaffirmed: 8/10, 7/06; Adopted: 7/00

8. Role Of Observers On A Site Visit: Commissioners, Review Committee members, public members of the Commission or Review Committees may participate on site visits as observers. The observer must not have a conflict of interest with the institution. This individual must be approved to participate in the site visit by the institution, receives all self-study materials from the institution and background information from the Commission prior to the site visit. This individual participates during all site visit conferences and executive sessions as a non-voting member of the site visit committee. As a participant of the site visit, it is expected that this individual will remain with the designated site visit team members at all times during the visit. The chairperson of the site visit committee has the right to excuse and/or exclude the observer from any or all aspects of the site visit for improper and/or unprofessional behavior.

Adopted: 8/10

L. POLICY ON SILENT OBSERVERS ON SITE VISITS

In order to facilitate a better understanding of the accreditation and site visit processes, any dental education program scheduled for a regularly-scheduled site visit of its program, may request the opportunity to send one administrator or faculty member as a silent observer to a Commission site visit. Representatives of international programs may also participate as a silent observer on a Commission site visit. The silent observer visit will be scheduled one to two years before the scheduled site visit of the observer’s program. The program being observed has the right to approve the designated observer. Requests for a faculty member or administrator to observe the site visit of another program are managed according to when the observer’s site visit is scheduled. The observer’s program pays all expenses for such an observer.

The observer receives all self-study materials and is allowed to observe all interviews and meetings, but does not attend the briefing at the end of each day. The observer must remain silent during all sessions where university and/or program officials, faculty, staff or students are present at the site visit. The observer is encouraged to ask questions of the visiting committee during executive session meetings only but does not participate in decision-making discussions.

All observers must sign the Commission’s Agreement of Confidentiality prior to the site visit. The chairperson of the site visit committee has the right to excuse and/or exclude the observer from any or all aspects of the site visit for improper and/or unprofessional behavior. The chairperson’s decision to remove or exclude an observer from the site visit cannot be appealed.

A representative of the state dental society may attend a comprehensive dental school site visit as a silent observer, if requested by the society and approved by the institution.

Reaffirmed: 8/10, 7/07, 7/01; Revised: 2/13, 07/98:2, 01/94:2, 05/93:1-2, 12/92:3

M. POLICY ON STATE BOARD PARTICIPATION DURING SITE VISITS

It is the policy of the Commission on Dental Accreditation that the state board of dentistry is notified when an accreditation visit will be conducted in its jurisdiction. The Commission believes that state
boards of dentistry have a legitimate interest in the accreditation process and, therefore, strongly urges institutions to invite a current member of the state board of dentistry to participate in Commission site visits. The Commission also encourages state boards of dentistry to accept invitations to participate in the site visit process.

If a state has a separate dental hygiene examining board, that board will be contacted when a dental hygiene program located in that state is site visited. In addition, the dental examining board for that state will be notified.

The following procedures are used in implementing this policy:

1. Correspondence will be directed to an institution notifying it of a pending accreditation visit and will include a copy of Commission policy on state board participation. The institution is urged to invite the state board to send a current member. The Commission copies the state board on this correspondence.

2. The institution notifies the Commission of its decision to invite/not invite a current member of the state board. If a current member of the state board is to be present, s/he will receive the same background information as other team members.

3. If it is the decision of the institution to invite a member of the state board, Commission staff will contact the state board and request the names of at least two of its current members to be representatives to the Commission.

4. The Commission provides the names of the two state board members, to the institution. The institution will be able to choose one of the state board members. If any board member is unacceptable to the institution, the Commission must be informed in writing.

5. The state board member, if authorized to participate in the site visit by the institution, receives the self-study document from the institution and background information from the Commission prior to the site visit.

6. The state board member must participate in all days of the site visit, including all site visit conferences and executive sessions.

7. In the event the chairperson of the site visit committee determines that a vote is necessary to make a recommendation to the Commission, only team members representing the Commission will be allowed to vote.

8. The state board reimburses its member for expenses incurred during the site visit.

The following statement was developed to assist state board members by clearly indicating their role while on-site with an accreditation team and what they may and may not report following a site visit. The statement is used on dental education, advanced dental education and allied dental education site visits.

The state board member participates in an accreditation site visit in order to develop a better understanding of the accreditation site visit process and its role in ensuring the competence of graduates for the protection of the public. The dental, advanced dental and allied dental education programs are evaluated utilizing the Commission’s approved accreditation standards for each respective discipline.

The state board member is expected to be in attendance for the entire site visit, including all scheduled conferences and during executive sessions of the visiting committee. While on site the state board member:

- provides assistance in interpreting the state’s dental practice act and/or provides background on other issues related to dental practice and licensure within the state.
- on allied dental education visits: assists the team in assessing the practice needs of employer-dentists in the community and in reviewing those aspects of the program which may involve the delegation of
expanded functions.

- on dental school visits: functions primarily as a clinical consultant, working closely with the clinical specialist member(s) who evaluate the adequacy of the preclinical and clinical program(s) and the clinical competency of students.

Following the site visit, state board members may be asked to provide either a written or oral report to their boards. Questions frequently arise regarding what information can be included in those reports while honoring the Agreement of Confidentiality that was signed before the site visit. The following are some general guidelines:

- What You May Share: Information about the Commission’s accreditation standards, process and policies
- What You May Not Share:
  - The school’s self-study;
  - Previous site visit reports and correspondence provided to you as background information;
  - Information revealed by faculty or students/residents during interviews and conferences;
  - The verbal or written findings and recommendations of the visiting committee; and
  - Any other information provided in confidence during the conduct of an accreditation visit.

The Commission staff is available to answer any questions you may have before, during or after a site visit.

Reaffirmed: 8/10, 7/07, 7/01, 12/82, 5/81, 12/78, 12/75; Revised: 7/09, 1/00; Adopted: 8/86

N. SITE VISIT PROCEDURES

The basic purpose of the site visit is to permit peers to assess a program’s compliance with the accreditation standards and with its own stated goals and objectives. Information provided in the self-study is confirmed, documentation is reviewed, interviews are conducted and the programs are observed by the visiting committee. Information related to the site visit is viewed as confidential. The Commission’s policy on confidentiality, elsewhere in this document, gives more specific information about the degree of confidentiality extended to various materials.

The Commission recognizes that there is considerable latitude in determining procedures and methodology for site visits. Experience has shown that the conference method for conducting a site visit is widely favored and effective. Conferences are scheduled with identified administrators, faculty and students at specified times.

In all cases, the recommendations of the dean or program director determine protocol to be followed during conferences with chief executive officers of the parent institution and/or their appointed representatives. Program administrators are excused during conferences scheduled with faculty members, students or other invitees.

In addition to formal scheduled conferences, committee members may informally discuss department and division programs with chairpersons and faculty members throughout the site visit. The visiting committee chairperson will make every effort to schedule hearings with any individual or group of individuals wishing to present information about a program.

Executive sessions of the visiting committee are a critical part of the on-site evaluation process. These sessions are scheduled at intervals during the day and evening and provide time for the committee to meet
privately to prepare its findings and recommendations.  

Reaffirmed: 8/10

1. **Duration Of Dental School Visits:** Dental school site visits are typically scheduled for two and one-half days. The determination is left to the discretion of Commission staff and is based on the number of programs to be reviewed and any problems anticipated during the review.  

   Reaffirmed: 8/10, 7/07; Revised: 7/01; CODA: 07/95:3

2. **Final Conferences:** It is the visiting committee’s responsibility to prepare and present an oral summary of its findings to the dean, chief of dental service, program director(s) and the institutional executives. Two separate conferences are scheduled at the end of every visit, one with the program director(s) and chief of dental service or dental dean and one with the chief executive officer(s) of the institution.

   During these conferences, the committee presents the findings it will submit to the Commission. These findings address both program strengths and weaknesses. The committee also informs individuals in charge of the program(s) about the Commission’s procedures for processing and acting on the report. In keeping with the Commission’s policy on Public Disclosure and Confidentiality, these final conferences are not recorded on tape or by stenographer. Note taking, however, is permitted and encouraged.

   Consultants/site visitors or any other participants are not authorized, under any circumstances, to disclose any information obtained during site visits. For more specific information, see the Commission’s Statement of Policy on Public Disclosure and Confidentiality.

   Reaffirmed: 8/10

3. **Rescheduling Dates Of Site Visits:** In extraordinary circumstances the Commission staff can reschedule the site visit if the program will be reviewed within the same calendar year. If the year of the visit would change because of the rescheduling, the request must be considered and acted on by the Commission. In general, the Commission does not approve such requests, but it does review each request on a case-by-case basis. Should a site visit be changed the term of the accreditation will remain unchanged.

   Reaffirmed: 8/10

4. **Enrollment Requirement For Site Visits For Fully Developed Programs:** Site visit evaluations of dental, allied dental and advanced dental education programs will be conducted at the regularly established intervals, provided that students are enrolled in at least one year of the program. If no students are enrolled on the established date for the site visit, the visit will be conducted when students are enrolled, preferably in the latter part of the program. (Refer to the Policy on Non-enrollment of First Year Students)

   Reaffirmed: 8/10, 7/07, 7/01; Revised: 5/93

5. **Post-Site Visit Evaluation:** After each site visit, electronic evaluation forms are completed by the visited program and the participating consultants to give the Commission feedback on the effectiveness of its processes and procedures. In addition, consultants/site visitors electronically evaluate their fellow consultants/site visitors and the visited programs electronically evaluate the individual consultants.

   Revised: 8/10

O. **SITE VISIT REPORTS**

1. **Preliminary Site Visit Report:** The site visit report is a written review of the quality of the program
and serves as the primary basis for the Commission’s accreditation decision. The report also serves to identify for officials and administrators of educational institutions any program weaknesses relative to the accreditation standards.

The report is an assessment the program’s compliance with the accreditation standards, including any areas needing improvement, and the program’s performance with respect to student achievement. The report may include recommendations and suggestions related to program quality. A program’s continued compliance with any standards for which deficiencies are noted in previous reports, as well as its compliance with current Commission policies and procedures are also noted.

Preliminary drafts of site visit reports are prepared by consultants/site visitors, consolidated by Commission staff and transmitted to visiting committee members for review, comment and approval prior to transmittal to the sponsoring institution for review and response.

Effective July 26, 2007, commendations are no longer cited in site visit reports; however, verbal acknowledgement of a program’s strengths may be provided during the exit interview.  
Reaffirmed: 8/10, 7/07, 7/01, 4/83

2. **Policy On Institutional Review Of Site Visit Reports:** Accreditation is an peer review process whereby an educational program is evaluated by individuals in education and the profession who are identified as having particular expertise in a specific area or field. In this context, a visiting committee is a fact-finding committee charged by the Commission with the responsibility of assessing the quality of an educational program utilizing pre-determined educational requirements and guidelines (standards).

Subsequent to such peer review, an evaluation report is developed based upon the factual findings, perceptions, interpretations, observations and conclusions of the external reviewing team. The information contained in site visit reports is obtained from review and verification of materials and documents submitted by the institution’s administration, program directors, faculty and students. Since the information is gathered from various sources, on occasion the perceptions, interpretations and conclusions of the visiting committee may not coincide with those of the administration and program directors who review and comment on the preliminary draft.

In compliance with the due process policy and procedures established by the Commission, the preliminary draft report is sent to the chief executive officer(s), chief academic officer(s), and appropriate program director(s). The Commission requests that the entire preliminary draft report, or specific sections, be released to departmental chairpersons, and appropriate faculty and standing committees for review. In reviewing the report the Commission requests that the program respond to correct factual inaccuracies within the report and/or note any differences in perception.

It is the policy of the Commission to correct bona fide factual inaccuracies in a report. It does not change the substance of a report based upon differences of interpretations and perceptions. In such cases, however, the institution’s observations regarding these matters are discussed and considered at the Commission’s meeting and the final judgment of the Commission is based not only on the site visit report, but also on the institution’s response to that report.

Reaffirmed: 8/10, 7/07, 7/01; CODA: 12/78:4

3. **Deadlines For Submission Of Supplemental Information:** All programs receive thirty (30) days in which to prepare a response to the preliminary draft site visit report. This response may address any factual inaccuracies or differences in perception and may also report any progress made in implementing
recommendations contained in the report.

After the response to the preliminary report has been submitted, a program may wish to report additional progress in implementing recommendations contained in the preliminary report or wish to submit other information for review by the Commission and its Review Committees. While submission of multiple reports is not encouraged, the Commission will accept supplemental information no later than December 1 or June 1 to allow time for review by the Review Committees.

In this way, fair review of the additional information can be ensured. Any unsolicited information received after December 1 or June 1 will be reviewed by the Review Committee Chairperson. If adequate time is not available to ensure appropriate review, the materials may be returned to the program or held for consideration at the following meeting in accord with the wishes of the program.

Reaffirmed: 8/10, 7/01, 5/93, 12/88; Revised: 7/05

4. **Final Site Visit Report:** After the Commission has reached a decision regarding the accreditation status of the program, a final site visit report is prepared and transmitted to the chief executive officer(s), chief academic officer(s), and appropriate program director(s). The site visit report reflects the program as it existed at the time of the site visit. The final report to the institution does not reflect any improvements or changes made subsequent to a site visit and described in the institution’s response to the preliminary draft of the site visit report. Such changes or improvements represent progress made by the institution subsequent to the site visit. It should be noted, however, that information on such progress is considered by the Commission in determining accreditation status.

Reaffirmed: 8/10

5. **Policy On Distribution Of Site Visit Reports:** The Commission recommends that the chief academic officer disseminate the preliminary draft report and the final site visit report to all program directors, chairpersons, appropriate faculty and standing committees for review to allow for broad input as the program works toward implementing any specific recommendations contained in the report.

Reaffirmed: 8/10, 7/07, 7/01, 12/91, 5/80

6. **Policy On Reports For Co-Sponsored Programs:** In special circumstances of co-sponsorship of programs where preparation of an integrated site visit report would breach confidentiality for one or more of the programs, the Commission has determined that confidentiality takes precedence over integration of reports and separate reports may be prepared. This decision will be made in consultation with the chief executive officers of the co-sponsoring institutions.

Reaffirmed: 8/10, 7/07, 7/01; CODA: 12/91:12

**P. REVIEW COMMITTEES**

1. **Structure:** The chairperson of each Review Committee will be the appointed Commissioner from the relevant discipline.
   
i. The Commission will appoint all Review Committee members.
   
a. Review Committee positions not designated as specialty or discipline specific will be appointed from the Commission where feasible, e.g. a public representative on the Commission could be appointed to serve as the public member on the Dental Laboratory Technology Review Committee; an ADA appointee to the Commission could be appointed to the Dental Assisting Review Committee as the general dentist practitioner.
   
b. Specialty or discipline specific positions on Review Committees will be filled by appointment by the Commission of an individual from a small group of qualified
nominees (at least two) submitted by the relevant national organization, specialty organization or certifying board. Nominating organizations may elect to rank their nominees, if they so choose. If fewer than two (2) qualified nominees are submitted, the appointment process will be delayed until such time as the minimum number of required qualified nominations is received.

ii. Consensus is the method used for decision making; however if consensus cannot be reached and a vote is required, then the Chairperson may only vote in the case of a tie (per Sturgis, Standard Code of Parliamentary Procedure).

iii. Member terms will be staggered, four year appointments; multiple terms may be served on the same or a different committee, with a one-year waiting period between terms. A maximum of two (2) terms may be served in total.

iv. One public member will be appointed to each committee.

v. The size of each Review Committee will be determined by the committee’s workload.

vi. As a committee’s workload increases, additional members will be appointed while maintaining the balance between the number of content experts and non-content experts. Committees may formally request an additional member through New Business at Review Committee/Commission meetings. If an additional member is approved, this member must be a joint nomination from the professional organization and certifying board, as applicable.

vii. Conflict of interest policies and procedures are applicable to all Review Committee members.

viii. Review Committee members who have not had not been on a site visit within the last two (2) years prior to their appointment on a Review Committee should observe at least one site visit within their first year of service on the Review Committee.

ix. The Review Committee Chairperson may reschedule the date of the Review Committee meeting if an adequate number of content experts are not present on the assigned date of the meeting.

Revised: 2/13, 8/10, 7/09; 7/08; 7/07; Adopted: 1/06

2. Composition

Predoctoral Education Review Committee (7 members)

1 discipline-specific Commissioner appointed by American Dental Education Association
1 public member
2 dental educators who are involved with a predoctoral dental education program (one of whom is a general dentist)

1 general dentist (One of whom is a practitioner
1 specialty dentist and the other an educator)
1 dental assistant, hygienist, or dental laboratory technology professional educator

Three (3) Advanced Specialty Education Review Committees (DPH, OMP, OMR) (5 members each. At least one member must be a dental educator.)

1 discipline-specific Commissioner appointed by specialty sponsoring organization
1 public member
1 specialty organization representative
1 specialty certifying board representative
1 general dentist

Six (6) Advanced Specialty Education Review Committees (ENDO, OMS, ORTHO, PERIO, PED, PROS) (6 members each. At least one member must be a dental educator.)

1 discipline-specific Commissioner appointed by specialty sponsoring organization
1 public member
1 specialty organization representative
1 specialty certifying board representative
1 specialty certifying board or specialty organization representative
1 general dentist

Postdoctoral General Dentistry Education Review Committee (12 members. At least one member must be a dental educator)
1 discipline-specific Commissioner, jointly appointed by American Dental Education Association (ADEA) and American Association of Hospital Dentists (AAHD)
1 public member
2 current General Practice Residency (GPR) educators nominated by the AAHD
2 current Advanced Education in General Dentistry (AEGD) educators nominated by ADEA
1 oral medicine educator nominated by the American Academy of Oral Medicine
1 dental anesthesiology educator nominated by the American Society of Dentist Anesthesiologists
1 orofacial pain educator nominated by the American Academy of Orofacial Pain
1 general dentist graduate of a GPR or AEGD
1 specialty dentist
1 higher education or hospital administrator with past or present experience in administration in a teaching institution

Dental Assisting Education Review Committee (10 members. At least one member must be a dental educator)
1 discipline-specific Commissioner appointed by American Dental Assisting Association
1 public member
2 general dentists (practitioner or educator)
5 dental assisting educators
1 dental assisting practitioner who is a graduate of a Commission accredited program

Dental Hygiene Education Review Committee (11 members. At least one member must be a dental educator)
1 discipline-specific Commissioner appointed by American Dental Hygiene Association
1 public member
4 dental hygienist educators
2 dental hygiene practitioner
1 dentist (general or specialist)
1 dentist educator
1 higher education administrator

Dental Laboratory Technology Education Review Committee (5 members. At least one member must be a dental educator)
1 discipline-specific Commissioner appointed by National Association of Dental Laboratories
1 public member
1 general dentist
1 dental laboratory technology educator
1 dental laboratory owner nominated by National Association of Dental Laboratories
Reaffirmed: 8/10; Revised: 2/13, 7/09, 7/08, 1/08; Adopted: 1/06

3. Nomination Criteria: The following criteria are requirements for nominating members to serve on
the Review Committees and Commission. Rules related to the appointment term on Review Committees and the Commission apply.

All Nominees:
- Ability to commit to one four (4) year term;
- Willingness to commit five (5) to ten (10) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters;
- Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment;
- Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; and Professional Conduct Policy and Prohibition Against Harassment);
- Ability to conduct business through electronic means (email, Commission Web Sites); and
- Active member of the American Dental Association, where applicable.

Educator Nominees:
- Commitment to dental, advanced dental and/or allied dental education;
- Active involvement in a dental or dental-related accredited program as a full- or part-time faculty member;
- Subject matter experts with formal education and credentialed in the applicable discipline; and
- Prior or current experience as a Commission consultant/site visitor.

Practitioner Nominees:
- Commitment to dental, advanced dental and/or allied dental education;
- Prior or current experience as a practitioner; and
- Formal education and credential in the applicable discipline.

Public/Consumer Nominees:
- A commitment to bring the public/consumer perspective to Review Committee deliberations. The nominee should not have any formal or informal connection to the profession of dentistry; also, the nominee should have an interest in, or knowledge of, health-related and accreditation issues. In order to serve, the nominee must not be a:
  a. Dentist or member of an allied dental discipline;
  b. Member of a dental, advanced dental or allied dental program faculty;
  c. Employee, member of the governing board, owner, or shareholder of, or consultant to, a dental, advanced dental or allied dental education program that is accredited by the Commission on Dental Accreditation, has applied for initial accreditation or is not-accredited;
  d. Member or employee of any professional/trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission, dental education or dentistry; and
  e. Spouse, parent, child or sibling of an individual identified above (a through d).

Higher Education Administrator:
- A commitment to bring the higher education administrator perspective to the Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
b. Spouse, parent, child or sibling of an individual identified above.

Hospital Administrator:

- A commitment to bring the hospital administrator perspective to Review Committee deliberations. In order to serve, the nominee must not be a:
  a. Member of any trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission; and
  b. Spouse, parent, child or sibling of an individual identified above.

Revised: 8/10; Adopted: 07/08

4. **Policy On Attendance At Open Portion Of Review Committee Meetings:** The policy portion of Review Committee meetings is open to the organizations and representatives from certifying boards represented on the Review Committee. Participation of these representatives during the meeting is at the discretion of the Review Committee Chairperson.

Representatives are asked to pre-register to assist the Commission in making arrangements for the meeting. Pre-registration ensures that the individual receives a copy of the meeting agenda and policy reports at the same time as Commission members.

Reaffirmed: 8/10, 7/01; Revised: 7/07, 7/97; CODA: 07/96:10

5. **Chairpersons Of Review Committees:** The Chairperson of the Predoctoral Review Committee is selected by the Chairperson of the Commission from among the four Commissioners appointed by ADEA. All other Review Committees are chaired by the Commissioner for the respective discipline/specialty.

Reaffirmed: 8/10

6. **Calibration Protocol:** The following protocol used to calibrate Review Committee members:

i. Documentation Guidelines for Selected Recommendations is provided to all programs scheduled to submit either a response to a preliminary draft site visit report or a progress report.

ii. Documentation Guidelines for Selected Recommendations is provided to all members of Review Committees for use as accreditation reports are reviewed.

iii. At the beginning of each committee meeting, the chairperson reminds the committee of the Documentation Guidelines for Selected Recommendations and reviews how the document is to be used.

iv. A specific calibration exercise is conducted prior to each committee’s consideration of accreditation reports.

v. Each staff secretary refers the committee to the Documentation Guidelines at appropriate points throughout the committee’s discussion of accreditation reports.

vi. At the end of the committee’s accreditation actions, the staff secretary asks for comments and feedback on the calibration process.

vii. Following each meeting of the Commission, a staff meeting is convened for the purpose of discussing input received from each committee on the Documentation Guidelines for Selected Recommendations. Appropriate adjustments are incorporated into the document annually, following the July meeting of the Commission.

viii. When specific calibration problems are identified, a specific exercise to address the problem will be designed and implemented as soon as feasible, usually at the next meeting.

ix. Reports of calibration activities are provided to the committees and the Commission as needed.

Reaffirmed: 8/10, 7/07, 7/01; Revised: 7/97, 7/00; CODA:12/92:8
7. **Procedure To Resolve Differences Between Allied Dental Review Committees:** The Dental Assisting, Dental Hygiene and Dental Laboratory Technology Education Review Committees usually consider reports with common recommendations as their first item of accreditation business. The staff secretaries compare the two or three committees’ decisions relative to the common recommendations, accreditation status and changes to the report. Discrepancies must then be reconsidered.

At the earliest opportunity convenient to the involved Review Committees, the two reviewers (primary and secondary) from each committee will meet to discuss and resolve any differences. These individuals will be excused, if necessary, from committee deliberations for this purpose and committees will adjust their agendas as much as possible to accommodate this process. The two reviewers from each committee will have delegated authority to act on behalf of their respective committees in reaching consensus.

Representatives of the Review Committees should be reminded prior to the joint meeting that every effort should be made to focus on substantive issues affecting accreditation status, to relate report contents to the discipline standards and to reach a consensus whenever appropriate. The agreed-upon decision, or the failure to achieve consensus, will be reported back to the disciplines’ Review Committees.

If a decision on a single joint recommendation cannot be reached by consensus, then each committee will prepare a report stating the rationale for its recommendation and all reports will be submitted to the Commission for consideration. The Chairperson and Director of the Commission should be informed promptly when this occurs.

The Chairperson of each Review Committee or its designated spokesperson will be expected to speak to the committee’s position during the Commission meeting. The Commission will consider both reports and will determine the accreditation status.

Reaffirmed: 8/10, 7/07, 7/01; Revised: 7/99

Q. **COMMISSION MEETINGS**

The Commission and its Review Committees meet twice each year to consider site visit reports and institutional responses, progress reports, information from annual surveys, applications for initial accreditation and policies related to accreditation. These meetings are held in the winter and the summer.

Reports from site visits conducted less than 90 days prior to a Commission meeting are usually deferred and considered at the next Commission meeting. Commission staff can provide information about the specific dates for consideration of a particular report.

The Commission has established policy and procedures for due process which are detailed in the Due Process section of this manual.

Reaffirmed: 8/10; Revised: 7/06, 7/96; Adopted: 7/96

1. **Policy On Absence From Commission Meetings:** When a Commissioner notifies the Director that he/she will be unable to attend a meeting of the Commission, the Director will notify the Chairperson. The Chairperson determines if another individual should be invited to attend the meeting in the Commissioner’s absence. A substitute will be invited if the Commissioner’s discipline would not otherwise be represented. This individual must be familiar with the Commission’s policies and procedures; and therefore, must be a current or former member of the appropriate-Review Committee and must represent the same discipline or appointing organization as the absent Commissioner. In the event that these criteria cannot be met, the Commission Chairperson may elect not to invite another individual.
to the meeting. The substitute would have the privileges of speaking, introducing business, making motions and voting.

Revised: 8/10, 7/97; Reaffirmed: 7/07, 7/01; CODA: 12/86:14

2. New Commissioner Orientation and Training: Newly appointed Commissioners will undergo a six-month training period prior to beginning their official term. This training includes attendance at a Commission meeting, at the discipline-specific review committee meeting, and an appropriate site visit.

Adopted: 8/11

3. Protocol For Review Of Report On Accreditation Status Of Educational Programs:
Commission staff sends the final listing of programs to be reviewed at the Commission meeting to each Commissioner immediately after Review Committee meetings to allow each Commissioner to identify all conflicts with these programs.

A conflict includes, but is not limited to:

- close professional or personal relationship or affiliation with the institution/program or key personnel in the institution/program which may create the appearance of a conflict;
- serving as a consultant to the institution/program;
- being a graduate of the institution/program;
- being a current employee or appointee of the institution/program;
- being a current student at the institution/program;
- having a family member who is employed by or affiliated with the institution;
- manifesting a professional or personal interest at odds with the institution or program;
- key personnel of the institution/program having graduated from the program of the Commissioner;
- having served on the program’s visiting committee; and/or
- no longer a current employee of the institution or program, but having been employed there within the past five (5) years.

Conflicts of interest for Commissioners may also include being from the same state, but not the same program. The Commission is aware that being from the same state may not itself be a conflict; however, when residence within the same state is in addition to any of the items listed above, a conflict would exist.

When a program is being considered, Commissioners must leave the room if they have any of the above conflicts.

Each year Commissioners report conflicts to the Director. Prior to each Commission meeting, staff analyze the reported conflicts to determine whether reformatting of the Report on Accreditation Status of Educational Programs (yellow sheet reports) is necessary. Reformatting of yellow sheet reports may include grouping all dental school based programs and/or any institution that sponsors multiple programs so that recusals leave the room once.

During the Commission meeting, in addition to yellow sheet reports, each Commissioner receives a copy of the key guidelines of the Commission’s Conflict of Interest policy and a listing of conflicts reflecting their listings. Explanation of protocol, including definitions of conflicts, will be provided to Commissioners prior to each Commission meeting.

The Chairperson will confirm conflicts and remind Commissioners of their responsibility to abstain from

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discussion and voting on a program if there is even the appearance of a conflict of interest. The Chairperson will then allow appropriate time for exiting of relevant Commissioners before review of each yellow sheet report and promptly invite the return of these Commissioners after the specific report is reviewed. Action on the grouped programs will be taken first, institution by institution, so that Commissioners who must recuse themselves from the vote leave the room only once.

After the Commission meeting, the Report of Accreditation Status of Education Programs in the minutes of the meeting will include the Commissioners’ identified conflicts.

Revised: 8/11, 8/10, 7/09; Adopted: 7/06

4. Policy On Attendance At Open Portion Of Commission Meetings: The policy portion of Commission meetings is open to interested observers from the communities of interest, international observers, and representatives of dental education programs. Those attending are observers only and do not participate in the Commission’s discussion. Confidential accreditation matters are discussed in a closed session of the meeting that is not open to observers.

Observers are asked to pre-register to assist the Commission in making arrangements for the meeting. Pre-registration ensures that the individual receives a copy of the preliminary agenda when it is ready for distribution. When possible, policy reports and committee summary reports related to agenda items will be available prior to the meeting for all pre-registered observers. A limited number of additional copies of these materials are available on a first-come-first-served basis during the meeting.

Copies of the preliminary meeting agenda are available upon request, but meeting materials are available only to individuals attending the meeting.

The Commission does not assume any travel, hotel or other costs for observers attending the meeting. Observers are not required to pay any registration or materials fee for observing the meeting.

Reaffirmed: 8/10, 7/07, 7/01, 7/95; Revised: 7/97; CODA: 12/92:13; 05/93:9

5. Guests Invited To Commission Meetings: Representatives from an accrediting agency in any country with which the Commission has a reciprocal agreement, such as the Commission on Dental Accreditation of Canada, may attend both the closed and open portion of Commission meetings as guests provided they comply with confidentiality guidelines and procedures.

Reaffirmed: 8/10, 7/01; Revised: 7/07; CODA: 05/93:11; 01/94:10

6. Commission Communication Of Actions To The Review Committees: On occasion, an accreditation action taken by the Commission differs from the action recommended by a Review Committee. In these instances, the actions taken by the Commission are communicated back to the relevant Review Committee with an explanation regarding the Commission’s final decision. The Chairperson of the Review Committee communicates the Commission’s final decision to members of the Review Committee through a letter of explanation.

Reaffirmed: 8/10, 7/09; CODA: 01/04:20

7. Confidentiality Of Accreditation Reports: Commission members are not authorized, under any circumstances, to disclose any information obtained during site visits or Commission meetings. All accreditation actions are confidential and accreditation reports are reviewed during the closed portion of the meeting. The extent to which publicity is given to site visit reports is determined by the chief executive officer of the educational institution. For more specific information, see the Commission’s Statement of Policy on Public Disclosure and Confidentiality in this manual.

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8. **Notice Of Accreditation Actions To Programs/Institutions**: An institution will receive the formal notice, including the accreditation status awarded to the program, within thirty (30) days following the official meeting of the Commission. Actions resulting in other than “approval without reporting requirements” will be accompanied by the specific date(s) for submission of progress report(s) and/or notification that a special site visit will be conducted.

When warranted, the Commission action may include a notification of its intent to withdraw a program’s accreditation and the time at which this intended action will be taken. This notification will advise the institution of an opportunity to submit additional information and that a special appearance (hearing) before the Commission or one of its Review Committees may be requested. If a program’s accreditation status is withdrawn, the institution is advised of its right to appeal the decision before the Appeal Board. For further information, refer to the Policy on Due Process in this manual.

Reaffirmed: 8/10

9. **Distribution Of Meeting Minutes**: Final minutes of each Commission meeting, including the report on accreditation status of dental education programs, are made available to the Commission’s communities of interest through an e-mail notice of posting on the Commission portion of the ADA website. Organizations may request to be added to the distribution list which follows.

- Academy of General Dentistry, Executive Director
- American Academy of Orofacial Pain, Executive Director
- American Academy of Oral Medicine, Executive Director
- American Association of Dental Boards, Executive Director
- American Association of Hospital Dentists, Executive Director
- American Dental Assistants Association, Executive Director
- American Dental Association, Board of Trustees
- American Dental Association, Council on Dental Education and Licensure
- American Dental Education Association, Executive Director
- American Dental Hygienists’ Association, Executive Director
- American Society of Dental Anesthesiologists, Executive Director
- American Student Dental Association, Executive Director
- Asociación Dental Mexicana, A.C., Director International Relations
- Chiefs of Federal Dental Services
- Commission on Dental Accreditation of Canada, Chairman, Director
- Constituent Dental Societies, Executive Directors
- Council for Higher Education Accreditation, President
- Dental Assisting National Board, Executive Director
- Members, Commission on Dental Accreditation
- Members, Review Committees, Commission on Dental Accreditation
- National Association of Dental Laboratories, Executive Director
- National Board for Certification of Dental Laboratories, Executive Director
- National Institutional and Specialized Accrediting Bodies, Executive Directors
- Recognized Dental Specialty Organizations, Executive Directors/Secretaries
- Regional Institutional Accrediting Agencies, Executive Directors
- Specialty Certifying Boards, Executive Directors/Secretaries
- State Boards of Dentistry, Executive Secretaries/Administrators

Revised: 8/10
10. **Notice Of Accreditation Actions To Communities Of Interest:** In carrying out its responsibilities as an accrediting agency, the Commission on Dental Accreditation announces its decisions to grant, renew or discontinue (at an institution’s request) accreditation to the USDE Secretary, the appropriate state licensing or authorizing agency, appropriate accrediting agencies, the public, educational institutions, dental examining boards, related dental organizations, and the profession no later than thirty (30) days after it makes the decisions.

The Commission publishes listings of accredited programs in predoctoral dental education, advanced specialty and general dentistry education and allied dental education. Lists of accredited programs are posted to the ADA website within thirty (30) days following a Commission meeting to be available to educational institutions’ executives and administrators, the USDE, regional and appropriate national accrediting agencies, state licensing agencies and to other interested agencies and organizations. Individuals are provided paper copies of such listings upon request.

When warranted, the Commission may notify an institution of its intent to withdraw a program’s accreditation and the time at which this intended action will be taken. The Commission may also reach the decision to deny or withdraw the accreditation of a program. In these instances, the Commission provides written notice of the final decisions to place a program on “intent to withdraw” or to deny or withdraw accreditation to the USDE Secretary, the appropriate accrediting agencies, and the appropriate state licensing or authorizing agency at the same time it notifies the sponsoring institution of the decision. Notice to the public is provided through the listings of accredited programs that is available on the ADA website and is updated within twenty-four (24) hours of providing the final notice to the program’s sponsoring institution.

**Reaffirmed: 8/10**

11. **Notice Of Reasons For Adverse Actions:** Accrediting agencies recognized by the Secretary of the USDE, including the Commission, are required to report any adverse accreditation action (defined as an action to deny or withdraw accreditation). Accordingly, when the Commission makes a final decision to deny or withdraw a program’s accreditation, a brief statement summarizing the reasons for the Commission’s decision and the official comments that the affected program may make with regard to that decision, is made available to the USDE Secretary, the appropriate state licensing or authorizing agency and the public. The Commission’s final decision; the statement summarizing the reasons for the Commission’s decision; and the program’s official comments will be posted on the Commission’s website no later than sixty (60) days after the decision is final.

The Commission’s Notice of Reasons for Adverse Action Disclosure Statement includes the following information about the program’s accreditation history, past problems, current problems, specific reasons why action to deny or withdraw accreditation was taken and what future option are available to the program.

To illustrate the scope of the statement and the level of reasons reported, a sample announcement follows:

**Disclosure Statement: Dental Assisting Program**

**Pick Your State Community College**

The Commission on Dental Accreditation, the only nationally-recognized accrediting agency for dental, allied dental and advanced dental education programs, reviewed an application for initial accreditation of the new dental assisting program offered by Pick-Your-State Community
College. On the basis of information provided in the application, the Commission was unable to grant “initial accreditation” status to the program.

The Commission determined, at its (date) meeting, that the application did not provide sufficient information and assurances that the proposed program meets the intent of the Accreditation Standards for Dental Assisting Education Programs. Specific concerns in compliance with the standards were noted in the following areas:

- Financial Support (adequacy of resources);
- Curriculum (adequacy of knowledge and skills offered, scope and depth of instruction in required areas, and documentation of student competence);
- Admissions (documentation that written criteria, procedures and policies are used);
- Faculty (adequacy of teaching and supervision of students);
- Facilities (insufficient documentation of adequacy of physical facilities and equipment).

The Commission informed the program and sponsoring institution that these specific concerns would need to be addressed before the institution reapplied for “initial accreditation” status of the dental assisting program.

____________________  ________________________
CEO, Sponsoring Institution   (date)

____________________  ________________________
Chairperson, Commission on Dental Accreditation   (date)

Revised: 5/12; Reaffirmed: 8/10

12. Procedure For Disclosure Notice Of Adverse Actions: The following procedure is used when an adverse action (to deny or withdraw accreditation) is taken. Applicants, when they inquire about initial accreditation, are to be notified by Commission staff that the Notice of Reasons for Adverse Actions statement will be prepared and distributed should accreditation be denied.

1. The Commission sends notice of any adverse action in a transmittal letter to the appropriate institutional executives no later than fourteen (14) days after the Commission meeting. This letter is sent by certified/tracked mail and includes the reasons for any adverse action to deny or withdraw accreditation.

2. A statement of the reasons for any adverse action is developed and available for distribution within sixty (60) days. This new statement will include the same information that has been contained in the transmittal letter. For this reason, the statement will be drafted and the draft will be sent to the institution/program for review at the same time as the transmittal letter. As needed, the draft statement will be reviewed by legal counsel prior to being sent.

3. The institution must notify the Commission within fourteen (14) days if it wishes to indicate an intent to appeal an adverse action. If an intent to appeal is received, the usual appeal procedures are followed according to the Commission policy on Due Process Related to Appeal of Accreditation Actions.

4. If an intent to appeal is not received by the fourteen (14) day deadline specified, the adverse action is considered final and the USDE Secretary, the appropriate state entities and any appropriate institutional accrediting agency are notified at this time, usually by a letter to the Secretary with copies to the other entities and the institution.

5. During the same fourteen (14) days, the institution/program will be asked to review the draft statement and:
   a. indicate agreement with the statement; and/or,
b. make official comments with regard to the decision, or state that the affected institution has been offered the opportunity to provide official comment.

6. When the final statement (or statement and response) has been developed and signed by both parties, it will be distributed as required in the regulations to the USDE Secretary, to the appropriate state licensing or authorizing agency, to any appropriate institutional accrediting agency and to the public

7. The Commission’s final decision; the statement summarizing the reasons for the Commission’s decision; and the program’s official comments will be posted on the Commission’s website no later than sixty (60) days after the decision is final.

When there are no differences of opinion regarding the statement, it may be possible to send it to the Secretary along with the letter in step #4 above, along with posting the final decision and reasons on the Commission’s website.

Revised: 5/12; Reaffirmed: 8/10; Revised: 7/06; Adopted: 7/00; CODA: 07/94:6

IV. OTHER POLICIES AND PROCEDURES RELATED TO ACCREDITATION

A. PERIODIC REMINDERS

The following reminders are posted on the accreditation area of the ADA website as indicated. Some of these reminder items are mandated by the Commission, while others are merely viewed as a service to accredited programs. Some reminders occur annually, while others are included at two (2) or three (3) year intervals.

Spring Posting: The following items are routinely posted following the Commission’s winter meeting:
- Report of Unofficial Actions of the Commission
- List of Commissioners and appended biographical information
- List of Scheduled Site Visits from July through December
- Policy On Third Party Comments
- Summer Commission Meeting – Open Session Announcement and Attendance Confirmation
- Additional Information – notes staff to contact about the Commission and its activities
- Policy on Authorization of Oral and Maxillofacial Surgery Program Enrollment
- Policy on Reporting Major Changes in Accredited Programs
- Policy on Cooperative Site Visits With Other Accreditors

Fall Posting: The following items are routinely posted following the Commission’s summer meeting:
- Report of Unofficial Actions of the Commission
- List of Commission Staff and appended biographical information
- List of Scheduled Site Visits from January through June
- Policy On Third Party Comments
- Winter Commission Meeting – Open Session Announcement and Attendance Confirmation
- Additional Information – notes staff to contact about the Commission and its activities
- Policy on Reporting Major Changes in Accredited Programs
- Policy on Cooperative Site Visits With Other Accreditors

The following items are posted at appropriate intervals:
- Department of Education Observers May Attend Site Visits
- Re-recognition: Opportunity for Third Party Testimony

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B. VOLUNTARY DISCONTINUANCE OF ACCREDITATION

The Commission may become aware of an accredited program’s decision to voluntary allow accreditation to lapse when a request to discontinue accreditation is received from the sponsoring institution’s chief executive officer or when it is time to schedule the dates for the next on-site review of the program. When the Commission becomes aware of the program’s intent to allow accreditation to lapse, it takes the following steps:

1. Commission staff verifies that both the program and institution understand the impact of this intended action and informs the institution and program of the specific audiences that will be notified of their decision to let accreditation lapse (the USDE Secretary, the appropriate accrediting agency and state licensing agency). This step prevents having to reinstate accreditation later due to potential misunderstandings.

2. Within thirty (30) days, Commission staff informs the institution’s chief executive officer and program director of the date when accreditation will lapse and the date by which the program will no longer be listed in the Commission's lists of accredited programs. The USDE Secretary and the state licensing or authorizing agency are copied on this letter.

3. At its next meeting, the Commission is informed of the decision to let accreditation lapse. The USDE Secretary and appropriate state licensing or authorizing agency are copied on any follow-up correspondence to the institution/program that may occur after this meeting.

C. PROGRESS REPORTS

Programs with recommendations identified as unmet following Commission review of site visit reports and institutional responses are required to submit progress reports. A progress report is submitted by the chief administrator of the program and it is due at a time specified by the Commission, usually at six (6) month intervals unless otherwise specified. If an interval of longer than six (6) months is established, an institution may submit its progress report earlier than requested, but prior approval is necessary if a delay is anticipated. Evidence of compliance with all recommendations must be demonstrated within the specified time frame (eighteen (18) months if the program is between one (1) and two (2) years in length or two (2) years if the program is at least two (2) years in length).

The progress report must respond specifically to each recommendation determined to be unmet that was contained in the Commission’s report. The progress report should quote each individual recommendation as it appears in the Commission report and follow each quote with comments and documentation of the institution’s implementation of the specific recommendation.

Questions on the preparation of progress reports should be directed to Commission staff. The Commission has developed Guidelines for Preparation of Progress Reports to assist programs and to illustrate acceptable documentation.

The Commission reviews a progress report in the same manner as a site visit report. Based on the progress report, the Commission will determine any subsequent actions necessary. The Commission may request a report of additional progress, an appearance of an institutional representative before the Commission, and/or a special focused reevaluation visit to the program.

If the program does not demonstrate compliance with the accreditation standards within the specified time
frame, the Commission will withdraw the program’s accreditation, unless the Commission extends the period for achieving compliance for good cause.

Reaffirmed: 8/10, 7/05; Revised: 1/99, 1/98; Adopted: 07/96

D. REPORTING PROGRAM CHANGES IN ACCREDITED PROGRAMS

The Commission on Dental Accreditation recognizes that education and accreditation are dynamic, not static, processes. Ongoing review and evaluation often lead to changes in an educational program. The Commission views change as part of a healthy educational process and encourages programs to make them as part of their normal operating procedures.

At times, however, more significant changes occur in a program. Changes have a direct and significant impact on the program’s potential ability to comply with the accreditation standards. These changes tend to occur in the areas of finances, program administration, enrollment, curriculum and clinical/laboratory facilities, but may also occur in other areas. Reporting changes in the Annual Survey does not preclude the requirement to report changes to the Commission. Failure to report and receive approval in advance of any increase in enrollment or other change, using the Guidelines for Reporting Program Change, may result in review by the Commission, a special site visit, and may jeopardize the program’s accreditation status. Advanced specialty education programs must adhere to the Policy on Enrollment Increases in Advanced Specialty Programs.

The Commission’s Policy on Integrity also applies to the reporting of changes. If the Commission determines that an intentional breech of integrity has occurred, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

When a change is planned, Commission staff should be consulted to determine reporting requirements. This report must document how the program will continue to meet accreditation standards. The Commission’s Guidelines for Reporting Program Changes are available on the ADA website and may clarify what constitutes a change and provide guidance in adequately explaining and documenting such changes.

The following examples illustrate, but are not limited to, changes that must be reported at least thirty (30) days prior to a regularly scheduled, semi-annual Review Committee meeting and must be reviewed by the appropriate Review Committee and approved by the Commission to ensure that the program continues to meet the accreditation standards:

- Establishment of Off-Campus Sites
- Transfer of sponsorship from one institution to another;
- Moving a program from one geographic site to another;
- Program director qualifications not being in compliance with the standards;
- Substantial increase in program enrollment beyond the apparent resources of the program. (Specialty programs see Policy on Enrollment Increases In Advanced Specialty Programs);
- Significant change in the nature of the program’s financial support;
- Curriculum changes that eliminate content areas required by the standards;
- Modification or reduction in faculty or support staff;
- Increase in the required length of the program; and/or
- Significant reduction of program dental facilities and
• Expansion of an existing dental hygiene program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

The Commission recognizes that unexpected, changes may occur. If an unexpected change occurs, it must be reported no more than 30 days following the occurrence. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster. Failure to proactively plan for change will not be considered unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

The following examples illustrate, but are not limited to, additional program changes that must be reported in writing at least thirty (30) days prior to anticipated implementation of the change and are not reviewed by the Review Committee and the Commission but are reviewed at the next site visit:

• Adding content to individual courses;
• Updating or replacing laboratory/clinical equipment;
• Expansion or relocation of dental facilities within the same institution;
• Re-sequencing specific courses within the curriculum; and/or
• Change in program director. A copy of the new or acting program director’s curriculum vitae should be provided to Commission staff.

The Commission uses the following process when considering reports of changes. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report at least thirty (30) days prior to a regularly scheduled Review Committee meeting.

2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.

3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.

4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of changes received from accredited educational programs.

• Approve the report of program change: If the Review Committees or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change(s) have been noted and will be reviewed at the next regularly-scheduled site visit to the program.

• Postpone action and continue the program’s accreditation status, but request additional information:
The transmittal letter will inform the institution that the report of program change has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request.

- Postpone action and continue the program’s accreditation status pending conduct of a special site visit: If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.
- Deny the request: If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for a program change. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 2/12, 8/11, 8/10, 7/09, 7/07, 8/02, 7/97; Reaffirmed: 7/07, 7/01, 5/90; CODA: 05/91:11

E. REQUESTS FOR TRANSFER OF SPONSORSHIP OF ACCREDITED PROGRAMS

The sponsorship of an accredited program may be transferred from one educational institution to another without affecting the accreditation status of the program, provided the accreditation standards continue to be met following the transfer. A request for transfer of sponsorship will be considered by the Commission if significant aspects of the program will remain unchanged following the transfer.

Critical factors that will be weighed in determining whether a transfer of sponsorship can be considered include: administration, funding sources, curriculum, faculty and facilities. If most of these critical factors will be unchanged, then the Commission will consider the request for transfer of sponsorship of the program. If most of these factors will be significantly altered following the change in sponsorship, then the program cannot be considered as a continuation of the same program under different sponsorship. Rather, the program to be offered by the new sponsoring institution will be considered as a new program and will be required to complete the established application process for initial accreditation appropriate to the discipline. If the program is viewed as a new program, the accreditation status of the previous program will be discontinued at an appropriate time.

Information regarding the transfer of sponsorship and its effect on the program’s compliance with the accreditation standards must be submitted prior to implementation of the transfer. Written notice of the agreement to transfer sponsorship of the program must be provided to the Commission by both institutions; the new sponsor must explicitly indicate its willingness to accept responsibility for the transferred program. The information to be submitted must include the expected date of the transfer and the anticipated enrollment in each year of the program following the transfer. In addition, documentation must be submitted to demonstrate how the program will continue to meet the accreditation standards related to administration, financial support, curriculum, faculty and facilities. Any other changes that will occur in the program as a result of the transfer of sponsorship must also be explained and documented.

Programs anticipating a possible transfer of sponsorship are strongly encouraged to consult with Commission staff prior to submitting a request. The Commission has guidelines for preparing a request for transfer of sponsorship, to assist institutions in adequately explaining and documenting such changes.

The following alternatives may be recommended by Review Committees and/or be taken by the
Commission in relation to the review of requests for transfer of sponsorship.

- Approve the transfer of sponsorship: If the Review Committee or Commission does not identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the program will be reviewed at the next regularly-scheduled site visit to the new sponsoring institution. If concerns have been identified that are not of such a nature as to require the submission of additional information immediately, the concerns may be cited in the transmittal letter; the institution will be advised that the concerns will be reviewed at the time of the next regularly-scheduled site visit.

- Postpone action and continue the program’s accreditation status, but request additional information: This action may be taken only once following submission of the initial request. The transmittal letter will inform the institutions that Commission action has been postponed because concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institutions will be further advised that, if the additional information submitted does not satisfy the identified concerns, the Commission reserves the right to conduct a special focused site visit of the program at an appropriate time following implementation of the transfer, or to deny the request.

- Postpone action and continue the program’s accreditation status pending conduct of a special site visit: If the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit to the new sponsoring institution will be conducted.

- Deny the request for transfer: If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for transfer of sponsorship. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 8/10, 7/07, 7/97; Reaffirmed: 7/07, 7/01, 5/91, 12/82; CODA: 05/91:11

F. POLICY ON MISSED DEADLINES

So that the Commission may conduct its accreditation program in an orderly fashion, all institutions offering programs accredited by the Commission are expected to adhere to deadlines for requests for program information. Programs/institutions must meet established deadlines to allow scheduling of regular or special site visits and for submission of requested information. Program information (i.e. self-studies, progress reports, annual surveys or other kinds of accreditation-related information requested by the Commission) is considered an integral part of the accreditation process. If an institution fails to comply with the Commission's request, it will be assumed that the institution no longer wishes to participate in the accreditation program. In this event, the Commission will immediately notify the chief executive officer of the institution of its intent to withdraw the accreditation of the program(s) at its next scheduled meeting.

Reaffirmed: 8/10, 7/07, 7/01, 5/88

G. POLICY ON PROGRAMS DECLINING A RE-EVALUATION VISIT

When an institution elects not to schedule a site visit, the chief executive officer of the institution will be informed of the Commission’s intent to withdraw accreditation at its next scheduled meeting. This notification shall be by certified/tracked mail.

Reaffirmed: 8/10, 7/07, 7/01, 12/80
H. POLICY ON FAILURE TO COMPLY WITH COMMISSION REQUESTS FOR SURVEY INFORMATION

The Commission on Dental Accreditation monitors the educational programs it accredits through annual surveys. Completion of the Commission’s annual survey by each accredited program is a requirement for continued participation in the voluntary accreditation program. The Commission expects that all accredited programs will return completed surveys by the stated deadline. Administrators who anticipate difficulty in submitting completed surveys on time must submit a written request for extension prior to the date on which the survey is due. Requests for extension must specify a submission date no later than thirty (30) days beyond the initial deadline date. If a program fails to submit its completed survey or request for extension by the deadline, the Commission will notify the institution that action to withdraw accreditation will be initiated at the next Commission meeting.

Reaffirmed: 8/10, 7/07, 7/01, 12/79, 4/83

I. REFERRAL OF POLICY MATTERS TO APPROPRIATE COMMITTEES

The Chairperson of the Commission, in consultation with the Director and Commission staff, will review all agenda items and refer policy matters to the appropriate committee(s) for discussion and recommendation.

Reaffirmed: 8/10, 7/07, 7/01; CODA: 05/83:9

J. POLICY ON NON-ENROLLMENT OF FIRST YEAR STUDENTS

The accreditation status of programs within the purview of the Commission on Dental Accreditation will be discontinued when all first-year positions remain vacant for two (2) consecutive years. Exceptions to this policy may be made by the Commission for programs with “approval without reporting requirements” status upon receipt of a formal request from the institution stating reasons why the accreditation of the program should not be discontinued. If the Commission grants an institution’s request to continue the accreditation of a program, the continuation of accreditation is effective for one (1) year. Only one request for continued accreditation will be granted for a total of three (3) consecutive years of non-enrollment. See the Commission’s policies related to Initial Accreditation, Intent to Withdraw Accreditation and Termination of Educational Programs for additional information.

Reaffirmed: 8/10, 7/07, 7/01, 7/99, 12/87, 4/83, 12/76

K. POLICY ON INTERRUPTION OF EDUCATION

Interruption of an educational program due to unforeseen circumstances that take faculty, administrators or students away from the program is a potentially serious problem. If such interruption may compromise the quality and effectiveness of education, the Commission must be notified in writing of any such disruption. The institution must provide a comprehensive plan for how the loss of instructional time will be addressed. A program which experiences an interruption of longer than two (2) years will be placed on the status of “accreditation with intent to withdraw.”

Revised: 8/10, 5/91, 1975; Reaffirmed: 7/07, 7/01

L. POLICY ON ENROLLMENT INCREASES IN ADVANCED DENTAL SPECIALTY PROGRAMS

A program considering or planning an enrollment increase, or any other substantive change, should notify the Commission early in the program’s planning. Such notification will provide an opportunity for the program to seek consultation from Commission staff regarding the potential effect of the proposed change.
on the accreditation status and the procedures to be followed.

A request for an increase in enrollment with all supporting documentation must be submitted in writing to the Commission at least thirty (30) days prior to a regularly scheduled, semi-annual Review Committee meeting. A program must receive Commission approval for an increase in enrollment prior to publishing or announcing the additional positions or accepting additional students/residents.

The Commission will not retroactively approve enrollment increases without a special focused site visit. Special circumstances may be considered on a case-by-case basis, including, but not limited to, temporary enrollment increases due to:

- Student/Resident extending program length due to illness, incomplete projects/clinical assignments, or concurrent enrollment in another program;
- Unexpected loss of an enrollee and need to maintain balance of manpower needs;
- Urgent manpower needs demanded by U.S. armed forces; and
- Natural disasters.

Failure to comply with this policy will jeopardize the program’s accreditation status, up to and including withdrawal of accreditation. If a program has enrolled beyond the approved number of students/residents without prior approval by the Commission, a special focused site visit will be required at the program’s expense.

If the focused visit determines that the program does not have the resources to support the additional student(s)/resident(s), the program will be placed on “intent to withdraw” status and no additional student(s)/resident(s) beyond the previously approved number may be admitted to the program until the deficiencies have been rectified and approved by the Commission. Student(s)/Resident(s) who have already been formally accepted or enrolled in the program will be allowed to continue.

Revised: 8/10; Reaffirmed: 7/07; CODA: 08/03:22

M. POLICY ON TERMINATION OF EDUCATIONAL PROGRAMS ACCREDITED BY THE COMMISSION AND TEACH-OUT PLANS

It is the responsibility of an institution sponsoring an accredited program to report to the Commission any major programmatic change that might affect a program’s ability to meet accreditation standards.

When an institution is considering termination of Commission accredited educational program, the Commission must be notified officially in writing as early as possible in the decision making process. Specifically, the Commission must be informed of the institution’s plans for the entire phase-out period, including a detailed explanation of any significant changes relative to retention of qualified faculty and support personnel, student enrollment by class, the didactic and clinical teaching programs (including curriculum, extramural experiences and facilities), and financial support that will be provided.

The institution must ensure that the program continues to meet minimum accreditation standards and that students and other interested parties are protected throughout the phase-out period. In this regard, the Commission reserves the right to closely monitor the phase-out through periodic reports from the institution detailing changes in administration, faculty, curriculum, facilities, finances and other major components that could affect the quality of the educational program. In addition, the Commission reserves the right to conduct a special site visit following review of each of these reports.
The institution has moral and ethical obligations to meet the commitment and responsibility it assumes when it matriculates students into the program; those obligations include providing the students with the opportunity to complete the educational sequence at that institution. When an institution indicates its intent to terminate an accredited program, and if there will not be adequate resources for the program to meet its obligations to enrolled students and allow them to complete their training, the institution must assist students in a timely fashion in transferring to other accredited programs in order to complete their educational program. The Commission will assist students in transferring to other accredited programs; this assistance will be provided in cooperation with the institution that sponsors the closing program.

The program to which students transfer should be able to demonstrate that the finances, facilities, faculty and patient resources can accommodate the transferring students. Any major changes in program enrollment that would result from the transfer of students must be reported to the Commission by the receiving program(s) in accordance with the Commission’s policy for reporting major changes. Formal teach-out agreements must be developed with all institutions accepting transferring students to specify the conditions of the transfer. These agreements must ensure that the combined educational experiences meet the Commission’s accreditation standards. Such teach-out agreements must be submitted to the Commission as part of the phase-out plan.

When an educational program accredited by the Commission is terminated by the institution, students who are enrolled in the program at the time accreditation is discontinued, and who successfully complete the program, will be considered graduates of an accredited program. Students who transfer to another program and successfully complete that program will be considered graduates of the latter program. Such students will be considered graduates of an accredited program if the latter program is accredited during the time such students are enrolled. It will be the closing institution’s responsibility to ensure that appropriate student records and transcripts are maintained for future reference.

The Commission will take action to discontinue the institution’s accreditation at the appropriate time based on program length. The Commission has developed Guidelines for Submitting Teach-Out Reports by Institutions Terminating Commission-Accredited Educational Programs to assist institutions with preparing teach-out reports for the Commission. These guidelines are routinely distributed along with the Commission’s policy on Termination of Educational Programs.

Reaffirmed: 8/10, 7/07, 07/01, 12/92, 12/85, 12/79; Revised: 5/93

N. POLICY ON ADVERTISING

Any advertising pertaining to an educational program that is accredited by the Commission on Dental Accreditation must be clear and comprehensive, indicating the accrediting body by name and accurately specifying the scope of accreditation. Any reference to a specific aspect of the program and its length should indicate that accreditation standards for the respective discipline are met.

The Commission has authorized use of the following statement by institutions or programs that wish to announce their programmatic accreditation by the Commission. Programs that wish to advertise the specific programmatic accreditation status granted by the Commission may include that information as indicated in italics below (see text inside square brackets); that portion of the statement is optional but, if used, must be complete and current. The logo of the Commission on Dental Accreditation cannot be used alone without the following advertising statement. When used in electronic publications, the logo must link to the Commission website included in the statement.

The program(s) in (--discipline(s)--) is/are accredited by the Commission on Dental Accreditation.

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[and has/ have been granted the accreditation status(es) of (---X---)]. The Commission is a specialized accrediting body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL  60611-2678. The Commission’s web address is: http://www.ada.org/100.aspx.

In addition to the statement noted above, programs in Advanced Education in General Dentistry, General Practice Residency, and other areas of advanced general dentistry education must include the following statement in advertising materials:

The Commission on Dental Accreditation has accredited the postdoctoral program in (---education area---). However, this education area is not one of the American Dental Association’s recognized dental specialty areas. Therefore, dentists graduating from this program cannot announce that they are specialists, as recognized by the American Dental Association.

Reaffirmed: 8/10, 7/04, 7/00, 1/95; Revised: 7/09; Adopted: 12/83

O. POLICY STATEMENT ON PRINCIPLES OF ETHICS IN PROGRAMMATIC ADVERTISING AND STUDENT RECRUITMENT

All accredited dental and dental-related education programs, or individuals acting on their behalf, are expected to exhibit integrity and responsibility in programmatic advertising and student recruitment. Responsible self-regulation requires rigorous attention to principles of ethical practice. If the Commission determines that the institution or program has provided the public with incorrect or misleading information regarding the accreditation status of the program, the contents of reports of site team members, or the Commission’s accrediting actions with respect to the program, the program must provide public correction of this information to all possible audiences that received the incorrect information. The Commission must be provided with documentation of the steps taken to provide public correction. Other areas covered in this policy include, but are not limited to:

Advertising, Publications, and Promotional Literature

- Educational programs and services offered should be the primary emphasis of all advertisements, publications, promotional literature and recruitment activities.
- All statements and representations should be clear, factually accurate and current. Supporting information should be kept on file and be readily available for review.
- Catalogs and other official publications should be readily available and accurately depict:
  a. purpose and goals of the program(s);
  b. admission requirements and procedures;
  c. degree and program completion requirements;
  d. faculty, with degrees held and the conferring institution;
  e. tuition, fees, and other program costs including policies and procedures for refund and withdrawal; and
  f. financial aid programs.
- College catalogs and/or official publications describing career opportunities should provide clear and accurate information on the following, as applicable:
  a. national and/or state requirements for eligibility for licensure or entry into the occupation or profession for which education and training are offered;
  b. any unique requirements for career paths, or for employment and advancement opportunities in the profession or occupation; and

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c. differentiation between postdoctoral general dentistry programs and advanced education programs in the dental specialties recognized by the American Dental Association.

Student Recruitment for Admissions
- Student recruitment should be conducted by well-qualified admissions officers, faculty or trained volunteers whose credentials, purposes, and position or affiliation with the program and/or institution are clearly specified.
- Independent contractors or agents used by the program and/or institution for recruiting purposes should be governed by the same principles as institutional admissions officers and volunteers.
- Prospective students must be fully informed of program costs, available financial aid and repayment options.
- All catalogs and career materials should accurately describe the skills and competencies that students will need at the time of admission to the program. Options to accommodate students with lesser or greater skills, such as remediation or advanced standing programs, should be included in this description.
- If information about employment or career opportunities is included in an official publication, such information must be current and accurate.
- Accurate information must be provided regarding postdoctoral general dentistry education programs and advanced education programs in the dental specialties recognized by the American Dental Association.

Educational programs accredited by the Commission on Dental Accreditation should assume responsibility for informing the Commission office of improper or misleading advertising or unethical practices which come to their attention, so that the Commission may take appropriate steps to be sure the situation is rectified as quickly as possible.

Reaffirmed: 8/10, 7/09, 7/01; Revised: 7/04, 7/96; Adopted: 12/88

P. STAFF CONSULTING SERVICES

The staff of the Commission on Dental Accreditation is available for consultation to all educational programs which fall within the Commission’s accreditation purview. Educational institutions conducting programs oriented to dentistry are encouraged to obtain such staff counsel and guidance by written or telephone request. Consultation is provided on request prior to, as well as subsequent to, the Commission’s granting of accreditation to specific programs. The Commission expects to be reimbursed if substantial costs are incurred.

Reaffirmed: 8/10

Staff consultation to international programs or groups may also be available. All consultation services are provided in English, and if necessary, the program or group is responsible for costs associated with the use of interpreters. The schedule for international consultation activities must be arranged around staff primary responsibilities in the United States. International consultation trips should be long enough to allow ample time for staff to adjust to any time change. The program pays a consultation fee and all expenses associated with the consultation visit, including travel, hotel, and meals. U. S. State Department travel warnings and advisories are consulted prior to international travel and Commission staff will not provide consultation services in any location where staff is placed at risk. This includes but is not limited to locations where a U. S. State Department travel warning and/or travel alert is in effect.

Adopted: 8/11
Q. POLICY STATEMENT ON ACCREDITATION OF OFF-CAMPUS SITES

The Commission recognizes primary and off-campus sites as locations for student/resident educational experiences. Guidance regarding policy and procedures for each type of site follows.

**Primary site:** The sponsoring institutional site for an accredited program is the primary site. This site holds responsibility for clinical or didactic learning experiences that meet the accreditation standards for a specific program. The site further holds responsibility for the written agreement with off-campus sites to meet accreditation standards.

**Off-campus site:** A training site located away from the primary site. For students/residents in a specific program, an off-campus site could be their principal learning site. An off-campus site could be one of the following:

1. A site with which a written agreement is held with the sponsoring institution regarding off-campus learning experiences that meet accreditation standards.
2. A site owned/operated by the sponsoring institution that does not require a separate written agreement.

**Optional Enrichment/Optional Observation site:** A site utilized for the purposes of providing elective enrichment or observational experiences. Students/residents assigned to these sites are not evaluated on achieving program or accreditation requirements. Enrichment/observation sites may be used episodically by the institution to augment student/resident learning with experiences of only a few days for a student/resident. These sites do not require Commission approval. Examples of such activities include but are not limited to (1) short duration clinical experiences at hospitals, clinics, elementary or secondary schools, or community centers, and (2) clinical enriching experiences in private practice offices. Institutions must maintain an ongoing file of experiences obtained at enrichment/observation sites that documents each site’s name, address, phone, and clinical activity gained from offered experiences, and duration of the experience. This file will be reviewed at the institution’s accreditation site visit to ensure reporting meets Commission policy. The Commission may randomly select and visit enrichment/observation facilities during the site visit if necessary to verify reported information.

An institution may use one or more than one site to support student learning and meet CODA standards. Initiation of activities at the off-campus site as well as documentation and reporting of site activities is expected to follow the EOPP guidelines and accreditation standards.

The Commission on Dental Accreditation must be informed when a program accredited by the Commission plans to initiate an off-campus site (distance site and/or additional training site not located on the main campus). The Commission must be informed in writing site at least thirty (30) days prior to a regularly scheduled semi-annual Review Committee meeting. There may be extenuating circumstances when a special review is necessary. A program must receive Commission on Dental Accreditation approval of the off-campus site prior to recruiting students/residents and initiating use of the site.

Generally, only programs without reporting requirements will be approved to initiate educational experiences at off-campus sites. The Commission must ensure that the necessary education as defined by the standards is available, and appropriate resources (adequate faculty and staff, availability of patient experiences, and distance learning provisions) are provided to all students/residents enrolled in an accredited program. When the Commission has received notification that an institution plans to offer its accredited program at an off-campus site, the Commission will conduct a special focused site visit to each
off-campus location where a significant portion of each student’s/resident’s educational experience is provided, based on the specifics of the program, the accreditation standards, and Commission policies and procedures, or if other cause exists for such a visit as determined by the Commission.

A significant portion of each student’s/resident’s educational experience at an off-campus site is defined as any experience that impacts the program’s ability to meet a CODA standard. The program must report the rationale for adding an off-campus site and how that site affects the program’s goals, objectives, and outcomes. For example, program goals, objectives, and outcome measures may address institutional support, faculty support, curriculum, student didactic and clinical learning, research, and community service. The program must support the addition of an off-campus site with trends from pertinent areas of its outcomes assessment program that indicates the rationale for the additional site.

After the initial visit, each off campus site may be visited during the regularly scheduled CODA evaluation visit to the program.

Expansion of a developing dental hygiene and/or assisting program will only be considered after the program has demonstrated success by graduating the first class, measured outcomes of the academic program, and received approval without reporting requirements.

All programs accredited by the Commission pay an annual fee. Additional fees will be based on actual accreditation costs incurred during the visit to on and off-campus location. The Commission office should be contacted for current information on fees.

The Commission uses the following process when considering reports for adding off-campus sites. Program administrators have the option of consulting with Commission staff at any time during this process.

1. A program administrator submits the report at least thirty (30) days prior to a regularly scheduled Review Committee meeting.
2. Commission staff reviews the report to assess its completeness and to determine whether the change could impact the program’s potential ability to comply with the accreditation standards. If this is the case, the report is reviewed by the appropriate Review Committee for the discipline and by the Commission.
3. Receipt of the report and accompanying documentation is acknowledged in one of the following ways:
   a. The program administrator is informed that the report will be reviewed by the appropriate Review Committee and by the Commission at their next regularly scheduled meeting. Additional information may be requested prior to this review if the change is not well-documented; or
   b. The program administrator is informed that the reported change will be reviewed during the next site visit.
4. If the report will be considered by a Review Committee and by the Commission, the report is added to the appropriate agendas. The program administrator receives notice of the results of the Commission’s review.

The following alternatives may be recommended by Review Committees and/or be taken by the Commission in relation to the review of reports of addition of off-campus sites received from accredited educational programs.

- *Approve the addition of the off-campus site:* If the Review Committees or Commission does not
identify any concerns regarding the program’s continued compliance with the accreditation standards, the transmittal letter should advise the institution that the change has been noted and will be reviewed at the next regularly-scheduled site visit to the program.

- **Approve the addition of the off-campus site and direct a special focused site visit be conducted:** If a student/resident will receive a significant portion of the clinical training at this site or if other cause exists, a special focused site visit can be directed to ensure accreditation standards continue to be met. Also, if the information submitted with the initial request is insufficient to provide reasonable assurance that the accreditation standards will continue to be met, and the Commission believes that the necessary information can only be obtained on-site, a special focused site visit will be conducted.

- **Postpone action and continue the program’s accreditation status, but request additional information:** The transmittal letter will inform the institution that the report of the addition of the off-campus site has been considered, but that concerns regarding continued compliance with the accreditation standards have been identified. Additional specific information regarding the identified concerns will be requested for review by the Commission. The institution will be further advised that, if the additional information submitted does not satisfy the Commission regarding the identified concerns, the Commission reserves the right to request additional documentation, conduct a special focused site visit of the program, or deny the request. Use of the site is not permitted until Commission approval is granted.

- **Deny the request:** If the submitted information does not indicate that the program will continue to comply with the accreditation standards, the Commission will deny the request for the addition of off-campus sites. The institutions will be advised that they may re-submit the request with additional information if they choose.

Revised: 2/13, 2/12, 8/10, 7/09, 7/07; Reaffirmed: 2/02, 1/06; Adopted: 07/98

**R. POLICY ON DISTANCE EDUCATION**

The Commission’s accreditation standards have been stated, purposefully, in terms which allow flexibility, innovation and experimentation. Regardless of the method(s) used to provide instruction, the Commission expects that each accredited program will comply with the accreditation standards.

Distance education means education that uses one or more of the technologies listed below to deliver instruction to students who are separated from the instructor and to support regular and substantive interaction between the students and the instructor, either synchronously or asynchronously. The technologies may include:

- the internet;
- one-way and two-way transmissions through open broadcast, closed circuit, cable, microwave, broadband lines, fiber optics, satellite, or wireless communications devices;
- audio conferencing; and/or
- video cassettes, DVDs, and CD–ROMs, if the cassettes, DVDs, or CD–ROMs are used in a course in conjunction with any of the technologies listed above.

Revised: 8/10

**1. Student Identity Verification Requirement For Programs That Have Distance Education Sites:**

Programs that offer distance education must have processes in place through which the program establishes that the student who registers in a distance education course or program is the same student who participates in and completes the course or program and receives the academic credit. Programs must verify the identity of a student who participates in class or coursework by using, at the option of the program, methods such as a secure login and pass code; proctored examinations; and/or new or other

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technologies and practices that are effective in verifying student identity. The program must make clear in writing that processes are used that protect student privacy and programs must notify students of any projected additional student charges associated with the verification of student identity at the time of registration or enrollment.

Adopted: 8/10

S. POLICY ON INSTITUTIONS OFFERING BOTH ACCREDITED AND NON-ACCREDITED PROGRAMS IN DENTAL ASSISTING AND DENTAL LABORATORY TECHNOLOGY

Institutions offering both accredited programs and non-accredited programs, which are more limited in scope (other than continuing education programs) in dental assisting or dental laboratory technology, have an obligation to explain program differences to potential students and the community. Therefore, any information publicizing the institution’s programs should indicate which programs are accredited by the Commission.

Because establishment of a non-accredited program may dilute the instructional resources available for the accredited program, the Commission reserves the right to request information about a non-accredited program and its relationship to the accredited program. Institutions offering a non-accredited program (other than continuing education) must provide information related to the program through the appropriate annual survey.

Institutions planning to offer such a program must provide information about the program and its relationship to the accredited program in compliance with the Commission's policy on reporting major program changes.

Reaffirmed: 8/10, 7/07, 7/01, 12/90, 12/85

T. POLICY ON PERSONALLY IDENTIFIABLE STUDENT INFORMATION

On behalf of the Commission on Dental Accreditation, the American Dental Association’s Survey Center annually collects data from each accredited dental, advanced dental and allied dental education program. As a specialized accrediting agency recognized by the United States Department of Education, the Commission is required to monitor accredited programs’ compliance with accreditation standards and established policies related to enrollment, diversity, student achievement and program outcomes. Data, which includes some personally identifiable student information, is collected via the annual surveys and is utilized to assist the Commission in meeting these requirements.

National aggregate data collected via the annual surveys is reported and published by the ADA Survey Center in the Annual Reports on Dental Education, Advanced Dental Education and Allied Dental Education. Data specific to an accredited program is reported in a summary data profile which is made available to a program and a visiting committee prior to a site visit.

Individual student identifiers such as the dental personal identification number (DENTPIN), gender, race or grade point average are not used in the site visit process or in any published reports. However, this information is used by the Commission in data verification procedures, e.g. determining if an individual student has been inadvertently listed and counted more than once, impacting summary data. For some advanced education programs with enrollment restrictions, this information is essential for determining compliance with accreditation standards.

The Commission and the ADA Survey Center recognize their responsibility to collect personally
identifiable student information solely for accreditation purposes and their obligation to preserve the confidential nature of the information. This information is not released to the public.

Revised: 8/10; Reaffirmed: 7/06; Adopted: 7/00

U. POLICY ON COMBINED CERTIFICATE AND DEGREE PROGRAMS IN ADVANCED DENTAL EDUCATION

The Commission supports the principle that postdoctoral education programs culminate with the awarding of a certificate attesting to successful completion of an accredited program. Further, such certificates indicate fulfillment of educational requirements and are recognized as meeting eligibility requirements for ethical announcement of limitation of practice and examination by the dental specialty certifying boards.

The Commission expects that postdoctoral programs leading to the awarding of a certificate and an academic degree, (M.S. or Ph.D. degree), will be conducted in compliance with standards stipulated by the graduate school. Graduate level academic degrees must maintain the level of excellence, quality controls and academic standards established by the graduate school of the university. The Commission further expects that the requirements for research projects and theses will demonstrate a scholarly effort. It is recognized that completion of the educational requirements, as stipulated in the accreditation standards on advanced education training and the academic degree requirements of a graduate school, may require an additional year of training devoted primarily to research and theses completion.

Reaffirmed: 8/10, 7/07, 7/01; CODA: 12/76:2

V. QUALIFICATIONS OF A PROGRAM DIRECTOR FOR A COMBINED ADVANCED EDUCATION PROGRAM

When an institution sponsors a combined advanced education program, (e.g. orthodontics and dentofacial orthopedics/pediatric dentistry or orthodontics and dentofacial orthopedics/periodontics), it is most desirable that the program director be qualified according to Standard 2 of the accreditation standards in all areas involved in the combined program. At a minimum, the program director must be qualified (i.e. board certified by an ADA recognized certifying board or grandfathered) in one of the involved areas and educationally trained (i.e. completed a Commission-accredited advanced specialty education program) in the other involved areas. Board certification is to be active and applies to an interim/acting program director as well.

Reaffirmed: 8/10, 7/07

W. POLICY ON REGARD FOR DECISIONS OF STATES AND OTHER ACCREDITING AGENCIES

The Commission takes into account decisions made by other recognized accrediting or state agencies. If the Commission determines that an institution sponsoring an accredited program or a program seeking accreditation is the subject of an interim action or threatened loss of accreditation or legal authority to provide postsecondary education, the Commission will act as follows.

If a recognized institutional accrediting agency takes adverse action with respect to the institution offering the program or places the institution on public probationary status, the Commission will promptly review its accreditation of the program to determine if it should take adverse action against the program.

The Commission does not renew the accreditation status of a program during any period in which the
institution offering the program

- Is the subject of an interim action by a recognized institutional accrediting agency potentially leading to the suspension, revocation, or termination of accreditation or pre-accreditation;
- Is the subject of an interim action by a state agency potentially leading to the suspension, revocation, or termination of the institution's legal authority to provide postsecondary education;
- Has been notified of a threatened loss of accreditation, and the due process procedures required by the action have not been completed; and/or
- Has been notified of a threatened suspension, revocation, or termination by a state of the institution's legal authority to provide postsecondary education, and the due process procedures required by the action have not been completed.

In considering whether to grant initial accreditation to a program, the Commission takes into account actions by:

- Recognized institutional accrediting agencies that have denied accreditation or pre-accreditation to the institution offering the program, placed the institution on public probationary status, or revoked the accreditation or pre-accreditation of the institution; and
- State agency that has suspended, revoked, or terminated the institution's legal authority to provide postsecondary education.

If the Commission grants accreditation to a program notwithstanding its actions described above, the Commission will provide to the USDE Secretary, within 30 days of granting initial or continued accreditation, a thorough explanation, consistent with the accreditation standards, why the previous action by a recognized institutional accrediting agency or the state does not preclude the Commission's grant of accreditation. The Commission’s review and explanation will consider each of the findings of the other agency in light of its own standards.

Revised: 5/12; Reaffirmed: 8/10, 7/07, 7/01; Revised: 7/96; 12/88

X. COMMENTS ON POLICY PROPOSED AND/OR ADOPTED BY PARTICIPATING ORGANIZATIONS

The Commission may provide comments on another organization’s proposed policy, procedures, or other documents as part of that organization’s review and comment period when requested.

Reaffirmed: 8/10, 7/09; Revised: 1/03; CODA: 05/93:10

Y. POLICY ON RESIDENT DUTY HOURS RESTRICTIONS

The Commission on Dental Accreditation (CODA) acknowledges the revised resident duty-hours and supervision requirements of the Accreditation Council for Graduate Medical Education (ACGME). Recognized by the United States Department of Education, the Commission is the specialized programmatic accreditor for dental and dental-related programs. Institutions in which both graduate medical education residencies and advanced dental education programs reside may determine that CODA-accredited programs should comply with ACGME standards. It is the policy of the Commission that the institution should consider the accreditation standards of the Commission on Dental Accreditation for hospital-based dental residency programs and consider whether the ACGME requirements are in the best interests of patient safety, resident education and the CODA-accredited programs.

Adopted: 8/11
Z. POLICY ON CUSTOMIZED SURVEY DATA REQUESTS

Periodically, the Commission receives requests for data collected in the annual surveys of accredited dental education programs from the communities of interest. The nature and scope of a request will determine whether approval of the Commission and the ADA Officers or the ADA Board of Trustees must be attained. For all types of requests, a “Survey Data Request Form” must be submitted to the Director of the Commission, who will consult with the ADA Survey Center or appropriate ADA agency regarding the potential for supplying requested data. This form is available upon request from the Commission office or the ADA Survey Center. Examples of potential requesting parties include member and non-member dentists; other dental professionals; deans, dental faculty and affiliates of dental education programs; non-profit dental organizations; researchers; and government officials (Federal and state). Granting the request is at the sole discretion of the ADA.

Requests which can be approved directly through the ADA Division of Education and Professional Services involve non-confidential and non-commercial data and include:

- Data that are collected in the annual surveys and are available publicly, but presented in a different way than the published report (e.g., broken down by certain characteristics, by individual school/program, and/or for a specific trend period).
- Data that are collected in different surveys and published in different reports, grouped together in a single report.

Survey data will not be provided for the following types of requests:

- Requests made for data from surveys that are still in the data collection or analysis phase. Custom data requests cannot be fulfilled if the corresponding published report has not yet been released.
- Confidential data (e.g., financial data; curriculum/patient care figures collected from advanced programs; protected student information).
- Requests at a level of granularity which would compromise confidentiality of the survey respondents.
- Requests that involve reproduction in a publication of any sort, appear to be for the purpose of monetary gain, or used in some type of litigation or for questionable motives.
- The scope of the request exceeds the Survey Center’s workload capacity.

Additional requirements:

- Requests will be granted only in the following output formats used by the Survey Center: Word, PDF, Excel, and certain SAS output types.
- Fees are charged based on a time estimate to complete the request, with a one-hour minimum. The Commission office should be contacted for current fees and rates.
- A formal agreement specifying the permitted use of the data is required before the Survey Center will act on the request.

Adopted: 8/11

AA. POLICY ON REQUESTS FOR EMAIL DISTRIBUTION LISTS

Periodically, the Commission receives requests for email distribution lists from the communities of interest. The nature and scope of a request will determine whether the Commission will be able to comply with the request. For all types of requests, an “Email Distribution List Form” must be submitted to the Director of the Commission, who will consult with CODA staff regarding the potential for supplying the requested lists based on staff workload capacity. This form is available upon request from the
Commission office. Examples of potential requesting parties include member and non-member dentists; other dental professionals; deans, dental faculty and affiliates of dental education programs; non-profit dental organizations; researchers; and government officials (Federal and state). Email distribution lists will not be supplied to commercial interests. Granting the request is at the sole discretion of the Commission.

Additional requirements:
- Requests will be granted only in the following output formats used by the Commission: Word or Excel.
- Fees are charged based on a time estimate to complete the request, with a minimum fee of $200.00. The Commission office should be contacted for current fees and rates.
- A formal agreement specifying the permitted use of the data is required before the Commission will act on the request.

Adopted: 8/12

V. COMPLAINTS

A. DEFINITION

A complaint is defined by the Commission on Dental Accreditation as one alleging that a Commission-accredited educational program, a program which has an application for initial accreditation pending, or the Commission may not be in substantial compliance with Commission standards or required accreditation procedures.

B. PROGRAM REQUIREMENTS AND PROCEDURES

NOTICE OF OPPORTUNITY TO FILE COMPLAINTS: In accord with the U.S. Department of Education’s Criteria and Procedures for Recognition of Accrediting Agencies, the Commission requires accredited programs to notify students of an opportunity to file complaints with the Commission.

Each program accredited by the Commission on Dental Accreditation must develop and implement a procedure to inform students of the mailing address and telephone number of the Commission on Dental Accreditation. The notice, to be distributed at regular intervals, but at least annually, must include but is not necessarily limited to the following language:

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 1-800-621-8099 extension 4653.

The accredited program must retain in its files information to document compliance with this policy so that it is available for review during the Commission's on-site reviews of the program.

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REQUIRED RECORD OF COMPLAINTS: The program must maintain a record of student complaints received since the Commission’s last comprehensive review of the program.

At the time of a program’s regularly scheduled on-site evaluation, visiting committees evaluate the program’s compliance with the Commission’s policy on the Required Record of Complaints. The team reviews the areas identified in the program’s record of complaints during the site visit and includes findings in the draft site visit report and note at the final conference.

Reaffirmed: 8/10, 7/09, 7/08, 7/04, 7/01, 7/96; Revised: 2/13, 8/02, 1/9; CODA: 01/94:6 4

C. COMMISSION LOG OF COMPLAINTS

A log is maintained of all complaints received by the Commission. A central log related to each complaint is maintained in an electronic data base. Detailed notes of each complaint and its disposition are also maintained in individual program files.

Revised: 8/10, 7/06, 7/02, 7/00, 7/96; CODA: 01/95:5

D. POLICY AND PROCEDURE REGARDING INVESTIGATION OF COMPLAINTS AGAINST EDUCATIONAL PROGRAMS

The following policy and procedures have been developed to handle the investigation of complaints about an accredited program, or a program which has a current application for initial accreditation pending, which may not be in substantial compliance with Commission standards or established accreditation policies.

Formal complaint is defined as a complaint filed in written (or electronic) form and signed by the complainant. This complaint should outline the specific policy, procedure or standard in question and rationale for the complaint, including specific documentation or examples. Complainants who submit complaints verbally will receive direction to submit a formal complaint to the Commission in written, signed form following guidelines in the EOPP manual guidelines. Anonymous comment will be added to the respective program’s file for evaluation during the institution’s next scheduled accreditation site visit, if received outside than the 60-day reporting timeframe prescribed by the Commission’s Third Party Comment Policy.

1. Investigative Procedures: The Commission will consider only formal, written, signed complaints; oral and unsigned complaints will not be considered. Students, faculty, constituent dental societies, state boards of dentistry, and other interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding any Commission accredited dental, allied dental or advanced dental education program, or a program that has an application for initial accreditation pending. An appropriate complaint is one that directly addresses a program’s compliance with the Commission’s standards, policies and procedures. The Commission is interested in the continued improvement and sustained quality of dental and dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for treatment received by patients or individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

In accord with its responsibilities to determine compliance with accreditation standards, policies, and procedures, the Commission does not intervene in complaints as a mediator but maintains, at all times, an investigative role. This investigative approach to complaints does not require that the complainant be
identified to the program.

The Commission, upon request, will take every reasonable precaution to prevent the identity of the complainant from being revealed to the program; however, the Commission cannot guarantee the confidentiality of the complainant.

Only written, signed complaints will be considered by the Commission; oral and unsigned complaints will not be considered. The Commission strongly encourages attempts at informal or formal resolution through the program's or sponsoring institution's internal processes prior to initiating a formal complaint with the Commission. The following procedures have been established to manage complaints:

When an inquiry about filing a complaint is received by the Commission office, the inquirer is provided a copy of the Commission’s Evaluation and Operational Policies and Procedures Manual which includes the policies and procedures for filing a complaint and the appropriate accreditation standards document.

The initial screening is usually completed within thirty (30) days and is intended to ascertain that the potential complaint relates to a required accreditation policy or procedure (i.e. one contained in the Commission’s Evaluation and Operational Policies and Procedure Manual) or to one or more accreditation standard(s) or portion of a standard which have been or can be specifically identified by the complainant.

Written correspondence clearly outlines the options available to the individual. It is noted that the burden rests on the complainant to keep his/her identity confidential. If the complainant does not wish to reveal his/her identity to the accredited program, he/she must develop the complaint in such a manner as to prevent the identity from being evident. The complaint must be based on the accreditation standards or required accreditation procedures. Submission of documentation which supports the noncompliance is strongly encouraged.

When a complainant submits a written, signed statement describing the program’s noncompliance with specifically identified policy(ies), procedure(s) or standard(s), along with the appropriate documentation, the following procedure is followed:

1. The materials submitted are entered in the Commission’s database and the program’s file and reviewed by Commission staff.
2. Legal counsel, the Chairperson of the appropriate Review Committee, and the applicable Review Committee members may be consulted to assist in determining whether there is sufficient information to proceed.
3. If the complaint provides sufficient evidence of probable cause of noncompliance with the standards or required accreditation procedures, the complainant is so advised and the complaint is investigated using the procedures in the following section, formal complaints.
4. If the complaint does not provide sufficient evidence of probable cause of noncompliance with the standard(s) or required accreditation policy(ies), or procedure(s), the complainant is so advised. The complainant may elect:
   a. to revise and submit sufficient information to pursue a formal complaint; or
   b. not to pursue the complaint. In that event, the decision will be so noted and no further action will be taken.

Initial investigation of a complaint may reveal that the Commission is already aware of the program’s noncompliance and is monitoring the program’s progress to demonstrate compliance. In this case, the complainant is notified that the Commission is currently addressing the noncompliance issues noted in the
2. **Formal Complaints**: Formal complaints (as defined above) are investigated as follows:

1. The complainant is informed in writing of the anticipated review schedule.

2. The Commission informs the chief administrative officer (CAO) of the institution sponsoring the accredited program that the Commission has received information indicating that the program’s compliance with specific required accreditation policy(ies), procedure(s) or designated standard(s) has been questioned.

3. Program officials are asked to report on the program’s compliance with the required policy(ies), procedure(s) or standard(s) in question by a specific date, usually within thirty (30) days.
   a. For standard(s)-related complaints, the Commission uses the questions contained in the appropriate sections of the self-study to provide guidance on the compliance issues to be addressed in the report and on any documentation required to demonstrate compliance.
   b. For policy(ies) or procedure(s)-related complaints, the Commission provides the program with the appropriate policy or procedural statement from the Commission’s Evaluation and Operational Policies and Procedures Manual. Additional guidance on how to best demonstrate compliance will be provided to the program. The Chairperson of the appropriate Review Committee and/or legal counsel may assist in developing this guidance.

4. Receipt of the program’s written compliance report, including documentation, is acknowledged.

5. The appropriate Review Committee and the Commission will investigate the issue(s) raised in the complaint and review the program’s written compliance report at the next regularly scheduled meeting. In the event that waiting until the next meeting would preclude a timely review, the appropriate Review Committee(s) will review the compliance report in a telephone conference call(s). The action recommended by the Review Committee(s) will be forwarded to the Commission for mail ballot approval in this later case.

6. The Commission may act on the compliance question(s) raised by the complaint by:
   a. determining that the program continues to comply with the policy(ies), procedure(s) or standard(s) in question and that no further action is required.
   b. determining that the program may not continue to comply with the policy(ies), procedure(s) or standard(s) in question and going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require an on-site review.
      i. If by written report: The Commission will describe the scope and nature of the problem and set a compliance deadline and submission date for the report and documentation of corrective action taken by the program.
      ii. If by on-site review: The Commission will describe the scope and nature of the problem and determine, based on the number and seriousness of the identified problem(s), whether the matter can be reviewed at the next regularly scheduled on-site review or whether a special on-site review will be conducted. If a special on-site review is required, the visit will be scheduled and conducted in accord with the Commission's usual procedures for such site visits.
   c. determining that a program does not comply with the policy(ies), procedure(s) or standards(s) in question and:
      i. changing a fully-operational program’s accreditation status to “approval with reporting requirements”
      ii. going on to determine whether the corrective action the program would take to come into full compliance could be documented and reported to the Commission in writing or would require
E. POLICY AND PROCEDURES ON COMPLAINTS DIRECTED AT THE COMMISSION ON DENTAL ACCREDITATION

Interested parties may submit an appropriate, signed complaint to the Commission on Dental Accreditation regarding Commission policy(ies), procedure(s) or the implementation thereof. The Commission will determine whether the information submitted constitutes an appropriate complaint and will follow up according to the established procedures.

Procedures:
1. Within two (2) weeks of receipt, the Commission will acknowledge the received information and provide the complainant with the policy(ies) and procedure(s).
2. The Commission will collect additional information internally, if necessary, and then conduct an initial screening to determine whether the complaint is appropriate. The initial screening is completed within thirty (30) days.
3. The Commission will inform the complainant of the results of the initial screening.
4. If the complaint is determined to be appropriate, the Commission and appropriate committees will consider the complaint at its next regularly scheduled meeting. The complaint will be considered in closed session if the discussion will involve specific programs or institutions; otherwise, consideration of the complaint will occur in open session. In the event that waiting until the next meeting would preclude a timely review, the appropriate committee(s) will review the complaint in a telephone conference call(s). The action recommended by the committees will be forwarded to the Commission for mail ballot approval in this later case.
5. The Commission will consider changes in its policies and procedures, if indicated.
6. The Commission will inform the complainant of the results of consideration of the complaint within
two (2) weeks following the meeting or mail balloting of the Commission.
Reaffirmed: 8/10, 7/09, 7/04; Revised: 1/98; Adopted: 7/96

VI. DUE PROCESS

The Commission makes every effort to protect the due process rights of institutions and programs and follow ethical accrediting practices. Because due process is a necessary and integral part of accreditation, the Commission builds due process measures into various aspects of the accreditation process. For example, the Commission sends a copy of the site visit report to the institution for review prior to action by the Commission and encourages the institution to prepare a response to the report.

Adverse actions, or those that may be appealed, are defined as those related to denial or withdrawal of accreditation. Such decisions become final fourteen (14) days after the date on the transmittal letter or when any appeal has been resolved. The Commission has procedures in place to provide notice of the reasons for taking an adverse accreditation action. Such procedures are required in order for accrediting agencies to comply with U.S. Department of Education's Criteria and Procedures for Recognition of Accrediting Agencies. Notice of “intent to withdraw” accreditation at a subsequent meeting is also sent by certified/tracked mail within fourteen (14) days. (See “Notice of Accreditation Actions to Programs/Institutions” for more information.)

The following segments describe the Commission’s due process practices and indicate the sequence of events that is typically followed when such procedures are needed.

A. DUE PROCESS RELATED TO SITE VISIT REPORTS

The most frequent way in which the Commission’s policies and procedures provide due process to an institution is the opportunity that is always provided to an institution to review and to respond to the site visit report prior to the Commission on Dental Accreditation taking an accreditation action. Due process related to site visit reports is provided in the following three stages:

First, the institution is provided with a copy of the draft site visit report. The site visit committee approves the draft site visit report which is then forwarded to the institution for review and comment.

Second, the institution is provided with an opportunity to respond to the draft report. The institution may respond in three ways. The response may address:
- factual inaccuracies;
- differences in perception with the visiting committee; and/or
- progress made subsequent to the site visit to implement recommendations cited in the report.

This institutional response must be transmitted to the Commission within the specified time, up to thirty (30) days from the time the report is sent to the institution. Factual inaccuracies noted in the report are corrected. In addition, the Commission considers any responses related to differences in perception and any reported progress in implementing recommendations contained in the report before it grants the accreditation status.

A third opportunity for due process may occur after the institution has submitted its initial response to the site visit report. An institution may provide supplemental information regarding implementation of
recommendations in the site visit report. Any supplemental information must be submitted prior to December 1 for consideration at the winter Commission meeting and June 1 for consideration at the summer Commission meeting. Such supplemental information is also considered by the Commission prior to reaching an accreditation decision.

Reaffirmed: 8/10

B. DUE PROCESS RELATED TO PROGRESS REPORTS

Another due process option is available to a program when an accreditation status of “approval with reporting requirements” has been granted. The option involves further consideration at a subsequent regularly scheduled meeting of the Commission.

The institution/program must submit a progress report at the time specified in the Commission’s transmittal letter, i.e., the following meeting six months later. All reported progress is considered by the Commission in determining the accreditation status. When a progress report is submitted, the specific instructions for preparing the report must be followed. The signature of the chief administrative officer of the sponsoring institution must be included with the report.

Reaffirmed: 8/10

C. DUE PROCESS RELATED TO REVIEW COMMITTEE SPECIAL APPEARANCES

An institution/program may request a special appearance (hearing) in order to supplement the written information about a program which has already been provided to the appropriate Review Committee. A representative of the institution would be permitted to appear in person before the Review Committee to present this additional information. Although this is not a routine practice, such appearances occur prior to the Review Committee’s consideration of the program’s accreditation classification. When such a special appearance is desired, a written request should be made to the Director of the Commission thirty (30) days prior to the meeting. The Chairperson and Director of the Commission will determine the disposition of the request and inform the requestor of the date, hour and amount of time that will be allocated for the appearance.

If the requestor wishes to submit additional written materials, copies for each Review Committee member should be provided by the requestor prior to the meeting. The committee will make a recommendation to the Director and Chairperson of the Commission and indicate whether an appearance before the full Commission is appropriate. The institution’s representative(s) may attend the committee or Commission meeting only during the time assigned for the hearing.

The Commission and its Review Committees permit special appearances using the following guidelines:

- The Review Committee will discuss the report of the program/institution prior to the appearance of the representative(s).
- The Review Committee Chairperson will introduce members of the Review Committee to the program/institutional representative.
- The Chairperson will restate to the representative(s) the amount of time allocated for the hearing.
- The representative is invited to make an opening statement and to provide materials and information, if any, which supplement the written report which was distributed to Review Committee members prior to the meeting.
- Following the presentation by the representative, the Chairperson allows members of the Review Committee to ask questions. Although primary and secondary reviewers are assigned primary
responsibility for questioning, all Review Committee members have the opportunity to participate in the discussion.

- The Chairperson thanks the representative for appearing before the Review Committee and the representative leaves.
- The Review Committee discusses the recommended action.
- Commission staff notifies the representative of the Review Committee’s recommendation. If the Review Committee’s recommendation is to deny or withdraw accreditation, the institution’s representation has the opportunity to have a hearing with the Commission on a subsequent day.
- In general, special appearances before the Commission also follow the process listed above.

Reaffirmed: 8/10; Revised: 7/06, 1/00, 5/93, 1991, 1983; Adopted: 1977

D. DUE PROCESS RELATED TO APPEAL OF ACCRETIDATION STATUS DECISIONS

An institution/program may request a special appearance (hearing) before the appropriate Review Committee in order to supplement the written information about the program which has already been provided to the Review Committee. New information regarding correction of deficiencies subsequent to the site visit and/or progress report, or subsequent to transmission of the program’s response to the site visit and/or progress report, may be presented. A representative of the institution would be permitted to appear in person before the Review Committee to present this additional information.

When such a special appearance is desired, a written request should be made to the Director of the Commission thirty (30) days prior to the Review Committee meeting. The Chairperson and Director of the Commission will determine the disposition of the request and inform the requestor of the date, hour and amount of time that will be allocated for the appearance. The institution’s representative(s) may attend the Review Committee meeting only during the time assigned for the hearing. If the requestor wishes to submit additional written materials, copies for each Review Committee member should be provided by the requestor prior to the meeting.

If the Review Committee’s accreditation status recommendation to the Commission is “approval with reporting requirements,” or “approval with reporting requirements-intent to withdraw,” the Review Committee will make a recommendation to the Director and Chairperson of the Commission and indicate whether an appearance before the full Commission is appropriate. Representatives of the institution may present arguments that the Review Committee made an error in judgment, based on the information available, in making the accreditation status recommendation. During this special appearance before the Commission, no new information regarding correction of deficiencies subsequent to the Review Committee special appearance may be presented. The institution’s representative(s) may attend the Commission meeting only during the time assigned for the hearing.

If the Commission determines the program accreditation status is “approval with reporting requirements,” or “approval with reporting requirements-intent to withdraw,” and the institution/program believes that the Commission has made an error in judgment regarding accreditation status, a special appearance (hearing) before the Commission may be requested thirty (30) days prior to the Commission meeting. The special appearance (hearing) before the Commission would be held at the next regularly scheduled meeting. At the hearing, representatives of the institution may present arguments that the Commission, based on the information available when the decision was made, made an error in judgment in determining the accreditation status of the program. Under these circumstances, no new information regarding correction of deficiencies subsequent to the site visit and previous Commission meeting may be presented. The institution’s representative(s) may attend the Commission meeting only during the time
assigned for the hearing.

The decision of the Commission on the accreditation status of the program after this special appearance is final.

Reaffirmed: 8/10

E. DUE PROCESS RELATED TO DENIAL OF INITIAL ACCREDITATION

An institution/program may request a special appearance (hearing) before the appropriate Review Committee in order to supplement the written information about the program which has already been provided to the Review Committee. New information regarding correction of deficiencies subsequent to the site visit, or subsequent to transmission of the program’s response to the site visit report, may be presented. A representative of the institution would be permitted to appear in person before the Review Committee to present this additional information.

When such a special appearance is desired, a written request should be made to the Director of the Commission thirty (30) days prior to the Review Committee meeting. The Chairperson and Director of the Commission will determine the disposition of the request and inform the requestor of the date, hour and amount of time that will be allocated for the appearance. The institution’s representative(s) may attend the Review Committee meeting only during the time assigned for the hearing. If the requestor wishes to submit additional written materials, copies for each committee member should be provided by the requestor prior to the meeting.

If the Review Committee’s recommendation to the Commission is to deny initial accreditation, the Review Committee will make a recommendation to the Director and Chairperson of the Commission and indicate whether an appearance by the program before the full Commission is appropriate. If so, representatives of the institution may present arguments that the Review Committee made an error in judgment, based on the information available, in making its recommendation to deny initial accreditation. During this special appearance before the Commission, no new information regarding correction of deficiencies subsequent to the Review Committee special appearance may be presented. The institution’s representative(s) may attend the Commission meeting only during the time assigned for the hearing. If a program is denied accreditation by the Commission, reasons for the denial are provided. Because denial of accreditation is defined as an adverse action, notice of such decisions occurs within fourteen (14) days and is sent by certified/tracked mail.

If the Review Committee recommendation to the Commission is to grant initial accreditation and the Commission subsequently denies initial accreditation, reasons for the denial are provided. Because denial of accreditation is defined as an adverse action, notice of such decisions occurs within fourteen (14) days and is sent by certified/tracked mail.

In both circumstances outlined above the program has the opportunity, at the next regularly scheduled Commission meeting, to present additional information to the Commission through the appropriate Review Committee, following the special appearance procedures outlined above. Such a request for a hearing automatically stays the Commission’s decision. When a program has been denied initial accreditation and requests a stay of that decision, no additional application fee will be assessed. Should a program choose to reapply, rather than request a stay of the Commission’s decision, a second application fee must be submitted with the program’s reapplication.

If, following reconsideration, the Commission again denies accreditation to the program, the program will
be notified of its right to appeal this decision to the Appeal Board.

Programs also have the right, after initial accreditation is denied by the Commission the FIRST time, to appeal this decision to the Appeal Board. If the Appeal Board sustains the decision of the Commission, the program forfeits the right to present additional information to the Commission through the appropriate Review Committee as outlined above.

Reaffirmed: 8/10

F. DUE PROCESS RELATED TO WITHDRAWAL OF ACCREDITATION

An institution/program may request a special appearance (hearing) before the appropriate Review Committee in order to supplement the written information about the program which has already been provided to the Review Committee. New information regarding correction of deficiencies subsequent to the site visit and/or progress report, or subsequent to transmission of the program’s response to the site visit and/or progress report, may be presented. A representative of the institution would be permitted to appear in person before the Review Committee to present this additional information.

When such a special appearance is desired, a written request should be made to the Director of the Commission thirty (30) days prior to the Review Committee meeting. The Chairperson and Director of the Commission will determine the disposition of the request and inform the requestor of the date, hour and amount of time that will be allocated for the appearance. The institution’s representative(s) may attend the Review Committee meeting only during the time assigned for the hearing. If the requestor wishes to submit additional written materials, copies for each Review Committee member should be provided by the requestor prior to the meeting.

If the Review Committee’s recommendation to the Commission is to withdraw accreditation, the Commission will notify the institution of the proposed action and the date of the Commission meeting at which the Review Committee’s recommendation will be considered. This notification will advise the institution of its right to provide additional information for the Commission to consider prior to reaching a decision on the proposed action. Any additional information must be submitted in writing and should include any reasons why the institution believes that the withdrawal of accreditation is unjustified.

If the Commission determines that accreditation should be withdrawn, the program will be notified within fourteen (14) days and the notification is sent by certified/tracked mail. The program is also notified of its right to appeal this decision to the Appeal Board.

Reaffirmed: 8/10

G. FUNCTION AND PROCEDURES OF THE APPEAL BOARD

The principal function of the Appeal Board is to determine whether the Commission on Dental Accreditation, in arriving at a decision regarding the withdrawal or denial of accreditation for a given program, has properly applied the facts presented to it. In addition, the Commission’s Rules stipulate that the Appeal Board shall provide the educational program filing the appeal the opportunity to be represented by legal counsel and shall give the program the opportunity to offer evidence and argument in writing and/or orally to try to refute or overcome the findings and decision of the Commission.

Reaffirmed: 8/10

1. Appeal Board: The four (4) permanent members of the Appeal Board include: one (1) representative selected by the American Dental Association, one (1) representative selected by the American
Association of Dental Boards, one (1) representative selected by the American Dental Education Association and one (1) consumer representative selected by the Commission on Dental Accreditation. Representatives from allied or advanced education areas may also be included on the Appeal Board, depending on the nature of the appeal. Appeal Board members do not concurrently serve on the Commission.

The Appeal Board is an autonomous body, separate from the Commission. Costs related to appeal procedures will be underwritten, whenever possible, by the institution and the Commission on a shared cost basis.

Reaffirmed: 8/10

2. Selection Criteria For Appeal Board Members: The Appeal Board Member shall not be:
   • a current member of a dental or allied dental faculty*;
   • an employee, member of the governing board, owner, shareholder of, or consultant to, a program that either is accredited by the Commission on Dental Accreditation or has applied for initial accreditation*; and
   • spouse, parent, child, or sibling of an individual identified above;
   • current member of the Commission; and/or
   • an individual who has participated in any step of the process leading up to the decision that is being appealed (e.g. member of the visiting committee, member of Review Committee, etc.).

The Appeal Board Member shall:
   • be willing to participate as a member of the appellate body should it be convened; and
   • be willing to comply with all Commission policies and procedures (e.g., Agreement of Confidentiality; Conflict of Interest Policy; and Professional Conduct Policy and Prohibition Against Harassment).

*Discipline-specific representatives from allied or advanced education areas can be a program director, faculty member or practitioner.

Reaffirmed: 8/10; Revised: 2/13

3. Appeal Procedures: If a program has been denied accreditation or if its accreditation has been withdrawn, the following appeal procedures are followed:
   1. Within fourteen (14) days after the institution’s receipt of notification of the Commission on Dental Accreditation’s decision to deny or withdraw accreditation, the program may file a written request of appeal to the Director of the Commission. If a request of appeal is not made, the Commission’s proposed decision will automatically become final and the appropriate announcement will be made.
   2. If a request of appeal is received, the Director of the Commission shall acknowledge receipt of the request and notify the program of the date of the appeal hearing. The appeal date shall be within sixty (60) days after the appeal has been filed.
   3. The program filing the appeal may be represented by legal counsel in addition to the program administrator or other program representatives.
   4. Legal counsel of the American Dental Association will be available to members of the Appeal Board upon request.
   5. No new information regarding correction of the deficiencies may be presented with the exception of review of new financial information if all of the following conditions are met: (i) The financial information was unavailable to the institution or program until after the decision subject to appeal was made. (ii) The financial information is significant and bears materially on the financial deficiencies
identified by the Commission. The criteria of significance and materiality are determined by the Commission. (iii) The only remaining deficiency cited by the Commission in support of a final adverse action decision is the institution’s or program’s failure to meet the Commission’s standard pertaining to finances. An institution or program may seek the review of new financial information described in this section only once and any determination by the Commission made with respect to that review does not provide a basis for an appeal.

6. The Appeal Board may make the following decisions: to affirm, amend, remand, or reverse the adverse actions of the Commission. A decision to affirm, amend or reverse the adverse action is implemented by the Commission. In a decision to remand the adverse action for further consideration, the Appeal Board will identify specific issues that the Commission must address. The Commission must act in a manner consistent with the Appeal Board’s decisions or instructions.

7. No change in the accreditation status of the program will occur pending disposition of the appeal.

8. Within ten (10) days of the hearing, the applicant shall be notified by certified/registered/tracked mail of the Appeal Board's decision. The decision may be to sustain the decision of the Commission or to remand the matter back to the Commission for reconsideration. Notice shall include a statement of the specifics on which the decision is based.

9. The decision rendered by the Appeal Board shall be final and binding.

10. In the event the educational program does not file a timely appeal of the Board of Commissioner’s findings and decisions, the Board of Commissioner’s decision shall become final.

In accord with due process measures, the Appeal Board will, when appropriate, review substantive procedural issues raised by the appellants. To this end, the Appeal Board is limited in its inquiry to the factual determinations up to the time of the Commission on Dental Accreditation’s decision regarding the status of the program at issue.

It is not proper for the Appeal Board to either receive or consider facts not previously presented to the Commission on Dental Accreditation since it does not sit as an initial reviewing body. Similarly, it is not the function of the Appeal Board to determine whether the facts, singularly or cumulatively, justify the decision of the Commission on Dental Accreditation unless it can be shown that the Commission’s decision was clearly against the manifest weight of the evidence. Further, the Appeal Board will not hear testimony relative to the reasonableness of previously determined requirements for accreditation since this is clearly outside the scope of authority of this reviewing body.

Reaffirmed: 8/10; Revised: 8/11, 1/03

4. MECHANISM FOR THE CONDUCT OF THE HEARING:

1. A brief opening statement may be made by the Commission of Dental Accreditation for the purpose of establishing the Commission’s finding and the reasons therefore.

2. The Appellant will then present its argument to the Board.

3. The Commission may then present its rebuttal of the Appellant’s argument.

4. After hearing the evidence, the Appeal Board shall meet in executive session to discuss the appeal and make its decision. The Appeal Board’s decision may be to sustain the decision of the Commission, or remand the matter to the Commission for reconsideration. The decision shall be based on a majority vote of the members of the Appeal Board with the Chairperson voting only to break a tie vote.

5. The Appellant shall be notified by registered mail of the decision of the Appeal Board, including a statement of specifics, within ten (10) days following the hearing.

Reaffirmed: 8/11, 8/10; Revised: 7/07, 7/06, 7/00, 12/88, 1978; Adopted: 12/77
VII. INTERNATIONAL POLICIES AND PROCEDURES

Dental accreditation in the United States is a voluntary quality evaluation system that includes a standard setting and review process to promote the goal of continuous quality improvement in dental education. Additional goals are to provide public protection and accountability and to assure prospective students and state licensing agencies that educational programs provide appropriate education, training and experience to adequately prepare individuals for dental licensure and practice in the U.S. International dental education programs may seek consultation and/or accreditation services from the Commission on Dental Accreditation for the purpose of obtaining an independent, external review, for benchmarking or to serve the needs of graduates who may wish to demonstrate their preparedness for licensure in a state in the U.S.

International consultation and accreditation fee-based services are available to international predoctoral dental education programs, upon request. Once an international dental education program meets the established criteria, consultation and accreditation services will be provided in accord with Commission policies and procedures. Eligibility criteria and Commission policies, standards and procedures are subject to change and will be periodically reviewed and updated. It is the responsibility of programs to keep informed of changes in accreditation policies and procedures, and abide by all current policies and procedures.

An international dental education program is defined as a program located and sponsored by an institution whose primary location is outside of the United States and Canada. The Commission will only accept requests for consultation and accreditation fee-based services from established international dental education programs. The international dental education program must be:
- accepted in its country of origin;
- officially chartered/recognized in its country of origin; and
- recognized or accredited by the country’s relevant government or non-governmental agency.

International dental education program seeking accreditation by the Commission must meet the same Accreditation Standards for Dental Education Programs as the United States-based programs and follow the same process and procedures.

All correspondence, written documents and conversation with the Commission must be in English. If any portion of the consultation and accreditation program is conducted in a language other than English, and translation is required, the Commission will employ a translator of its choosing. The cost of translation will be charged to the international dental education program.

Reaffirmed: 8/10

A. THE CONSULTATION PROCESS FOR INTERNATIONAL PROGRAMS

Attainment of accreditation from the Commission on Dental Accreditation is a multi-step process that involves self-study, observation of the Commission’s accreditation process, and consultation with Commission staff, site reviewers, and the Joint Advisory Committee on International Accreditation (JACIA). To begin the process, the Dean of the International Education Program or International University President/Provost requests, in writing, information from the Commission regarding its fee-based consultation and accreditation services.

The consultation process includes the following steps:
1. Completion of the Preliminary Accreditation Consultation Visit (PACV) survey.
2. Observation of a Commission dental school site visit and individual consultation
3. Completion of a PACV self-study and consultation visit
4. Application for accreditation from the Commission on Dental Accreditation.

At each step of the process a report is submitted to the Joint Advisory Committee on International Accreditation for its consideration. The Committee’s findings are communicated to the international dental education program and the Commission. If the consensus of the Joint Advisory Committee is that the international program has the potential to achieve U.S. accreditation, the program may elect to submit an application for accreditation. A positive determination from the Joint Advisory Committee at any step in the process does not guarantee that an application for accreditation will be successful. An international program may elect to withdraw from the consultation and or accreditation process at any time; however, the chief academic officer should inform JACIA in writing of the program’s intent.

Reaffirmed: 8/10

B. INTERNATIONAL DENTAL EDUCATION SITE VISITS

Three types of site visits may be conducted to international dental education programs.

FOCUSED CONSULTATION VISIT: Focused, fee-based programmatic consultation services are available for programs requesting less than comprehensive consultation services or for programs that JACIA has determined would benefit from a focused consultation. Trained content experts will provide the consultation services.

In preparation for the consultation visit, the international dental school will prepare a written document describing its policies and procedures related to the focused topics. The written material will be submitted ninety (90) days prior to an on-site focused consultation visit. All documents and communications will be in English.

Two consultants/site visitors (Commission staff and/or volunteers) selected for their expertise in the focused topic areas will make up the visiting committee that provides the focused consultation services and carries out the visit. The trip may be seven days in length, allowing ample time for the committee to adjust to any time change and to access lower airfares. The program will receive a written report summarizing the review and recommendations within sixty (60) days.

COMPREHENSIVE CONSULTATION VISIT: A comprehensive, fee-based site visit with programmatic consultation by trained content experts regarding topics such as:
- Institutional effectiveness/outcomes assessment
- Curriculum content and scope
- Competency-based curriculum
- Faculty and staff qualifications and numbers
- Type and adequacy of facilities
- Patient care services and policies
- Student policies and services
- Research for both faculty and staff
- Readiness for accreditation
- Quality assurance
- Comprehensive patient care
• Relationship of dental school to the university and government
• Standards of care

In preparation for a comprehensive consultative site visit, the international dental schools will prepare a written document describing its policies and procedures related to the above topics. All documents and communications will be in English. Four consultants/site visitors (curriculum specialist, basic science specialist, clinician educator, and clinician practitioner representing the American Dental Association) and one Commission staff will make up the visiting committee that will conduct the PACV.

The visit will involve several interviews with the identified stakeholders of the international dental education program and the institution’s administration. Interviews will be conducted with the appropriate administrators, faculty, staff and students. The visiting committee will also provide consultation regarding the facilities. A written report summarizing the evaluation will be provided to the program within sixty (60) days.

ACCREDITATION SITE VISIT: The Commission’s accreditation service for international dental education programs is the same as the process and procedures of the accreditation program for U.S.-based dental education programs. Programs that are successful in the PACV may submit an application for accreditation and an application fee for accreditation. Commission consultants/site visitors will then be selected to evaluate the written application and determine whether the application is complete and the program is ready for an accreditation site visit. Once the Commission determines that the program has submitted sufficient information to determine the program’s potential for complying with the accreditation standards, a site visit will be scheduled.

A visiting committee consists of six (6) Commission trained volunteer consultants/site visitors and one Commission staff. The committee includes a chairperson, basic scientist, curriculum consultant/site visitor, clinical science consultant/site visitor, finance consultant/site visitor, and a national licensure consultant/site visitor.

The accreditation visit, following the process established for U.S.-based programs, will involve several interviews with the identified stakeholders of the international dental program and the institution’s administration. Interviews are conducted with the appropriate administrators, faculty, staff and students. The accreditation site visit committee also verifies that the written application accurately represents the program through multiple interviews, observations, on-site documentation review and facility inspection.

Following the site visit, the visiting committee writes a preliminary draft site visit report that will be considered by the Review Committee on Predoctoral Dental Education and the Commission. The Commission then determines whether to grant the program the appropriate accreditation status.

International dental education programs who are successful in the PACV and wish to seek accreditation will be assessed an accreditation application fee. The program will also be responsible for all site visit expenses. All fees must be paid in advance in United States dollars. Accredited programs also pay an annual fee.

Reaffirmed: 8/10; Adopted: 7/06

C. BROAD ELIGIBILITY CRITERIA FOR PRELIMINARY ACCREDITATION CONSULTATION VISIT (PACV)

The PACV survey will be evaluated by the Joint Advisory Committee on International Accreditation

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using the following broad criteria. These criteria are subject to change and will be periodically reviewed and updated.

- Information from the U.S. State Department confirms that no conditions (war, threat of terrorism, etc.) exist that might put the safety of a visiting committee at risk.
- There are no cultural restrictions or legal restrictions which would make site visits by U.S. citizens problematic.
- The PACV survey responses in English are appropriate and understandable.
- The dental school or program has a sponsoring university.
- There is an accreditation and/or approval process within the country for higher education and the sponsoring university or dental school is accredited/approved within the country.
- A letter of support from the accreditation/approval agency has been submitted to the Commission.
- The university or institution that sponsors the dental program has been determined to meet the requirements for equivalency to U.S. regional accreditation.
- The school or program is degree granting.
- It appears the program has adequate financial support.
- The dental school or program has been in existence long enough to have had several graduating classes.
- The education model is essentially similar to that in the U.S. and Canada.
- Pre-requisites for admission to the dental school are appropriate and adequate.
- The number of full-time and part-time faculty appears to be adequate based on the number of students enrolled.
- There appears to be a developed curriculum plan with adequate clock hours in:
  - Basic Sciences
  - Preclinical laboratory
  - Clinical sciences
- Clinical treatment of patients is an essential part of the educational program.
- There appears to be developed facilities for dental education.
- Health care standards and standards of care for dentistry support the practice of dentistry in essentially the same manner as in the U.S.

Reaffirmed: 8/10

VIII. COMMISSION HISTORY AND BACKGROUND

The American Dental Association (ADA) authorized the Council on Dental Education to accredit dental schools in 1938; however, the Requirements for the Approval of a Dental School did not go into effect until the 1941-42 academic year. The Council’s initial accrediting activities were confined to dental schools. As the dental profession developed and grew, however, the scope of accrediting activities also grew. Current activities include accreditation of educational programs for dental assisting, dental hygiene and dental laboratory technology and accreditation of advanced education programs for general dentistry, the recognized dental specialties and general practice residencies, in addition to predoctoral dental education programs.

In 1973, the House of Delegates of the American Dental Association approved the establishment of a Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. In 1979 this body’s name was officially changed to the Commission on Dental Accreditation. The twenty (20) member Commission included the twelve (12) Council on Dental Education members, four of whom represented the American Dental Association (ADEA), four the American Association of Dental Boards and four the
American Dental Education Association. The additional eight (8) Commission representatives included two (2) dental specialists selected by specialty organizations having certifying boards recognized by the Association, one (1) representative selected by the American Dental Assistants Association, one (1) representative selected by the American Dental Hygienists’ Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student representative selected jointly by the American Student Dental Association and the Council of Students of the American Dental Education Association and two (2) public representatives selected by the Council on Dental Education.

In 1979 the Commission on Accreditation of Dental and Dental Auxiliary Education Programs was renamed the Commission on Dental Accreditation.

In 1996, the ADA House of Delegates adopted two resolutions (84H-1996 and 142H-1996) calling for the restructuring of the ADA’s Council on Dental Education and the Commission on Dental Accreditation. Specifically, members of the Council on Dental Education would no longer serve concurrently as members of the Commission. The Council and Commission became two distinct agencies with separate memberships, at the adjournment of the 1997 House of Delegates.

In August 1997, the Commission adopted revised Rules of the Commission on Dental Accreditation to complement the resolutions adopted by the 1996 House of Delegates. In October 1997, the ADA House of Delegates approved the Commission’s revised Rules. The members of the Commission now includes: four (4) dentists appointed by the American Dental Association, four (4) dentists appointed by the American Dental Education Association, four (4) dentists appointed by the American Association of Dental Boards, one (1) dentist for each ADA recognized specialty appointed by the respective specialty sponsoring organization, one (1) dentist to represent postdoctoral general dentistry jointly appointed by the ADEA and the American Association of Hospital Dentists, one (1) certified dental assistant selected by the American Dental Assistants Association, one (1) licensed dental hygienist selected by the American Dental Hygienists’ Association, one (1) certified dental laboratory technician selected by the National Association of Dental Laboratories, one (1) student jointly selected by ADEA and the American Student Dental Association, and four (4) consumers. Language was also added to clarify that when assigned by the ADA Board of Trustees, a member of the Standing Committee on the New Dentist is an ex-officio member of the Commission without the right to vote (in accord with Chapter VII, Section 150 of the ADA Bylaws.)

In July 2004, the Commission adopted the Request to Establish a Process of Accreditation for Programs in Areas of Advanced Training in General Dentistry.

In January 2005, the Commission directed that a process of accreditation be established for advanced general dentistry programs in the area of dental anesthesiology and in the area of oral medicine.

In January 2006, the Commission adopted the revised Review Committee Composition which was implemented in January 2007.

In July 2006, the Commission discontinued the use of commendations in written site visit reports.

In July 2006, the Commission adopted CODA: International Policies and Procedures for accreditation of international predoctoral dental education programs.

In January 2008, the Commission directed that a process of accreditation be established for advanced
general dentistry programs in the area of orofacial pain.

IX. NON-GOVERNMENTAL RECOGNITION OF POSTSECONDARY ACCREDITATION

Since 1952, the Commission on Dental Accreditation has been recognized by the Secretary of the United States Department of Education (USDE) as the agency responsible for the accreditation of dental and dental-related educational programs. In addition, the Commission has sought and received recognition from a non-governmental recognition agency since the 1960’s. These non-governmental agencies have included the National Commission on Accrediting (NCA), the Council on Postsecondary Accreditation (COPA) and the Commission on Recognition of Postsecondary Accreditation (CORPA).

COPA was formed in 1975. The Commission received full recognition for the maximum period when evaluated in 1977 by COPA. In 1984 and again in 1989, the Commission submitted re-recognition materials to COPA and was awarded full recognition each time. In April 1993, the COPA Board voted to dissolve the Council on Postsecondary Accreditation, effective at the end of 1993. The Commission on Recognition of Postsecondary Accreditation (CORPA) was formed and took over the recognition function from COPA, effective January 1, 1994.

The Commission on Dental Accreditation submitted re-recognition materials for review by CORPA at its February 1996 meeting. In March 1996, the Commission received notification that CORPA had granted the Commission re-recognition for the maximum period of five years and cited no areas of noncompliance. The Commission’s next re-recognition review by CORPA would be conducted in 2001.

On December 31, 1996, CORPA filed Articles of Dissolution, as voted by CORPA at its August 1996 meeting. The Commission was informed that CORPA recognition function would become a responsibility of the newly-established Council on Higher Education Accreditation (CHEA). In February 1997, the accrediting community was informed about recent actions of the CHEA Board of Directors. The letter stated that for an accrediting agency to be eligible for CHEA recognition, it must have a majority of degree granting programs or institutions. In early March 1997 the Commission was informed that CHEA had accepted the Commission’s CORPA recognition status.

In January 1999, the Commission on Dental Accreditation considered a report on the recently established Council on Higher Education Accreditation (CHEA) and its newly approved Recognition of Accrediting Organizations Policy and Procedures, effective January 1999. The Commission noted that accreditation agencies were eligible to apply for recognition of CHEA if the majority of the accredited programs were degree granting. At that time, 41.3% of Commission-accredited programs were granting degrees. Thus, the Commission was not eligible for CHEA recognition and would have to pursue an exemption from the eligibility requirements if CHEA recognition were to be sought. At that time, the Commission determined not to request an exemption for the Eligibility Policy, but to continue to monitor issues being addressed by the higher education community through attendance at CHEA conferences. The Commission may pursue CHEA recognition in the future.

X. RECOGNITION CHRONOLOGY - - DENTISTRY

1840 The first dental school was established and the first state statute requiring a license to practice dentistry was passed.

1847 The American Medical Association was founded to advance the profession through state
licensing and improving educational quality.

1859 The American Dental Association (ADA) was founded. At the time of the Civil War, it divided into two organizations, the ADA and the Southern Dental Association. In 1897, these two groups merged into the National Dental Association. In 1921, the NDA changed its name back to the ADA.

1867 The Office of Education was established to collect statistics, including data on the numbers of schools and colleges.

1906 The nine-member Dental Educational Council of America was established with its membership equally representing education, licensure and practice.

1934 The Dental Educational Council of America issued its last listing of dental schools using the A, B, C terminology (Reports 1958:59). There were 39 dental schools at this time.

1937 The nine-member ADA Council on Dental Education was established, retaining the tripartite structure of the earlier Dental Educational Council of America (educators, examiners, practitioners); the Council membership expanded to 12 members in 1974, again retaining the tripartite structure.

1937 Educational standards for dental schools were approved by the ADA House of Delegates for implementation in 1941-42.

1949 The National Commission on Accrediting (NCA) began operating, taking over responsibilities and files of the Joint Committee on Accrediting which had been established in 1938 to control proliferation of accrediting entities.

1952 Public Law 82-250 tries to correct abuses in the G.I. Bill by requiring the U.S. Commissioner of Education to publish a list of nationally recognized accrediting agencies.

1952 The Council on Dental Education is recognized by the U.S. Office of Education as the national accrediting agency for dentistry (Trans.1954:26).

1963 The first reference to the National Commission on Accrediting (NCA) occurs in the Council’s annual report (Reports 1963:11).

1964 The Council received recognition from NCA as the “official accrediting agency in the area of dental hygiene education” and had previously received similar recognition for accreditation of dental education programs (Reports 1964:10).

1964 The Federation of Regional Accrediting Agencies for Higher Education (FRACHE) replaces the National Commission of Regional Accrediting Agencies (NCRAA) which was formed in 1947 by the American Council on Education (ACE).

1968 The NCA recognized the Council for its accreditation of dental assisting and dental laboratory technology education programs (Trans.1968:37).

1972 The Council’s recognition by NCA was continued for five years; the U.S. Office of Education
criteria were being revised (Reports 1972:19; see also pp.17-20 for discussion of federal influence on education).

1973 The ADA House of Delegates transferred dentistry’s accreditation program from the Council on Dental Education to the new 20-member Commission on Accreditation of Dental and Dental Auxiliary Education Programs (effective January 1975). Support for the tripartite membership of the Council was reaffirmed (Reports 1973:21). The Council reported to the House that it would jeopardize its recognition were to use accreditation sanctions to enforce Association policy (Reports 1973:25).

1973 The Council on Postsecondary Accreditation (COPA) formed; NCA and FRACHE dissolved.

1974 The Council membership expanded to 12 members, again retaining the tripartite structure originated when the Dental Educational Council of America was formed in 1906.

1975 The Commission on Accreditation of Dental and Dental Auxiliary Education Programs began to accredit educational programs. There were 59 dental schools at this time.

1975 After several years of effort, the National Commission on Accrediting and the Federation of Regional Accrediting Commission of Higher Education merged on January 1, 1975 to become the Council on Postsecondary Accreditation (COPA). For the first time, representatives from the Council of Specialized Accrediting Agencies (the group representing all recognized specialized accrediting agencies) had a voice within COPA in policy and decision-making processes.


1979 The Commission on Accreditation of Dental and Dental Auxiliary Education Programs was renamed the Commission on Dental Accreditation (Reports 1979:67); the U.S. Office of Education became the U.S. Department of Education and its first Secretary was sworn in on December 6, 1979.

1980 The Commission presented testimony to a subcommittee of the U.S. Department/Office of Education against the 1979 petition of the Accrediting Bureau of Health Education Schools (ABHES) to expand its scope to 14 additional areas of education in the proprietary sector, including the two Commission-accredited areas of dental assisting and dental laboratory technician. In 1980 this ABHES petition was denied (Reports 1980:43).

1981 The Accrediting Bureau of Health Education Schools (ABHES) petitioned USDE to expand its accreditation scope to include institutional accreditation of private, postsecondary institutions offering allied health education programs. The Commission did not support or oppose the institutional expansion of scope, but did express concern about how the public might interpret ABHES' institutional accreditation where DA and DLT programs are concerned. In late 1982, the Department approved the petition, despite the Commission's concern to ABHES (Reports 1982:45; 1983:38).

1984 The Commission submitted one application/petition to the Council on Postsecondary Accreditation (COPA) and the U.S. Department of Education (USDE) and received full recognition for the maximum terms (5 and 4 years) from each agency. The Commission’s
accreditation of advanced and specialty education programs was now recognized by COPA, as well as by USDE.

1988-1989  The Commission submitted re-recognition materials to COPA and USDE; COPA granted the Commission the maximum period of five years, citing no specific areas of noncompliance, but required an annual progress report until revision of the dental hygiene accreditation standards was completed; USDE granted the Commission the maximum period of five years and cited no areas of noncompliance.

1993  In April 1993, the COPA Board voted to dissolve the Council on Postsecondary Accreditation, effective the end of 1993. Partially in response to the anticipated dissolution of COPA, the Association of Specialized and Professional Accreditors (ASPA) was incorporated in August 1993. In June 1993, nine regional and seven national higher education associations formed the National Policy Board on Higher Education Institutional Accreditation (NPB).

1994  The Commission on Recognition of Postsecondary Accreditation (CORPA) was formed and took over the recognition function from COPA, effective January 1, 1994.


1995-1996  The Commission submitted re-recognition materials for review by the Commission on Recognition of Postsecondary Accreditation (CORPA) at its February 1996 meeting based on the Provisions revised by COPA during its last year of operation. The Provisions were adopted by CORPA when it was formed and went into effect in January 1994. CORPA granted the Commission re-recognition for the maximum period of five years and cited no areas of noncompliance.

1996  On December 31, 1996 CORPA filed Articles of Dissolution. The Commission on Dental Accreditation was informed that the CORPA recognition function would be assumed by the Council on Higher Education Accreditation (CHEA).

1997  In March 1997 the Commission was informed that because the Commission was recognized by CORPA, CHEA was extending that recognition until new recognition standards can be developed.

1997  In June 1997 the USDE considered the Commission’s progress report demonstrating strengthened compliance with several of the new recognition criteria. The USDE accepted the report and requested an interim report by June 1, 1998 demonstrating full compliance with four cited criteria.

1998  In December 1998, the USDE considered the Commission’s interim report on compliance with the four cited criteria. The USDE determined that the Commission was in full compliance with §602.21(b)(2); §602.26(c)(3); and §602.27(f), but needed to take additional action to come into full compliance with criterion §602.26(c)(4). The USDE requested that another report be submitted by December 9, 1999 demonstrating full compliance with criterion §602.26(c)(4).
On September 28, 1998, the CHEA Board of Directors approved the CHEA Recognition of Accrediting Organizations Policy and Procedures, effective January 1999. CHEA’s Institutional Eligibility and Recognition Policy stated that organizations which accredit programs were eligible to apply for recognition by CHEA if the majority of the accredited programs are degree-granting. CHEA reserved the right to amend its eligibility criteria for an ineligible accrediting agency.

At its January 1999 meeting, the Commission noted that 545 of the Commission’s 1321 accredited programs (41.3%) grant degrees and concluded that the Commission was not eligible for recognition by CHEA. The Commission determined not to seek a waiver in pursuit of CHEA recognition at that time, but to monitor the success of the newly established recognition program for accrediting agencies, and continue participation in CHEA activities.

In December 1999, the USDE considered the Commission’s interim report on compliance with criterion §602.26(c)(4). The USDE Secretary found the Commission to be in compliance with the requirement and accepted the interim report.

On November 15, 2000, the Commission submitted its application to the Secretary of the United States Department of Education (USDE) for continued recognition as the accrediting agency for dental and dental-related education programs. The Secretary’s National Advisory Committee on Institutional Quality and Integrity reviewed the USDE Staff Analysis of the application and the Commission’s response at its May 2001 meeting. The Commission received the Secretary’s final transmittal letter, dated December 17, 2001, granting recognition to the Commission for the maximum period of five years at its February 2002 meeting.

In November 2005, the Commission submitted its application to the Secretary of the United States Department of Education (USDE) for continued recognition as the accrediting agency for dental and dental-related education programs. The Secretary’s National Advisory Committee on Institutional Quality and Integrity reviewed the USDE Staff Analysis of the application and the Commission’s response at its June 2006 meeting.

The Commission’s petition for continued recognition by the United States Department of Education (USDE) received a favorable review by the National Advisory Committee on Institutional Quality and Integrity (NACIQI) at its meeting on June 5, 2006. The Secretary of the USDE granted recognition to the Commission for the maximum period of five years starting December 12, 2006.

On January 9, 2012, the Commission submitted its application to the Secretary of the United States Department of Education (USDE) for continued recognition as the accrediting agency for dental and dental-related education programs. The Secretary’s National Advisory Committee on Institutional Quality and Integrity reviewed the USDE Staff Analysis of the application and the Commission’s response at its June 2012 meeting.

In August 2012, the Commission received confirmation that the U.S. Secretary of Education accepted the National Advisory Committee on Institutional Quality and Integrity recommendation that recognition be continued to permit the Commission an opportunity to, within a 12 month period, bring itself into compliance with three criteria. In January 2013, the Commission submitted documentation that it is in compliance with the three criteria cited in the final report.
XI. COMMISSION COMMITTEES

The Commission on Dental Accreditation has five (5) standing committees: Quality Assurance and Strategic Planning, Documentation and Policy Review, Finance, Nomination and Communication and Technology. Additionally, ad hoc committees and other committees and task forces may be formed to address specific issues or concerns. An ad hoc committee functions until the issue is resolved or until it becomes a standing committee of the Commission.

Occasionally, a Commissioner may be asked to serve on other task forces or joint committees that could include representatives from the American Dental Association, the American Dental Education Association or other organizations.

The charge to each of the Commission’s standing committees follows:

Quality Assurance and Strategic Planning
- Develop and implement an ongoing strategic planning process;
- Develop and implement a formal program of outcomes assessment tied to strategic planning;
- Use results of the assessment processes to evaluate the effectiveness of the Commission and make recommendations for appropriate changes, including the appropriateness of its structure;
- Monitor USDE, and other quality assurance organizations i.e. Council on Higher Education Accreditation (CHEA), American National Standards Institute/International Organization for Standardization (ANSI/ISO), and International Network for Quality Assurance Agencies in Higher Education (INQAHE) for trends and changes in parameters of quality assurance; and
- Monitor and make recommendations to the Commission regarding changes that may affect its operations, including expansion of scope and international issues.

Documentation and Policy Review
- Ensure all Commission documents reflect consistency in application of Commission policies, and that relevant sections of accreditation standards are consistent across disciplines;
- Review and consolidate the recommendations of all review committees into standard language for the Commission’s consideration for adoption, when new or revised standards are proposed and will impact more than one discipline; and
- Periodically review current Commission policies and procedures to ensure that they are current and relevant.

Nomination
- Review nominations and make recommendations for appointment of consumer/public members to the Commission;
- Review nominations and make recommendations for appointment of individuals to Review Committees of the Commission;
- Ensure the pre-nomination education process provides information regarding expectations and duties of commissioners, review committee members, and site visitors; and
- Periodically review nomination and selection criteria and make recommendations for changes if necessary, consistent with the Commission’s strategic plan and policies.

Finance
- Monitor, review and make recommendations to the Commission concerning the annual budget.
Communication and Technology

- Evaluate and recommend alternative methods, including the use of enhanced technology, for monitoring programs’ continuous compliance with the standards;
- Evaluate and recommend new technological advances in accreditation for reporting and management of information, allowing accreditation to move toward the concepts of continuous assessment, data collection, and readiness;
- Monitor technological trends in alternative site visit methods;
- Develop and implement strategies to increase the effectiveness, quality, content, and processes of communication with all the Commission’s communities of interest;
- Ensure that Commission communications strategies allow for transparency and accountability; and
- Oversee the publication of the e-newsletter, the CODA Communicator, with emphasis on communicating the value/outcomes of accreditation.

Adopted: 8/10

XII. MATERIALS AVAILABLE FROM THE COMMISSION

These materials are available from the Commission on Dental Accreditation upon request.

- Application for initial accreditation for each discipline
- Accreditation standards documents for each discipline
- Self-study documents for each discipline
- Accredited Program Listing:
  - Dental Education Programs,
  - Dental Assisting, Dental Hygiene and Dental Laboratory Technology Education Programs, and
  - Advanced Specialty and General Dentistry Education Programs
- Annual Reports for Dental Education, Allied Dental Education and Advanced Dental Education are available online, including:
  - Supplement: Dental School Tuition, Admission and Attrition
  - Supplement: Dental School Faculty and Support
  - Supplement: Dental School Trends
  - Supplement: Dental School Curriculum, Clock Hours of Instruction

Reports listed as confidential include information which was collected with the understanding that the reports would not identify specific educational institutions. Thus, these reports use randomly assigned code numbers for each predoctoral dental education program rather than the name of the institution. Confidential reports include the Supplement: Analysis of Dental School Finances - Financial Report

- Guidelines:
  - Guidelines for Preparation of Reports (Response to Site Visit Reports and Progress Reports)
  - Preparing Phase-out Reports by Institutions Terminating Educational Programs Accredited by the Commission
  - Preparing Requests for Transfer of Sponsorship
  - Reporting Major Changes in Accredited Programs
  - Documentation Guidelines for Selected Recommendations (in site visit reports)
  - Guidelines for Enrollment Increases (Specialty Programs)
- Outcomes Assessment - a resource packet of articles/instruments on assessing outcomes
- Accreditation - an informational brochure explaining the Commission’s accreditation process
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Graduate Program in Prosthodontics Faculty Curriculum
Vitae
CURRICULUM VITAE

Heather J Conrad, DMD, MS, FACP, FRCD(C)

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IDENTIFYING INFORMATION

Academic Rank

Associate Professor with Tenure in the Department of Restorative Sciences
Director, Advanced Education Program in Prosthodontics

Education

<table>
<thead>
<tr>
<th>Degree</th>
<th>Institution</th>
<th>Date Degree Granted</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMD</td>
<td>University of Saskatchewan College of Dentistry</td>
<td>1997</td>
</tr>
<tr>
<td>MS</td>
<td>University of Minnesota Graduate School</td>
<td>2006</td>
</tr>
<tr>
<td>Certificate</td>
<td>University of Minnesota School of Dentistry, Prosthodontics</td>
<td>2006</td>
</tr>
</tbody>
</table>

Licenses, certifications, certificates

- State of Minnesota Board of Dentistry Dental License
- Diplomate of the American Board of Prosthodontics
- Fellow of the American College of Prosthodontists
- Fellow of the Royal College of Dentists of Canada

Positions/Employment

University of Minnesota, School of Dentistry, Twin Cities Campus

- April 1, 2012 – present
- Director, Advanced Education Program in Prosthodontics
- September 7, 2010 – March 31, 2012
- Associate Director, Advanced Education Program in Prosthodontics

University of Minnesota, School of Dentistry, Twin Cities Campus

- July 1, 2012 – present
- Associate Professor with Tenure
- July 1, 2006 – June 30, 2012
- Assistant Professor
University of Minnesota, School of Dentistry, Twin Cities Campus
- July 1, 2003 – May 31, 2006
  - Dental Fellow

University of Saskatchewan, College of Dentistry, Saskatoon, Canada
- September 1997 – May 2003
  - Adjunct Faculty

Davidson Dental Clinic and Dr. Bowerman & Associates, Saskatoon, Canada
- May 1997 – May 2003
  - General dentist full time private practice

Current Membership in Professional Organizations
- Beta Beta Chapter of Omicron Kappa Upsilon
- American College of Prosthodontists
- American Academy of Fixed Prosthodontics
- University of Minnesota Alumni Association
- American Dental Education Association
- Minnesota Section of the American College of Prosthodontists
- Honor Society of Phi Kappa Phi (ΦΚΦ)

HONORS AND AWARDS FOR RESEARCH/CREATIVE WORK, TEACHING, PUBLIC ENGAGEMENT, AND SERVICE

University of Minnesota
- 2011 • Professor of the Year in recognition of outstanding teaching, service and support
- 2010 • Professor of the Year in recognition of outstanding teaching, service and support
- 2009 • Professor of the Year in recognition of outstanding teaching, service and support
- 2007 • Thank a Teacher certificate sponsored by the Center for Teaching and Learning

External Sources
- 2011 • Elected Secretary of the ADEA Prosthodontic Section
- 2010 • Elected to the Council for the American Board of Prosthodontics
- 2007 • First Place AAFP Stanley D. Tylman Research Award
- 2005 • American College of Prosthodontists Education Foundation Scholarship
- 2003 • American College of Prosthodontists Education Foundation Scholarship
- 2001 • Student’s Union Teaching Excellence Award, University of Saskatchewan
RESEARCH, SCHOLARSHIP, AND CREATIVE WORK

Grants and Contracts (funded)

• 2014 • Nobel Biocare Grant – CAD/CAM lithium disilicate crown performance cemented extra-orally and delivered as a screw-retained implant restoration – Co-investigator $5,000
• 2011 • Center for Translational Medicine – The safety and efficacy of a novel dental implant bone cement: a dog study – Co-investigator $202,416
• 2011 • Technology Enhanced Award for Teaching and Learning – Acquisition and development of audio-visual learning aids for the clinical laboratories – Principal Investigator $1,000
• 2010 • Astra Tech AB Grant – Evaluation of initial implant stability of posterior maxillary implants with bicortical fixation – Co-investigator $11,250.00 plus $44,250.00 supplies/equipment
• 2009 • American Academy of Implant Dentistry Research Foundation – The effect of surgical guide design and surgeon’s experience on the accuracy of implant placement – Co-investigator $9,955.00
• 2007 • Lifecore Dental – Effect of retightening on abutment screw preload as a function of time – Principal Investigator $22,550
• 2005 • American Academy of Fixed Prosthodontics Stanley D. Tylman Research Grant – Accuracy of two impression techniques with angulated implants – Principal Investigator $2,000

Grants and Contracts (not funded)

• 2012 • American Academy of Fixed Prosthodontics Stanley D. Tylman Research Grant – Quantifying Aesthetic Maxillary Central Incisor Dimensions – Co-investigator $4,000.00
• 2010 • Grant-in-Aid – Intelligent dental handpiece – Co-investigator $50,000.00
• 2010 • American Academy of Fixed Prosthodontics Stanley D. Tylman Research Grant – The effect of time lapse and sectioning on the accuracy of an acrylic resin verification jig – Principal Investigator $2,400.00
• 2009 • Institute for Engineering and Medicine Seed Grant Program – Intelligent dental equipment – Co-investigator $50,000.00
• 2009 • American Academy of Implant Dentistry Research Foundation Research Grant – Is surgical guide fabricated from prosthodontic planning predictive of final implant placement? – Co-investigator $9,976.00
• 2007 • Technology-Enhanced Learning Grant – Development of an interactive Web Vista Course to integrate virtual reality based technology into the School of Dentistry curriculum – Principal Investigator $10,000.00

Publications

Refereed Journal Articles or Publications

• Conrad H, Buchanan J, Welk A. Advanced Simulation Clinic Orientation. MedEdPORTAL: http://services.aamc.org/mededportal/servlet/s/segment/mededportal/?subid=8235


• **Conrad HJ**, Mills EA. Dental students choosing licensure path give more consideration to career flexibility rather than ethical dilemmas. J Am Coll Dent 2011;78:24-32.


• Tiossi R, de Torres EM, Rodrigues RCS, **Conrad HJ**, de Mattos Mda G, Fok ASL, Ribeiro RF. Comparison of the correlation of photoelasticity and digital imaging to characterize the load transfer of implant-supported restorations. J Prostheth Dent 2014; in press.


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**Software Development**

• Advanced Simulation Clinic Orientation • online computer based training for DentSim


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**Presentations, Posters, and Exhibits**

*Invited Presentations at Professional Meetings, Conferences*
• 2013 December 3 • 3M Company – Residual excess cement associated with cement-retained implant restorations
• 2013 March 18 • ADEA Annual Session & Exhibition – Promoting the Prosthodontic Specialty to Predoctoral Students
• 2012 November 30 • TEATL Awards – Acquisition and Development of Audio-Visual Learning Aids for the Clinical Laboratories
• 2012 August 1 • West Central District Golf Event – Esthetic Evaluation
• 2012 February 2 • Clinical Grand Rounds – U of M SOD Continuing Dental Education – Space of a Smile
• 2011 March 14 • MedEdPORTAL Oral Health Teaching Resource Showcase – ADEA Annual Session & Exhibition – Advanced Simulation Clinic Orientation
• 2011 February 8 • Prosthodontic Update – University of British Columbia – The Space of a Smile
• 2008 October 10 • Restorative Dentistry Update – U of M SOD Continuing Dental Education – Current Ceramic Materials and Systems
• 2008 February 7 • Clinical Grand Rounds – U of M SOD Continuing Dental Education – Removable Prosthodontics/Implants
• 2008 January 25 • What’s New in Dentistry – U of M SOD Continuing Dental Education – Current Ceramic Materials and Systems
• 2007 February 23 • American Academy of Fixed Prosthodontics – Accuracy of two impression techniques with angulated implants
• 2006 October 26 • Board Certification in Prosthodontics – Minnesota Section of ACP

Abstracts and Posters or Exhibitions
• 2013 • Keyes J, Conrad HJ. Restoration of the partially dentate maxilla following traumatic injury: Case report. ACP 43rd Annual Session, Las Vegas, NV, October 10, 2013.
• 2012 • James KW, Keyes RA, Conrad HJ. Interim immediate denture driven maxillary screw-retained implant prosthesis. ACP 42nd Annual Session, Baltimore, MD, November 1, 2012.

• 2011 • Tiossi R, Vasco MA, Conrad HJ, Bezzon OL, Fok AS, Ribeiro RF. Estudo comparativo de dois métodos para analise das tensões geradas por próteses implantossuportadas. IADR Brazilian Division, September 2011.
  o Award received


• 2010 • Tiossi R, Lin L, Rodrigues RC, Heo TC, Conrad HJ, Mattos MG, Ribeiro RF, Fok AS. A digital image correlation analysis on the influence of prosthesis material on strain distribution of implant-supported crowns. IADR Brazilian Division, September 2010.

• 2010 • Martinelli J, Tiossi R, Rodrigues RCS, Heo YC, Conrad HJ, Mattos MGC, Fok AS, Ribeiro RF. Efeito dos recobrimentos estéticos nas tensões geradas por próteses implantosuportadas. IADR Brazilian Division, September 2010.

• 2010 • Faria ACL, Tiossi R, Rodrigues RCS, Heo YC, Conrad HJ, Mattos MGC, Fok AS, Ribeiro RF. Análise fotoelástica e extensométrica das tensões geradas por próteses implantosuportadas, unidas ou isoladas. IADR Brazilian Division, September 2010.
  o Award received

• 2010 • Macedo AP, Tiossi R, Rodrigues RCS, Heo YC, Conrad HJ, Mattos MGC, Fok AS, Ribeiro RF. Estudo comparativo entre dois métodos in vitro para análise de tensões geradas por próteses suportadas por implantes. IADR Brazilian Division, September 2010.
  o Award received


• 2008 • Vallee MC, Conrad HJ, Basu S, Seong WJ. Accuracy of friction-style and spring-style mechanical torque limiting devices for dental implants. AAFP Table Clinic Session, Chicago, IL, February 23, 2008.

Professional Artistic and Creative Experience
- Introduction to Complete Dentures • [http://mediamill.cla.umn.edu/mediamill/display/124217](http://mediamill.cla.umn.edu/mediamill/display/124217)
- Preliminary Impressions • [http://mediamill.cla.umn.edu/mediamill/display/124513](http://mediamill.cla.umn.edu/mediamill/display/124513)
- Custom Trays • [http://mediamill.cla.umn.edu/mediamill/display/124515](http://mediamill.cla.umn.edu/mediamill/display/124515)
- Border Molding • [http://mediamill.cla.umn.edu/mediamill/display/125466](http://mediamill.cla.umn.edu/mediamill/display/125466)
- Final Impressions • [http://mediamill.cla.umn.edu/mediamill/display/126298](http://mediamill.cla.umn.edu/mediamill/display/126298)
- Boxing • [http://mediamill.cla.umn.edu/mediamill/display/126800](http://mediamill.cla.umn.edu/mediamill/display/126800)
- Record Base and Wax Rim • [http://mediamill.cla.umn.edu/mediamill/display/127726](http://mediamill.cla.umn.edu/mediamill/display/127726)
- Maxillomandibular Relations • [http://mediamill.cla.umn.edu/mediamill/display/129364](http://mediamill.cla.umn.edu/mediamill/display/129364)
- Facebow • [http://mediamill.cla.umn.edu/mediamill/display/129838](http://mediamill.cla.umn.edu/mediamill/display/129838)
- Centric Relation • [http://mediamill.cla.umn.edu/mediamill/display/128631](http://mediamill.cla.umn.edu/mediamill/display/128631)
- Anterior Tooth Arrangement • [http://mediamill.cla.umn.edu/mediamill/display/83200](http://mediamill.cla.umn.edu/mediamill/display/83200)
- Posterior Tooth Arrangement • [http://mediamill.cla.umn.edu/mediamill/display/133052](http://mediamill.cla.umn.edu/mediamill/display/133052)
- Complete Denture Repair • [http://mediamill.cla.umn.edu/mediamill/display/84291](http://mediamill.cla.umn.edu/mediamill/display/84291)
- Tissue Conditioning • [http://mediamill.cla.umn.edu/mediamill/display/97519](http://mediamill.cla.umn.edu/mediamill/display/97519)
- Clinical CD Patient Part I • [http://mediamill.cla.umn.edu/mediamill/display/86418](http://mediamill.cla.umn.edu/mediamill/display/86418)
- Festooning • [http://mediamill.cla.umn.edu/mediamill/display/97526](http://mediamill.cla.umn.edu/mediamill/display/97526)
- Complete Denture Processing • [http://mediamill.cla.umn.edu/mediamill/display/85186](http://mediamill.cla.umn.edu/mediamill/display/85186)
- Complete Denture Reline Processing • [http://mediamill.cla.umn.edu/mediamill/display/89239](http://mediamill.cla.umn.edu/mediamill/display/89239)
- Surgerizing Cast • [http://mediamill.cla.umn.edu/mediamill/display/86430](http://mediamill.cla.umn.edu/mediamill/display/86430)
- Finishing & Polishing • [http://mediamill.cla.umn.edu/mediamill/display/138588](http://mediamill.cla.umn.edu/mediamill/display/138588)
- Remount Cast Fabrication • [http://mediamill.cla.umn.edu/mediamill/display/97523](http://mediamill.cla.umn.edu/mediamill/display/97523)
- Clinical CD Patient Part II • [http://mediamill.cla.umn.edu/mediamill/display/89237](http://mediamill.cla.umn.edu/mediamill/display/89237)
- Denture Tooth Repair • [http://mediamill.cla.umn.edu/mediamill/display/138667](http://mediamill.cla.umn.edu/mediamill/display/138667)
TEACHING AND CURRICULUM DEVELOPMENT

University of Minnesota

Graduate Courses – Course Director

- **DENT 7111** • Current Literature Review Seminar
  - 2011 to present – Fall and Spring semesters
- **DENT 7112** • Treatment Planning Seminar
  - 2011 to present – Fall and Spring semesters
- **Dent 7220** • Prosthetically-Driven Implant Surgery and Treatment Planning
  - 2012 to present – Fall semesters
- **PROS 7200** • Advanced Clinical Prosthodontics
  - 2011 to present – Fall, Spring, and Summer semesters
- **PROS 7210** • Advanced Technical Restorative Dentistry
  - 2012 to present – Summer semesters

Predoctoral Prosthodontic Honors Course – Course Director

- **DDS 6496** • Predoctoral Prosthodontic Honors Course
  - Fall 2011, Spring 2012, Fall 2013

Graduate Courses – Course Co-Director

- **DENT 7112** • Treatment Planning Seminar
  - Fall 2010, Spring 2011
- **PROS 7200** • Advanced Clinical Prosthodontics
  - Spring 2011

Pre-Doctoral Pre-Clinical Courses – Course Director

- **DDS 6475 Fall 2011** • Preclinical Prosthodontic Technique Lecture IV Complete Dentures
- **DDS 6476 Fall 2011** • Preclinical Prosthodontic Technique Laboratory IV Complete Dentures
- **DDS 6475 Fall 2010** • Preclinical Prosthodontic Technique Lecture IV Complete Dentures
- **DDS 6476 Fall 2010** • Preclinical Prosthodontic Technique Laboratory IV Complete Dentures
- **DDS 6477 Spring 2010** • Preclinical Prosthodontic Technique Lecture V Complete Dentures
- **DDS 6478 Spring 2010** • Preclinical Prosthodontic Technique Laboratory V Complete Dentures
- **DENT 5909 Spring 2009** • Preclinical Prosthodontic Technique Lecture V Complete Dentures
- **DENT 5910 Spring 2009** • Preclinical Prosthodontic Technique Laboratory V Complete Dentures
- **DENT 5909 Spring 2008** • Preclinical Prosthodontic Technique Lecture V Occlusion component
- **DENT 5910 Spring 2008** • Preclinical Prosthodontic Technique Lab V Occlusion component
- **DENT 5909 Spring 2007** • Preclinical Prosthodontic Technique Lecture V Occlusion component
- **DENT 5910 Spring 2007** • Preclinical Prosthodontic Technique Laboratory V Occlusion component

Pre-Doctoral Pre-Clinical Courses – Instructor

- **DDS 6311 Summer 2012** • Introduction to Clinical Dentistry
- **DDS 6475 Fall 2009** • Preclinical Prosthodontic Technique Lecture IV Partial Dentures
- **DDS 6476 Fall 2009** • Preclinical Prosthodontic Technique Laboratory IV Partial Dentures
- **DENT 5912 Summer 2007** • Preclinical Prosthodontic Technique Laboratory VI Implants
Pre-Doctoral Clinical Courses – Advanced Restorative Clinic Faculty – each semester as designated

- **DENT 6914** • Fixed Prosthodontics Clinic III
- **DENT 6915** • Fixed Prosthodontics Clinic IV
- **DENT 6923** • Removable Prosthodontics Clinic III
- **DENT 6924** • Removable Prosthodontics Clinic IV

Curriculum Development

- **Dent 7220** • Prosthetically-Driven Implant Surgery and Treatment Planning
  - Developed a new course 2012
  - The objectives of this course are to provide in-depth didactic instruction in: patient selection & treatment planning for implant therapy from simple cases to esthetically demanding cases to full-arch cases, indications & contra-indications of various types of implants with respect to final restoration, surgical anatomical considerations, flap design, suture types and suturing methods, materials and methods for socket grafting and ridge augmentation, surgical placement of implants, immediate versus delayed implant placement protocols, management of surgical complications, maintenance of dental implants, the management and prevention of peri-implantitis.

- **DDS 6496** • Predoctoral Prosthodontic Honors Course
  - Developed a new course 2011
  - This clinical, laboratory, and seminar based course is designed to provide the senior dental honors student with a fundamental and an advanced level of theory and practice in complete denture construction and implant restoration. Experience will be gained in treatment planning complex restorative patient situations, coordinating multidisciplinary care, fabrication of immediate complete dentures in preparation for implant supported dentures, fabrication of implant surgical guides for completely edentulous patients, fabrication of implant supported dentures, and restoration of implants by designing, ordering, and delivery of CAD/CAM patient-specific abutments and crowns.
    - Major Course Revision 2013
      - The objectives of this course are to provide in-depth didactic instruction in: patient selection & treatment planning for implant therapy from simple cases to esthetically demanding cases to full-arch cases, indications & contra-indications of various types of implants with respect to final restoration, surgical anatomical considerations, flap design, suture types and suturing methods, materials and methods for socket grafting and ridge augmentation, surgical placement of implants, immediate versus delayed implant placement protocols, management of surgical complications, maintenance of dental implants, the management and prevention of peri-implantitis. The honor student will also have the opportunity to surgically place a dental implant.
  - DDS 6475/76 Fall 2010 & Fall 2011 • DDS 6477/78 Spring 2010 • DENT 5909/10 Spring 2009
  - Preclinical Prosthodontic Technique Lecture and Laboratory Complete Dentures
  - Write syllabus, develop lecture materials, develop laboratory procedures, create PowerPoint presentations, develop grading booklets, take and edit photos, create models and laboratory projects, develop creative learning videos, writing quizzes, writing examinations, develop practical examinations, documentation of patient care as learning tools, setting up WebVista sites, order supplies
Faculty Development Activities regarding teaching

- 2014 April 4-5 • ACP Invitational Joint Educators’ Conference
- 2014 March 15-18 • ADEA Annual Session & Exhibition
- 2013 October 9 • ACP Mentor/Educators Workshop
- 2013 April 5-6 • ACP Invitational Joint Educators’ Conference
- 2013 March 16-19 • ADEA Annual Session & Exhibition
- 2012 April 20-21 • ACP Invitational Joint Educators’ Conference
- 2012 March 17-20 • ADEA Annual Session & Exhibition
- 2011 March 14-16 • ADEA Annual Session & Exhibition
- 2010 November 3 • ACP Mentor/Educators Workshop
- 2010 August 31, October 21 • Moodle seminars
- 2010 • Meetings with Dr. Tom Larson to develop teaching portfolio
- 2010 May 21-22 • Complete Denture Update Course
- 2009 November 24 • Issues and Options in Grading Practice: Making the Grade
- 2009 July 30 • The Value of Grading – Jane O’Brien
- 2008 October 29 • ACP Mentor/Educators Workshop
- 2007 January-April • Early Career Teaching Program – Center for Teaching and Learning
- 2006 September-December • Early Career Teaching Program – Center for Teaching and Learning
- 2006 August 28-31 • Teaching Enrichment Series – Center for Teaching and Learning
ADVISING AND MENTORING

Undergraduate Student Activities

Undergraduate advising
- Matthew Yu • CaseCAT – Replacing Posterior Occlusion in Shortened Dental Arches 2014
- Aaron Giuseffi • Research mentor 2011
- Jessica Rustad • Senior case presentation 2009
- Jason Murray • Senior case presentation 2008
- Andrew Morabu • DDS candidate mentor 2008
- Judson Smith • DDS candidate mentor 2008

Graduate Student Activities

Master’s Theses Directed
- John Keyes • Repeatability of an electronic pantograph tracing device • In progress
- Michael Lassle • CAD/CAM lithium disilicate crown performance cemented extra-orally and delivered as a screw-retained implant restoration • In progress
- Lynn Kiangsoontra • Dental cements • In progress
- Kendall James • Quantifying aesthetic maxillary central incisor dimensions • In progress
- Richard Dryer • In vitro testing of the accuracy of a computerized pantograph • Thesis edits
- Soo Cheol Jeong • Animal study for Portland cement and calcium sulfate-based dental implant bone cement • In progress
- Luis Delima • Plan B papers • in progress
- Ryan Keyes • Stress state of a bone analogue under implant crowns via digital image correlation • In progress
- Jason Chong • Prediction of initial implant stability using cone beam computerized tomography and conventional periapical radiographs • In progress
- Andrea Hsu • Comparison of initial implant stability of posterior maxillary implants with bicortical fixation to implants engaging only the alveolar crest • In progress
- Jerod Klava • Is surgical guide fabricated from prosthodontic planning predictive of final implant placement • In progress
- Roxana Saldarriaga • Volumetric measurement of misfit in CAD/CAM and cast implant frameworks • In progress
- Laura Lindquist • Case control study on risk factors associated with dental implant failure • April 2, 2012
- Ben Ricks • Plan B papers • July 13, 2011
- Mike Barczak • Prevalence of sinus augmentation associated with maxillary posterior implants • November 29, 2010
- Tyler Kuhlman • The loosening of threaded fasteners in dental implants • July 19, 2010
- Simon Hinckfuss • The effect of surgical guide design and surgeon’s experience on the accuracy of implant placement • April 29, 2010
- Anne Fundakowski • The loosening of threaded fasteners in dental implants • March 1, 2010
Master’s Student Advisees

- Jae Jung • Retrospective cohort study of the predictors of implant failure in the posterior maxilla • Defense TBD
- Rodrigo Tiossi • Digital image correlation analysis of the load transfer by implant supported restorations • defense in Brazil 2010
- Alfredo Montes • Proximal bone levels of natural teeth adjacent to plateau-designed, press fit implants • October 30, 2009
- Kevin McLennan • Characterization of the torque-to-preload relationship in threaded fasteners for dental implants • April 28, 2008
- Mark Vallee • Accuracy of friction-style and spring-style mechanical torque limiting devices for dental implants • April 4, 2008

Visiting Scholars Hosted

- Alexander Welk • Germany, September 2007

Other Mentoring Activities [Prosthodontic Board Certification Advisor]

- Fouad Badr
- Saad Bassas
- Jason Kiangsoonthra
- Sae-Eun Schlottke
- John Keyes
- Michael Lassle
- Lynn Kiangsoonthra
- Kendall James
- Richard Dryer
- Jason Chong
- Ryan Keyes
- Luis Delima
- Mark Vallee
- Cary McNeil
- Sujey Rodriguez
- Bobby Birdi
- Roxana Saldarriaga
- Ahmed Koheil
- Loscar Perez
SERVICE AND PUBLIC OUTREACH

Service to the Discipline/Profession/Interdisciplinary Area(s)

*Editorships/Journal Reviewer Experience*

- 2014 January • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2012 November • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2012 September • Northwest Dentistry – Peer Review Panel
- 2012 August • Journal of Adhesive Dentistry – guest reviewer
- 2012 July • Journal of Oral Implantology – guest reviewer
- 2012 May • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2011 August • Journal of Oral Implantology – guest reviewer
- 2011 June • Journal of Oral Implantology – guest reviewer
- 2011 May • Journal of Oral Implantology – guest reviewer
- 2011 April • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2010 December • Journal of Dental Education – guest reviewer
- 2010 October • Journal of Dental Education – guest reviewer
- 2010 September • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2009 October • Journal of Prosthetic Dentistry – guest reviewer
- 2009 October • International Journal of Oral and Maxillofacial Implants – guest reviewer
- 2009 August • Journal of Prosthodontics – guest reviewer
- 2009 January • Journal of Prosthetic Dentistry – guest reviewer
- 2008 March • Indian Journal of Dental Research – guest reviewer

*Committee memberships*

- 2014 to present • ACP Board Preparation Mock Written Exam Subcommittee
- 2013 to present • ACP Task Force on Developing New Advanced Prosthodontic Programs
- 2013 • ADEA Prosthodontics Section Chair
- 2012 to present • ACP Postgraduate Educator Committee Member
- 2012 • ADEA Prosthodontics Section Chair-Elect
- 2011 • ADEA Prosthodontics Section Secretary
- 2010 – 2013 • Council of the American Board of Prosthodontics
- 2009 – 2012 • Member of the Question Development Team for the National Dental Examining Board of Canada

*Organization of conferences, workshops, panels, symposia*

- 2014 February 22 • ADEA Dental Student Virtual Fair: Dental Specialties, Post-Graduate Opportunities, and Resources for the New Dentist • Developed, Organized, and Staffed the Prosthodontic Booth
- 2013 February 2 • ADEA Career Fair for Dental Students: Practice, Residency, and Beyond • Developed, Organized, and Staffed the Prosthodontic Booth
Director – Dental School Preparation Course – A 20 hour course providing pre-dental students with dental and manual dexterity experiences

Service to the University/College/Department

University of Minnesota

University-wide service
- 2010 to present • Member/Advising Graduate School Faculty Roster

Collegiate Service and Intercollegiate Service
- 2013 • MS Dentistry Faculty Ad Hoc Committee
- 2013 to present • Omicron Kappa Upsilon Scholarship Selection Committee
- 2012 – 2014 • Associate Dean for Academic Affairs Search Committee Member
- 2011 – 2013 • Private Practice Advisory Committee Member
- 2011 – 2012 • Dentistry Dean Search Committee Member
- 2011 to present • Technology Enhanced Awards for Teaching and Learning Ad hoc Committee Member
- 2011 to present • Building Bridges to a Career in Dentistry for underrepresented communities • Dental School Preparation Course
- 2010 to present • Maxillofacial Prosthodontic consultant for the Craniofacial Clinic
- 2008 – 2013 • Multiple demonstrations in the Advanced Simulation Clinic
- 2007 to present • School of Dentistry Admissions Interviews
- 2011 • Psychomotor skills testing of dental therapy interview candidates

Department/Unit Service
- 2013 • Advanced Education Program in Prosthodontics Accreditation Self-Study Report and Site Visit
- 2013 • Department Chair Search Committee Member
- 2012 • Prosthodontic Search Committee Chair
- 2012 • Operative Dentistry Search Committee Member
- 2011 to present • Advanced Education Program Directors Committee Member
- 2011 to present • Core Scholastic Standing Committee Member
- 2011 • Dental Laboratory Technician Search Committee Member
- 2010 – 2011 • Scholastic Standing Committee • D2 Course Director Representative
- 2009 • Division and Faculty Practice axUm Superuser
- 2009 – 2013 • Educational Policy Committee Member
- 2008 • Clinical Affairs Subcommittee Member
- 2007 – 2011 • Endodontic Search Committee Member
- 2006 – 2010 • Faculty Consultative Committee Member

Public and Other Service
- 2013 March 17 • ADEA Annual Session & Exhibition • Table Clinic Judge
- 2012 – 2013 • Developed and Chaired the Goodkind/Holtan Fundraising Campaign
• 2012 March 1 • American Student Dental Association Annual Session • Represented the ACP at the Prosthodontic Booth in the Exhibit Hall
• 2012 February 4 • Give Kids a Smile • Faculty Supervisor
• 2011 November 3 • ACP Annual Meeting Table Clinic Judge
• 2011 June 7 • ADEA Annual Session & Exhibition program submission peer review
• 2009 to present • Prosthodontic Consultant to the Minnesota Board of Dentistry
• 2008 October 30 • ACP Annual Meeting Table Clinic Judge
• 2006 to present • Prosthodontic provider in the Dental Faculty Practice Clinic
CURRICULUM VITAE
DR. RICHARD R. DRYER

EDUCATION:

▪ Master of Science in Dentistry, University of Minnesota, Minneapolis, MN. Anticipated Date: May 2013.
▪ Specialty Certificate in Prosthodontics, University of Minnesota, Minneapolis, MN. Anticipated Date: April 2013.
▪ Certificate, Miami Valley Hospital General Practice Residency, Dayton, OH; June 2003.
▪ Doctor of Dental Surgery, University of Michigan, Ann Arbor, MI; April 2002.
▪ Bachelor of Arts, Kalamazoo College, Kalamazoo, MI; June 1997.

MASTERSHIPS, FELLOWSHIPS AND AWARDS:

▪ Master, The College of Sedation in Dentistry, American Dental Society of Anesthesiology; June 2008.
▪ Fellow, Academy of General Dentistry; August 2006.
▪ Clinical Excellence Award, Indian Health Service Division of Oral Health; July 2009.
▪ Distinguished Service Award, Albuquerque Area Indian Health Service Honor Awards; April 2009.
▪ Superior Customer Service Award, Zuni Service Unit; May 2008.

RESEARCH:

▪ Master of Science in Dentistry, In Vitro Testing of the Accuracy of a Computerized Pantograph. Anticipated Date: May 2013.

PROFESSIONAL AFFILIATIONS:

▪ The American College of Prosthodontists
▪ The American Academy of Maxillofacial Prosthetics
▪ The American Dental Society of Anesthesiology
CLINICAL EXPERIENCE:

▪ Prosthodontics Residency  
  Chief Resident  
  University of Minnesota, Minneapolis, MN  
  June 2010-present  
  Completing coursework in fixed, removable and implant prosthodontics, and dental implant surgery at the University of Minnesota to fulfill the requirements for specialty certification in prosthodontics.  
  Conducting research to fulfill the requirements for a Master of Science in Dentistry.  
  One half day per week teaching responsibility with undergraduate dental students in the clinic and pre-clinic in prosthodontics.

▪ Federal Dental Service  
  Indian Health Service, Zuni Pueblo, NM  
  July 2005-May 2010  
  Practiced as a general dentist with an interest in oral surgery, dental implant surgery and implant prosthodontics, fixed and removable prosthodontics, intravenous moderate sedation, full mouth rehabilitation and the treatment of medically compromised patients.  
  Developed a program in implant dentistry which increased the quality and scope of care through the following procedures: surgical placement of dental implants, ridge preservation following dental extractions, hard and soft tissue grafting, maxillary sinus grafting, implementation of CT guidance software (Simplant) in implant treatment planning, single unit to multiple unit fixed prosthetic restorations, and removable implant supported prosthetics.  
  Established a program to deliver intravenous moderate sedation in the department of dentistry, according to JCAHO standards. Developed a continuing education program for dentists to deliver intravenous moderate sedation in the department of dentistry through 60 hours didactic instruction and testing, venipuncture technique, operatory set-up for sedation, nitrous oxide and oral conscious sedation, intravenous sedation, patient monitoring, medical emergencies, and delivery of intravenous moderate sedation to 20 patients.  
  Administrative duties within the department of dentistry included: JCAHO certification, chart review, program improvement, community outreach, development of continuing education courses, recruiting, clinical instruction of medical and dental students and medical residents and active member of medical staff.
Private Practice
Chicago, IL
July 2003-July 2005
Practiced as a general dentist with an interest in oral surgery, intravenous moderate sedation, implant dentistry, and removable prosthodontics.
Graduate, Misch International Implant Institute with coursework in implant prosthetics, implant surgery and bone grafting.

General Practice Residency
Miami Valley Hospital, Dayton, OH
July 2002-July 2003
Completed one year of a general practice residency in dentistry with training in intravenous moderate sedation, oral surgery, prosthodontics, pediatric dentistry, endodontics, dental implants, periodontics, treatment of patients under general anesthesia in the operating room, oral and maxillofacial trauma, and the treatment of medically compromised patients.
Extensive experience in oral surgery ranging from simple to bony impacted third molar extraction, alveoloplasty, dental implant surgery, hard and soft tissue grafting, and delivery of intravenous moderate sedation under the instruction of board certified oral and maxillofacial surgeons.
Off-service rotations included: one month of anesthesia, family and internal medicine, infectious disease, ENT, and OB-GYN.
Certificate in intravenous moderate sedation.

CONTINUING EDUCATION:

American College of Prosthodontists Annual Meeting, November 2010.
Oral Pathology Review, Indian Health Service, December 3, 2008.
ACLS and BLS Certification, Northern Arizona Health Education, May 29-30, 2008
▪ Master Course-Arizona Academy of General Dentistry: Endodontics, May 10-12, 2008
▪ Physical Diagnosis, Occlusion and TMD, Scottsdale Center for Dentistry, February 28-29, 2008
▪ Master Course-Arizona Academy of General Dentistry: Photography and Anterior Esthetics, November 15-17, 2007
▪ The Clinical Application of Computer Guided Implant Dentistry, Simplant Academy, September 14-15, 2007
▪ General Anesthesia and Moderate Sedation, American Dental Society of Anesthesiology, December 3-5, 2006
▪ Bone Biology, Harvesting and Grafting, International Congress of Oral Implantologists, November 10-12, 2006
▪ Operative Dentistry: Ceroc Hands-On, Indian Health Service, October 25, 2006
▪ Contemporary Assessment and Management of the Pediatric Patient/Annual Session, American Dental Society of Anesthesiology, May 4-6, 2006
▪ CAD/CAM Dentistry, University of North Carolina, April 21, 2006
▪ Advanced Bone Grafting, Misch Implant Institute, November 4-6, 2005
▪ ACLS, Misch Implant Institute, November 3, 2005
▪ Academy of General Dentistry Annual Meeting, July 13-17, 2005
▪ Surgical Oral Implantology, Misch Implant Institute/Temple University, February – October 2005 (15 days of course work)
▪ Prosthetic Oral Implantology, Misch Implant Institute/Temple University, February – October 2005 (9 days of course work)
▪ Ambulatory Anesthesia Review, American Dental Society of Anesthesiology, December 5-6, 2004
▪ Office Oral Surgery, University of Minnesota, November 1-2, 2004
▪ Achieving Predictable Success in Restorative Dentistry, Chicago Academy of General Dentistry, October 22, 2004
▪ Restorative Periodontal and Perio-Plastic Surgery for the General Practitioner, Indiana University, July 2004
▪ Ambulatory Anesthesia Review, American Dental Society of Anesthesiology, December 7-8, 2003
▪ Intravenous (Parenteral) Moderate Sedation, Miami Valley Hospital, July 1, 2002-May 22, 2003 (12.5 hrs in Pharmacology; 48.5 hrs. in Conscious/Moderate Sedation; One Month General Anesthesia; Management of 25 pts. with Intravenous Sedation)
▪ Implant Workshop, Perio. Institute, April 25-26, 2003
REFERENCES:

- Dr. Heather Conrad. Director, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (651) 283-3094; E-mail: conr0094@umn.edu.
- Dr. James Holtan. Director Emeritus, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (612) 625-5650; E-mail: holta001@umn.edu.
- Dr. Bobbi Birdi. Adjunct Professor, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (778) 316-4221; E-mail: bobbirdi@gmail.com.
- Dr. Nixon Roberts, Former Chief Dentist, Zuni PHS Hospital/Department of Dentistry, Route 301 North “B” St., Zuni, NM 87327. Phone: (505) 782-7417.
- Dr. Gary Ensor, Former Director, Miami Valley Hospital-General Practice Residency, One Wyoming St., Dayton, OH 45409. Phone: (937) 208-2204; E-mail: GHEnsor@mvh.org
- Dr. David Jimenez, Prosthodontist, P.O. Box 92994, Albuquerque, NM 87199. Phone: (505) 823-4566; E-mail: david.jimenez3@va.gov

CONTACT INFORMATION:

- Dr. Richard Dryer
- 3036 33rd Ave. S., Minneapolis, MN 55406.
- Cell Phone: (734) 323-9705
- E-mail: rdryerdds75@yahoo.com

LICENSES:

- Licensed Dentist, State of Illinois # 019-026001
- Intravenous Moderate Sedation License, State of Illinois # 137-000585
- BLS and ACLS Certification
REFERENCES

▪ Dr. Heather Conrad. Director, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (651) 283-3094; E-mail: conr0094@umn.edu.

▪ Dr. James Holtan. Director Emeritus, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (612) 625-5650; E-mail: holta001@umn.edu.

Dr. Bobbi Birdi. Adjunct Professor, Graduate Prosthodontics. University of Minnesota School of Dentistry. 515 Delaware Street S.E., Minneapolis, MN 55455. Phone: (778) 316-4221; E-mail: bobbirdi@gmail.com.

▪ Dr. Nixon Roberts, Former Chief Dentist, Zuni PHS Hospital/Department of Dentistry, Route 301 North “B” St., Zuni, NM 87327. Phone: (505) 782-7417.

▪ Dr. Gary Ensor, Former Director, Miami Valley Hospital-General Practice Residency, One Wyoming St., Dayton, OH 45409. Phone: (937) 208-2204; E-mail: GHEnsor@mvh.org

▪ Dr. David Jimenez, Prosthodontist, P.O. Box 92994, Albuquerque, NM 87199. Phone: (505) 823-4566; E-mail: david.jimenez3@va.gov
LETTER OF INTENT

I received my Doctor of Dental Surgery from the University of Michigan in 2002 and entered a one year general practice residency at Miami Valley Hospital in Dayton, OH. During residency, I received additional training in all fields of dentistry as they relate to the delivery of dental care in a hospital environment and the treatment of medically compromised patients. In particular, I received excellent training in dentoalveolar surgery ranging from simple to complete bony impacted third molar extractions, alveoloplasty, dental implant surgery, hard and soft tissue grafting, and delivery of intravenous moderate sedation under the instruction of board certified oral and maxillofacial surgeons. In addition, I completed the requirements for certification in intravenous moderate sedation.

On completion of my general practice residency, I entered private practice in Chicago, IL. I practiced as a general dentist for two years with an interest in oral surgery, intravenous moderate sedation, removable prosthodontics and the treatment of medically compromised patients. During this period, I continued my education at the prestigious Misch Implant Institute and received additional training in implant surgery and implant prosthodontics.

In July of 2005, I entered the Indian Health Service as a federal civil servant. I practiced general dentistry within a hospital located on the Zuni Indian Reservation providing a broad range of dental services to a population of patients with extensive unmet dental needs and complex medical conditions. In Federal Service, I had the opportunity to develop two unique initiatives in the Indian Health Service. First, I developed a program for the surgical placement of dental implants and implant prosthodontics to improve the quality of life for our patient population. Second, I developed a program to deliver intravenous moderate sedation according to JCAHO standards to improve access to care. In addition, I performed over 3,500 surgical procedures ranging from simple to surgical extractions, soft tissue to complete bony impacted third molar extractions, canine exposures for our orthodontic program, alveoloplasty, hard and soft tissue biopsies, dental implant surgery with associated hard and soft tissue grafting, sinus elevation surgery, CT guided implant treatment planning and fixed and removable implant prosthodontics. Additional duties in our department included: active member of medical staff, development of continuing education programs, chart review and program improvement, recruiting, oversight of dental students on externship and training dental assistants, JCAHO accreditation, and clinical instruction and certification of two dentists to deliver intravenous moderate sedation following the ADA guidelines on sedation. During my tenure, I decided that I would like to embark on a career in academics. In order to achieve this goal, I elected to pursue advanced training in the specialty of prosthodontics.
Currently, I am chief resident in the Department of Graduate Prosthodontics at the University of Minnesota with an expected graduation date of April 13, 2013. In addition, I expect to complete my Masters of Science degree at the University of Minnesota in the spring of 2013. During my residency, I have received extensive training in the fields of fixed, removable and implant prosthodontics, and dental implant surgery. One half day per week includes instruction of pre-doctoral dental students in the field of prosthodontics.

I am applying to the open faculty position in the department of prosthodontics because I am uniquely qualified to provide instruction in dental implant surgery and related oral surgical procedures to the residents in graduate prosthodontics; including the medical evaluation and management of patients receiving surgical procedures. In addition, I have administrative experience related to program development, recruiting, continuing education, and preparation for accreditation. Professionally, I plan on completing board certification in prosthodontics.
CURRICULUM VITAE

Name and Address: Holtan, James R.
18730 Ridgewood Road, South Wayzata, Minnesota 55391
(612) 470-0453

Current Position: Associate Professor and Director,
Graduate Prosthodontics Program
University of Minnesota School of Dentistry
515 Delaware Street, SE
Minneapolis, Minnesota 55455
(612) 625-5650

Specialty Board Status: Diplomate, American Board of
Prosthodontics, 1974

Professional Licensures: National Board of Dental Examiners
State of Minnesota

Education:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Dates</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washburn High School</td>
<td>June, 1956</td>
<td>Diploma</td>
</tr>
<tr>
<td>Minneapolis, Minnesota</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Minnesota</td>
<td>June, 1963</td>
<td>B.S., D.D.S.</td>
</tr>
<tr>
<td>Minneapolis, Minnesota</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naval Dental Clinic</td>
<td>July, 1970</td>
<td>Certificate, Fellowship in Prosthodontics</td>
</tr>
<tr>
<td>Norfolk, Virginia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naval Graduate Dental School</td>
<td>July, 1972</td>
<td>Certificate, Residency in Prosthodontics</td>
</tr>
<tr>
<td>Bethesda, Maryland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgetown University</td>
<td>July, 1972</td>
<td>Certificate in Graduate Studies</td>
</tr>
<tr>
<td>Washington, D.C.</td>
<td></td>
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</tr>
<tr>
<td>Air University, Allied Officer &amp;</td>
<td>April, 1977</td>
<td>Certificate, Academic Instructor Course</td>
</tr>
<tr>
<td>Academic Instructors School,</td>
<td></td>
<td></td>
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<tr>
<td>Maxwell Air Force Base</td>
<td></td>
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<tr>
<td>Montgomery, Alabama</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naval School of Health Care Adm.</td>
<td>January, 1980</td>
<td>Certificate, Executive Medicine</td>
</tr>
<tr>
<td>Bethesda, Maryland</td>
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</tbody>
</table>
Naval School of Health Care Adm. May, 1981 Certificate
Adv. Health Policy/Planning Course Bethesda, Maryland

Inter-Agency Institute for Federal March, 1984
Advanced Training, Health Care Executives Health Care Adm.
St. Louis, Missouri

**Continuing Dental Education:**

Regular attendance at professional meetings and Dental Continuing Education short courses since graduation from dental school.

The following meetings are attended on a yearly basis:

American Academy of Crown and Bridge Prosthodontics Annual Meeting
American College of Prosthodontics Annual Meeting,

**Teaching Experience:**

<table>
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<tr>
<th>Position/Institution</th>
<th>Dates</th>
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<tbody>
<tr>
<td>University of Minnesota School of Dentistry</td>
<td>1966-67</td>
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<tr>
<td>Department of Operative Dentistry</td>
<td></td>
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<tr>
<td>Clinical Instructor</td>
<td>1972</td>
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<tr>
<td>Georgetown University School of Dentistry</td>
<td></td>
</tr>
<tr>
<td>Department of Prosthodontics</td>
<td></td>
</tr>
<tr>
<td>Consultant in Prosthodontics</td>
<td>1972-74</td>
</tr>
<tr>
<td>Naval Hospital, Portsmouth, Virginia</td>
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</tr>
<tr>
<td>Chief, Fixed Partial Denture Division</td>
<td>1976-80</td>
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<tr>
<td>Prosthodontic Department</td>
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<tr>
<td>Naval Graduate Dental School</td>
<td></td>
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<tr>
<td>Bethesda, Maryland</td>
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</tr>
<tr>
<td>-Course Director, Fixed Partial Dentures: 20 hrs. lecture; 26 participants</td>
<td></td>
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<tr>
<td>-Course Director, Annual Fixed Partial Denture Continuing Education Course (5 days) 11 hrs. lecture/seminar; 35 participants</td>
<td></td>
</tr>
<tr>
<td>-Course Director, Dental Materials Continuing Education Course (5 days): 10 hrs. lecture; 40 participants</td>
<td></td>
</tr>
<tr>
<td>-Clinical Consultant, Fixed/Removable Prosthodontics to residents in Comprehensive Dentistry, first</td>
<td></td>
</tr>
</tbody>
</table>
year level, 20 residents, contact time - one day/week
-Consultant/Seminar Director, fixed partial dentures
to Comprehensive Dentistry Residents, second year
level: 8 hrs. seminar, 20 participants
-Mentor, Prosthodontic Residents, first year level
(six residents per year)
-Lecturer, Occlusion Course, first year level,
Specialty and Comprehensive Dentistry Residents: 4 hrs. lecture, 26
participants
-Primary Lecturer, 27 hour course on Dental Materials: 14 hrs. lecture, 26
participants first year level, Specialty and Comprehensive Dentistry
Residents
-Lecturer, Occlusion Continuing Education Course: 2 hrs. lecture; 40 participants
-Member, Faculty Committee on Curriculum Development

Consultant for Prosthodontics 1980-83
Head, Navy Area Dental Prosthetic Laboratory
Naval Regional Dental Center
Norfolk, Virginia

Lecturer, Dental Materials 1984
Naval Dental School
Bethesda, Maryland

University of Minnesota School of Dentistry 1986-present
Department of Restorative Sciences
Division of Prosthodontics

-Director, Preclinical Course in Fixed Prosthodontics F,W,S,; 34 hrs. lecture;
170 hrs. lab 1987-1989
-Instructor, Course on Ethics in Dentistry 1986-89
10 hrs. seminar, 10 participants
-Lecturer, AGD Program 10/88-present
-Instructor, Preclinical Fixed Prosthodontics F,W,S;
12 students at a bench 1989-91
-Group Clinic Director: 40 students in group 1989-93

9/90
Director, Continuing Education Course on Advanced Restorative Dentistry: 8-16 hrs.; 18 participants
Small Group Facilitator 9/91-6/94
University of Minnesota Graduate Prosthodontics Program Director - 10 Residents

Courses Taught:
- Graduate Prosthodontic Clinic
- Restorative Dental Materials
- Prosthodontic Technique Course
- Current Literature Seminar
- Classic Literature Seminar
- Articulator Seminar
- Implant Seminar
- Treatment Planning Seminar

**Hospital Experience:**

<table>
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<th>Position/Institution</th>
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<tbody>
<tr>
<td>Resident</td>
<td>1970-72</td>
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<tr>
<td>Bethesda Naval Hospital</td>
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<tr>
<td>Bethesda, Maryland</td>
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<tr>
<td>Consultant/Staff Prosthodontist</td>
<td>1972-74</td>
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<tr>
<td>Portsmouth Naval Hospital</td>
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<tr>
<td>Portsmouth, Virginia</td>
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<tr>
<td>Consultant/Staff Prosthodontist</td>
<td>1976-80</td>
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<tr>
<td>Bethesda Naval Hospital</td>
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<tr>
<td>Bethesda, Maryland</td>
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<tr>
<td>Consultant/Staff Prosthodontist</td>
<td>2005-Present</td>
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<tr>
<td>VAMC</td>
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<tr>
<td>Minneapolis Minnesota</td>
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**Military Experience:**

<table>
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<th>Position/Location</th>
<th>Dates</th>
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<tbody>
<tr>
<td>Marine Corps Recruit</td>
<td>6/63 - 6/66</td>
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<tr>
<td>Depot Dental Clinic, San Diego, California</td>
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<tr>
<td>Naval Dental Clinic, Norfolk, Virginia</td>
<td>4/67 - 6/67</td>
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<tr>
<td>USS Taconic (LCC-17)</td>
<td>6/67 - 6/69</td>
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<tr>
<td>Norfolk, Virginia</td>
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<tr>
<td>Naval Dental Clinic, Norfolk, Virginia</td>
<td>6/69 - 7/70</td>
</tr>
<tr>
<td>Naval Graduate Dental School</td>
<td>7/70 - 7/72</td>
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<tr>
<td>Bethesda, Maryland</td>
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<tr>
<td>Naval Hospital, Portsmouth, Virginia</td>
<td>7/72 - 7/74</td>
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</table>
USS John F. Kennedy (CV-67) 7/74 - 7/76
Norfolk, Virginia

Naval Graduate Dental School, Bethesda, Maryland 7/76 - 7/80

Head, Navy Area Dental Prosthetic Lab, Naval Dental Clinic; and Staff Dental Officer for Commander, Naval Air Force, Atlantic Fleet 7/80 - 3/83

Naval Medical Command, Washington, D.C. 3/83 - 4/84

Executive Officer, Naval Dental Clinic Bethesda, Maryland 4/84 - 2/86

Retired, US Navy Dental Corps following 22 years of service, with the grade of Captain

**Professional Experience:**

<table>
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<th>Dates</th>
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<tbody>
<tr>
<td>General practice, San Diego, California</td>
<td>6/63 - 6/66</td>
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<tr>
<td>General practice, instructor - Univ. of MN, Mpls.</td>
<td>6/66 - 4/67</td>
</tr>
<tr>
<td>General practice, Norfolk, Virginia</td>
<td>4/67 - 6/67</td>
</tr>
<tr>
<td>General practice, USS Taconic</td>
<td>6/67 - 6/69</td>
</tr>
<tr>
<td>Fellow in Prosthodontics, Norfolk, Virginia</td>
<td>6/69 - 7/70</td>
</tr>
<tr>
<td>Resident in Prosthodontics, Bethesda, Maryland</td>
<td>7/70 - 7/72</td>
</tr>
<tr>
<td>Prosthodontist, Portsmouth, Virginia</td>
<td>7/72 - 7/74</td>
</tr>
<tr>
<td>Prosthodontist, USS John F. Kennedy</td>
<td>7/74 - 7/76</td>
</tr>
<tr>
<td>Instructor, Prosthodontics/Dental Materials Staff Prosthodontist, Bethesda, Maryland</td>
<td>7/76 - 7/80</td>
</tr>
<tr>
<td>Prosthodontist/Head, Navy Area Dental Prosthetic Laboratory, Norfolk, Virginia</td>
<td>7/80 - 3/83</td>
</tr>
<tr>
<td>Head, Career Planning Branch, Naval Medical Command, Washington, D.C.</td>
<td>3/83 - 4/84</td>
</tr>
</tbody>
</table>
Executive Officer, Naval Dental Clinic  4/84 - 2/86
Bethesda, Maryland

Department of Restorative Sciences  3/86 - present

Chairperson, Department of Restorative Sciences  10/94 – 2/02
University of Minnesota School of Dentistry
Minneapolis, Minnesota

Director, Graduate Program in Prosthodontics  9/97 - present
Department of Restorative Sciences
University of Minnesota School of Dentistry
Minneapolis, Minnesota

Publications:

Periodicals:


Textbooks:


Published Articles:


Published Abstracts:


Presented Abstracts:

IADR Dublin, Ireland (Oral Presentation), 1989
AADR Cincinnati, OH (Poster Presentation), 1990
IADR Acapulco, Mexico (Oral Presentation), 1991
IADR Glasgow, Scotland (Poster Presentation), 1992
AADR San Francisco, CA (Oral/Poster Presentation), 1996

Research Reports on File:

Holtan JR (1972). The effect of epinephrine impregnated string on heart rate and blood pressure. Research report on file, Naval Graduate Dental School, Bethesda, MD.


Current efforts: Ongoing research projects within the School of Dentistry

1) Effect of chemicals used as retraction agents on the gingival complex of humans. Supported by University of Minnesota Clinical Dental Research Center.


Currently involved with 10 graduate students and their research thesis.

Grants:

$10,000; Regent Hospital Products Limited. Project: Effect of Glove Retained Talc on Bond Strength of Porcelain Laminate Veneers. Project completed 7/1/94.

$5,647.00; University of Minnesota Clinical Dental Research Center. Effect of chemicals used as retraction agents on the gingival complex of humans.

$11,825.00 University of Minnesota Clinical Dental Research Center. Parameter Controlled Clinical Study of Wear of Posterior Restorations: A One Year Pilot Project.

Grant Proposals Submitted:
To: Seney Research, Key West, Fla.
Title: Evaluation of the analgesic efficacy of a new high speed handpiece and bur system.
Amount: $60,000.00          Date: 7/13/94

Scientific Presentations - Continuing Education Courses Presented:

Minneapolis District Dental Society, Breakfast Seminar, Fixed Prosthodontics: 1 hr; 12 participants 12/12/86
Northwest District Dental Society, Minot ND All Day Topics in Fixed Prosthodontics: 6 hr. lecture; 45 participants 12/13/86
West Central District Dental Society, St. Cloud, MN Fixed Prosthodontics: 3 hr. lecture; 45 participants 1/31/87
U of M Continuing Education Series, Earl Brown Ctr. What's New in Fixed Prosthodontics: 1 hr. lecture; 168 participants 2/27/87
51st Reunion Annual DeLa Academia De Estomatologia Del Peru, Arequipa, Peru- Fixed Prosthodontic Topics 18 hr. lecture; 250 participants 11/25-11/28, 1987
DentiClinics, St. Petersburg Beach, FL Fixed Prosthodontics Topics: 6 hr. lecture; 73 participants 2/1-2/5, 1988
Duluth Dental Forum - Fixed Prosthodontics: 3 hr. lecture; 30 participants 3/3/88
Minnesota State Dental Association Annual Meeting Fixed Prosthodontics: 1 1/2 hr. lecture; 100 participants 4/22/88
Minneapolis District Dental Society, "Tissue Issues": 1 1/2 hr. lecture; 60 participants 3/30/89
U of M Continuing Education Series, Annual Dental Assistants Seminar, "What's New in Fixed Prosthodontics": 1 1/2 hr. lecture; 82 participants 11/11/89
U of M Study Abroad, Ocho Rios, Jamaica Prosthodontic Diagnosis and Treatment Planning for Complex Restorative Patients": 16 hr. lecture; 8 participants 1/22-1/29, 1990
Spring Education Program for Dr. Dale Erickson (State Board of Dentistry): 24 hours 3/1-5/1, 1990
U of M Continuing Education Series Directed Course "Prosthodontic Diagnosis and Treatment Planning": 16 hr. lecture; 18 participants 10/1-10/2, 1990
Minnesota State Dental Association Annual Meeting "Color in Fixed Prosthodontics": 1 1/2 hr. lecture; 100 participants 4/22/91
U of M Continuing Education Series Directed Course Diagnosis and Treatment Planning 1991 for Complex Restorative Patients": 16 hr. lecture; 8 participants 10/21-10/22, Prosthodontic Study Abroad, Palmas Del Mar, Puerto Rico 2/25-3/3, 1992
Topics in Fixed Prosthodontics: 6 hr. lecture; 43 participants
Bite Right Study Club, Minnetonka, MN 3/9/92
“Color in Dentistry”: 1 1/2 hr lecture; 25 participants
U of M Continuing Education Series, "Incorporating
Porcelain Veneers in Your Practice" A hands on program with Dr. Paul Olin: 8 hours; 20 participants
U of M Continuing Education Series Directed Course
"Alternative Treatment Options for Complex Patients": 8 hr. lecture; 18 participants
U of M Continuing Education Series Annual Dental Assistants Seminar, "What's New in Restorative Dentistry": 1 1/2 hr. lecture; 367 participants
Group Health Inc. "Occlusion in Fixed Prosthodontics" 10/15/92
1 1/2 hr. lecture; 30 participants
U of M Continuing Education Series Directed Course
"Alternative Treatment Options for Complex Patients" 2/5/93
8 hr. lecture; 18 participants
U of M Continuing Education Series, "What's New in Dentistry - Impressions and Temporization" 3/8/93
1/2 hr lecture; 200 participants
Minnesota State Dental Association Annual Meeting, "Occlusion in Fixed Prosthodontics": 5/3/94
U of M Continuing Education Series, 5/4/94
"Temporary Restorations" 8 hr lecture/demonstration; 8 participants
U of M Education Series, St. Petersburg Beach, FL 3/25-29-96
"What's New in Dentistry?", "Color in Fixed Prosthodontics", "Diagnosis and Treatment Planning for the Complex Restorative Patient", "Occlusion in Fixed Prosthodontics": 2hrs/lecture, 2 days, 60-110 participants
U of M/Dental Lab Association 3/30/96
"Occlusion in Fixed Prosthodontics" 2 hr lecture, 50 participants

Membership in Professional Organizations
American College of Prosthodontists (fellow) 1977-present
Capital Area Prosthodontic Study Club 1972-present
International College of Dentists (fellow) 1984-present
American Academy of Crown & Bridge Prosthodontics 1987-present
International Association for Dental Research 1988-present
American Dental Association 1994-present
Minnesota Dental Association 1994-present
Minneapolis District Dental Society 1994-present
Service to Profession:

Committee on Color and Color Matching
American College of Prosthodontists

Responsible for Table Clinic portion
American Prosthodontic Society
Annual Meeting, Miami, Florida, October, 1977

President, Minnesota Section, American College of Prosthodontists,

Delegate to House of Delegates for Minnesota Section, American College of Prosthodontists,

Committee on the Young Dentist, Minneapolis District Dental Society, 1994.


Speaker of the House of Delegates, American College of Prosthodontists Annual Meeting,
Kansas City, MO, 1996

Membership to Dental School/University Committees:

Admissions Committee  1988-present
Clinical Affairs Committee  1991-92
Search Committee for Department of Restorative Sciences Chair  1990, 1992

Chair, Search Committee for Fixed Prosthodontic Faculty Position  1988
University Senate Member  1992-94
Chair, 1st Year Class Committee  1988-89
Member, 1st Year Class Committee  1989-90
Member, 2nd Year Class Committee  1988-89
Member, 3rd Year Class Committee  1989-95
Member, 4th Year Class Committee  1989-90
Search Committee for Clinical Track Position, Prosthodontics  1993
Student Affairs Committee  1993
Health Sciences Interview Committee for Health Sciences Provost  1994
Search Committee for Clinical Track Position, Dental Hygiene  1994
Educational Policy Committee  1995-96
Search Committee, Chair of Preventive Sciences  1996
Chair, Search Committee for Div. of Prosthodontics  1998
Search Committee for Dean 2004

**Military Honors:**

Sea Service Ribbon, US Navy 1976
Battle Efficiency Ribbon, US Navy 1976
Meritorious Service Medal, US Navy 1983
Meritorious Service Medal, US Navy 1986

**Other Awards/Honors:**

Elected OKU 1991
Outstanding Instructor Award, 1987, 1989, 1990
University of Minnesota School of Dentistry 1992
Selected as Faculty Advisor to Student Council 1990, 1991, 1992
Selected in conjunction with Dr. James Jensen to present graduation address by Class of 1992 1992
Selected by graduating class as a sponsor for the graduation ceremony 1993, 1994
Selected to participate in the "Bush Faculty Development Program on Excellence and Diversity in Teaching" 1994, 1995
Accepted to the Graduate School Faculty of the University of Minnesota 1994
Nominated as first Speaker of the House of Delegates, American College of Prosthodontists 1996

**Personal Interests/Hobbies:**

Jogging, fishing, woodworking, golf
CURRICULUM VITAE
of
CHARLES G. STENDAHL, D.D.S., M.S.

Curriculum Vitae
Charles G. Stendahl
PERSONAL INFORMATION

Name: Charles G. Stendahl, D.D.S., M.S.
Home Address: 14049 Dunbar Ct.
(Preferred for correspondence) Apple Valley MN  55124
612-423-3154
stend001@umn.edu

Work Address: Charles G. Stendahl, D.D.S., M.S.
825 Nicollet Mall
Suite 1921
Minneapolis, MN 55402-2793
612-332-5916

Dental Licensure: Illinois (1971)
Minnesota (2007)

EDUCATION

School                      Date         Degree
University of Illinois      1965-67
Northwestern University     1967-71     D.D.S.
School of Dentistry
U.S. Public Health Service Hospital, Baltimore, Maryland 1971-72
Certificate for completion of dental internship
Marquette University        1976-78     M. S. (Prosthodontics)
V.A. Medical Center         1976-78     Certificate for completion of prosthodontic residency

PROFESSIONAL WORK EXPERIENCE

Staff Dentist
United States Public Health Service Hospital
Indian Health Service
Keams Canyon, Arizona 1972-74

Assistant Professor of Pedodontics
Northwestern University Dental School
and
Director of the Robert R. McCormick Boys
Club Dental Clinic 1975-76

Part-time private, general practice
Evanston, Illinois 1974-76

Clinical Instructor of Removable Prosthodontics
University of Minnesota School of Dentistry
Minneapolis, Minnesota 1978-81

Clinical Assistant Professor of Removable Prosthodontics
University of Minnesota School of Dentistry
Minneapolis, Minnesota 1981-1990

Clinical Associate Professor of Removable Prosthodontics
University of Minnesota School of Dentistry
Minneapolis, Minnesota 1990-1997

Clinical Associate Professor
Department of Restorative Sciences
Graduate Prosthodontic Program
University of Minnesota School of Dentistry
Minneapolis, Minnesota 1997-2005

Adjunct Professor
Department of Restorative Sciences
University of Minnesota School of Dentistry
Minneapolis, Minnesota 2005-present

Section Director
Advanced Technical Restorative Dentistry
PROS 7210
University of Minnesota School of Dentistry
Minneapolis, Minnesota 2012-present
Staff Prosthodontist
Veterans Administration Medical Center
Minneapolis, Minnesota 1978-2007, (retired)

Acting Chief, Dental Service
Veterans Administration Medical Center
Minneapolis, Minnesota  1983-1986

PROFESSIONAL WORK EXPERIENCE (Con’t.)

Consultant to Commission on Dental Accreditation of the
American Dental Association July 1983-1996

Private Specialty Practice of Prosthodontics (Part time)
Minneapolis, Minnesota September 2007-present

PROFESSIONAL AFFILIATIONS AND ASSOCIATED APPOINTMENTS

<table>
<thead>
<tr>
<th>Status</th>
<th>Organization</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>Minnesota Association of Prosthodontists</td>
<td>1979-present</td>
</tr>
<tr>
<td>Member</td>
<td>American Prosthodontic Society</td>
<td>1980-present</td>
</tr>
<tr>
<td>President</td>
<td>Minnesota Prosthodontic Society</td>
<td>1997</td>
</tr>
<tr>
<td>Member (elected)</td>
<td>Minnesota Academy of Restorative Dentistry/Minnesota Academy of Comprehensive Dentistry</td>
<td>1983-present</td>
</tr>
<tr>
<td>Secretary/Treasurer</td>
<td>Minnesota Academy of Restorative Dentistry</td>
<td>1987-1990</td>
</tr>
<tr>
<td>Member (elected)</td>
<td>Omicron Kappa Upsilon</td>
<td>1989-present</td>
</tr>
<tr>
<td>President</td>
<td>Minnesota Academy of Restorative Dentistry</td>
<td>1999-2000</td>
</tr>
</tbody>
</table>
TEACHING ACTIVITY

I. Northwestern University Dental School, Chicago, Illinois
   a) Robert McCormick Boys Club Dental Clinic (1974-75)
      Clinical Pediatric Dentistry
   b) Department of Removable Prosthodontics (1975-75)
      Clinical instruction with occasional lecture responsibility

II. University of Minnesota School of Dentistry, Minneapolis, Minnesota
    Department of Restorative Sciences, Division of Removable Prosthodontics (1978-1997) - Clinical instruction

III. University of Minnesota School of Dentistry, Minneapolis Minnesota
     Department of Restorative Sciences, Division of Graduate Prosthodontics Program (1997-present) - Clinical instruction

IV. North Central Regional Medical Education Center
    Veterans Administration Medical Center, Minneapolis, Minnesota
    Denture Prosthesis IV - October 5-9, 1981 - Faculty member for a five day, hands-on complete denture course for VA dentists and laboratory technicians.

V. Dental Education Center, Washington, D.C. and Dental Service,
   Veterans Administration Center, Minneapolis, Minnesota
   Complete Denture Prosthodontics - August 29 - September 2, 1983
   Faculty member for a five day, hands-on complete denture course for VA dentists and laboratory technicians.

VI. Department of Veterans Affairs Medical Center, Minneapolis, Minnesota - Clinical and didactic instruction for general practice residents (1978-2007)

VI. Department of Veterans Affairs Medical Center, Minneapolis, Minnesota
    Clinical instruction in complete denture prosthesis for students enrolled in the Graduate Prosthodontic Program at the University of Minnesota (1997-2005)

LECTURE PRESENTATIONS

United States Public health Service
Commissioned Officers Association Meeting at Washington, D.C.
“Partial Overdentures” - April, 1974
Minnesota Prosthodontic Society
“The Three-quarter Crown Revisited” - April 1979

Minnesota Prosthodontic Society
“Tissue Conditioning for Complete Dentures” - April, 1983

Minnesota Academy of Restorative Dentistry
“Improving Tissue Support for Distal Extension Removable Partial Dentures” - December, 1983

Minnesota Academy of Restorative Dentistry
“Tissue Conditioning” - November, 1988

University of Minnesota Geriatric Dental Symposium
“Soft Tissue Conditioning” - February, 1989

Minnesota Academy of Restorative Dentistry
“Helpful Concepts in Restorative Dentistry” - March, 1998

Minnesota Academy of Restorative Dentistry
“Jaw Relations” – March 2008

Minnesota Academy of Comprehensive Dentistry
“The Ends of Dentures” – March 2010

**TABLE CLINICS**

Greater Milwaukee Dental Exposition
“Complete Dentures for the Gagging Patient” - November 1976

Chicago Dental Society Mid-Winter Meeting
“Detection of Binding Areas on Removable Partial Denture Frameworks”
February 1977

Wisconsin State Dental Society Meeting
“Prosthodontics for the Irradiated Patient” - March 1977

Midwest Academy of Prosthodontics
“Detection of Binding Areas on Removable Partial Denture Frameworks”
September 1977

Chicago Dental Society Mid-Winter Meeting
“Physiologic Contours for Complete Dentures” - February 1978
Minnesota State Dental Association Meeting
“A Remount Technique for Removable Partial Dentures” - April 1981

Minnesota State Dental Association Meeting
“Partial Overlay Dentures” - April 1982

Minnesota State Dental Association Meeting
“Immediate Dentures - A Simplified Approach” - April 1983

Minnesota State Dental Association Meeting
“Bar Splint Removable Partial Dentures” - April 1984

Minnesota State Dental Association Meeting
“Preparation of the Tilted Molar Abutment” - April 1985
Minnesota State Dental Association Meeting
“Clasping the Tilted Molar Abutment” - April 1986

Minnesota State Dental Association Meeting
“Prosthodontic Applications for Light Cured Composite Resins”
April 1987

Minnesota Academy of Restorative Dentistry
“Indirect Post and Core Fabrication” - March 1995

Minnesota Academy of Restorative Dentistry
“Overview of the Rotherman Attachment” - March 1997

PUBLICATION


RESEARCH EXPERIENCE

“A Comparison of Proximal Groove Forms for Three-quarter Crown Preparations”
Masters thesis completed July 1980
CURRICULUM VITAE
Wook-Jin Seong, DDS, MS, PhD, FACP

1. Identification Information

A. **Current Position and Responsibilities**

*Associate Professor*, Division of Prosthodontics, Department of Restorative Sciences, School of Dentistry, University of Minnesota, Twin city, MN

**Responsibilities**

Research (30%): University of Minnesota Bio-Engineering Lab (UMBEL; 16-280 Moos tower)

Teaching (40%): Clinical and didactic instruction to predoctoral, residents, and graduate students, and to practitioners through continuing education courses. Research mentoring and formal thesis advising

Services and administration (30%): Leader in students’ clinical learning improvement project. University Senator. Participates in committees and discipline related professional services. A day (20%) per week patient care at the Univ. of Minnesota Dental Faculty Practice Clinic

B. **Education and Training**

1987 – 1989 No degree, Pre-Dentistry, College of Natural Sciences, Seoul National Univ.
1989 – 1993 DDS, Dentistry, College of Dentistry, Seoul National University
1996 – 1999 Certificate, Prosthodontic residency, School of Dentistry, Univ. of Minnesota
1996 – 2000 MS, Dentistry/Dental implant, School of Dentistry, University of Minnesota
2000 – 2006 PhD, Oral biology & Biomedical engineering, University of Minnesota

C. **Positions, Honors, and Professional Memberships**

**Positions/Employment**

1993 – 1996 Dental Officer in Korean Army, General dentistry, PyungTaek, Korea
1996 – 1999 Resident, Prosthodontics/Restorative Sciences, University of Minnesota
1999 – 2000 Assistant Professor, Prosthodontics/Restorative Sciences, Univ. of Minnesota
2000 –2006 Associate Clinical Specialist, Prosthodontics/Restorative Science, Univ. of MN
2006 – 2012 Assistant Professor, Prosthodontics/Restorative Sciences, Univ. of Minnesota
2012 – present Associate Professor, Prosthodontics/Restorative Sciences, Univ. of Minnesota
2006 – present Graduate faculty member in “Dentistry”, University of Minnesota
2007 – present Graduate faculty member in “Oral Biology”, University of Minnesota

**Boards & Honors**

1993 National Board of Dental Examiners, Korea license #11544
2000 Diplomate, American Board of Prosthodontics
2001 Minnesota Board of Dentistry, Minnesota license #D11605
2003 Omicron Kappa Upsilon Honorary Dental Society
2011 Omicron Kappa Upsilon Honorary Dental Society, Vice president

**Professional Memberships**

1996- present Member/Fellow, American College of Prosthodontists
1999- present Member, Academy of Osseointegration
2000- present  Member, International Association for Dental Research/AADR
2000- present  Member, American Board of Prosthodontics
2006- present  Member, American Dental Education Association
2010- present  Member, Korean-American Scientists and Engineers Association

2. Research and Scholarship

D.  Research Support

Ongoing Research Support

Center for Translational Medicine, University of Minnesota, Seong (PI) 1/2011 – 6/2013, $330,249
Role: Principal Investigator

Investigator initiated study grant, Astra Tech, Seong (PI) 9/2010 – 12/2014, $27,750
Project title: Evaluation of initial implant stability of posterior maxillary implants with bi-cortical fixation
Role: Principal Investigator

Oral Health Clinical Research Center, University of Minnesota, Seong (PI) 5/2012 – 12/2014, $1,500
Project title: Evaluation of initial implant stability of posterior maxillary implants with bi-cortical fixation
Role: Principal Investigator

Technology Enhanced Awards for Teaching and Learning (TEATL) School of Dentistry, University of Minnesota, Seong (PI) 4/2013 – 3/2014, $6,500
Project title: Improving students’ learning in prosthodontics clinic using Moodle
Role: Principal Investigator

Completed

Dentsply IIS Travel Grant (D-2010-021), Seong (PI), IADR meeting 3/2013, $1,000
Project title: Bi-cortical Fixation of Implants in Maxillary Sinus Area
Role: Principal Investigator

Grant in aid, University of Minnesota, Seong (PI) 7/2009 – 12/2010, $35,094
Project title: Developing rapid-setting unresorbable load-bearable bone cement for initially unstable dental implant: a rabbit study.
Role: Principal Investigator

Project title: The effect of surgical guide design and surgeon’s experience on the accuracy of implant placement
Role: Principal Investigator
Investigator initiated research grant, Osstem Implant Co., **Seong (PI)** 11/2007 – 10/2010, $11,821
Diagnostic imaging tools on composite apparent density measurements of human jawbone
Role: Principal Investigator

**Major not-Funded**
2008 AO (Arbeitsgemeinschaft für Osteosynthesefragen) Research Foundation, Fund requested $102,450, Unresorbable but bioactive fiber reinforced bone cement for initially unstable dental implant, PI: Seong
2006 NIDCR, R01, Fund requested $1,116,629, A clinical approach to the oral physiological stress-strain environment, PI: A. Versluis, Co-I: Seong

**Industry Support (≈ $167,469)**
2007-6-15 In vivo biting force measurement, Dr. Kazuo Hayashi, GM 10 bite force meter ($500)
2007-6-30 Torque wrench study, Astra, 3i, Zimmer, ITI, Lifecore, 25 torques wrenches ($25,000)
2007-7-7 Preload measurement, Lifecore, dental implants, abutments, and abutment screws ($22,550)
2007-11-9 Radiodensity and apparent density, Osstem, 60 implants and surgical kits ($11,821)
2007-12-10 Human cadaver study, Bien air, surgical engine, motors, saws, handpieces, drills ($20,000)
2008-2-26 Implant bone cement, Zimmer, Elcomed surgical engine/motor, 20 implants ($5,000)
2008-3-5 Implant bone cement, CTS cement, rapid set cement ($50)
2008-3-21 Implant bone cement, DIO, 50 dental implants, abutments and surgical kits ($20,032)
2008-4-11 Composite apparent density and CT HU, Cybermed, CT software ($10,000)
2008-4-23 Implant bone cement, Zoltek, carbon fiber ($50)
2008-5-1 Human cadaver study, Schick, CDR sensor and software ($5,000)
2009-7-6 Rabbit femur implant study, Osstem, 150 implants and surgical drills ($28,160)
2011-2-7 Dog intraoral bone cement study, Dio, 100 implant and 2 surgical kits ($19,306)

**E. Peer-Reviewed Publications**

**Seong WJ**, Birdi HS, Hinrichs JE. A technique for fabricating a cement-retained implant provisional restoration with a customized temporary abutment. J Prostheth Dent (in progress)
Lee JW, **Seong WJ**, Heo YC, Huh JK, Nam KY, Kim JR. Modeling of push-in and pull-out tests for dental implants of rabbit tibia healing model. IEEE Transactions on Biomedical Engineering (in progress)

**Seong WJ**, Polack MA, Delima LF. A technique for mounting maxillary definitive cast in the same spatial relation as the diagnostic and/or diagnostic wax-up cast in a full mouth rehabilitation case. J Prostheth Dent (in progress)

Kelsey M, Seong WJ, Hinrichs J. Prevalence of calculus on implant-supported prosthesis and effectiveness of calculus removal. JOP submitted in 1/22/2013


Adarve R and Seong, WJ. Self-Guided Instructional Material: Cast Post and Core Restoration. MedEdPORTAL; 2010 -MedEdPORTAL ID 8203


Seong WJ, Conrad HJ Hinrichs JE. Potential damage to the bone-implant interface when measuring initial implant stability: Case report. J Periodontol 2009c;80:1868-1874


F. Patents, Book chapters, Abstracts, Presentations

Patents & FDA
2012-6-28 US patent application. Bone cement and method, Seong WJ. University of Minnesota
2010-12-29 PCT # 600.832WO1 Bone cement and method, Seong WJ. University of Minnesota
2009-12-30 Provisional patent #61/291,006 Dental implant bone cement composition, Seong WJ. University of Minnesota
2009-12-24, 2010-2-11, 2010-4-8, 2010-5-17, 2010-9-14 FDA Pre-IDE documents, #I091008 Dental implant bone cement, Seong WJ. University of Minnesota

Book Chapters

Abstracts/Presentations
Jeong SC, Conrad H, Seong WJ. Dental implant bone cement (DIBC) for initially unstable implants; Dog study. AAFP poster session, Chicago, IL, 2013 Feb.
Vallee MC, Conrad HJ, Basu S, Seong WJ. Accuracy of friction style and spring style mechanical torque limiting devices for dental implants. AAFP (American academy of fixed prosthodontics), Table clinic, Chicago, IL, 2008 Feb.


Kim UK, Heo J, Chung IK, Cha SM, Hwang DS, Km YD, Shin SH, Seong WJ, Ko CC. Bone regeneration in mandibular distraction osteogenesis combined with compression stimulation. 84th IADR General Session and Exhibition, Brisbane, Australia, 2006 June.

3. Teaching

G. Courses Taught

Predoctoral Didactic Courses
2006-present DDS 6491/6492 Dental Implant and Extensively Damaged Tooth Restoration, Course director
2006-2006 DDS 6475/6476 Complete Denture Prosthodontics, Guest lecturer and Bench instructor
2009-2010 DDS 6211 Introduction to Oral Biology, Seminar leader

2011-present DDS 6411 Applied Dental Materials, Guest lecturer.

Predoctoral Clinical Courses
2006-present DDS 6481-6484 Fixed and Removable Prosthodontics Clinic, Clinical instructor,
2006-2007 Dent 5910 Special Prosthodontics Clinic, Clinical instructor

Graduate Didactic Courses
2007-2008 Dent 7081 Basic Concepts in Skeletal and Craniofacial Development, Guest lecturer
2008-present Dent 8101 Dental Implantology, Guest lecturer
2010-present Pros 7210 Advanced Technical Restorative Dentistry, Implant section director

Graduate Clinical Courses
2009-present Pros 7200 Advanced Prosthodontics Clinic, Clinical instructor

Directed Research Courses (research mentor)
2009 Fall Obio 8904 Directed Research (3 credit) on Ms. Shahrzad Grami, MS candidate in Industrial Engineering
2010 Spring Bio 4994 Directed Research (3 credit) on Mr. Kou Thao, BS candidate in College of Biological Sciences

H. Advising/Mentoring & Collaborating Activity

Undergraduate Students, College of Biological Sciences
2007-2007 Amy Kim
2008-2009 Emma Jung
2009-2010        Herbert Jun
2009-2010        Soo Jung Park
2010-2010        Kou Thao (Directed Research)

Post-Baccalaureate Scientists
2008-2008        David Nedrelow
2009-2010        Dan DeVeau
2009-2010        Pablo Avendano
2010-2012        Aleksandr Katane
2012-present    Calvin Chang

D.D.S. Students (Summer Research Fellowship Program)
2010-present    David Nedrelow, Fabrication of 3D porous scaffold with layer-by-layer carbon nanotubule treatment, 2011 AADR Bloc Travel Grant ($1,150) Recipient, Supported by Award Number T14DE017284 from the NIDCR, 89th General Session & Exhibition of the IADR in San Diego, California
2011-present    Patricia Nguyen, Fabrication and characterization of bone scaffold using PCL (polycaprolactone) and CNT

Graduate Students (9 advisor, 4 co-advisor, 4 committee member, 1 direct research mentor roles)
2006-2008        Mark C Vallee, DDS, MS (Prosthodontics/Dentistry), Accuracy of friction style and spring style mechanical torque limiting devices for dental implants. MS: Advisor.
2007-2008        Kevin McLennan, BS, MS (Mechanical Engineering), Characterization of the torque-to-preload relationship in threaded fasteners for dental implants. MS: Co-Advisor.
2008-2008        Jonathan Richards, DDS, MS (Endodontics/Dentistry), Metallic restorations as a source of possible error during electrical pulp testing. MS: Committee member.
2008-2009        Sujey Rodriguez-Lozano, DDS, MS (Prosthodontics/Dentistry), Crestal bone level and its association with varying densities of bone. MS: Committee member.
2007-2010        Simon Hinckfuss, DDS, MS (Periodontics/Dentistry), The effect of surgical guide design and surgeon’s experience on the accuracy of implant placement. MS: Advisor.
2009-2010        Anne Fundakowski, BS, MS (Mechanical Engineering), The loosening of threaded fasteners in dental implants. MS: Co-Advisor.
2008-2010        Michael Barczak, DDS, MS (Prosthodontics/Dentistry), Prevalence of sinus augmentation associated with maxillary posterior implants. MS: Advisor.
2010-2010        Tyler Kuhlmann, BS, MS (Mechanical Engineering), Test stand modeling of threaded fasteners in dental implants. MS: Co-Advisor.
2009-2010        Shahrzad Grami, BS, MS candidate (Industrial Engineering), Comparison of pull-out versus push-in tests on bone-implant interfaces of rabbit tibia dental implant healing model, Directed research mentor.
2008-present Jerod Klava, DDS, MS candidate (Periodontics/Dentistry), Is a surgical guide fabricated from a prosthodontic plan predictive of the implant’s post-surgery placement? MS: Advisor.
2010-present Matthew Kelsey, DDS, MS candidate (Periodontics/Dentistry), Prevalence of calculus on implant-supported prosthesis and effectiveness of calculus removal. MS: Committee member.
2009-present Andrea Hsu, DMD, MS candidate (Periodontics/Dentistry), Comparison of initial implant stability of posterior maxillary implants with bicortical fixation to implants engaging only the alveolar crest. MS: Advisor.
2009-present Jason S Chong, DDS, MS candidate (Prosthodontics/Dentistry), Predictability of initial implant stability using cone beam computerized tomography and conventional periapical radiographs. MS: Advisor.
2010-present Jay S Jeong, DDS, MS, PhD, MS candidate (Prosthodontics/Dentistry), The response of periodontium to Portland cement and calcium sulfate based dental bone cement (DBC) used in the treatment of advanced periodontitis: a dog pilot study. MS: Advisor.
2011-present Ryan Wolff, DDS, MS candidate (Periodontics/Dentistry), Comparison of secondary implant stability and endo-sinus bone formation of posterior maxillary implants placed with bicortical fixation to indirect sinus lift procedure. MS: Advisor.

Postdoctoral Fellows
2007-2008 Woo-Bin Song, BE, ME, PhD (Electrical engineering)
2008-2009 Soo Cheol Jeong, DDS, MS, PhD (Dental Implantology)
2010-2011 Jong Ryul Kim, DMD, MSD, PhD, (Endodontics/Dental Materials)

Visiting Professors and Scholars
2007-2009 Hyeon-Cheol Kim, DDS, MSD, PhD, Assistant Professor (Endodontist), Department of Conservative Dentistry, Pusan National University, Pusan, Korea.
2009-2011 Jong-Ki Huh, DDS, MSD, PhD, Associate Professor (Oral Surgeon), Department of Oral and Maxillofacial Surgery, Yonsei University, Seoul, Korea.
2010-2011 Ki-Young Nam, DDS, MS, DMSc, Assistant Professor (Prosthodontist), Department of Dentistry, Keimyung University Dong-San Medical Center, Daegu, Korea.
2011-2012 Chandoo Park, DDS, Research Scholar, Pusan National University, Pusan, Korea.

I. Invited Presentations and Continuing Education Courses
2006-6-20 Dental Research Institute in Seoul National University, College of Dentistry, Seoul, Korea. “Bone mechanical properties, initial implant stability, and what next?”
2006-11-10 3rd Annual Minnesota Biomedical Nanotechnology Workshop, Minneapolis, MN. “Bone elastic property measurement using nano-indentation”
2007-7-20 Osstem Implant Company Research Center, Pusan, Korea. “Diagnostic imaging tools on composite apparent density measurements”
2008-3-28 4th Annual Dean’s Research Day, University of Minnesota School of Dentistry, Minneapolis, MN. “Dental implant research update”
2008-10-10 Continuing Education by University of Minnesota School of Dentistry, St. Paul, MN. “What’s new in dentistry; Contemporary implant”
2009-12-1 Continuing Education by Specialists in Periodontics, Hudson, WI. “What you should know about Implant-supported restorations”
2010-12-9  Department of Primary Care Faculty Forum, University of Minnesota School of Dentistry, Minneapolis, MN. “Crown build up; issues and evidences”
2011-3-4  7th Annual Dean’s Research Day, University of Minnesota School of Dentistry, Minneapolis, MN. “Dental implant research update: Dental Implant Bone Cement”
2012-7-19  Center for Translational Medicine, Univ. of Minnesota. “DIBC (dental implant bone cement) for initially unstable dental implant”

4. Service

J. School Services

Committees
2006-2008  Strategic Planning Sub-Committee in “Research”, School of Dentistry
2007-present  Alternate, Educational Policy Committee, School of Dentistry
2009-present  Research Committee, School of Dentistry
2010-present  Research Strategic Planning Committee, School of Dentistry
2010-present  Clinical Management Committee, Division of Prosthodontics, School of Dentistry
2010-present  Lasby Visiting Professorship Committee, School of Dentistry
2010-present  Paper of the Year Committee, School of Dentistry
2012-present  University Senate

Interviews
2008-present  Interviewer, School of Dentistry DDS student admissions (about 10 interviews /year)

Graduate Faculty appointments
2006-present  Member, Graduate Faculty in Dentistry, School of Dentistry
2007-present  Member, Graduate Faculty in Oral Biology, School of Dentistry

Advisory & Examining Committees for Graduate Students
2008  Mark C Vallee, DDS, MS (Prosthodontics/Dentistry), Accuracy of friction style and spring style mechanical torque limiting devices for dental implants.
2008  Kevin McLennan, BS, MS (Mechanical Engineering), Characterization of the torque-to-preload relationship in threaded fasteners for dental implants.
2008  Jonathan Richards, DDS, MS (Endodontics/Dentistry), Metallic restorations as a source of possible error during electrical pulp testing.
2009  Sujey Rodriguez-Lozano, DDS, MS (Prosthodontics/Dentistry), Crestal bone level and its association with varying densities of bone.
2010  Simon Hinckfuss, DDS, MS (Periodontics/Dentistry), The effect of surgical guide design and surgeon’s experience on the accuracy of implant placement
2010  Anne Fundakowski, BS, MS (Mechanical Engineering), The loosening of threaded fasteners in dental implants.
2010  Michael Barczak, DDS, MS (Prosthodontics/Dentistry), Prevalence of sinus augmentation associated with maxillary posterior implants.
2010 Tyler Kuhlmann, BS, MS (Mechanical Engineering), Test stand modeling of threaded fasteners in dental implants.
2012 Matthew Kelsey, DDS, MS (Periodontics/Dentistry), Prevalence of calculus on implant-supported prosthesis and effectiveness of calculus removal.

K. Discipline Related Professional Services

Journal Manuscript Review
2007 Ad hoc reviewer (1), Clinical Oral Implants Research
2009 Ad hoc reviewer (2), Journal of Dental Education
2010 Ad hoc reviewer (2), International Journal of Oral and Maxillofacial Implants
2010 Ad hoc reviewer (2), Journal of Periodontology

Grant Application Review
2009 Ad hoc reviewer, Faculty Developmental Grant, Academic Health Center, Univ. of Minnesota
2010 - present reviewer, AO (Arbeitsgemeinschaft für Osteosynthesefragen) Research Foundation review panel

On-line and Year Book Review

Moderator & Symposium Organizer
2006 Session Chair, Implant Outcome, 35th AADR Oral Session in Implantology Research Group, Orlando, FL
2013 Session Chair, Implant-related Surgical Treatment Modalities and Outcome, 91th IADR Poster Session, Seattle, WA, 2013 March. Poster session chair

L. Clinical Services
Dr. Seong currently provides clinical care services equivalent to one day per week (20%) of his time at the Dental Faculty Practice Clinic at the School of Dentistry. Dr. Seong has managed a successful and up-to-date practice focusing on dental implant and prosthodontic treatments since 2000. He uses this opportunity to serve patients referred from the Prosthodontics, Periodontics, Orthodontics, and Oral & Maxillofacial Surgery residency programs and from outside practicing dentists who refer patients because of the complexity of the required treatments. Clinical practice has been an extremely important part of Dr. Seong’s academic career not only as a source for research and teaching ideas, but also as a medium to collaborate and meet with other professionals and to have a sense of doing “good” for patients.
Curriculum Vitae
2013

Ranier M. Adarve, DMD, MS, MHPE

Recipient, 2012 Teaching Excellence Award by the American Dental Education Association
Ranier M. Adarve, DMD, MS, MHPE

Recipient, 2012 Teaching Excellence Award by the American Dental Education Association

13483 Carlingford Way
Rosemount, MN 55068

Mobile: 612-702-4228
Email: adar0002@umn.edu
Website: http://www.ranieradarve.com

Professional Aim
To Advance Dental Education to the Highest Level

Career Summary

Prosthodontics | Health Professions Education | Multimedia Design

Well experienced oral health care provider with comprehensive background in clinical Prosthodontics. Technical expertise covers all clinical and laboratory aspects of all restorative and prosthetic services including implants. Have work in various clinical settings such as private practice, school-based clinics as well as hospital-based training programs. Board Topnotch in Philippine Dental Licensure Exam out of 2,167 Examinees.

Extensive professional involvement in Dental Education having worked in four Dental Schools with varying educational contexts as an educator in multiple capacities. Have lectured to local and international organizations and conferences. Organized and implemented workshops for Faculty Development and career advancement. Furthermore, actively participated in the design and development of curriculum and instruction and deep involvement in the Strategic Planning for the future of the dental school.

As multimedia instructional designer, innovated several technology-enhanced learning, designed and developed several instructional materials including, on-line courses, self-instructional material in CD-Rom. Set up Websites, On-line Learning Resource Site and other electronic media to support dental education. Expertise includes working knowledge on several programs and educational tools such as WebCT, Macromedia Programs and Microsoft Office.
I. Current Position

- Assistant Professor

  Division of Prosthodontics, Department of Restorative Sciences

  School of Dentistry, University of Minnesota

II. Education

- Certificate of Completion, 2010

  Systems Approach to Assessment in Health Science Education

  Harvard Macy, Boston

- Certificate of Completion, 2009

  Computer Based Guided Surgery

  Nobel Biocare Training Institute, California

- Masters in Science of Dentistry, 2005

  Graduate School

  University of Minnesota, Minneapolis

- Certificate of Proficiency in Prosthodontics, 2005

  Graduate Prosthodontic Program

  School of Dentistry

  University of Minnesota, Minneapolis

- Certificate in Multimedia Design and Development, 2005

  Department of Curriculum and Instruction

  College of Education

  University of Minnesota, Minneapolis

- Masters in Health Professions Education, 2002

  National Teachers Training Center for Health Professions

  University of the Philippines, Manila

- Doctor of Dental Medicine, 1996

  College of Dentistry

  University of the Philippines, Manila

III. FACULTY APPOINTMENTS

- Assistant Professor, 2007- current

  Division of Prosthodontics

  Department of Restorative Sciences

  University of Minnesota School of Dentistry
• Assistant Professor, 2005-2007  
  Division of Prosthodontics  
  Department of Restorative Dentistry  
  Oregon Health & Sciences University

• Dental Fellow, 2002-2005  
  Graduate Prosthodontic Program  
  University of Minnesota School of Dentistry

• Administrative Assistant, 2003  
  Academic Health Center  
  University of Minnesota

• Senior Lecturer, 1998-2002  
  Section of Fixed Prosthodontics  
  Department of Clinical Dentistry  
  University of the Philippines

• Chairman, 1998-2002  
  Department of Prosthodontics  
  College of Dentistry  
  Emilio Aguinaldo College, Manila

IV. PROFESSIONAL EMPLOYMENT

• Faculty Dental Practice  
  University of Minnesota  
  2007-present year

• Faculty Dental Practice  
  Oregon Health and Science University  
  2005

• Hennepin County Medical Center  
  Dental Resident  
  2004

V. CERTIFICATION AND LICENSURE

• State of Minnesota Board of Dentistry, Dental Specialist License  
• State of Washington Board of Dentistry, Dental License  
• State of Oregon Board of Dentistry, Dental License
VI. HONORS AND AWARDS

- 2012 ADEA Excellence in Teaching Award
  American Dental Education Association / Colgate-Palmolive Co

- 2012 UPAA Distinguished Award in Educational Innovations
  University of the Philippines Alumni Association

- Professor of the Year
  American Student Dental Association
  Given by Class 2012

VII. COMMITTEE SERVICE

- PASS and International Affairs Committee, member, 2011-2013
- Scholastic Standing Committee, member, 2009 to present
- Scholarship Committee, member, 2009 to present
- Council of Faculty, member, 2008 to present
- Educational Policy Committee, member, 2008 to 2011

VIII. PROFESSIONAL MEMBERSHIP

- President 2010-2011
  Educational Research / Development and Curriculum Section, American Dental Education Association

- President-elect 2009-2010
  Educational Research / Development and Curriculum Section, American Dental Education Association

- Secretary-elect 2008-2009
  Educational Research / Development and Curriculum Section, American Dental Education Association

- Permanent Representative, 2008 to present
  Commission on Change and Innovation
  American Dental Education Association

- Advocate, 2008-present
  MedEdPORTAL, Association of American Medical Schools and Colleges

- Founding Member, Scholarship with Academic Technology (SWAT)
  Interprofessional Group, Academic Health Center, University of Minnesota
• Reviewer, 2005-2012
  TechExpo Abstracts and Presentations
  American Dental Education Association

• Reviewer, 2006-2012
  Scientific Program, Annual Conference
  American Dental Education Association

• Member, 2008
  Speaker’s Bureau
  School of Dentistry
  University of Minnesota

Association / Society

• American Dental Education Association (ADEA)
• Association of Dental Education of Europe (ADEE)
• International Federation of Dental Education and Associations (IFDEA)
• Association for Educational Communication and Technology (AECT)
• Philippine Dental Association
• Philippine Prosthodontic Society
• University of the Philippines Alumni Association
• Rotary Club

IX. STUDENT ADVISING OR MENTORING

• Abigail Wesley – Summer Research Program, DDS Program, 2012
• Sanket Nagarkar—Research Project, DDS Program, 2011
• Enoch Ng – Research Project, DDS Program, 2011
• Nathan Robison – Presentation Project, DDS Program, 2009

X. TEACHING ACTIVITIES

Didactic and Clinical Teaching

• Course Director
  DDS 6471 and DDS 6472 – are didactic and laboratory course in
  Pre clinical Fixed Prosthodontics. It is a 32-Session Spring
  Semester program for 98 Dental Students

• PASS, Course Director in Fixed Prosthodontics
  DDS 6311 –it is an introduction to clinical dentistry for foreign-trained
  Dentist admitted to Program for Advance Standing
  Students (PASS). It is a 27-session summer semester program for
  10 dental students.
• Graduate Prosthodontics Clinical Faculty
  Pros 7200 Clinical teaching to Graduate Prosthodontic Residency program. Summer semester.

• Clinical Faculty
  DDS 6483 and DDS 6484 - Clinical teaching to Undergraduate DS3 and DS4 during Spring, Summer and Fall semesters.

• Pre-Clinical Faculty
  DDS 6473, DDS 6474, DDS 6491, DDS 6491 – Pre clinical teaching in undergraduate fixed prosthodontic, removable prosthodontics and implant course Summer course.

• FIPCC Facilitator
  Foundations for Interprofessional Collaboration and Communication. Fall semester.

• Lecturer, Dental Hygiene
  Provide lecture on Direct Restoration for 25 dental hygiene students.

• Lecturer, Masters Program in Dental Hygiene
  DH 5407 – Dental Hygiene students in masters program.

• Program Director, Pre Dental Course
  28-32 students attend the 20-hour course to learn basic restorative procedures. The course is offered 4 times per year.

• CE Lecturer
  Provides lecture in annual meetings/conferences and lectures in study clubs.

• Mentor
  mentor students in their research and projects.
  mentor faculty in the performance of their teaching.

Curriculum Development

• Developed comprehensive Evaluation Rubrics for every Fixed Prosthodontic procedures in the course of DDS 6472.

• Implemented the use Concept Map to engage students to active learning process.

• Utilized Advance Organizers to activate prior knowledge and connect with new learning.

• Produced Videos of Prosthodontic procedures.

• Conducted regular calibration sessions for faculty involved in practical exam evaluations.
XI. AREAS OF RESEARCH INTEREST

My scholarly activities are focused on educational research with emphasis on the design and development of educational technologies to transform curricular and instructional experiences in the field of prosthodontics. The development of evaluation rubrics, production of procedural videos and the use of concept maps are representative of the classroom technologies being investigated for their effects in improving teaching and learning transactions.

XII. GRANT AWARD/ FUNDED PROJECTS

- Transformation of Classroom Learning Using Augmented Reality Technology.  
  $3000.00  
  Technology Enhanced Teaching and Learning 2012. School of Dentistry, University of Minnesota.

- Student Learning Preferences for Teaching Biomechanics and Tooth movement" Clinical Laboratories. $3,000.00  
  Technology Enhanced Teaching and Learning 2012. School of Dentistry, University of Minnesota.

- Development of Web-based Videos for Removable Partial Denture Course . $1800  
  Technology Enhanced Teaching and Learning 2009. School of Dentistry, University of Minnesota.

- Development of an Online Training Resource for U of M Clinical Mock Board Exams,  
  $3,000  
  Technology Enhanced Teaching and Learning 2010. School of Dentistry, University of Minnesota.

XIII. INVITED PRESENTATIONS

- *Augmented Reality in Dental Education.* American Dental Educators Association – 89\textsuperscript{th} Annual Convention, March 2012, Orlando, Florida

  American Dental Educators Association – 89\textsuperscript{th} Annual Convention, March 2012, Orlando, Florida

  American Dental Educators Association – 88\textsuperscript{th} Annual Convention, March 2011, San Diego, CA

  American Dental Educators Association – 88\textsuperscript{th} Annual Convention, March 2011, San Diego, CA
• Use of an Innovative Tool to Develop Test Items and Generate Test Blueprint, American Dental Educators Association – 87th Annual Convention, February 2010, Washington DC

• Use of Concept Mapping Tool as an Advance Organizer for Treatment Procedures in Fixed Prosthodontics, Tech Expo, American Dental Educators Association – 87th Annual Convention, February 2010, Washington DC

• Development and Implementation of Evaluation Rubric in a Preclinical Fixed Prosthodontics Course: Students’ Perception. Poster Presentation, American Dental Educators Association – 87th Annual Convention, February 2010, Washington DC

• Test Construction and Banking Tool, Fourth Best Practice Institute, Academic Health Center, University of Minnesota, May 2009

• Crown Seating Procedures, In-Service, Division of Operative Dentistry, University of Minnesota, February 2009

• Dental Educators as Evaluators: Use of Contemporary Evaluation Tool, Association of Dental Educators of Europe – 34th Annual Meeting, September 2008, Zagreb, Croatia

• Rubric-Driven Evaluation of Performance and Calibration of Raters, American Dental Educators Association – 86th Annual Convention, March 2009, Phoenix, Arizona

• Multimedia RPD Course, Section of Prosthodontics, American Dental Education Association, Dallas, TX, March 2008

• Advancing Predoctoral and Postdoctoral Prosthodontic Curriculum, Educator’s Mentoring and Predoctoral Educators’ Workshops, American College of Prosthodontics, Miami, Florida November, 2006

• Cognitive Influence of Interactive Multimedia Design, American Dental Education Association, February, Baltimore, Maryland, 2005

• Course Management Tools, American Dental Education Association, March 2007, New Orleans, Louisiana

• Learning with Technology: Enhancing the Students’ Learning Environment, Department of Restorative Dentistry, Oregon Health and Science University, Bend, Oregon, November 2005

• Teaching Portfolio Development. Inter-Professional Faculty Workshop. Academic Health Center, University Of Minnesota, June 2003

• ZOPP (”Ziel-Orientierte Projekt Planung”) – Objective Oriented Project Planning. Faculty Wokshop for the Faculty of University of the Philippines College of Dentistry, April 2002

• Development of Test Blueprint and Test Construction, Faculty Development Workshop for the Health Professionals, Philippines, February 2002
XIV. CONSULTING EFFORTS

Minnesota Board of Dentistry

I have been working closely with the Minnesota Board of Dentistry since 2008 to assist them in resolving clinical cases arising from malpractice related to fixed prosthodontics. I prepare a customized program for dentist with pending cases with the board of dentistry and implement the approved program to completion. An average of 2 to 3 practicing dentist per year have gone through the program. A service I provide to protect the community and the public.

Speaker’s Bureau and Continuing Education

As part of the University of Minnesota Speaker’s Bureau, I am providing continuing education lectures.

In the past years, I have been invited to speak to several study groups and clubs. I have also provided hands-on clinical training to dental offices in the state. I have been providing support to practicing dentist in the community to enhance their clinical skills.

XV. BIBLIOGRAPHY

Refereed Publications


Published Research / Educational Abstracts


- Adarve, R. Use of Innovative Tool to Develop Test Items and Generate Test Blueprint. Journal of Dental Education. 2010:74


- Adarve, R and Madden, M. Development of an Innovative Faculty Tool to Systematically Construct, Bank and Retrieve Test Items. Journal of Dental Education. 2009:73 pp 271-276


• Adarve, R and Brunner J. *The Use of Course Management Tools to Support P2P Instruction.* Journal of Dental Education. 2007:71 pp 104-114

Masters Thesis

• Adarve, R. *Learning Approach and Academic Performance of the University of Minnesota School of Dentistry Students: Drawing Implications for Dental Education,* Thesis presented to Graduate School, University Of Minnesota, April 2005

• Adarve, R. *A Study of Students’ Learning Approaches and their Engagement with the Context of Learning: The Case of University of the Philippines College of Dentistry.* Thesis presented to National Teachers’ Training Center for Health Professionals, University of the Philippines, April 2002

XVI. INVENTION

• Adarve Full Crown Training Block (Part No. 3100) 
  Manufactured by Panadent, Colton Ca
  info@panadent.com

As of date, the following dental schools are using my invention in their curriculum:
• Southern Illinois University School of Dental Medicine
• University of Manitoba Faculty of Dentistry
• East Carolina University School of Dentistry
• University of North Carolina at Chapel Hill School of Dental Medicine
• University of Minnesota School of Dentistry

XVII. SOFTWARE DEVELOPMENT

• Augmented Reality based Dental Teaching Models 
  ARDL Software and Google Sketchup

• Anatomy of Human Adult Dentition 
  Adobe Flash / Dreamweaver and HTML

• *Computer Based Performance Assessment and Calibration Tool, 2008* 
  Web-Based Application / ASP.NET 
  Programming Software used: Microsoft Visual C#

• *Module on Full Crown Preparation, 2008* 
  Web-Base Application/ SWF 
  Programming Software used: Adobe Captivate 3
• Test Construction and Banking Tool
  Program Application for Window
  Programming Software used: Microsoft Visual C#

• Dynamic Concept Map in Learning Fixed Prosthodontic Procedure
  Programming Software used: TheBrain Knowledge Management Software

• Procedural Videos in Fixed Prosthodontics
  For Web-Based Programs,

• Procedural Videos in Fixed Prosthodontics
  For iPod, iTunes

• Procedural Videos in Fixed Prosthodontics
  For WebCT

• Computer-Based Instruction- Removable Partial Denture, 2005
  Web-Based Application/ SWF
  Programming Software used: Macromedia Flash MX

XVIII. OTHER CREATIVE WORKS

• Evaluation Rubrics
  Grading guidelines for the different procedures in Fixed Prosthodontics

• Concepts Maps
  Use of mind mapping tools to graphically represent important conceptual relationships for meaningful learning

• Test Questions and Test Banking
  Collection of test items used to comprehensively evaluate student performance

• Advance Organizers
  Primers to activate students prior knowledge before learning a new information

• Power Point Lectures
DUANE CARY MCNEIL, DDS, MSD
Diplomate, American Board of Prosthodontics

535 Sandhurst Dr West• Apt. 303
Roseville, MN• 55113
Ph: 612-270-9702 (c)
carymcneil@yahoo.ca

EDUCATION

2005-2008 University of Minnesota – Certificate in Prosthodontics
– Masters of Science (Dentistry)
2001-2005 Dalhousie University – Doctor of Dental Surgery Program (DDS)
1997-2001 University of New Brunswick – Bachelor of Science – Biochemistry

QUALIFICATIONS

2005 US Dental Boards: Part 2
US Dental Boards: Part 1
2005 National Dental Examining Board of Canada exams
2008 • Board certified by the Royal College of Dentists of Canada
• Board certified by the American Board of Prosthodontics
• Current Minnesota general dental license
2010 • Diplomate, American Board of Implant Dentistry

WORK EXPERIENCE

04/08-08/08 Clinical Adjunct Professor – University of Minnesota
09/08-present Clinical Associate Professor – University of Minnesota
01/09-07/09 Associate Prosthodontist – Family Cosmetic and Gentle Dentistry
08/09-present Associate Prosthodontist – The Dental Specialists
12/12-present Associate Prosthodontist – Clear Choice Dental Implant Center

REFERENCES

Available upon request
BOBBY HARDEEP SINGH BIRDI

#3102 – 833 Homer Street  Tel: 778.316.4221
Vancouver, BC, Canada V6B 0H4  bobbirdi@gmail.com

EDUCATION

University of Minnesota School of Dentistry, Minneapolis, MN, USA  2009-2012
Certificate of Advanced Education in Periodontics
  - Fellow of the Royal College of Dentists of Canada
  - In process of becoming a Diplomate of the American Board of Periodontics

University of Minnesota School of Dentistry, Minneapolis, MN, USA  2006-2009
Certificate of Advanced Education in Prosthodontics & MSc
  - Diplomate of the American Board of Prosthodontics
  - Fellow of the American College of Prosthodontists
  - Fellow of the Royal College of Dentists of Canada
  - Examiner for the Royal College of Dentists of Canada

University of Saskatchewan College of Dentistry, Saskatoon, SK, Canada  2002-2006
DMD with Academic Distinction

University of Alberta, Edmonton, AB, Canada  1997-2002
BSc (Double Major in Biological & Physical Sciences)

PROFESSIONAL EXPERIENCE

PerioPartners Private Practice, Edmonton, AB  01/10-Present
  - Active in Complex Esthetic Implant Treatment
  - Active in both Periodontic and Prosthodontic Therapy
  - Lecture Nationally and Internationally in the field of Implant Dentistry

University of British Columbia School of Dentistry, Vancouver, BC  12/12-Present
  - Faculty Member in Graduate Prosthodontics & Periodontics
  - Clinical Instructor

University of Minnesota School of Dentistry, Minneapolis, MN, USA  07/12-Present
  - Faculty Member in Graduate Prosthodontics & Periodontics
  - Created and Teach “Prosthetically Driven Implant Surgery” Course
  - Select Literature for Implantology Courses/Literature Review
  - Instruct the Computer Guided Implant Surgery Course
  - Active in Implant Surgery and Prosthodontics CE Lecturing
Imperio Group Dental Health Specialists, North Vancouver, BC, Canada 12/12-3/13
- Active in Complex Esthetic Implant Treatment
- Active in both Periodontic and Prosthodontic Therapy
- Lecture Nationally and Internationally in the field of Implant Dentistry

JOURNAL AFFILIATIONS
International Journal of Oral & Maxillofacial Implants (JOMI) 01/10–Present
Review manuscripts for acceptance and publication

Journal of Oral Implantology (JOI) 01/11–Present
Review manuscripts for acceptance and publication

Clinical Advances in Periodontics (CAP) 09/12–Present
Review manuscripts for acceptance and publication

RESEARCH
Implant Failure Risk Factors. A Retrospective 10-year Analysis of over 6000 Implants. 10/11-Present
University of Minnesota School of Dentistry, Minneapolis, MN, USA

10-year Retrospective Cohort Study of the Predictors of Implant Failure in the Posterior Maxilla. 10/11-Present
University of Minnesota School of Dentistry, Minneapolis, MN, USA

Incidence of Calculus Deposits on Implant-Supported Dental Prosthesis and Effectiveness of Methods for Calculus Removal. 08/10-01/12
University of Minnesota School of Dentistry, Minneapolis, MN, USA

Bone Level Changes on Teeth Adjacent to Platform-Switched Plateau Design Implants: The Effect of Implant-Tooth Spacing 10/09-10/11
University of Minnesota School of Dentistry, Minneapolis, MN, USA

Customized Implant Provisional Restorations 09/10-03/11
University of Minnesota School of Dentistry, Minneapolis, MN, USA
A Technique for Fabricating a Cement-Retained Implant Provisional Restoration with a Customized Temporary Abutment
Seong WJ, Birdi H, Hinrichs J,
(Submitted for Publication)
Survival of Short Length Implants and Crown-to-Implant Ratios

University of Minnesota School of Dentistry, Minneapolis, MN, USA

3-Year Survival Estimates of Short (≤ 6 mm) Length Implants and the Relationship to Crown-to-Implant Ratios

Saldarriaga A, Birdi H, Schulte J, Emanuel K, Weed M, Chuang SK.
(Submitted for Publication)

Crown to Implant Ratios of Short Length Implants

University of Minnesota School of Dentistry, Minneapolis, MN, USA

- Masters research conducted on 6mm long dental implants
- Research Presented at 2008 Academy of Osseointegration Meeting

Crown-to-Implant Ratios of Short Length Implants

Birdi H, Schulte J, Kovacs A, Weed M, Chuang SK.

PROFESSIONAL AFFILIATIONS

- Member of American Academy of Periodontology
- Member and Fellow of American College of Prosthodontics
- Member of Academy of Osseointegration (Young-Clinicians Committee 2011, 2012)
- Member of International Congress of Oral Implantologists
- Member of American Academy of Implant Dentistry
- Member of International Team for Implantology (ITI)
- Member of American Academy of Fixed Prosthodontics
- Member of Association of Prosthodontists of Canada
- Member of American Dental Association
- Member of Canadian Dental Association
- Dentistry Class President (University of Saskatchewan)
- College of Dentistry Appointed MSC Representative (University of Saskatchewan)
- Elected Co-Chair of University of Saskatchewan USSU Health and Dental Board
- Elected Member of University of Saskatchewan USSU Academic Affairs Board
- Founding Member of AO Dental Fraternity – University of Saskatchewan Chapter
BRANDON DEWITT

Hennepin County Medical Center
Department of Dentistry
Minneapolis, Minnesota
May 2011 - Present
Staff Prosthodontist

University of Minnesota
School of Dentistry
Minneapolis, Minnesota
June 2008 - April 2011
Graduate Prosthodontics
Master of Science in Dentistry
Completed thesis: A Review of Clinical Outcomes Associated with Dental Implant Treatment Performed by Residents in Advanced Training Programs at the University of Minnesota School of Dentistry
GPA: 3.95/4.0

Hennepin County Medical Center
Department of Dentistry
Minneapolis, Minnesota
June 2007 - June 2008
General Practice Residency
Certificate

State University of New York at Buffalo
School of Dental Medicine
Buffalo, New York
August 2003 - May 2007
Doctor of Dental Surgery (cum laude)
GPA: 3.39/4.00

Academic Honors:
Dean’s List (8 of 8 semesters)
Teaching and Tutoring Scholarship, 2006
Earle J. Kelsey Memorial Scholarship, 2005 (for character and service)
WNY Dental Group Scholarship, 2005 (for class service)
Tucker Scholarship, 2004 (for academic performance)

Brigham Young University
Provo, Utah
January 1999 - December 2002
Bachelor of Arts (magna cum laude)
Major: Humanities, Art History Emphasis
Minors: Japanese, Chemistry, and Zoology
Completed an honors thesis titled,
Villainy, Debauchery, and the Pursuit of Happiness
GPA: 3.89/4.00

**Academic Honors:**
Alvina Soffel Barret Scholarship, 2002 (for contribution to the humanities)
University Scholarship, 1999 - 2001 (for academic performance)
Member Phi Kappa Phi National Honor Society (for academic standing)

**Affiliations**

American College of Prosthodontists

American Dental Association

National Health Service Corps
Curriculum Vitae and Bibliography
Steven E. Eckert, DDS

PERSONAL INFORMATION

Place of Birth:
Jackson Heights, NY

Citizenship:
United States

Work Address:
ClearChoice Dental Implant Center
7450 France Avenue
Edina MN 55435

Email Address:
Steven.eckert@clearchoice.com

Professor Emeritus
Mayo Clinic
200 First Street SW
Rochester, MN 55905

Email Address:
seeckert@mayo.edu

PRESENT ACADEMIC RANK AND POSITION

Teaching/Examining Membership in Biomedical Sciences - Department of Prosthodontics, Mayo Graduate School of Medicine, Rochester, Minnesota
1989 - Present

Consultant - Division of Prosthodontics, Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
1992 - Present

Program Director for Prosthodontics - Mayo Graduate School, College of Medicine, Mayo Clinic, Rochester, Minnesota
2005 - Present

Professor in Dentistry - College of Medicine, Mayo Clinic
06/01/2007 – 2010

Professor Emeritus – College of Medicine, Mayo Clinic
05/31/2010 - Present

Adjunct Professor – School of Dentistry, University of Minnesota
05/01/2011 - Present

EDUCATION


Muskingum College

1972 - 1974
College of Dentistry, Ohio State University
DDS
1974 - 1977
Mt. Sinai Hospital and Medical Center of Chicago
Residency, General Practice
1977 - 1978
Mayo Graduate School of Medicine, College of Medicine, Mayo Clinic
Residency, Certificate in Prosthodontics
1985 - 1988
Mayo Graduate School of Medicine, College of Medicine, Mayo Clinic
MS
1991

Additional Education

Mayo Program Directors Workshop
Scottsdale, Arizona
03/25/1999 - 03/26/1999

BOARD CERTIFICATION(S)

American Board of Prosthodontics

Diplomate
1991

American Red Cross

Cardio-Pulmonary Resuscitation

LICENSURE

Illinois
Dental Licensure
1977 - 1988
Minnesota
Dental Licensure
1988 - Present
HONORS/AWARDS

Honorary Fellow - Societas Implantologica Bohemica

Award for best article published in International Journal of Oral and Maxillofacial Implants - Academy of Osseointegration Annual Session
03/2000

2007 American College of Prosthodontists' Clinician/Researcher of the Year Award - American College of Prosthodontists
11/2007

MILITARY SERVICE

Captain - United States Army Reserve
01/01/1987 - 12/01/1994

Major - United States Army Reserve
01/01/1994 - 12/01/1995

PREVIOUS PROFESSIONAL POSITIONS AND MAJOR APPOINTMENTS

Attending Staff - Division of Dentistry, Department of Surgery, Mount Sinai Hospital, Chicago, Illinois
1979 - 1985

Clinical Assistant Professor - Department of Fixed Prosthodontics, Loyola University, Maywood, Illinois
1981 - 1985

Consultant - Private Practice, Chicago, Illinois
1982 - 1985

Associate Consultant (Joint Appointment) - Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
10/01/1988 - 1990

Teaching/Examining Privileges in Dentistry - Mayo Graduate School, College of Medicine, Mayo Clinic
12/14/1989 - 08/17/1999

Senior Associate Consultant (Joint Appointment) - Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
1990 - 06/30/1992

Instructor in Dentistry - College of Medicine, Mayo Clinic
01/01/1991 - 07/01/1993

Graduate Program Director - Division of Prosthodontics, Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
1992 - 2001

Consultant - Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
07/01/1992 - 05/31/2010

Assistant Professor in Dentistry - College of Medicine, Mayo Clinic
07/01/1993 - 04/01/2001
**Master's Faculty Privileges in Dentistry** - Mayo Graduate School, College of Medicine, Mayo Clinic
08/18/1999 - 05/31/2010

**Associate Professor in Dentistry** - College of Medicine, Mayo Clinic
04/01/2001 - 05/31/2007

**Emeritus** - Department of Dental Specialties, Mayo Clinic, Rochester, Minnesota
05/31/2010

**Adjunct Professor** – School of Dentistry, University of Minnesota
05/01/2011 - Present

**PROFESSIONAL & COMMUNITY MEMBERSHIPS, SOCIETIES AND SERVICES**

**Professional Memberships & Services**

**Academy of Osseointegration**
- Active Member
  01/1992 - Present
- Fellow
  01/2002 - Present
- Fellow
  01/2002 - Present
- Officer-Secretary
  01/2003 - 01/2005
- Officer-Secretary
  01/2003 - 01/2005
- Vice President
  01/2005 - 01/2006
- Vice President
  01/2005 - 01/2006
- President-Elect
  01/2006 - 01/2007
- President-Elect
  01/2006 - 01/2007
- President
  01/2007 - 01/2008
- President
  01/2007 - 01/2008
- Board of Directors
  01/2001 - Present

**Academy of Prosthodontics**
Associate Fellow
01/1995 - 01/1998
Active Fellow
01/1998 - Present
Recording Secretary
01/2004 - 01/2006
Secretary/Treasurer
01/2006 – 01/2009
Vice President
01/2009 - 01/2010
President Elect
01/2010 – 01/2011
President
01/2011 – 01/2012

Ad Hoc Strategic Planning Committee

Member
01/2003 - Present
Communications Committee

Chair
01/2001 - 01/2003
Member
01/2003 - Present
Education and Research Committee

Chair
01/2003 - Present
Evidence Based Dentistry Committee

Member
01/1999 - Present
Liaison Committee

Member
01/2004 - Present
Newsletter

Associate Editor
01/1998 - 01/1999
Editor
01/1999 - 01/2003
Nomenclature Committee

Member
01/1998 - Present
Officers Committee

Member
01/2003 - Present
   Place of Meeting Committee
      Member
01/2003 - Present
   Program Committee
      Member
01/2003

American Academy of Maxillofacial Prosthetics

   Associate Member
01/1992 - 01/1996
      Fellow
01/1996 - Present
      Vice President-Elect
01/2006 - Present
      Scientific Program Chair
01/2008 - Present
      President
01/2009 – 01/2010
      Ad Hoc Educational Standards Committee
         Chair
01/1999 - Present
      Board of Directors
         Member
01/1999 - Present
      Insurance/Oral Health Committee
         Member
01/2001
      Internet Website Committee
         Member
01/2001
      National Database Committee
         Member
01/2001
      Oral Health Committee
         Member
01/1993 - 01/1996
      Program Committee
         Member
01/2001
   Quality of Life Committee
       Member
01/2001 - Present

American Association of Dental Research

       Member
01/1995 - Present

American Board of Prosthodontics

       Diplomate
01/1991 - Present
       Examiner
01/2007 - Present
       Board Member
01/2007 – Present
       President Elect
01/2013 - Present

American College of Prosthodontists

       Associate Member
01/1988 - 01/1991
       Fellow
01/1991 - Present
       Scientific Program Chair
01/2005 - Present
       Secretary
01/2009 – 01/2011
       Educational Standards Committee
           Member
01/2001
           Implant Special Interest Group

       Chair
01/2001 - 01/2003
           Implant Steering Committee

       Member
01/1994
       Member
01/1994 - 01/1996
       Minnesota Section
           Member
01/1992 - Present
American Dental Association
   Member
01/1977 - Present
Commission on Dental Accreditation
   Site Visit
01/2000 - 01/2005
   Site Visitor
01/2007 - Present
Chicago Dental Society
   Member
01/1977 - 01/1985
Chicago Lake Shore Study Club
   Member
01/1978 - 01/1981
Federation of Prosthodontic Organizations
   Member
01/1990 - 01/1994
Illinois State Dental Society
   Member
01/1977 - 01/1985
International Association for Dental Research
   Member
01/1995 - Present
International College of Prosthodontics
   Member
01/1999 - Present
   Scientific Program Co-Chair
05/2005 – 05/2016
   Scientific Program Chair
01/2007 - Present
   Board Member
01/2009 – Present
   Treasurer
05/2011 - Present
Minnesota Association For Dental Research
Member
01/1993 - Present
President
01/1996 - 01/1997
Minnesota Association of Prosthodontists
Member
01/1988 - 01/1996
North Suburban Dental Society Club
Member
01/1982 - 01/1985
Precision Attachment Study Club
Member
01/1980 - 01/1982
Rochester Dental Implant Study Club
Founding Member
01/1993 - Present
Societas Implantologica Bohemica
Honorary Fellow
Society of Occlusal Studies
Member
01/1981 - 01/1985
Southeastern District Dental Society
Member
01/1994
MDA Annual House of Delegates
Alternate Delegate
01/1993 - 01/1994
Delegate
01/1995

Zumbro Valley Dental Society

   Member
   01/1989 - Present

**JOURNAL RESPONSIBILITIES**

**Journal Editorial Responsibilities**

Academy of Prosthodontics News

   Associate Editor
   01/1997 - 01/1998
   Editor
   01/1998 - 01/2003

International Journal of Prosthodontics

   Associate Editor
   01/2004 - 01/2006

Journal of Prosthetic Dentistry

   Abstract Editor
   01/1994 - 01/2004

Journal of Prosthodontics

   Basic Science Section

   Editor
   01/1999 - 07/2004

The International Journal of Oral and Maxillofacial Implants

   Editorial Staff
   01/1995 - Present
   Associate Editor
   01/2004 - 01/2005
   Editor-in-Chief
   01/2006 - Present

**Journal Other Responsibilities**
Academy of Prosthodontics News

Consultant
01/2003 - Present

Journal of Biomedical Materials Research

Reviewer
01/2004 - Present

Journal of Prosthetic Dentistry

Article Reviewer
01/1994 - Present

Journal of Prosthodontics

Editorial Review Board

Reviewer

The International Journal of Oral and Maxillofacial Implants

Reviewer
01/1994 - 01/2004
Consultant
01/1995 - Present

EDUCATIONAL ACTIVITIES

Curriculum/Course Development
Clinical Rotations
Established clinical rotation in implant supported dental prostheses

Combined Interests In Orthodontics, Periodontics And Prosthodontics
Substantially revised course/seminar

Dental Implants
Substantially revised course/seminar

Documentation of educational efforts for purpose of accreditation: Description and purpose of the course/program and teaching methods used. Evaluation of program by learners.
Ethics In Dental Practice And Dental Research
Development of new course/seminar

Fixed Prosthodontics
Substantially revised course/seminar

Geriatric Dentistry
Development of new course/seminar

Maxillofacial Prosthetics (Extraoral)
Substantially revised course/seminar

Occlusion
Substantially revised course/seminar

Pharmacology And Physiology Relevant To Prosthodontics
Development of new course/seminar

Pre-Prosthetic Surgery
Development of new course/seminar

Prosthodontic Practice Management
Development of new course/seminar

Prosthodontics
Changed curriculum to add 12 months of additional training to meet “Standards for Graduate Education” in Prosthodontics as mandated by the Commission on Dental Accreditation

Temporomandibular Disorders and Orofacial Pain
Development of new course/seminar

**Teaching**
Applied Physiology in Maxillofacial Prosthodontics
Given to residents
Mayo Clinic Department of Dentistry
Section of Prosthodontics
Rochester, Minnesota
1988 - Present
Complete Denture Prosthodontics
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Ethics Video Seminar
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Fixed Partial Dentures
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Growth and Development
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Implant Prosthodontics
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Literature Review and Scientific Writing
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Maxillofacial Prosthetics
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Medically Compromised Patients
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Microbiology and Immunology
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Occlusion
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Oncology
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present
Orthodontic, Periodontics, and Prosthodontics Seminar
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Periodontics
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Pharmacology
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Physiology
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Preprosthetic Surgery
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Removable Partial Denture Prosthodontics
Mayo Clinic Department of Dentistry
Section of Prosthodontics
1988 - Present

Prosthetic Reconstruction of Maxillary Defects
Head and Neck Core Curriculum, Mayo Clinic
Rochester, Minnesota
1996 - Present

Mayo Program Directors Workshop
Scottsdale, Arizona
03/25/1999 - 03/26/1999

Fun with Prosthodontics
Mayo Foundation Dental Review
Rochester, Minnesota
03/23/2002

Fun with Prosthodontics
Mayo Foundation Dental Review
Rochester, Minnesota
04/06/2002

Scholarship

Presentations
I have presented to the ACP, AP, AAMP, ICP, IADR/AADR meetings on numerous occasions, and at a variety of international meetings in Turkey, Singapore, Japan, Germany, Sweden, Switzerland, Egypt, etc.
Presentations
Academy of Prosthodontics Annual Meeting, Evidence Based Dentistry Session
1999 - Present
How to Prepare your Manuscript for Publication in JOMI
Round Table Clinic
Academy of Osseointegration
San Diego, California
02/2009

Honors and Awards for Education
Teacher of the Year Award - Department of Dental Specialties, Mayo Clinic
01/2003
Teacher of the Year Award - Department of Dental Specialties, Mayo Clinic
01/2005

INSTITUTIONAL/DEPARTMENTAL ADMINISTRATIVE RESPONSIBILITIES,
COMMITTEE MEMBERSHIPS AND OTHER ACTIVITIES

Mayo Clinic

Mayo Clinic Committees

Member
01/1997 - Present

Mayo Clinic Rochester

Department of Dental Specialties

Ad Hoc Computer Committee

Member
01/1993 - 01/1997
Clinical Practice Committee

Member
01/1993 - 01/1995
Member
01/1998
Division of Prosthodontics

Program Director
07/2005 - Present
Residency Program
Program Director
01/1992 - 01/2001
Education Committee

Member
01/1992 - 01/2001
Chair
01/1994 - 01/1995
Chair
01/1998 - 01/2000
Executive Committee

Member
01/1998 - 01/1999
Research Committee

Member
01/1991 - 01/1998
Chair
01/1993 - 01/1998

PRESENTATIONS

International

Choosing a Dental Implant System – System Validation Through Literature Review
Austrian Green Cross
Salzburg, Austria
11/09/1996

Selection of a Dental Implant System
Freier Verband deutscher Zahnarzte Organization, Arbeitskreis Fur Parodontologie Meeting
Munich, Germany
11/11/1996

Posterior Mandibular Endosseous Implant Reconstruction: A Long-Term Retrospective Study
(Parein, Eckert, Keller)
Third International Congress on Tissue Integration in Oral and Maxillofacial Reconstruction
Tokyo, Japan

Implant Supported Restorations in the Treatment of Partial Edentulism: What Have We Learned?
Academy of Prosthodontics
Halifax, Nova Scotia, Canada
05/31/1997

Retrospective Complications Before and After Restorative Components Revisions
Nice, France
06/25/1998

Prosthetic Complications Before and After Implant Restorative Components Revisions
Baveno, Italy
06/30/1998
Free Flaps and Reconstruction of Mandibular Defects
The American Academy of Maxillofacial Prosthetics
Victoria, British Columbia, Canada
10/04/1998
Rehabilitation of the Maxillary and Mandibular Defects, Quality of Life
Moderator
The American Academy of Maxillofacial Prosthetics
Victoria, British Columbia, Canada
10/06/1998
Implants in Restoration of Partially Edentulous Jaws
International College of Prosthodontics
Stockholm, Sweden
07/06/1999 - 07/09/1999
Evidence Based Dentistry Breakout Session
Moderator
Academy of Prosthodontics
Quebec City, Quebec, Canada
05/19/2000
Wide Diameter Implants: Early Clinical Experience
Academy of Prosthodontics
Quebec City, Quebec, Canada
05/22/2000
CISS 17
Moderator
International Team Days (Nobel Biocare)
Goteborg, Sweden
07/09/2000
The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
Academy of Osseointegration
Toronto, Ontario, Canada
03/21/2001 - 03/24/2001
Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
International Association for Dental Research
Chiba, Japan
06/27/2001 - 06/30/2001
The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
5th World Congress for Oral Implantology
Tokyo, Japan
06/30/2001 - 07/02/2001
The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
European Prosthodontic Association
Prague, Czech Republic
09/06/2001 - 09/08/2001
The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
International College of Prosthodontics
Sydney, Australia
10/17/2001 - 10/20/2001
7-year Clinical Outcomes Using a 1-Stage Dental Implant
Poster Presentation
International Association for Dental Research
San Diego, California
03/06/2002 - 03/09/2002
American Academy of Maxillofacial Prosthetics Interim Board Meeting
Nobel Biocare 2003 World Conference
Las Vegas, Nevada
04/04/2003 - 04/06/2003
Clinical Performance of Wide Diameter, Wide Platform Implant, A Multi Center Study
81st General Session & Exhibition of the International Association for Dental Research
Goteborg, Sweden
06/25/2003 - 06/28/2003
Finite Element Analysis of Forces Transmission to Bone Supporting Endosseous Implants
IADR
Honolulu, Hawaii
03/2004
Finite Element Analysis of Force Transmission to Bone Supporting Endosseous Implants
American Academy of Maxillofacial Prosthetics
Ottawa, Ontario, Canada
10/2004
Evidence Based Evaluation of Ceramic Restorations
Academy of Prosthodontics 87th Annual Scientific Session
Scottsdale, Arizona
05/2005
Finite Element Analysis of Force Transmission to Bone Supporting Edentulous Implants
ICP
Crete, Greece
05/2005
Academy of Prosthodontics
Los Angeles, California
10/2005
Finite Element Analysis of Force Transmission to Bone Supporting Edentulous Implants
American Academy of Maxillofacial Prosthetics
Los Angeles, California
10/2005
Finite Element Analysis of Force Transmission to Bone Supporting Edentulous Implants
Academy of Osseointegration
Seattle, Washington
03/2006
Finite Element Analysis of Force Transmission to Bone Supporting Edentulous Implants
Academy of Osseointegration
Seattle, Washington
03/2006
Prosthodontic patient classification: Odds calculation to predict causative factors

Evaluation of Force Transmission to Bone Supporting Endosseous
International Association of Dental Research
Brisbane, Australia
06/2006

Academy of Prosthodontics 89th Scientific Session
Academy of Prosthodontics
New York, New York
04/2007

International College of Prosthodontists
Fukuoka, Japan
09/2007

AAMP Board Meeting
Chicago, Illinois
02/2008

AO 23th Annual Meeting Implant Dentistry: A Trip Up the Implant
New York, New York
02/2008

How to Prepare your Manuscript for Publication in the JOMI
Round Table Clinic
Academy of Osseointegration
San Diego, California
02/2009

National

Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory Course
American College of Prosthodontics
1998

Academy of Prosthodontics Evidence Based Dentistry Session, Annual AP meeting
1999

Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory Course
American College of Prosthodontics
1999

Immediate and Delayed Pull-out Strengths of Endosseous Dental Implants
International Academy of Dental Research
Washington, District of Columbia
04/06/2000

Presentation of Results of Education Survey
American Academy of Maxillofacial Prosthetics
Kauai, Hawaii
11/10/2000

American Academy of Maxillofacial Prosthetics
Kauai, Hawaii
Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory Course
American College of Prosthodontics
Kona, Hawaii
11/15/2000

Maxillofacial Prosthetics
American College of Prosthodontics Board Preparation Course
Kona, Hawaii
11/15/2000

The Prosthodontic Management of the Malaligned Implant
American College of Prosthodontics
The Big Island of Hawaii, Hawaii
11/16/2000

Restoration of the Malaligned Implant
American College of Prosthodontics Annual Session
Kona, Hawaii
11/16/2000

Nobel Biocare Team Day
Orlando, Florida
02/14/2001 - 02/16/2001

Board Meeting and CDA Accreditation
American Academy of Maxillofacial Prosthetics
02/22/2001 - 02/25/2001

Nobel Biocare Board Meeting
West Palm Beach, Florida
03/30/2001 - 03/31/2001

Implants in Partially Edentulous Jaws
University of Buffalo, Department of Restorative Dentistry
Buffalo, New York
04/06/2001

Immediate Loading of Implants in Animal Models
University of Buffalo, Department of Restorative Dentistry
Buffalo, New York
04/06/2001

Preliminary Experience with Wide Platform/Wide Diameter Implants
University of Buffalo, Department of Restorative Dentistry
Buffalo, New York
04/06/2001

The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
Academy of Prosthodontics
Santa Fe, New Mexico
05/17/2001 - 05/21/2001

Prosthodontics
Humbolt Del Norte Dental Society
Eureka, California
09/26/2001

The Influence of Mandibular Dentition of Implant Failures in Edentulous Maxillae with Bone Graft
American Academy of Maxillofacial Prosthodontics
New Orleans, Louisiana
10/27/2001 - 10/31/2001
Maxillofacial Prosthetics
American College of Prosthodontics Board Preparation Course
New Orleans, Louisiana
10/31/2001
Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory Course
American College of Prosthodontics
New Orleans, Louisiana
11/01/2001
Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory Course
American College of Prosthodontics
New Orleans, Louisiana
11/01/2001 - 11/03/2001
Immediate Loading of Implants
Session Moderator
American College of Prosthodontics Annual Session
New Orleans, Louisiana
11/03/2001
Conventional Management of Maxillofacial Defects
American Academy of Maxillofacial Prosthodontics
Orlando, Florida
11/04/2002
Maxillofacial Prosthetics section of American Board of Prosthodontics Preparatory course
American College of Prosthodontics
Orlando, Florida
Research Directions and Prosthodontic Management of Dental Implants
Academy of Osseointegration
Boston, Massachusetts
02/26/2003 - 03/02/2003
Academy of Osseointegration
Boston, Massachusetts
05/01/2003 - 05/05/2003
Maxillofacial Prosthetics
American College of Prosthodontics
Dallas, Texas
10/08/2003 - 10/10/2003
American Academy of Maxillofacial Prosthetics
Scottsdale, Arizona
11/01/2003 - 11/04/2003
ACP Board Meeting
Chicago, Illinois
02/14/2004
AAMP Board Meeting
Chicago, Illinois
02/20/2004 - 02/22/2004
AO Board Member
San Francisco, California
03/17/2004 - 03/21/2004
Finite Element Analysis of Force Transmission to Bone Supporting Endosseous Implants
American Academy of Prosthodontists
Ottawa, Ontario, Canada
10/2004
In an Evidence Based World, How Do You Look at the Truth?
Academy of Osseointegration
Orlando, Florida
03/2005
Academy of Osseointegration Board Meeting
Chicago, Illinois
06/2005
Board Meeting and Strategic Planning Session
American College of Prosthodontics
Los Angeles, California
06/2005
Academy of Osseointegration Board Meeting
Chicago, Illinois
10/2005
Academy of Prosthodontics Board Meeting
Chicago, Illinois
11/2005
Academy of Prosthodontics EBD Task Force
Chicago, Illinois
11/2005
American Academy of Maxillofacial Prosthetics
Chicago, Illinois
02/2006
Academy of Prosthodontics
San Francisco, California
05/2006
AAMP Board Meeting
AAMP Board Meeting
Maui, Hawaii
10/2006
ACP Committee Meeting
American College of Prosthodontists
Miami, Florida
11/2006
American Academy of Maxillofacial Prosthetics
Chicago, Illinois
02/2007
American Board of Prosthodontics
Chicago, Illinois

02/2007
How to Get My Work Published in the JOMI
The Academy of Osseointegration
San Antonio, Texas

03/2007
ACP Program Directors Education Standards Revision
ACP Program Directors
Chicago, Illinois

05/2007
Collaborative Research Group
Chicago, Illinois

05/2007
Regional

APM Sterngold Precision Attachments
Loyola University School of Dentistry
Chicago, Illinois
1982 - 1984
Role of Fixed Prosthodontics in Removable Prosthetics
Junior Class Course 360
Loyola University School of Dentistry
Maywood, Illinois
05/1983
Esthetic Considerations in the Use of Osseointegrated Implants
Esthetic Possibilities of Implant Prosthodontics Seminar, Minnesota Prosthodontic Society
Minneapolis, Minnesota
04/05/1991
Oral Cancer: Diagnosis, Treatment, and Surgical Prosthetic Reconstruction
Minnesota Dental Association Star of the North Meeting
St. Paul, Minnesota
04/22/1991

INVITED PRESENTATIONS AND VISITING PROFESSORSHIPS

Invited Presentations

Radiation Therapy in Head and Neck Cancer Patients
Mayo Clinic Department of Dentistry
Rochester, Minnesota
02/1986
Dental Care for Cancer Patients
Mayo Clinic
Rochester, Minnesota
06/1986
Effects of Radiation Therapy on the Dental Patient
Mayo Clinic
Rochester, Minnesota
10/1986
Maxillofacial Prosthetics
Conference on Craniofacial Surgery
Rochester, Minnesota
03/1988
The Oral Effects of Radiation Therapy
Zumbro Valley Dental Society
Rochester, Minnesota
04/1988
Maxillofacial Prosthetics
550-1st USA Hospital Medical Staff, Ft. Snelling
St. Paul, Minnesota
05/14/1988
The Use of Implants in Dentistry
Rochester Area Ostomy Group, Charter House
Rochester, Minnesota
05/09/1989
Continuing Education Course
Participant
American Academy of Maxillofacial Prosthetics
Tucson, Arizona
10/28/1989
Implants Reconstruction of the Resected Mandible
Poster Presentation
Academy of Denture Prosthetics
Palm Springs, California
05/20/1990 - 05/23/1990
Participation in Residency Training Program
Fort Bliss Army Medical Hospital, US Army Prosthodontic Clinic
El Paso, Texas
08/06/1990 - 08/17/1990
Indications and Contraindications of Implant Prosthesis from the Prosthodontists’ Viewpoint
Oral and Maxillofacial Surgery Specialists, P.A. Dental Implant Seminar
Minneapolis, Minnesota
11/15/1990
Esthetic Considerations in the Use of Osseointegrated Implants
Minnesota Prosthodontic Society
Minneapolis, Minnesota
04/05/1991
Oral Cancer: Diagnosis, Treatment, and Surgical Prosthetic Reconstruction
Minnesota Dental Association, Star of the North Meeting
St. Paul, Minnesota
04/22/1991
Maintenance of Prosthetic Screw Tension Through the Use of an Anti-rotational Inlay
Poster Presentation
The Academy of Denture Prosthetics Annual Meeting
Wintergreen, Virginia
05/18/1991 - 05/25/1991
Osseointegration Implants: The Mayo Experience
Minnesota Academy of Restorative Dentistry
Minneapolis, Minnesota
01/20/1992
Anterior Porcelain Veneers
Rochester Dental Study Club
Rochester, Minnesota
04/13/1992
Parameters Associated with Spontaneous Mandibular Fracture After Endosseous Implant Placement
The Academy of Prosthodontics
Lexington, Kentucky
05/14/1992 - 05/20/1992
Reconstruction of the Severely Compromised Jaw
American Association of Oral and Maxillofacial Surgeons
Chicago, Illinois
Participation in resident training
Fort Bliss Army Medical Hospital, US Army Prosthodontic Clinic
El Paso, Texas
09/14/1992 - 09/18/1992
Esthetic Restoration of Implants in the Partially Edentulous Situation
Hermanson Dental Services, Inc.
St. Paul, Minnesota
04/23/1993
Dental Implants
Rochester Dental Assistant Society
Rochester, Minnesota
12/07/1993
Dental Implants
Minnesota Riverland Technical College, Second Year Dental Hygiene Students
Rochester, Minnesota
01/24/1994
Composite Bone Graft Reconstruction of the Compromised Maxilla and Mandible
Michigan Osseointegration Implant Study Club
Ann Arbor, Michigan
03/07/1994
Dental Implants Placed in Bone Within a Radiation Field
1st International Congress on Maxillofacial Prosthetics
Palm Springs, California
04/27/1994 - 04/30/1994
FDA Requirements for Implant Distribution in the American Marketplace
Academy of Prosthodontics
Orlando, Florida

05/16/1994
Rochester Dental Implant Study Club Sponsored Two-Day Dental Implant Course
Riverside Hospital
Minneapolis, Minnesota

06/17/1994 - 06/18/1994
Hygiene and Prosthodontics: How Can We Work Together?
Department of Dental specialties, Dental Hygienists
Rochester, Minnesota

04/26/1995
Implants in Maxillary Antral and Nasal Inlay Grafts
American Academy of Maxillofacial Prosthetics
Washington, District of Columbia

10/18/1995
Dental Implant Selection - Making Informed Choices
Zumbro Valley Dental Society
Rochester, Minnesota

11/27/1995
Advanced Prosthodontics
Rochester Dental Assistants
Rochester, Minnesota

12/05/1995
Validation of Dental Implant Systems Through a Comprehensive Literature Review
Academy of Prosthodontics
Newport Beach, California

05/06/1996
Prosthetic Care for the Difficult Patient
Illinois State Dental Society
Oak Brook, Illinois

09/07/1996
Surgical and Prosthetic Management of the Acute and Chronic Patient
Waterloo Dental Society
Waterloo, Iowa

09/19/1996
Selecting a Dental Implant System
Carl O. Boucher Prosthodontic Conference
Columbus, Ohio

04/18/1997
Evidence Based Dentistry
Academy of Prosthodontics
Chicago, Illinois

08/11/1997 - 08/13/1997
Implant Supported Restorations in the Treatment of Partial Edentulism: What Have We Learned?
American College of Prosthodontists
Orlando, Florida
11/08/1997
Selecting a Dental Implant System
Minneapolis District Society
Minneapolis, Minnesota
01/22/1998
Implants in Modern Dentistry
Minnesota Academy of Restoration Dentistry
Minneapolis, Minnesota
01/23/1998
TIDC Risk management Workshop
Sacramento, California
03/17/1998
Journal of Prosthetic Dentistry Reviewers Workshop
Chapel Hill, North Carolina
04/03/1998 - 04/05/1998
Implants in Partially Edentulous Jaws
Rochester, Minnesota
05/27/1998
Quality of Life and Outcomes
Moderator
American Academy of Maxillofacial Prosthetics
Victoria, Canada
09/16/1998
Board Preparation in Maxillofacial Prosthetics
American College of Prosthodontics
San Diego, California
10/17/1998
Implants in Modern Dentistry
Iowa Academy of General Dentistry
11/06/1998
Choosing a Dental Implant System and Experience in Implant Usage in Partially Edentulous Jaws
New York University School of Dentistry
12/11/1998
Evidence Based Dentistry: Therapy
Moderator
Academy of Prosthodontics
Calgary, Canada
05/18/1999
Implants in Modern Dental Practice
Implant Society of Bohemia
Hradec Kralove, Czech Republic
09/27/1999 - 09/29/1999
Board Preparation for Maxillofacial Prosthetics
American College of Prosthodontists  
New York, New York  
10/20/1999 - 10/23/1999

American Academy of Maxillofacial Prosthetics Board Meeting  
Chicago, Illinois  
02/25/2000 - 02/26/2000

Academy of Prosthodontic Newsletter and Web Page Committee Meeting  
Chicago, Illinois  
06/01/2001

Academy of Osseointegration Board Meeting  
Chicago, Illinois  
06/08/2001

American Dental Association Site Visit Memorial Sloan Kettering Cancer Center  
New York, New York  
01/27/2002 - 01/28/2002

American Academy of Maxillofacial Prosthetics Board of Directors & Quality of Life Committee Meeting  
Chicago, Illinois  
02/21/2002 - 02/23/2002

PM Session  
Moderator  
Academy of Osseointegration  
Dallas, Texas  
03/08/2002

Evidence Based Dentistry  
Academy of Prosthodontics  
Portland, Oregon  
05/04/2002

Evidence Based Dentistry Presentation  
Academy of Prosthodontics  
Portland, Oregon  
05/04/2002

Implants in Partial Edentulism  
Keynote Speaker  
Turkish Dental Association  
Izmir, Turkey  
06/29/2002

The Implant Alternative: When to Choose It?/What Do You Do When the Implant is in the Wrong Spot?  
The Ninth Turkish Dental Association  
Izmir, Turkey  
06/29/2002

Keynote Speaker  
HMDP  
Singapore  
09/24/2002 - 10/04/2002

Series of 17 lectures on topics of Maxillofacial Prosthetics, Dental Implants and Evidence Based Dentistry
National Dental Centre of Singapore
Singapore
09/29/2002 - 10/04/2002
Dental Implant Outcome Assessment
National University of Singapore, Singapore Prosthodontic Society
Singapore
10/02/2002
John Cranham, DDS, Trachsel
Rochester, Minnesota
12/08/2002
Site Visit
The Forsythe Institute
Boston, Massachusetts
01/11/2003
Research Directions and Prosthodontic Management of Dental Implants
20th Annual Osseointegration in Canada: On Scholarship in Implant Dentistry, University of Toronto
Toronto, Ontario, Canada
02/07/2003
Editors of Journal of Prosthodontics
Chicago, Illinois
02/16/2003 - 02/17/2003
Osseointegration Study Club of Southern California
Los Angeles, California
03/14/2003
Implant Dentistry: History, Research, and Clinical Practice
Harrisburg Dental Society
Harrisburg, Virginia
03/21/2003
Academy of Osseointegration Board Meeting
Chicago, Illinois
06/06/2003
Clinical Performances in Wide Diameter Implants: Are They a Predictable Improvement?
International College of Prosthodontists
Halifax, Nova Scotia, Canada
07/09/2003 - 07/12/2003
Antalya Turkish Dental Congress
Istanbul, Turkey
09/22/2003 - 09/26/2003
Academy of Prosthodontists Executive Council Meeting
Chicago, Illinois
10/17/2003 - 10/20/2003
Maxillofacial Prosthetics
American College of Prosthodontists, Center for Prosthodontic Education
Chicago, Illinois
11/14/2003 - 11/15/2003
World Congress of Prosthodontics  
Nwe Delhi, India  
11/25/2003  
Board meeting  
AO Board Meeting  
Chicago, Illinois  
02/2004  
Board meeting  
ACP Board Meeting  
Chicago, Illinois  
02/2004  
Site Visit to University of California, Los Angeles, CA  
Los Angeles, California  
02/09/2004 - 02/11/2004  
Finite Element Analysis for Forces Transmission to Bone Supporting Implant  
AO  
San Francisco, California  
03/2004  
Finite Element Analysis of Force Transmission to Bone Supporting Endosseous Implants  
IADR  
Honolulu, Hawaii  
03/09/2004 - 03/14/2004  
The Partial Edentulism Paradigm  
Anakara University International Congress  
Ankara, Turkey  
04/2004  
Endosseous Implants: Ideal Placement and Restoration from a Prosthodontic Perspective  
Ankara University International Congress  
Ankara, Turkey  
04/2004  
Finite Element Analysis of Forces Transmission to Bone Supporting Endosseous Implants  
AP  
Niagara Falls, Ontario, Canada  
05/03/2004 - 09/2004  
Board meeting  
AO Board Meeting  
Chicago, Illinois  
06/2004  
Finite Element Analysis of Forces Transmission to Bone Supporting Endosseous Implant  
ESBE - Paris, France  
Amsterdam, Netherlands  
07/03/2004 - 09/2004  
Board Meeting  
Board meeting  
Academy Prosthodontics  
Chicago, Illinois
10/2004
Board Meeting
Academy of Osseointegration
Chicago, Illinois
10/2004
Evening of Clinical Discussion
3I
Rochester, Minnesota
11/2004
American College of Prosthodontics Pros Review Course
American College of Prosthodontics
Chicago, Illinois
11/2004
Dental Implants
Faculty of School of Dentistry, Pennsylvania
Pennsylvania
02/2005
The Good, The Bad, and The Ugly
American Prosthodontic Society
Chicago, Illinois
02/25/2005
Dental Implants
Faculty of Dentistry, Toronto
Toronto, Ontario, Canada
03/2005
The Good, The Bad, and The Ugly
Minneapolis Dental Study Club
Minneapolis, Minnesota
03/24/2005
Evidence Based Dentistry: Subjective Concerns
Academy of Prosthodontics
Scottsdale, Arizona
05/20/2005
In an Evidence Based World, How Do You Look at Truth?
International College of Prosthodontics
Crete, Greece
05/26/2005
Finite Element Analysis of Force Transmission to bone Supporting Edentulous Implants
DGZI International Meeting
Berlin, Germany
09/2005
Comparison of Dental Implants Clinical Evidence and Prediction of 5-Year Survival
Institute for Advanced Dental Studies Karlsrud
Karlsrud, Germany
03/2006
Comparison of Dental Implants Clinical Evidence and Prediction of 5-Year Survival
Alexandria Oral Implantology Association
Alexandria, Egypt
04/2006
Karlsruhe Workshop
Karlsruhe Workshop
Karlsruhe, Germany
10/2006
Complications in Implant Dentistry
Institut Straumann
Basel, Switzerland
01/2007
Does Education in Implant Dentistry Serve the Needs of the Patient and Profession?
12th Biennial Conference
Charleston, South Carolina
04/2007
Does Education in Implant Dentistry Serve the Needs of the Patient and Profession?
International Conference on Reconstructive Preprosthetic Surgery
Charleston, South Carolina
04/2007
Irene Hermann's thesis "Influences of Statistical Analyses on Result Presentation of Oral Implant Treatment"
Goterboug University
Goterborg, Germany
06/2007
Complications in Implant Dentistry
Mexican Implantology Group
Queretaro, Mexico
09/2007
Endosseous Implants: Ideal Root Substitute?
Chicago Dental Society 2008 Midwinter Meeting
Chicago, Illinois
02/2008
"Introduction and Rationale for Dental Implants", "Diagnostics and Occlusion in Restorative and Implant Dentistry", "Digital Diagnostic Solutions for Treatment Planning", "Surface and Design of Implants", and "...
University of Louisville, School of Dentistry, XII Annual ULSD Beach Seminar
Destin, Florida
04/2008
The Transmucosal Component CAD/CAM Abutments: From Rescue to Routine
Toronto Osseointegration Conference Revisited
Toronto, Ontario, Canada
05/2008
Interview for the Journal Ilapeo experiencia in San Paulo, Brazil
Interview
San Paulo, Mexico interview for upcoming International Brazilian Congress
San Paulo, Brazil
2009
Complications in Implant Dentistry: Are All Problems Created Equally?
60 Years of Quintessence Conference
Berlin, Germany
01/2009
Complications in Implant Dentistry: Are All Problems Created Equally?
Italian Dental Implant Group
Bologna, Italy
03/2009
The Current State of Implant Dentistry and Its Likely Future
1st International Neodent Congress
Barau, Brazil
06/2009

CLINICAL PRACTICE, INTERESTS, AND ACCOMPLISHMENTS

Prosthodontics, Maxillofacial Prosthetics, Implant Prostodontics, Evidence Based Dental Practice

RESEARCH INTERESTS

Thesis: Effect of Therapeutic Radiation on Tooth Pulp

Study of Bone Regeneration Around Endosseous Oral Implants in Fresh Extraction Sockets of Dogs
JD Harvey, PJ Sheridan, CM Reeve, and SE Eckert

Bone Regeneration Around Endosseous Oral Implants in Fresh Extraction Sockets of Dogs: A Study with Dog-Derived Freeze-Dried Demineralized Bone, Osteograf/N-300 and Osteograf/N 300+Peptide-15Grafts and e-PTFE for GTR
PJ Blaha, CM Reeve, PJ Sheridan, and SE Eckert

A Comparison Between Endosseous Brånemark Implants and A Prototype Implant in Dogs
JL Padilla, CM Reeve, PJ Sheridan, and SE Eckert

Deformation of the Gold Cylinder to Implant Abutment Interface Following Simulated Functional Loading
DM Hecker and SE Eckert

Retrospective Review of Implants in the Partially Edentulous Mandible
A Parein, SE Eckert, P Wollan

Retrospective Review of 1170 Endosseous Implants in Partially Edentulous Jaws
SE Eckert and P. Wollan

Analysis of Endosseous Dental Implant Surgical Trends at the Mayo Clinic
SJ Meraw, SE Eckert, C Yacyshyn

Endosseous Implant Experience Following Changes in Prosthodontic Componentry
SE Eckert and P Wollan

Review of Fractured Endosseous Implants
SE Eckert, E Cal

Statistical Analysis of Wide Platform Implant Survival
RESEARCH GRANTS AWARDED

Active Grants

Industry
Program Director / Principal Investigator
Clinical Assessment of Multi-Unit Abutment in the Treatment of Partial Edentulism. Funded by Nobel Biocare.
07/2000 - 12/2009
Program Director / Principal Investigator
A case series to document the treatment of implant patients with the Straumann Bone Level Dental Implants. Funded by Strauman-ITI.
08/2007 - 08/2008
Co-Investigator
The Effect of Different Torque Values and Removal of the Abutment Carrier. Funded by Astra Tech. (Astra Tech Reference: D-2)
02/2009 - 05/2009

Completed Grants

Federal
Co-Investigator
Mechanical Testing System. Funded by National Center for Research Resources. (S10 RR 16913)
04/2002 - 03/2003

Industry
Principal Investigator
Evaluation of the Efficacy of the MK III Endosseous Implant in the Partially Edentulous Mandible (Molar Area). Funded by Nobel Biocare. (NOBEL #2)
09/2000 - 08/2003
Co-Investigator
05/2001 - 04/2004

Mayo Clinic
Principal Investigator
Immediate and Delayed Pull-Out Strengths of Endosseous IMCOR Dental Implants: A Pilot Study. Funded by CR Programs.

Principal Investigator
Effect of Implant Configuration, Prosthesis Height, and Cuspal Angulation on Load Transfer to Dental Implants. Funded by CR Programs.
12/2000 - 12/2003
Other

Principal Investigator

AAMP - Quality of Life Study at the Mayo Clinic. Funded by University Medical Associates.

12/2002 - 11/2003
BIBLIOGRAPHY

Peer-reviewed Articles


Books


Book Chapters


Books Edited

Editorials


Abstracts and Letters


Mary Elizabeth Brosky Imdieke D.M.D.

Curriculum Vitae

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14009 51st Avenue North
Plymouth, MN 55446
Home phone: 763-565-0156
Cell phone: 612-237-5503
Email: bimdieke@wh-link.net

Education and Training

1998 University of Pittsburgh Medical Center
Regional Center for Maxillofacial Prosthetic Rehabilitation, Pittsburgh, Pennsylvania
Hussein S. Zaki DDS, MS
Certificate: Maxillofacial Prosthetics

1997 University of Pittsburgh School of Dental Medicine
Department of Prosthodontics, Pittsburgh, Pennsylvania
Yahia Ismail DDS, MS
Certificate: Prosthodontics

1994 University of Pittsburgh School of Dental Medicine
Pittsburgh, Pennsylvania
Degree: D.M.D.

1989 Chatham College
Pittsburgh, Pennsylvania
Degree: B.A.

1986 University of Pittsburgh School of Dental Medicine
Department of Dental Assisting and Dental Hygiene
Certificate: Dental Assisting
1984  Community College of Allegheny County
Monroeville, Pennsylvania
Major: Biology

**Academic Appointments**

2007-Present  University of Minnesota School of Dentistry, Adjunct Professor, Division of Prosthodontics, Department of Restorative Sciences.

2004-2007    University of Minnesota School of Dentistry, Associate Professor, Division of Prosthodontics, Department of Restorative Sciences.

1998 - 2004  University of Minnesota School of Dentistry, Assistant Professor, Division of Prosthodontics, Department of Restorative Sciences.

**Professional Positions**

2007-Present  Veterans Affairs Medical Center Staff Maxillofacial Prosthodontist.

2003-2007    University of Minnesota Member/Advising: Graduate faculty in the field of Dentistry. Graduate School, School of Dentistry.

2004-2007    University of Minnesota Medical Center, Active Staff Member.

2002-2004    University of Minnesota School of Dentistry Faculty Senator.

1999-2007    University of Minnesota Cancer Center, Affiliate member.

1998-2007    University of Minnesota, Associate Dentist Faculty Practice.

**Licensure and Certification**

Professional Licensure

1998  State of Minnesota
1994  State of Pennsylvania

**Specialty Certification**

1997  American Board of Prosthodontics, Part I

**Memberships and Professional Societies**

2006  American Dental Education Association

2003-Present  American Academy of Maxillofacial Prosthetics. Elevated to Fellow 2006
   Board member 2009-2011

2002-Present  Omicron Kappa Upsilon, Beta Beta Chapter
   President    2007-2008

1998-2005  International Association of Dental Research/American Association of Dental Research

1994-Present  American College of Prosthodontics

**Community Outreach**

1994-Present  Collection of supplies/textbooks for community hospitals and dental clinics, Antanarivo, Madagascar.


**Publications**


*The above manuscript was selected by the British Dental Association for inclusion in their 2003 educational library.*


*The above manuscript was selected to be abstracted and published in Dental Abstracts 2003 Year Book, by Dr. Lawrence H. Meskin, editor.*

*The above manuscript was selected to be abstracted and published in Practical Procedures & Aesthetic Dentistry. Prosthodontic Literature Review. 2003;15(4):291.*

*The above manuscript was selected for publication online by EuroDnet. This is a non-profit organization preparing to launch the first international internet site for health professionals, 2003.*


