STATE OF IOWA
IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

IOWA DENTAL BOARD
AGENDA
April 28-29, 2016

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa
Members: *Steve Bradley, D.D.S., Board Chair; Steven Fuller, D.D.S., Board Vice Chair; Kaaren Vargas, D.D.S., Board Secretary; Tom Jeneary, D.D.S.; William McBride, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier, Public Member; Lori Elmitt, Public Member*

Thursday April 28, 2016
8:30 a.m.

I. DISCIPLINARY HEARING IN THE MATTER OF JAY BUCKLEY, DDS (Pursuant to Iowa Code § 272C.6(1), this disciplinary hearing will be held in closed session at the request of the licensee. Pursuant to Iowa Code § 21.5(1)(f) Board deliberation in a contested case will be held in closed session).

If time permits the Board will address the following closed session agenda items after the conclusion of the disciplinary hearing. Discussion of items may resume on Friday, April 29, 2016.

CLOSED SESSION AGENDA

II. EXECUTIVE DIRECTOR PERFORMANCE REVIEW (Pursuant to Iowa Code section 21.5(1)(i), this portion of the meeting may be held in closed session at the request of the individual.)

III. ITEMS FOR REVIEW AND DISCUSSION

a. **Closed Session Minutes** (Closed session pursuant to Iowa Code § 21.5(1)(a) "to review or discuss records which are required or authorized by state or federal law to be kept confidential…", specifically to review or discuss information that is confidential under Iowa Code § 21.5(4)).
b. **Compliance with Board Orders** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential, specifically Iowa Code § 272C.6(4) and Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
c. **Board Appearance** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).
d. **Combined Statement of Charges, Settlement Agreement and Final Order** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings, and Iowa code § 21.5(1)(f) to discuss the decision to be rendered in a contested case).

e. **Notice of Hearing and Statement of Charges** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
f. **Investigative Reports** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).
g. **New Complaints** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).
h. **Additional Information on Previous Complaints** (Closed session pursuant to Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4)).
i. **Application for Licensure/Registration** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential).
j. **Hygiene Committee (Disciplinary Only)** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential, specifically Iowa Code § 272C.6(4) and Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings).
k. **Request to Modify Board Orders** (Closed session pursuant to Iowa Code § 21.5(1)(a) to review information required by state or federal law to be kept confidential).

Friday April 29, 2016

COMMITTEE MEETINGS:

8:00 A.M. **DENTAL HYGIENE COMMITTEE**
(See separate committee agendas)

9:00 A.M. **EXECUTIVE COMMITTEE**

9:45 A.M. **BOARD MEETING:**

OPEN SESSION

I.	**CALL MEETING TO ORDER – ROLL CALL**	*Steven Bradley*
II.	**1st OPPORTUNITY FOR PUBLIC COMMENT**	*Steven Bradley*
III.	**APPROVAL OF OPEN SESSION MINUTES** a. January 28, 2016 – Quarterly Meeting	*Steven Bradley*

Please Note: At the discretion of the Board Chair, agenda items may be taken out of order to accommodate scheduling requests of Board members, presenters or attendees or to facilitate meeting efficiency.

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515-281-5157.

IV. REPORTS

A. EXECUTIVE DIRECTOR'S REPORT *Jill Stuecker*

B. BUDGET REPORT *Jill Stuecker*

C. LEGAL REPORT *Sara Scott*

D. ANESTHESIA CREDENTIALS COMMITTEE REPORT *Kaaren Vargas*

a. Actions Taken by the Committee on General Anesthesia & Moderate Sedation Permit Applications
b. Other Committee Recommendations, if any

E. CONTINUING EDUCATION ADVISORY COMMITTEE REPORT *Lori Elmitt*

a. Vote on Recommendations: RE: Continuing Education Course Applications
b. Vote on Recommendations: RE: Continuing Education Sponsor Applications
c. Other Committee Recommendations, if any

F. EXECUTIVE COMMITTEE REPORT *Steven Bradley*

a. Committee Update

G. LICENSURE/REGISTRATION COMMITTEE REPORT *Kaaren Vargas*

(Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential).

a. Recommendations by the Committee on Applications
   i. Kayla Hewitt
   ii. Lyda Bubenyak

H. DENTAL HYGIENE COMMITTEE REPORT *Mary Kelly*

a. Pending Dental Hygiene Applications (Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential).
b. Actions Taken at the Dental Hygiene Committee Meeting for Board Ratification
   i. Penny Lane Chambers, R.D.H.
c. Other Committee Recommendations, if any
   i. Final and Adopted – Iowa Administrative Code 650 – Chapter 10, Students Enrolled in Dental Hygiene Programs

I. DENTAL ASSISTANT REGISTRATION COMMITTEE *Steven Bradley*

a. Committee Update
b. Other Committee Recommendations, if any

J. EXAMINATIONS REPORTS – CRDTS (CENTRAL REGIONAL DENTAL TESTING SERVICE) –

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a. CRDTS – Dental Steering Committee Report *Steven Bradley*
b. CRDTS – Dental Hygiene Examination Review Committee Report *Mary Kelly*
c. CRDTS – Dental Examination Review Committee Report *Kaaren Vargas*

K. IOWA PRACTITIONER REVIEW COMMITTEE REPORT *David Schultz*
a. Quarterly Update

L. EXPANDED FUNCTION COMMITTEE REPORT *Nancy Slach*
a. Vote on Recommendations RE: Expanded Functions Course Applications
b. Other Committee Recommendations, If Any

V. ADMINISTRATIVE RULES/ADMINISTRATIVE RULE WAIVERS
a. Vote on Adopted and Final – Iowa Administrative Code 650– Chapter 10, "Students Enrolled in Dental Hygiene Programs" *Phil McCollum*
b. Vote on Adopted and Final – Iowa Administrative Code 650– Chapter 20, "Students Enrolled in Dental Assisting Programs"
c. Rulemaking Update: Draft of Chapter 25, "Continuing Education"
d. Rulemaking Update: Draft of Chapter 14, "Renewal and Reinstatement"
e. Rule Waiver Request for Reconsideration- Axel Ruprecht, DDS Iowa Administrative Code 650.11.2(2)d-e, "Dental licensure by examination"

VI. LEGISLATIVE UPDATES *Jill Stuecker*
a. For Discussion: Alternate Pathways for Licensure *Kaaren Vargas*

VII. OTHER BUSINESS *Jill Stuecker*
a. Approval of Expanded Functions Q&A Document
b. Retired Volunteer License Update
c. Committee Appointments
i. Anesthesia Credentials Committee
ii. IPRC
iii. Licensure and Registration Committee
d. Teledentistry Discussion with Dr. Paul Glassman
e. Confirmed 2017 Meeting Dates
f. Set Date for Future Board Teleconference

VIII. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS (Pursuant to Iowa Code § 21.5(1)(a) some licensure/registration information is required by state or federal law to be kept confidential). *Christel Braness*
a. Ratification of Actions Taken on Applications Since Last Meeting

IX. 2nd OPPORTUNITY FOR PUBLIC COMMENT *Steven Bradley*

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CONTINUATION OF CLOSED SESSION AGENDA ITEMS

OPEN SESSION

IV. ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

a. Closed Session Minutes
b. Compliance with Board Orders
c. Board Appearance
d. Combined Statement of Charges and Settlement Agreement
e. Notice of Hearing and Statement of Charges
f. Investigative Reports
g. New Complaints
h. Additional Information on Previous Complaints
i. Application for Licensure/Registration
j. Hygiene Committee Recommendations (Disciplinary Only)
k. Request to Modify Board Orders

V. ADJOURN

NEXT QUARTERLY MEETING: JULY 21-22, 2016

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IOWA DENTAL BOARD
MINUTES
January 28-29, 2016
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Board Members	**January 28, 2016**	**January 29, 2016***
Steven Bradley, D.D.S.,	Present	Present
Steven C. Fuller, D.D.S.	Present	Present
Kaaren G. Vargas, D.D.S.	Present	Present
Thomas M. Jeneary, D.D.S.	Present	Present
William G. McBride, D.D.S.	Present	Present
Mary C. Kelly, R.D.H.	Present	Present
Nancy A. Slach, R.D.H.	Present	Present
Diane Meier, Public Member	Present	Present
Lori Elmitt, Public Member	Present	Present

*Hearing in the Matter of Jay R. Buckley, D.D.S. held on January 29, 2016.

Staff Members
Jill Stuecker, Phil McCollum, Christel Braness, David Schultz, Dee Ann Argo, Janet Arjes

Attorney General's Office
Sara Scott, Assistant Attorney General

Other Attendees
Jane Slach, R.D.A. Iowa Dental Assistants Association
Carol Van Aernam, R.D.H., Iowa Dental Hygienists' Association
Emily Boge, R.D.H., Hawkeye Community College
Bob Russell, D.D.S, Iowa Department of Public Health
Larry Carl, Iowa Dental Association
Bruce Cochrane, D.D.S., Iowa Dental Association
Mike Moffitt, D.D.S., Iowa Dental Association
Jackie Krueger, Western Iowa Technical Community College
Lori Brown, R.D.H., Des Moines Area Community College
Tom Cope, Iowa Dental Hygienists' Association
Lynh Patterson, Delta Dental of Iowa
Sue Hyland, R.D.H., Iowa Dental Hygienists' Association
Stephen Thies, Iowa Academy of General Dentistry

DRAFT

Francisco Olalde, University of Iowa, Office of Statewide Clinical Education Programs
Patricia Meredith, D.D.S., University of Iowa College of Dentistry

I. CALL TO ORDER FOR JANUARY 28, 2016

Dr. Bradley called the open session meeting of the Iowa Dental Board to order at 11:33 a.m. on Thursday, January 28, 2016.

Roll Call:

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McBride	Meier	Slach	Vargas
Present	x	x	x	x	x	x	x	x	x
Absent									

A quorum was established with all members present.

II. 1st OPPORTUNITY FOR PUBLIC COMMENT

Dr. Bradley asked everyone to introduce themselves. Dr. Bradley allowed the opportunity for public comment.

Dr. Cochrane reported that he and the Iowa Dental Association put a lot of time and effort into the retired volunteer license; and he thanked Ms. Stuecker and Mr. McCollum for their time and efforts on this.

Ms. Krueger, Iowa Western Technical Community College, stated that there was some discussion about supervision for lab activities of level 1 expanded functions training in educational programs. As she understood, the Board was leaning towards requiring supervision by a licensed dentist. Ms. Krueger suggested specifying certain tasks, or allowing peer-to-peer activities without that level of supervision, or to make allowances for non-invasive procedures. Dr. Bradley stated that this will be addressed later in the meeting.

III. APPROVAL OF OPEN SESSION MINUTES

- *October 22, 2015 – Quarterly Meeting Minutes*

❖ MOVED by JENEARY, SECONDED by KELLY, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

- *December 3, 2015 – Teleconference Meeting Minutes*

❖ MOVED by MEIER, SECONDED by FULLER, to APPROVE the open session minutes as submitted. Motion APPROVED unanimously.

IV. PRESENTATION ON LEVEL 2 EXPANDED FUNCTIONS CURRICULUM PRESENTED BY THE UNIVERSITY OF IOWA COLLEGE OF DENTISTRY

DRAFT

Dr. Patricia Meredith, University of Iowa College of Dentistry, presented information to the Board about the University of Iowa College of Dentistry's proposed curriculum for level 2 expanded functions training. Dr. Meredith reported that the detailed curriculum was submitted previously. This discussion was an overview.

Dr. Meredith reported that they had interpreted forming and placement of stainless steel crowns to include full coverage crowns for primary teeth. Dr. Vargas stated that she had some reservations about this. Some of the crowns are technique sensitive and can be difficult to remove if cemented incorrectly. Dr. Vargas stated that she preferred to limit this to stainless steel crowns. Dr. Mabry, who was not present, believed that either these crowns fit or they did not. Dr. Vargas stated that the seating of the crown was the area where she had concerns, and with zirconia crowns more specifically.

Ms. Kelly asked for clarification that stainless steel crowns were considered temporary crowns. Dr. Vargas stated that she believed so. Dr. Meredith stated that this is what the University of Iowa College of Dentistry teaches.

Dr. Meredith indicated that the pre-test would cover level 1 materials. There was some question about what the pretest should cover. Ms. Stuecker checked the rule. The rules reference an "entrance exam."

The course will be broken into two parts: permanent dentition and edentulous arch; and pediatric dentition. This was intended to address the fact that not all dental offices treat pediatric patients. The Board members expressed some concern with this approach as Iowa Administrative Code 650 does not allow an a la carte approach to level 2 expanded functions. Dr. Meredith believed that this could be a problem since the University of Iowa College of Dentistry will not provide clinical experiences during the course of training. The intention is to have the sponsoring dentist provide the clinical experiences.

Dr. Meredith indicated that the University of Iowa College of Dentistry can offer this as a level 2 course, and stipulate the requirements for completion of the training. Dr. McBride stated that he believed the sponsoring dentist and the participant to be responsible for meeting those requirements. A number of the Board members agreed. If there are problems with this, they can reach out to the Board and the Board can consider changes as needed.

Dr. Meredith reported that the training will consist of five (5) modules. Dr. Meredith stated that the procedures must be clinically acceptable. Dr. Meredith indicated that they intend to involve the sponsoring dentists during some portions of the training.

Dr. Meredith stated that they will verify the training; however, they will leave "certification" up to the Board. Dr. Meredith stated that faculty will sign off on the completion of the procedures.

Dr. Meredith stated that they will provide remediation as needed. They are hoping that this will be limited. Additional fees may be charged based on the amount of remediation required.

The course will be approximately 140 hours between coursework completed online, and time spent in training at the school.

Ms. Elmitt asked about the cost. Dr. Meredith stated that they are still calculating the costs, but expected the cost to be around $7000. This would include the materials, including the typodont.

Ms. Kelly asked if there would be a proposed limit to how many auxiliary could train in-office at a time. Dr. Meredith stated that they had not discussed that. Dr. Meredith indicated that this may require a discussion with the sponsoring dentist so that the sponsoring dentist can effectively manage the training.

Dr. Fuller asked if the supervising dentists could sit in on all modules. Dr. Meredith stated that they would welcome that. Dr. Meredith encouraged the Board to offer continuing education credit for the training. Board members stated that the University of Iowa College of Dentistry could request review for continuing education credit.

Dr. Meredith stated that they would like to offer the course this spring. This would require input from the Board regarding approval to move forward on the proposed coursework.

- MOVED by FULLER, SECONDED by MCBRIDE, to APPROVE the course with the modifications to include training in pediatric procedures in the training sessions, and to remove teaching of the use of zirconia crowns. Motion APPROVED unanimously.

V. REPORTS

EXECUTIVE DIRECTOR'S REPORT

Ms. Stuecker reported that the Board had been provided some statistics regarding licensure. Ms. Stuecker stated that staff was working on finalizing an annual report with more data.

Ms. Stuecker welcomed Mr. Schultz to the Board as the new investigator. Mr. Schultz came from the Iowa Board of Medicine, and also had previous law enforcement experience.

Ms. Stuecker thanked Ms. Argo and Mr. McCollum for their time and efforts while being short an investigator.

BUDGET REPORT

Ms. Stuecker reported that an updated financial report was provided to the Board. The Board members did not have any comments or questions about the report.

LEGAL REPORT

Ms. Scott reported that there wasn't anything to report.

ANESTHESIA CREDENTIALS COMMITTEE REPORT

DRAFT

Dr. Vargas reported that the Anesthesia Credentials Committee met recently to review and consider applications for general anesthesia and moderate sedation permits, which were approved for issuance.

CONTINUING EDUCATION ADVISORY COMMITTEE REPORT

- *Recommendations RE: Continuing Education Course Applications*
- *Recommendations RE: Continuing Education Sponsor Application(s)*

Ms. Elmitt reported that the Continuing Education Advisory Committee met recently. Ms. Elmitt provided an overview of the committee's recommendations.

- ❖ MOVED by KELLY, SECONDED by VARGAS, to APPROVE the committee's recommendations as submitted. Motion APPROVED unanimously.

- *Other Committee Recommendations, If Any*

There weren't any other recommendations.

EXECUTIVE COMMITTEE REPORT

Dr. Bradley reported that the committee met earlier that morning. Most of the topics discussed will be addressed later in the meeting.

LICENSURE/REGISTRATION COMMITTEE REPORT

- *Actions Taken by Committee on Applications*
- *Kayla Hewitt, Dental Assistant*
- *Shawn Leonard, Dental Assistant*

Dr. Vargas reported that due to the confidentiality of the information, these applications will be discussed in closed session. A list of actions taken by the committee was included in the Board members' folders.

DENTAL HYGIENE COMMITTEE REPORT

- *Pending Dental Hygiene Applications*

There weren't any dental hygiene applications for review.

- *Actions Taken at Dental Hygiene Committee Meeting*
  - *Definition of Ongoing Practice in the Administration of Local Anesthesia in Another State*

DRAFT

Ms. Kelly reported that the committee met earlier this morning. The Dental Hygiene Committee discussed silver diamine fluoride, which is a recent issue of conversation, and may require further review.

Ms. Kelly reported that the committee directed Board staff to allow out-of-state practitioners to qualify for a local anesthesia permit on the basis of "ongoing practice in the administration of local anesthesia" if they have administered local anesthesia in another state, which allows the administration by dental hygienists, within 24 months preceding the date of application.

- *Other Committee Recommendations, If Any*
  - *Final and Adopted – Iowa Administrative Code 650—Chapter 13, Retired Volunteer Dentist and Dental Hygiene License*
  - *Notice of Intended Action – Iowa Administrative Code 650—Chapter 10, Students Enrolled in Dental Hygiene Programs*
  - *Rule Waiver Request – SuzAnne Mahrt, R.D.H. – Iowa Administrative Code 650—10.4, "Unauthorized Practice of a Dental Hygienist"*
  - *IDHA Bill*

Ms. Kelly reported that these matters will be discussed later in the meeting.

DENTAL ASSISTANT REGISTRATION COMMITTEE REPORT

- *Committee Update*

Dr. Bradley reported that the committee has not met since the last Board meeting, and had nothing new to report.

EXAMINATIONS REPORT

- *CRDTS – Dental Steering Committee Report*

Dr. Bradley reported that they met the week prior to the Board meeting. CRDTS has indicated that they were very interested in what is going on in Iowa as far as the clinical examination issues were concerned.

- *CRDTS – Dental Hygiene Examination Review Committee Report*

Ms. Kelly reported that the committee will meet again in July 2016.

- *CRDTS – Dental Examinations Review Committee Report*

Dr. Vargas reported that there was nothing new to report.

QUARTERLY IPRC REPORT

Ms. Stuecker provided an overview of the current IPRC data.

DRAFT

EXPANDED FUNCTIONS COMMITTEE REPORT

- *Vote on Recommendations: RE: Expanded Functions Course Applications*
- *Other Committee Recommendations, If Any*

Ms. Slach reported that the committee had not met since the last Board meeting and had nothing new to report.

VI. ADMINISTRATIVE RULES/PETITIONS FOR RULE WAIVER

- *Vote on Adopted and Final – Iowa Administrative Code 650—Chapter 13, "Retired Volunteer Dentist and Dental Hygiene License"*

Mr. McCollum reported that the Board approved the Notice of Intended Action at October 2015 meeting. The Board did not receive any comments. The proposed rules are eligible for adoption. There have been no changes to the language since the Notice of Intended Action was approved.

Ms. Kelly reported that the Dental Hygiene Committee recommended approval of the rules as drafted.

- ❖ MOVED by KELLY, SECONDED by MCBRIDE, to ADOPT the rules as drafted. Motion APPROVED unanimously.

Mr. McCollum reported the rules would be filed, and would potentially be effective on April 6, 2016.

- *Vote on Notice of Intended Action – Iowa Administrative Code 650—Chapter 10, "Students Enrolled in Dental Hygiene Programs"*

Mr. McCollum reported that this was a first draft of the proposed changes. Approval of the Notice of Intended Action would begin the rulemaking process. Mr. McCollum provided an overview of the proposed supervision levels in dental hygiene programs: dental hygiene students, who complete clinical services on peers enrolled in the same program, could perform those serviced under direct supervision of a faculty member, who holds either an active dental hygiene license, faculty permit or dental license; clinical skills performed on the public would require general supervision by a licensed dentist; and clinical administration of local anesthesia or nitrous oxide would require direct supervision by a licensed dentist.

Ms. Kelly reported that the Dental Hygiene Committee recommended approval of the Notice of Intended Action as drafted.

- ❖ MOVED by KELLY, SECONDED by SLACH, to APPROVE the Notice of Intended Action as drafted. Motion APPROVED unanimously.

DRAFT

- *Vote on Notice of Intended Action – Iowa Administrative Code 650—Chapter 20, "Students Enrolled in Dental Assisting Programs"*

Mr. McCollum provided an overview of the proposed supervision requirements: dental assistant students, who complete clinical services on peers enrolled in the same program, could perform those serviced under direct supervision of a faculty member, who holds either an active dental hygiene license, faculty permit, dental assistant registration, or dental license; clinical skills performed on the public would require direct supervision by a licensed dentist; and clinical expanded functions duties would require supervision by a licensed dentist.

Mr. McCollum addressed Ms. Krueger's comments from earlier in the meeting regarding supervision; the supervision levels were based on what would be required in private practice. The public will have an opportunity to comment on the proposed rules during the rulemaking process.

- ❖ MOVED by FULLER, SECONDED by MEIER, to APPROVE the Notice of Intended Action as drafted.

Ms. Jane Slach commented on the expanded functions supervision as part of the curriculum since those duties would be performed on fellow students. Ms. Jane Slach asked if this would still require direct supervision by a licensed dentist. Mr. McCollum stated that proposed rules would require direct supervision by a licensed dentist if performing clinical expanded functions procedures. The proposed supervision levels were intended to correlate to that required in private settings.

- ❖ Vote taken. Motion APPROVED unanimously.

- *Vote on Notice of Intended Action – Iowa Administrative Code 650—Chapter 27, "Standards of Practice and Principles of Professional Ethics"*

Mr. McCollum reported that this was submitted as a Notice of Intended Action. The proposed changes would clarify notification requirements for licensees discontinuing practice in a community. The proposed changes clarified that patient records may be transferred to another licensee for retention.

- ❖ MOVED by ELMITT, SECONDED by JENEARY, to APPROVE the Notice of Intended Action as drafted.

Dr. Bradley asked if licensees would be allowed to provide notification in the newspaper. Mr. McCollum clarified that this, along with other options, would be allowed.

Ms. Kelly asked about locum tenens dentists. Ms. Kelly inquired as to how the proposed rule would affect those practitioners. Mr. McCollum noted that the designation to "permanent practice location" was not made in this draft; therefore, that was something to consider. Mr. McCollum believed that the assumption would be that a locum tenens practitioner would be considered part of the practice. Ms. Slach asked about faculty. Ms. Stuecker stated that that if the University of Iowa College of Dentistry is considered a practice then they would need to do this also.

DRAFT

Mr. McCollum asked if the Board needed to look at some of these things further prior to approving the Notice of Intended Action. Mr. McCollum stated that with all of the questions, it may be better to wait and come back at a later date with an updated draft, which may better address some of these concerns. Ms. Kelly stated that the current rule would still be enforceable. Mr. McCollum agreed, and stated that the intent of the rule was to clarify requirements.

Dr. Cochrane asked about corporate practices with a revolving number of dentists. Ms. Stuecker stated that they would be required to notify patients upon discontinuation of practice under the current rules.

- ❖ Dr. Jeneary withdrew his motion.

- ▪ *Discuss Next Rulemaking Priority*

Ms. Stuecker referred the Board to its list of ongoing rulemaking priorities. Ms. Stuecker recommended prioritizing the continuing education rules in Iowa Administrative Code 650—Chapter 25 given the length of time since these rules have been reviewed and updated. This could take a couple of meeting cycles to complete; however, an update will be provided at the next meeting.

- ▪ *Rule Waiver Request – Axel Ruprecht, D.D.S. – Iowa Administrative Code 650—11.2(2)d-e, "Dental Licensure by Examination"*

Ms. Braness reported that this was a request that was first discussed at the October 2015 meeting. Ms. Braness provided an overview of the request. The Board has been provided updated information about the Canadian national board, which Dr. Ruprecht reported having completed.

- ❖ MOVED by VARGAS, SECONDED by KELLY, to DENY the waiver request.

Dr. Vargas stated that Iowa Administrative Code 650—Chapter 11 requires passage of a clinical examination to obtain a license on the basis of examination. To date, there wasn't any information indicating that Dr. Ruprecht had completed a clinical examination. Dr. Ruprecht is also a specialist; and the Iowa Dental Board does not have provisions to issue specialty licenses or permits, which would restrict the practice of dentistry.

Ms. Slach wondered if there were any options available. Ms. Slach believed that denying the request would mean denying the citizens of Iowa Dr. Ruprecht's expertise. Dr. Vargas stated that the unbiased argument would be to require compliance with what is required by rule, or what is substantially similar. Exceptions to policy may be difficult to justify in the future.

Ms. Braness stated that Dr. Ruprecht could complete the CRDTS examination to qualify for licensure. The question to consider was whether taking CRDTS would be considered a significant hardship for the purposes of the request for rule waiver.

DRAFT

Ms. Slach stated that the Board could choose to grant the rule waiver to allow his licensure. There was some additional discussion about whether the rule waiver could be allowed. Ms. Braness and Ms. Scott clarified that the Iowa Code makes reference to requirement for examinations approved by the Board, but does not specify which examinations.

Ms. Braness noted that approval of this rule waiver would set a precedent. Ms. Braness reported on two past requests for rule waivers related to the Board's examination requirements. In one case, a practitioner had failed one portion of the CRDTS examination and asked to be licensed without having to retest in that section. The Board denied that waiver request. The other request related to a practitioner who had completed a clinical examination approved by the Board, but had missed the cut-off for licensure by examination by a couple months, and was ineligible for licensure by credentials. The Board approved the second request. The past precedent has been to deny licensure to those who have not successfully completed clinical examinations.

Ms. Slach believed that these circumstances were unique in that Dr. Ruprecht is not a general practitioner. Ms. Slach stated that Dr. Ruprecht has no intention to practice general dentistry. Ms. Slach stated that Dr. Ruprecht's expertise was far beyond anyone else. Ms. Slach stated that the Board did not receive many of these requests and ought to approve it based on his expertise.

Dr. Vargas reported that she went through the rule waiver process to obtain her dental license. Dr. Vargas believed that the Board had to treat this request without bias as to who Dr. Ruprecht is.

- ❖ Motion APPROVED, 8-1. Ms. Slach voted in opposition to the motion.

- ▪ *Rule Waiver Request – SuzAnne Mahrt, R.D.H. – Iowa Administrative Code 650—10.4, "Unauthorized Practice of a Dental Hygienist"*

Ms. Stuecker reported that Ms. Mahrt requested a rule waiver to be allowed to own a dental practice, and also to be allowed to work as a dental hygienist within that practice. Ms. Stuecker provided an overview of the current rule. The rule has been interpreted to mean that a dental hygienist may not own a practice, and cannot work for a dentist, who would be employed by that hygienist.

Ms. Stuecker stated that there are two issues to consider: ownership, and practicing as a dental hygienist in the practice where she would be the employer of the supervising dentist(s).

Ms. Kelly reported that the Dental Hygiene Committee recommended approval of the rule waiver as requested. Ms. Kelly stated that dental assistants and others could legally own a dental practice; the prohibition is only stated with respect to dental hygienists. Ms. Stuecker agreed that the rules are inequitable when it came to ownership of a practice.

- ❖ MOVED by VARGAS, SECONDED by KELLY, to APPROVE the rule waiver as requested.

DRAFT

Dr. Vargas believed that the current rule was discriminatory when anyone else would be allowed to own a practice. The licenses would still allow the Board to take action if wrongdoing were to occur.

Dr. Jeneary wanted to deny the request based on the current language in rule. Dr. Vargas stated that the rule should be changed. Dr. Jeneary believed that the rule should be changed prior to allowing this to occur.

Dr. Vargas believed the rule was antiquated and recommended that the rule be made a priority for change.

Ms. Stuecker asked for input regarding the supervision issue. Dr. Vargas reiterated her support to approve the request. Ms. Slach agreed with Dr. Vargas.

- ❖ Motion APPROVED, 8-1. Dr. Jeneary voted in opposition to the motion.

The Board asked that rulemaking with respect to this rule be made a priority.

VII. LEGISLATIVE UPDATES

Ms. Stuecker reported that House Study Bill 532 was introduced that would require an alternative examination for licensure, which would include a station-based examination that does not involve the use of patients.

Ms. Stuecker reported that this issue had been discussed at previous meetings, and the Board's position on this issue was clear. Ms. Stuecker reported that she met with Representative Taylor, who is the subcommittee chair for this bill. Ms. Stuecker believes the Buffalo Model may address the concerns expressed. The bill subcommittee is scheduled for February 10, 2016.

Ms. Stuecker reported that a bill would likely be filed regarding dental assistants. Mr. Carl stated that he was approached by a legislator to remove the legislative intent language from 2000 that stated that the Iowa Dental Board could not adopt rules as it related to dental assistant placing sealants. Mr. Carl had not yet seen the language. Mr. McCollum stated that it just came through during the meeting. Mr. Carl stated that he was not certain if the language addressed their concerns, which was to remove the legislative intent language. Mr. McCollum read the language of the bill as drafted at that time. Mr. Carl stated that the removal of this language would allow the Board to write rules to address those services as needed.

Mr. Cope asked to speak on this proposed legislation. Mr. Cope was concerned about the proposed legislation as it would potentially allow dental assistants to do more than place sealants. Mr. Carl stated that the proposed legislation would grant the Board authority to draft rules to address these services if they determined that it was appropriate.

- ▪ *Discussion and Vote on IDHA Bill*

Mr. Cope reported that Senate Study Bill 3060 has been filed. This would allow dental hygienists to provide educational services and oral screening services without requiring supervision by a dentist.

Mr. Cope reported that the Dental Hygiene Committee discussed this earlier. There was a question of what an oral inspection is. There were concerns about whether this could be construed as a diagnosis. Board staff proposed language to be added to clarify that an oral screening would not include diagnosis. The leadership of the Iowa Dental Hygienists' Association met briefly after the Dental Hygiene Committee meeting; they were in support of the proposed amendment to address these concerns.

Ms. Kelly reported that the Dental Hygiene Committee recommended approval for the legislation.

- ❖ MOVED by KELLY, SECONDED by VARGAS, to SUPPORT the legislation as proposed.

Dr. Vargas believed that this made sense since pediatricians can complete oral inspection. It made sense to allow dental hygienists to provide these services as well. Ms. Kelly stated that the language would still require referral to a licensed dentist for further examination, and treatment as needed.

Ms. Slach asked about the inclusion of dental assistants within this. The scope of the proposed legislation was limited to dental hygienists; and that discussion of dental assistants would need to be addressed as a separate matter.

Mr. Carl asked about the impact on public health supervision. Mr. Cope clarified that the intent was not to mirror the locations as allowed by public health supervision.

Ms. Boge provided an example as to how this legislation would benefit her, by allowing her to provide educational services within her community.

- ❖ Motion APPROVED unanimously.

Ms. Stuecker asked for clarification regarding the motion. The Board confirmed that the motion meant Ms. Stuecker should register in support of the bill and lobby in favor of it at the legislature.

VIII. OTHER BUSINESS

- *Nancy Slach Report on CODA Site Visit*

Ms. Slach stated that there was limited information to share as much of the information related to the site visit is confidential. Indian Hills Community College intends to start a dental hygiene program at its school. The proposed dental hygiene program is a “one+one” program. The ADA-accredited program would include one year of dental assisting education, and one year of dental hygiene education.

DRAFT

- *Set Date for Future Board Teleconference*

Ms. Stuecker stated that the Board will need to meet again in about 4-5 weeks. Ms. Stuecker proposed meeting on February 25, 2016 or March 3, 2016.

The Board agreed to meet on February 25, 2016 at 7:00 a.m. via teleconference.

IX. APPLICATIONS FOR LICENSURE/REGISTRATION & OTHER REQUESTS

- *Ratification of Actions Taken on Applications Since Last Meeting*

Mr. Braness reported that the Board was provided an updated list of actions taken in response to applications for license, registration, qualification, and permit.

- ❖ MOVED by ELMITT, SECONDED by KELLY, to APPROVE the list as submitted. Motion APPROVED unanimously.

X. 2nd OPPORTUNITY FOR PUBLIC COMMENT

Dr. Bradley allowed the opportunity for public comment.

Dr. Steven Thies inquired about the proposed changes to the notification of the discontinuation of practice. Dr. Thies asked about the situations in which a practitioner would be required to notify patients of a discontinuation of practice. Ms. Braness and Mr. McCollum stated that the requirement would be to notify active patients of record, which is defined in rule. Mr. McCollum reported that this was proposed for clarification due to turnover rates in some offices, and there have also been questions about where patient records are maintained. The proposal was intended to address those concerns.

- ➢ The Board took a recess at 1:08 p.m.
- ➢ The Board reconvened at 1:20 p.m.

CLOSED SESSION

- ❖ MOVED by BRADLEY, SECONDED by ELMITT, for the Board to go into closed session at 1:20 p.m., pursuant to:

Section 21.5(1)(h) for agenda item 1a "to avoid disclosure of specific law enforcement matters, such as allowable tolerances or criteria for the selection, prosecution, or settlement of cases, which if disclosed would facilitate disregard of requirements imposed by law".

Section 21.5(1)(a) for agenda item 2a "to review or discuss records which are required or authorized by state or federal law to be kept confidential…", specifically to review or discuss information that is confidential under Iowa Code § 21.5(4).

DRAFT

Section 21.5(1)(f) for agenda item 2b, to discuss the decision to be rendered in a contested case.

Section 21.5(1)(d) for agenda item 2c to discuss whether to initiate licensee disciplinary investigations or proceedings, and Iowa code § 21.5(1)(f) to discuss the decision to be rendered in a contested case.

Section 21.5(1)(d) for agenda items 2d, 2e, 2f and 2g to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4).

Section 21.5(1)(a) for agenda items 2h, 2i, 2j and 2k to review information required by state or federal law to be kept confidential, specifically Iowa Code § 272C.6(4) and Iowa Code § 21.5(1)(d) to discuss whether to initiate licensee disciplinary investigations or proceedings.

Section 21.5(1)(d) for agenda item 2l to discuss whether to initiate licensee disciplinary investigations or proceedings and pursuant to Iowa Code § 21.5(1)(a) to review or discuss records which are required or authorized by state or federal law to be kept confidential, specifically information that is confidential under Iowa Code § 272C.6(4).

Member	Bradley	Elmitt	Fuller	Jeneary	Kelly	McBride	Meier	Slach	Vargas
Aye	x	x	x	x	x	x	x	x	x
Nay									
Absent									

Motion APPROVED by ROLL CALL.

OPEN SESSION

- ❖ MOVED by KELLY, SECONDED by VARGAS, to return to open session. Motion APPROVED unanimously.

- ➢ The Board reconvened in open session at 4:44 p.m. on January 28, 2016.

ACTION ON CLOSED SESSION ITEMS

1. *Closed Session Minutes*

- ❖ MOVED by MEIER, SECONDED by VARGAS, to approve the closed session minutes for the October 22-23, 2015 quarterly meeting. Motion APPROVED unanimously.

DRAFT

- MOVED by MEIER, SECONDED by VARGAS, to approve the closed session hearing minutes in the Matter of Cynthia D. Adams, Q.D.A. hearing on October 23, 2015. Motion APPROVED unanimously.

2. Requests to Modify Board Orders

- MOVED by KELLY, SECONDED by MCBRIDE, to DENY the request for termination of probation in the Matter of Andre' Q. Bell, D.DS., file number 06-055. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to APPROVE the request to modify his Board Order in the Matter of Lance P. Forbes, D.D.S., file numbers 12-059, 12-091. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to DENY the request to modify his Board Order in the Matter of David C. Reff, D.D.S., file number 14-0139. Motion APPROVED unanimously.

3. Final Action on Cases

- MOVED by SLACH, SECONDED by FULLER, to keep open file numbers 13-0056, 13-0064. Motion APPROVED unanimously.

- MOVED by SLACH, SECONDED by FULLER, to close file number 14-0111. Motion APPROVED unanimously.

- MOVED by SLACH, SECONDED by FULLER, to close file numbers 15-0043. Motion APPROVED unanimously.

- MOVED by SLACH, SECONDED by FULLER, to close file numbers 15-0044, 15-0069, 15-0070. Motion APPROVED unanimously.

- MOVED by SLACH, SECONDED by FULLER, to keep open file number 15-0046. Motion APPROVED unanimously.

- MOVED by SLACH, SECONDED by FULLER, to keep open file number 15-0080. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to keep open file number 15-0050. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0095. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0104. Motion APPROVED unanimously.

DRAFT

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0110. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0125. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0131. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file numbers 15-0132, 15-0121. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0133. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0134. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0135. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0136. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0137. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0138. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0139. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0140. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to keep open file number 15-0141. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to keep open file number 15-0142. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0143. Motion APPROVED unanimously. Vargas recused.

DRAFT

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0144. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0145. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to keep open file number 15-0146. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to keep open file number 15-0147. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0148. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0149. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0150. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0151. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0152. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0153. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0154. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0155. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0158. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0159. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0160. Motion APPROVED unanimously.

DRAFT

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0162. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0164. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0167. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0168. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0169. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0170. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0173. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0175. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0176. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0179. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0180. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close file number 15-0181. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close the matter Board reviewed on insurance company rejecting a claim that was submitted by a licensee. Motion APPROVED unanimously.

- MOVED by ELMITT, SECONDED by JENEARY, to close the matter Board reviewed regarding licensees names appearing under specialty headings when googled on the internet. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to keep open file number 11-190. Motion APPROVED unanimously.

DRAFT

- MOVED by VARGAS, SECONDED by KELLY, to keep open file numbers 14-0081, 15-0048. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to close file number 15-0018. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to close file number 15-0035. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to keep open file number 15-0055. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to close file number 15-0064. Motion APPROVED unanimously.

- MOVED by VARGAS, SECONDED by KELLY, to close file number 15-0079. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to approve registration and close file number 15-0183. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to keep open file number 15-0184. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to close file number 15-0103. Motion APPROVED unanimously.

- MOVED by KELLY, SECONDED by MCBRIDE, to close file number 15-0166. Motion APPROVED unanimously.

XVII. ADJOURN

The meeting took a recess at 4:50 p.m. on January 28, 2016.

The Board convened at 8:30 a.m. on January 29, 2016 for the hearing in the Matter of Jay R. Buckley, D.D.S.

NEXT MEETING OF THE BOARD

The next quarterly meeting of the Board is scheduled for April 28-29, 2016, in Des Moines, Iowa.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

DRAFT

REPORT TO THE IOWA DENTAL BOARD

FYI

DATE OF MEETING: April 29, 2016
RE: **Actions Taken by the Committee on Applications for Sedation Permits**
SUBMITTED BY: **Anesthesia Credentials Committee**

COMMITTEE ACTIONS TAKEN ON APPLICATIONS
The committee voted to take action on the applications as indicated below:

APPLICATIONS FOR GENERAL ANESTHESIA PERMITS:

- Lois I. Jacobs, D.D.S. – Requested additional information regarding training, and intended facility location(s).

ACTION

REPORT TO THE IOWA DENTAL BOARD

DATE OF MEETING: April 28-29, 2016
RE: **Recommendations: Course, Sponsor & Requests**
SUBMITTED BY: **Continuing Education Advisory Committee**
ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS

The committee requests that the Board accept the following recommendations:

CONTINUING EDUCATION COURSE REVIEW

1. Iowa Dental Association – *"Designed for Accomplishment; Engineered for Success (1st Session)"* – Requested 3 hours; Recommended APPROVAL
2. Iowa Dental Association – *"Designed for Accomplishment; Engineered for Success (2nd Session)"* – Requested 3 hours; Recommended APPROVAL
3. Iowa Dental Association – *"Lunch and Learn"* – Requested 1 hour for each session; Recommended APPROVAL for the following courses:
    a. *Simplified Extractions and Socket Grafting Techniques*
    b. *The Versatility of Locators in Your Practice*
    c. *What Do We Know About Cracked Teeth*
    d. *Periodontal Solutions for Everyday Practice: Change the Microenvironment and Address the Biofilm Cause*
    e. *Oral Cancer Screening with VELscope Vx*
4. Joan Stover – *"Iowa Governor's Conference on Public Health 2016"* – Requested 2 hours; Recommended APPROVAL for the following courses:
    a. *"Community Recruitment and Collaboration for a Strong Dental Workforce"*
    b. *"I-Smile Silver: A Community-Based Pilot Project for the Oral Health of Older Iowans"*
5. North Central District of Iowa Dental Association – *"Periodontal Disease: From Probing to Presenting to Planning"* – Requested 3 hours; Recommended APPROVAL
6. Dental Professionals Resource Group, LLC – *"Oral Pathology Review: "Red-Blue Lesions of the Oral Cavity""* – Requested 2 hours; Recommended APPROVAL
7. Iowa Dental Hygienists' Association – *"Tongue-Tied: A Story Not Silenced by Oral Cancer"* – Requested 3 hours; Recommended APPROVAL
8. Iowa Department of Public Health – *"I-Smile Coordinator Training"* – Requested 2 hours; Recommended APPROVAL
9. Great River Oral & Maxillofacial Surgery – *"Meth Mouth: Current Concepts for the Management of High Risk Population"* – Requested 2 hours; Recommended APPROVAL
10. Great River Oral & Maxillofacial Surgery – *"Lawful Prescribing and Current Trends in Prescription Drug Abuse"* – Requested 2 hours; Recommended APPROVAL

11. Dubuque Periodontics, P.C. – *"Introduction to Pinhole Procedure (for Soft Tissue Grafting)* – Requested 1.5 hours; Recommended APPROVAL
12. Oral Arts Laboratory – *"Risk Management and Jurisprudence. Our Dental Board Rules and Laws"* – Requested 6 hours; Recommended APPROVAL
13. CNA – *"Dental Professional Liability Risk Management Seminar"* – Requested 4.5 hours; Recommended APPROVAL for 4 hours
14. Midlands Dental Group – *"Prosthodontics for the General Dentist"* – Requested 2 hours; Recommended APPROVAL
15. Midlands Dental Group – *"Soft Tissue Management"* – Requested 2 hours; Recommended APPROVAL
16. Midlands Dental Group – *"Post and Core Techniques"* – Requested 2 hours; Recommended APPROVAL
17. Iowa Central Community College – *"Conditions Affecting the Oral Cavity: Table Clinic Overview"* – Requested 2 hours; Recommended APPROVAL
18. Black and Gold Study Club – *"Growth, Change, and Sharing Best Practices"* – Requested 4 hours; Recommended APPROVAL for 2 hours for the treatment planning portion of the course. The remainder of the course appeared to address business aspects of practice.
19. Dental Prosthetic Services – *"Beyond Basics"* – Requested 9 hours (2 hours for 1st day, 7 hours for 2nd); Recommended APPROVAL
20. Northeast Iowa Dental Study Club – *"Pediatric Update with Dr. Annie Fencl & GC America"* – Requested 2 hours; Recommended APPROVAL

CONTINUING EDUCATION COURSE APPLICATIONS FOR RECONSIDERATION

1. Iowa Dental Hygienists' Association – *"Trends in Instrumentation: A Hands-On Experience with XP Instruments"* – Originally awarded 4 hours; Recommended APPROVAL for 4 hours after reviewing submitted course changes.

CONTINUING EDUCATION COURSE APPLICATIONS REVIEWED BY BOARD STAFF

The Continuing Education Advisory Committee recommended APPROVAL for the staff recommendations as follows:

1. Davenport District Dental Society – *"Pediatric and Orthodontic Treatment Considerations"* – Requested 5 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
2. Parks & Schmit Orthodontics – *"Orthodontic Management of Problems in the Mixed Dentition"* – Requested 2 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
3. Spring Park Oral & Maxillofacial Surgeons Study Club – *"Immediate Loading of a Full Arch Prosthesis – Simulation Workshop"* – Requested 2 hours (Clinical portions would be limited to those who can legally provide those services) Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
4. Iowa Dental Hygienists' Association – *"Exploring the Oral Microbiome – Stunning Revelations About How Microbes Actually Create Disease"* – Requested 3 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*

5. Eastern Iowa Community College – *"Maintaining Geriatric Patient"* – Requested 2 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
6. Iowa Academy of General Dentistry – *"Digital Implant Dentistry – New Technology for Teeth and Implants & Dental Implants in Your Practice"* – Requested 8 hours lecture, 16 hours participation: 24 hours total (Clinical portions would be limited to those who can legally provide those services) Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
7. Spring Park Implant Study Club – *"Advanced Implant Mini Residency"* – Requested 28 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
8. Spring Park Oral & Maxillofacial Surgeons Study Club – *"2016 OSHA/Infection Prevention Update"* – Requested 2 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
9. Metro West Dental Specialty Group – *"Micro-Endodontics & Endodontic Surgery"* – Requested 2 hours. Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
10. Dental Professionals Resource Group, L.L.C. – *"Full Arch Implant Supported Restoration"* – Requested 2 hours. Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
11. Arctic Dental, P.L.C. – *"The Blunderbuss Apex: A Search for the Smoking Gun"* – Requested 2 hours. Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*
12. Eastern Iowa Community College – *"Dental Radiography Update"* – Requested 2 hours Board staff recommends APPROVAL pursuant to Iowa Administrative Code 650—25.3(7)b.*

* Iowa Administrative Code 650—25.3(7)b. *"Acceptable subject matter includes courses in patient treatment record keeping, risk management, sexual boundaries, communication, and OSHA regulations, and courses related to clinical practice. A course on Iowa jurisprudence that has been prior-approved by the board is also acceptable subject matter."*

CONTINUING EDUCATION SPONSOR APPLICATIONS FOR REVIEW

- Eastern Iowa Oral & Maxillofacial Surgery – Committee recommended APPROVAL
- Black & Gold Study Club – Committee recommended APPROVAL

OTHER RECOMMENDATIONS

- Iowa Administrative Code 650—Chapter 25 draft: in support of the proposed draft with a recommendation to consider allowing credit for courses related to ergonomics and other closely related topics.

REPORT TO THE IOWA DENTAL BOARD

FYI ONLY

DATE OF MEETING: April 28, 2016
RE: **Quarterly Report on IPRC Activities**
SUBMITTED BY: Angie Davidson, Administrative Assistant
ACTION REQUESTED: None.

The Iowa Practitioner Review Committee evaluates, assists, and monitors the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. As necessary, the Committee notifies the Board in the event of noncompliance with contract provisions.

The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

The Board's administrative rules require the Committee to submit a quarterly report to the Board on the activities of the IPRC. Below is the quarterly report.

Iowa Dental Board

Iowa Practitioner Review Committee

Current Numbers (as of 04/14/16)	2016 Totals
Self Reports	1
Current Participants	10
Contracts under Review	2
Discharged Participants	3

ACTION

REPORT TO THE IOWA DENTAL BOARD

DATE OF MEETING: April 28-29, 2016

RE: **Recommendations: Course Requests**

SUBMITTED BY: **Expanded Functions Committee**

ACTION REQUESTED: Board Action on Committee Recommendation

COMMITTEE RECOMMENDATIONS

The committee requests that the Board accept the following recommendations:

EXPANDED FUNCTIONS COURSE REVIEW

- Iowa Dental Assistant Educators Council*
  - Removal of Adhesives
  - Preliminary Charting of Existing Dental Restorations and Teeth

The committee has recommended approval of the courses. The following comments were received as part the review:

> "Might make a minor change or two – pg 32 Instructional Objective #3 might add hand instrument(s). Later on in the evaluation by the DDS it is clear it is hand instrumentation only. Could also insert hand on pg 33 VI Removing dental adhesives B."
>
> "Cement and adhesive removal
>
> 1. Commonly a scaler is used to remove cement. An explorer may be used to feel for cement or to remove a small piece of cement that is loose. An explorer does not have an edge to shear off the cement. It is a weak instrument. The correct answer should be a scaler.
>
> 2. All strokes are used during the cement removal. An exploratory stroke finds the cement. Push stroke is sometimes needed to shear the cement. A horizontal stroke is the most desirable stroke because it shears the cement and avoids vertical pressure which can dislodge the restoration. A vertical stroke is used carefully to avoid dislodgment of the restoration.
>
> 5. Excess cement should be removed when it is gelatinous or tack or partially set. Waiting for the cement to fully set can be difficult to remove. Also, fully set cement is impossible to remove with an explorer.
>
> Dental charting
>
> 9. Compound cavity usually involves two or more surfaces.
>
> 13. Incipient decay is generally considered beginning decay forming superficially in enamel or in enamel pit or fissure. Incipient decay may be slow to progress or may become arrested."

*Two of the committee members were asked to recuse themselves from this vote as they are a members of the Iowa Dental Assistant Educators Council.

REQUEST FOR MODIFICATION OF PREVIOUSLY-APPROVED COURSE

- Impact Dental Training
  - Request to increase number of continuing education credit for "Removing Dental Adhesives Didactic Course" from 1.0 hours to 1.5 hours.
  - Request to modify number of required clinical experiences for the following:
    - Application of Cavity Liners, Bases, Desensitizing Agents & Bonding Systems – from 3 each to 6 combined cases.
    - Placement of Periodontal Dressings – from 3 to 2 in lab or on a person
    - Placing and Removing Dry Socket Medication – from 3 to 2 in lab or on a person.

The committee recommendation is still pending final comments and review.

Dental Assistant

Expanded Functions
Core Curriculum
Basic Expanded Functions
Certified Level I Provider

Approved by the
Iowa Dental Board (IDB)
January 14, 2004
CE Units approved April 21, 2004
Updated and Approved by IDB ____2016

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Removal of Adhesives *(hand instrumentation only)*

Instructional Description:

This instructional unit provides the participant with the basic knowledge of materials, procedures, and techniques necessary in performing the removal of adhesives.

Instructional Objective:

At the completion of this instructional unit, the participant will be able to:

1. Identify various methods and procedures used when removing adhesives.
2. Identify characteristics of adhesive.
3. Identify how, when, and where to use a fulcrum, mirror, and instrument intraorally.

Participants must:

1. Be a graduate of an ADA-accredited dental assistant program; **or**
2. Be currently certified by the Dental Assisting National Board (DANB); **or**
3. Have at least one year of clinical practice as a registered dental assistant; **or**
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration

Pre-instructional competency assessment: all participants must complete a preliminary written assessment at 75%

Minimum number of total hours:

Didactic hours: 1
Lab/Clinical hours: 1

Minimum number of requirements:

Patients 6

Post-instructional competency assessment:

Written assessment – 75% competency required
Clinical assessment – all prescribed criteria must be met

Continuing Education Units: 2

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Removal of Adhesives *(hand instrumentation only)*

I. Dental adhesive
   A. Definition
   B. Indications

II. Types of adhesives
   A. Micromechanical
   B. Macromechanical

III. Classifications of dental adhesives
   A. Type I cement
   B. Type II cement
   C. Type III cement

IV. Provisional (temporary) cements
   A. Categories
   B. Uses
   C. Clinical requirements
   D. Cement variables

V. Permanent cements
   A. Categories
   B. Uses
   C. Clinical requirements
   D. Cement variables

VI. Removing dental adhesives
   A. Guidelines
   B. Instrumentation
   C. Fulcrum

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Preliminary Charting of Existing Dental Restorations and Teeth

Instructional Description:

This instructional unit provides the participant with the basic knowledge of procedures and techniques necessary in performing the task of preliminary charting of existing dental restorations and teeth.

Instructional Objective:

At the completion of this instructional unit, the participant will be able to:

1. Explain why charting is used in dentistry.
2. Identify charting systems.
3. Relate the role of the expanded functions dental assistant.
4. Describe basic dental charting terminology, numbering systems, symbols, and cavity classifications.
5. Utilized various assessment resources.

Participants must:

1. Be a graduate of an ADA-accredited dental assistant program; **or**
2. Be currently certified by the Dental Assisting National Board (DANB); **or**
3. Have at least one year of clinical practice as a registered dental assistant; **or**
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration

Pre-instructional competency assessment: all participants must complete a preliminary written assessment at 75%

Minimum number of total hours:

Didactic hours: 2
Lab/Clinical hours: 2

Minimum number of requirements:

Patient 4

Post-instructional competency assessment:

Written assessment – 75% competency required
Clinical assessment – all prescribed criteria must be met

Continuing Education Units: 4

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Preliminary Charting of Existing Dental Restorations

I. Preliminary charting
   A. Purpose
   B. Systems
   C. Role of the expanded functions dental assistant

II. Charting (tools)
   A. Charting symbols
   B. Color coding
   C. Abbreviations
   D. Cavity classifications

III. Dentitions
   A. Primary
   B. Permanent
   C. Mixed

IV. Assessment resources
   A. Patient history/records
   B. Visual
   C. Tactile
   D. Images
      1. Radiographs
      2. Intraoral

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Name _____ RDA # _____

DENTAL ASSISTING EXPANDED FUNCTIONS
CLINICAL COMPETENCY EVALUATION

Removal of Adhesives

#1 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All cement is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____
Supervising Dentist Signature Date

#2 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All adhesive is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____
Supervising Dentist Signature Date

#3 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All adhesive is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____
Supervising Dentist Signature Date

#4 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All adhesive is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____
Supervising Dentist Signature Date

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Removal of Adhesives

#5 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All adhesive is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

#6 Supervising Dentist Evaluation

- ☐ Correct hand instrument is used
- ☐ Correct instrumentation stroke is used
- ☐ Uses a proper fulcrum
- ☐ Checks contacts with floss
- ☐ Inspects margins for excess adhesive
- ☐ All adhesive is removed from gingival margins and interproximal areas

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

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Questions for both the Pre and Post-assessment are taken randomly from a computerized test bank.

Iowa Dental Board **Kirkwood Community College**

EFDA Cement & Adhesive Removal

*The correct answer is shaded

Multiple Choice

Identify the choice that best completes the statement or answers the question

_____ 1. Which of the following instruments is used in removing excessive temporary adhesive cement?
   a. Scaler
   b. Curette
   c. Explorer
   d. Spoon excavator
   e. Plastic

_____ 2. Which of the following stroke is used primarily to remove excess cement?
   a. Exploratory stroke
   b. Push stroke
   c. Horizontal stroke
   d. Vertical stroke

_____ 3. Excess temporary cement or adhesive, when felt with an explorer will feel:
   a. Bumpy
   b. Slippery
   c. Smooth

_____ 4. Oblique strokes should be used for which of the following surfaces:
   a. Occlusal/incisal surfaces
   b. Lingual surfaces
   c. Facial surfaces
   d. Line angle of the molars

_____ 5. Excess temporary cement or adhesive, may be removed:
   a. When the doctor tell you
   b. Immediately after seating the crown
   c. When the cement is fully set
   d. When the cement becomes “tacky”

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_____ 6. As the operator, your eye focal distance should be:
   a. 6 inches
   b. 8 inches
   c. 10 inches
   d. 12 inches
   e. 14 inches

_____ 7. All of the following are acceptable methods in preventing fogging of the mirror EXCEPT:
   a. Have patient breath through the mouth
   b. Rub against buccal mucosa
   c. Warm mirror face with water

_____ 8. When the patient has an edentulous area, all of the following are acceptable for locating your fulcrum EXCEPT:
   a. Extend from the edentulous space
   b. Use a cotton roll in the space
   c. Reinsert appliance
   d. Use your other hand

_____ 9. A fulcrum is always used when an instrument is utilized in the mouth.
   a. True
   b. False

_____ 10. The fulcrum is maintained with the middle finger.
   a. True
   b. False

_____ 11. The fulcrum should be located on tooth structure.
   a. True
   b. False

_____ 12. It is best to establish a fulcrum in the same quadrant as the work that is being done.
   a. True
   b. False

_____ 13. The farther away the fulcrum from the necessary tooth, the more balance and control the operator has.
   a. True
   b. False

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_____ 14. The ring finger is used as the fulcrum when using a mirror.

a. True
b. False

_____ 15. The mirror is held with a modified pen or pen grasp

a. True
b. False

_____ 16. Keeping the mirror parallel to the occlusal plan when inserting or removing the mirror will prevent you from hitting the patient's teeth.

a. True
b. False

_____ 17. When using the instrument, the tip must be maintained on the tooth structure at all times to prevent injury.

a. True
b. False

_____ 18. To avoid injury to the patient's mucosa when removing isolating cotton rolls from the oral cavity, the chairside assistant _____ .

a. Lubricates the cotton roll with topical anesthetic prior to placement
b. Lubricates the cotton roll with topical anesthetic prior to removal
c. Moistens the cotton roll with water prior to placement
d. Moistens the cotton roll with water prior to removal

_____ 19. All of the following are functions of the dental mirror except one. Which one is the ***exception?***

a. Fulcrum
b. Illumination
c. Indirect vision
d. Retraction

_____ 20. What function does the mirror predominately serve, when operating on the lingual of tooth #4?

a. Fulcrum
b. Indirect vision
c. Retraction
d. Illumination

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_____ 21. What function does the mirror predominately serve, when operating on the occlusal of tooth #18?

a. Fulcrum
b. Indirect
c. Retraction
d. Illumination

_____ 22. An effective fulcrum or finger rest is utilized during intraoral instrumentation to provide all the following EXCEPT?

a. A controlled instrument stroke
b. Instrument access and adaptation
c. Minimal tissue trauma
d. Stabilization of the hand

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Name _____ RDA # _____

DENTAL ASSISTING EXPANDED FUNCTIONS CLINICAL COMPETENCY EVALUATION

Preliminary Charting of Existing Dental Restorations and Teeth

#1 Supervising Dentist Evaluation

Patient Procedure

- Confirmed with supervising dentist patient history and prescribed diagnostic testing procedure(s).
- Perform preliminary evaluation of patient in preferred document system for accurate charting
- Follow appropriate ADA/State legal documentation protocol.

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

#1 Supervising Dentist Evaluation

Patient Procedure

- Confirmed with supervising dentist patient history and prescribed diagnostic testing procedure(s).
- Perform preliminary evaluation of patient in preferred document system for accurate charting
- Follow appropriate ADA/State legal documentation protocol.

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

#1 Supervising Dentist Evaluation

Patient Procedure

- Confirmed with supervising dentist patient history and prescribed diagnostic testing procedure(s).
- Perform preliminary evaluation of patient in preferred document system for accurate charting
- Follow appropriate ADA/State legal documentation protocol.

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

#1 Supervising Dentist Evaluation

Patient Procedure

- Confirmed with supervising dentist patient history and prescribed diagnostic testing procedure(s).
- Perform preliminary evaluation of patient in preferred document system for accurate charting
- Follow appropriate ADA/State legal documentation protocol.

☐ Acceptable ☐ Unacceptable

_____

Supervising Dentist Signature Date

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Questions for both the Pre and Post-assessment are taken randomly from a computerized test bank.

Iowa Dental Board **Kirkwood Community College**

EFDA Dental Charting

*The correct answer is shaded

Multiple Choice

Identify the choice that best completes the statement or answers the question.

____ 1. The dental chart
a. Belongs to the patient
b. Is mailed to the patient's insurance company
c. Is part of the patient's legal record and belongs to the dentist
d. None of the above

____ 2. The five cavity classifications were developed by
a. The American Dental Association
b. Dr. Edmund Kells
c. Dr. G. V. Black
d. Dr. Lucy Hobbs

____ 3. Caries on the interproximal surfaces of the anterior teeth are Class
a. I
b. II
c. III
d. V

____ 4. Caries on the interproximal surfaces and involving the incisal edges of the anterior teeth are Class
a. I
b. II
c. III
d. IV

____ 5. Caries on the interproximal surfaces of the posterior teeth are Class
a. I
b. II
c. III
d. V

____ 6. Caries on the pits and fissures of the teeth are Class
a. I
b. II
c. IV
d. V

____ 7. Caries on the facial or lingual gingival one-third are Class
a. I
b. II
c. III
d. V

____ 8. A simple cavity
a. Involves one tooth surface
b. Is an easy restoration to place
c. Involves two tooth surfaces
d. Involves two or more tooth surfaces

____ 9. A compound cavity
a. Involves one tooth surface
b. Is an easy restoration to place
c. Involves two tooth surfaces
d. Involves two or more tooth surfaces

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____ 10. The type of bridge in which the pontic has wings and is attached on the lingual sides of the abutment teeth is the

a. Cantilever
b. Maryland
c. Marilyn
d. Merryland

____ 11. Crowns are made of

1. Gold
2. Porcelain
3. Gold and porcelain

a. 1 only
b. 2 only
c. 3 only
d. 1, 2, 3

____ 12. When an entire arch of teeth is replaced, the patient wears a

a. Crown
b. Bridge
c. Partial denture
d. Full denture

____ 13. Incipient decay is

a. Arrested decay
b. Decay going into the dentin
c. Decay that has reached the pulp
d. None of the above

____ 14. In dental charting, the color red indicates

a. Existing restorations
b. Work that needs to be done
c. Work that insurance will pay for
d. None of the above

____ 15. In dental charting, the color blue indicates

a. Completed work
b. Work that needs to be done
c. Work that insurance will pay for
d. None of the above

____ 16. A gold restoration is charted by an

a. Outlined area with crosshatch lines through it
b. Outlined area filled with red or blue
c. Outline in red or blue
d. None of the above

____ 17. An amalgam restoration is charted by an

a. Outlined area with crosshatch lines through it
b. Outlined area filled with red or blue
c. Outline in red or blue
d. None of the above

____ 18. A composite restoration is charted by an

a. Outlined area with crosshatch lines through it
b. Outlined area filled with red or blue
c. Outline in red or blue
d. None of the above

____ 19. The charting symbol for a tooth that is to be removed is a(n)

a. "X" over the tooth
b. Arrow over the tooth
c. Diagonal line over the tooth
d. None of the above

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____ 20. The charting symbol for an abscessed tooth is a(n)
a. Arrow over the tooth
b. Line through the root
c. Circle under the root that is abscessed.
d. None of the above

____ 21. The charting symbol for a completed root canal is a(n)
a. Arrow over the tooth
b. Line through the root
c. Circle around the tooth
d. None of the above

____ 22. The charting symbol for a tooth with a full gold crown is a(n)
a. Outline of the tooth and crosshatch
b. Line through the root
c. Circle around the tooth
d. None of the above

____ 23. The charting symbol for caries is an outline
a. In red
b. In blue
c. Filled in red
d. Filled in blue

____ 24. The charting symbol for an impacted tooth is a(n)
a. Circle around the tooth
b. Line through the tooth
c. "I" on the tooth
d. None of the above

____ 25. A dental implant is charted by
a. No chart marks, just list remarks
b. Horizontal lines through the entire tooth
c. Horizontal lines through the root
d. A circle around the tooth

____ 26. Missing teeth are charted by a(n)
a. Circle around the tooth
b. Diagonal line through the tooth
c. "X" on the tooth or root
d. None of the above

____ 27. The patient's dental record (chart) is used as a ____ document.
a. Legal
b. Forensic dentistry
c. Neither a nor b
d. Both a and b

____ 28. The space between the maxillary central incisor is called the
a. Overhang
b. Diastema
c. Occlusal
d. Sealant

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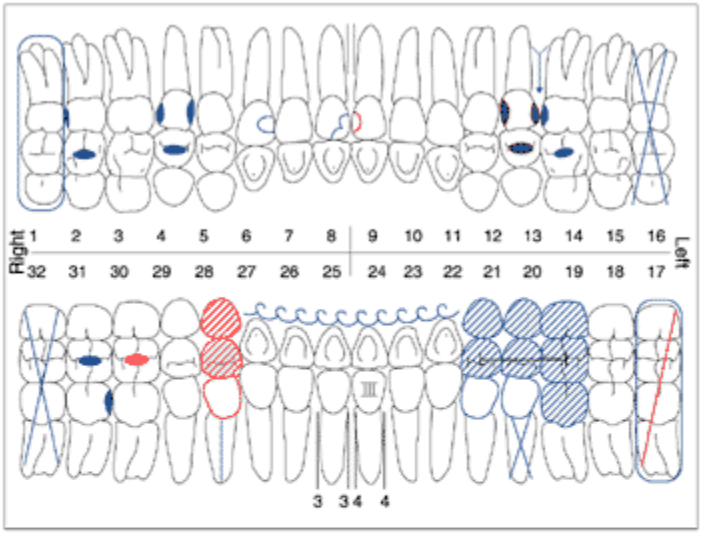

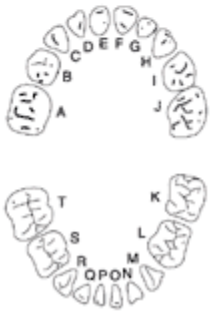

____ 29. Using the chart above, what is charted on Tooth #1?
- a. Impacted
- b. Missing
- c. Extraction needed
- d. None of the above

____ 30. Using the chart above, what is charted on Tooth #4?
- a. MOD
- b. O
- c. Missing
- d. None of the above

____ 31. Using the chart above, what is charted on Tooth #7?
- a. MOD
- b. DO
- c. Missing
- d. None of the above

____ 32. Using the chart above, what is charted on Tooth #9?
- a. MF composite
- b. ML composite
- c. DF composite
- d. DL composite

____ 33. Using the chart above, what is charted on Tooth #16?
- a. abscessed
- b. DO
- c. Missing
- d. None of the above

____ 34. Using the chart above, what is charted on Tooth #21?
- a. Missing
- b. Abutment for a three-unit bridge
- c. Porcelain fused to a metal crown
- d. None of the above

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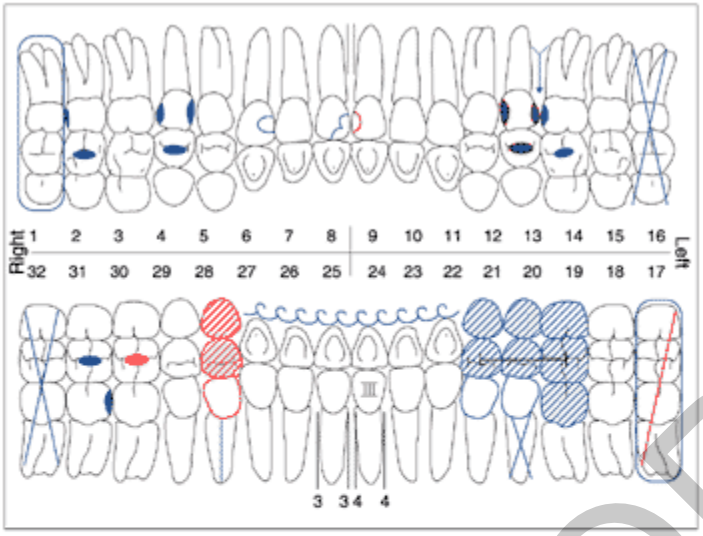

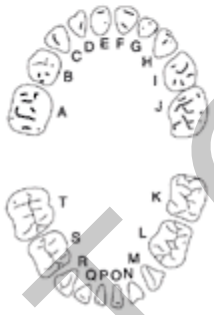

____ 35. Using the chart above, what is charted on Tooth #24?
- a. abscessed
- b. Extraction needed
- c. Class III mobility
- d. Class III cavity

____ 36. Using the chart above, what is charted on Tooth #28?
- a. abscessed and a porcelain fused to a metal crown
- b. Missing
- c. Completed root canal and a porcelain fused to a metal crown
- d. None of the above

____ 37. Using the chart above, what is charted on Tooth #30?
- a. Occlusal
- b. Mesial
- c. Distal
- d. Buccal

____ 38. Using the chart above, what is charted on Tooth #32?
- a. abscessed
- b. Needs to be extracted
- c. Needs a crown
- d. None of the above

____ 39. Using the chart above, what is charted on the markings on the lingual of 22–27?
- a. Extraction needed
- b. Supernumerary teeth
- c. Sealants
- d. Heavy calculus

____ 40. Class III caries are found on the following surfaces
- a. Mesial of canines
- b. Distal of lateral incisors
- c. Mesial of central incisors
- d. All of the above

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____ 41. Several Class V caries are possible in one quadrant due to a patient's
   a. Taking medications over a long period of time
   b. Chewing gum over a long period of time
   c. Drinking soft drinks over a long period of time
   d. All of the above

____ 42. A prosthetic device that attaches the sides of a bridge are called
   a. Cantilever
   b. Pontic
   c. Abutment
   d. Clasps

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LASER DENTISTRY OF IOWA

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April 7, 2016

Iowa Dental Board
Expanded Functions Committee
400 SW 8th Street, Suite D
Des Moines, IA 50309

RE: Request for Modification of Expanded Function Curriculum

Dear Iowa Dental Board,

We have been providing Level One Expanded Functions courses during the last 8 months and are asking for approval to make some minor modifications to the originally approved curriculum.

We are hearing from dental assistants that our curriculum is quite different from other providers and tends to have more intensive/harder requirements for completion. Our program is based on the Dental Assistant Expanded Functions Core Curriculum, developed by the Educator's Council in 2003. We have a very strong lab component incorporated into our didactic lectures where the participants have hands on experience with different materials and techniques related to expanded function skill. We also require signed clinical evaluation rubrics from the dentist for each skill completion to provide what we consider essential documentation of their competency.

We would like to make modifications based on the educators council recommendations and/or our experience in facilitating our expanded functions course. We would like to increase our didactic CEU for Removal of Adhesives (hand instrumentation only) to 1.5 CEU's up from 1.0 CEU since it is taking us longer to get through the lecture and following lab component than we anticipated.

We have found the completion of the clinical component for the placement of periodontal dressing is nearly impossible for many of our assistants since their offices do not perform this procedure/use the material. For future consideration, the board may want to consider that the placement of periodontal dressing be removed from the core eleven Level One expanded functions. It could still be an expanded function for hose assistants/offices that need the skill but would not be an impediment to gaining Level One status for those assistants in general, pedodontic, orthodontic, endodontic offices that do not use this skill.

There are the four changes we would like the board to approve. We would like the three having to with clinical requirements be retroactive for our students currently engaged in their clinical competency training.

	Expanded Function	Current	Change
1	Removing Dental Adhesives (hand instrumentation only) Didactic Course	1.0 CEU	Increase to 1.5 CEU's
2	Application of Cavity Liners, Bases, Desensitizing Agents & Bonding Systems clinical requirements	3 each	6 combination cases*
3	Placement of Periodontal Dressings clinical requirements	3	2 lab or live person*
4	Placing & Removing of Dry Socket Medications clinical requirements	3	2 lab or live person*
	** number of repetitions based on Educator Council recommendations*		

Thank you for considering our requests.

Sincerely,

Lisa Swett

Lisa Swett, RDH, BS, MS

DENTAL BOARD[650]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 147.76 and 153.33, the Dental Board adopts an amendment to Chapter 10, "General Requirements," Iowa Administrative Code.

This amendment clarifies supervision requirements in an accredited dental hygiene program. The subrule establishes the supervision criteria that must be met when students practice clinical skills as part of their regular course of instruction.

Notice of Intended Action was published in the Iowa Administrative Bulletin on March 2, 2016, as ARC 2432C.

A public hearing was held on March 30, 2016 at 2pm at the office of the Iowa Dental Board. There were no attendees. No written comments were received.

This amendment was approved by the Board on April 29, 2016.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment will become effective on XXXX, 2016.

This amendment is intended to implement Iowa Code sections 153.38 and 153.39.

The following amendment is adopted.

ITEM 1. Add subrule 650—10.4(4)

10.4(4) Students enrolled in dental hygiene programs. Students enrolled in an accredited dental hygiene program are not considered to be engaged in the unlawful practice of dental hygiene provided that such practice is in connection with their regular course of instruction and meets the following:

a. The practice of clinical skills on peers enrolled in the same program must be under the direct supervision of a program instructor with an active Iowa dental hygiene license, Iowa faculty permit, or Iowa dental license;

b. The practice of clinical skills on members of the public must be under the general supervision of a dentist with an active Iowa dental license;

c. The practice of clinical skills involving the administration or monitoring of nitrous oxide or

Pending Board Approval

the administration of local anesthesia must be under the direct supervision of a dentist with an active Iowa dental license.

Pending Board Approval

DENTAL BOARD[650]

Adopted and Filed

Pursuant to the authority of Iowa Code sections 147.76 and 153.33, the Dental Board adopts an amendment to Chapter 20, "Dental Assistants," Iowa Administrative Code.

This amendment clarifies supervision requirements in an accredited dental assisting program. The rule establishes the supervision criteria that must be met when students practice clinical skills as part of their regular course of instruction.

Notice of Intended Action was published in the Iowa Administrative Bulletin on March 2, 2016, as **ARC 2431C**. A public hearing was held on March 30, 2016 at 2pm at the offices of the Iowa Dental Board. There was one attendee, Joni Miller, representing Western Iowa Tech Community College, who read their previously submitted written comments.

There were three written comments received. All written comments asked for the ability to permit a program instructor to supervise the practice of clinical skills involving expanded function procedures.

This amendment was approved by the Board on April 29, 2016.

After analysis and review of this rule making, no impact on jobs has been found.

This amendment will become effective on XXXX, 2016.

This amendment is intended to implement Iowa Code sections 153.38 and 153.39.

The following amendment is adopted.

ITEM 1. Add subrule 650—20.17

650—20.17(153) Students enrolled in dental assisting programs. Students enrolled in an accredited dental assisting program are not considered to be engaged in the unlawful practice of dental assisting provided that such practice is in connection with their regular course of instruction and meets the following:

1. The practice of clinical skills on peers enrolled in the same program must be under the direct supervision of a program instructor with an active Iowa dental assistant registration, Iowa dental hygiene license, Iowa faculty permit, or Iowa dental license;

2. The practice of clinical skills on members of the public must be under the direct supervision

Pending Board Approval

of a dentist with an active Iowa dental license;

~~3. The practice of clinical skills involving expanded function procedures must be under the direct supervision of a dentist with an active Iowa dental license.~~

Pending Board Approval

TITLE V
PROFESSIONAL STANDARDS

CHAPTER 25
CONTINUING EDUCATION

[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—25.1(153) Definitions. For the purpose of these rules on continuing education, definitions shall apply:

"Advisory committee." An advisory committee on continuing education shall be formed to review and advise the board with respect to applications for approval of sponsors or activities and requests for ~~postapproval~~ of activities. Its members shall be appointed by the board and consist of a member of the board, two licensed dentists with expertise in the area of professional continuing education, two licensed dental hygienists with expertise in the area of professional continuing education, and two registered dental assistants with expertise in the area of professional continuing education. The advisory committee on continuing education may tentatively approve or deny applications or requests submitted to it pending final approval or disapproval of the board at its next meeting.

"Approved program or activity" means a continuing education program activity meeting the standards set forth in these rules which has received ~~advanced~~ approval by the board pursuant to these rules~~.~~, or which otherwise meets the requirements herein.

"Approved sponsor" means a person or an organization sponsoring continuing education activities which has been approved by the board as a sponsor pursuant to these rules. During the time an organization, educational institution, or person is an approved sponsor, all continuing education activities of such person or organization may be deemed automatically approved provided they meet the continuing education guidelines of the board.

"Board" means the dental board ~~of dental examiners~~.

"Continuing dental education" consists of education activities designed to review existing concepts and techniques and to update knowledge on advances in dental and medical sciences. The objective is to improve the knowledge, skills, and ability of the individual to deliver the highest quality of service to the public and professions.

Continuing dental education should favorably enrich past dental education experiences. Programs should make it possible for practitioners to attune dental practice to new knowledge as it becomes available. All continuing dental education should strengthen the skills of critical inquiry, balanced judgment and professional technique.

"Dental public health" is the science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice in which the community serves as the patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.

"Hour" of continuing education means one unit of credit which shall be granted for each hour of ~~contact~~ instruction and shall be designated as a "clock hour." ~~This credit shall apply to either academic or clinical instruction.~~

"Licensee" means any person licensed to practice dentistry or dental hygiene in the state of Iowa.

"Registrant" means any person registered to practice as a dental assistant in the state of Iowa.

650—25.2(153) Continuing education requirements.

25.2(1) Each person licensed to practice dentistry or dental hygiene in this state shall complete during the biennium renewal period a minimum of 30 hours of continuing education approved by the board. ~~However, for the dental hygiene renewal period beginning July 1, 2006, and ending August 30, 2007, a dental hygienist shall complete a minimum of 12 hours of continuing education approved by the board.~~

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25.2(2) The continuing education compliance period shall be the 24-month period commencing September 1 and ending on August 31 of the renewal cycle~~. However, for the dental hygiene renewal period beginning July 1, 2006, and ending August 30, 2007, the continuing education compliance period for dental hygienists shall be the 14-month period commencing July 1, 2006, and ending August 30, 2007. For the dental assistant renewal period beginning July 1, 2005, and ending August 30, 2007, the continuing education compliance period for dental assistants shall be the previous 26-month period. For the dental license renewal period beginning July 1, 2006, and ending August 30, 2008, the continuing education compliance period for dentists shall be the previous 26-month period.~~

25.2(3) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity, either ~~previously~~ approved by the board or which otherwise meets the requirement herein ~~and is approved by the board~~ pursuant to subrule 25.3(5).

25.2(4) It is the responsibility of each licensee or registrant to finance the costs of continuing education.

25.2(5) Every licensee or registrant shall maintain a record of all courses attended by keeping the certificates of attendance for four years after the end of the year of attendance. The board reserves the right to require any licensee or registrant to submit the certificates of attendance for the continuing education courses attended. If selected for continuing education audit, the licensee or registrant shall file a signed continuing education form reflecting the continuing education hours reported to include the evidence of attendance.

25.2(6) Licensees and registrants are responsible for obtaining proof of attendance forms when attending courses. Clock hours must be verified by the sponsor with the issuance of proof of attendance forms to the licensee or registrant.

25.2(7) Each licensee or registrant shall ~~file a signed continuing education reporting form reflecting the required minimum~~ report the number of continuing education credit hours completed during the current renewal cycle reflecting the required minimum in compliance with this chapter and 650—Chapter 20. Such report shall be filed with the board at the time of application for renewal of a dental or dental hygiene license or renewal of dental assistant registration.

25.2(8) No carryover of credits from one biennial period to the next will be allowed.

25.2(9) Mandatory training for child abuse and dependent adult abuse reporting.

a. Licensees or registrants who regularly examine, attend, counsel or treat children in Iowa shall indicate on the renewal application completion ~~of two hours~~ of training in child abuse identification and reporting in the previous five years or conditions for exemptions as identified in paragraph "*f*" of this subrule.

b. Licensees or registrants who regularly examine, attend, counsel or treat adults in Iowa shall indicate on the renewal application completion ~~of two hours~~ of training in dependent adult abuse identification and reporting in the previous five years or conditions for exemptions as identified in paragraph "*f*" of this subrule.

c. Licensees or registrants who regularly examine, attend, counsel or treat both children and adults in Iowa shall indicate on the renewal application completion of ~~at least two hours of~~ training on the identification and reporting of abuse in children and dependent adults in the previous five years or conditions for exemptions as identified in paragraph "*f*" of this subrule. Training may be completed through separate courses or in one combined course that includes curricula for identifying and reporting child abuse and dependent adult abuse. ~~Up to three hours of continuing education may be awarded for taking a combined course.~~

d. The licensee or registrant shall maintain written documentation for five years after completion of the mandatory training, including program date(s), content, duration, and proof of participation. The board may audit this information at any time within the five-year period.

e. Training programs in child and dependent adult abuse identification and reporting that are approved by the board are those that use a curriculum approved by the abuse education review panel of the department of public health or a training program offered by the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement

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academy, an Iowa college or university, or a similar state agency.

f. Exemptions. Licensees and registrants shall be exempt from the requirement for mandatory training for identifying and reporting child and dependent adult abuse if the board determines that it is in the public interest or that at the time of the renewal the licensee or registrant is issued an extension or exemption pursuant to 650—25.7(153).

25.2(10) Licensees~~, faculty permit holders,~~ and registrants shall furnish evidence of valid certification for cardiopulmonary resuscitation (CPR), which shall be credited toward the continuing education requirement for renewal of the license, faculty permit or registration. Such evidence shall be filed at the time of renewal of the license, faculty permit or registration. ~~Credit hours awarded shall not exceed three continuing education credit hours per biennium.~~ Valid certification means certification by an organization on an annual basis or, if that certifying organization requires certification on a less frequent basis, evidence that the licensee or registrant has been properly certified for each year covered by the renewal period. In addition, the course must include a clinical component.

650—25.3(153) Approval of programs and activities. A continuing education activity shall be qualified for approval if the board determines that:

25.3(1) It constitutes an organized program of learning (including a workshop or symposium) which contributes directly to the professional competency of the licensee or registrant; and

25.3(2) It pertains to ~~common~~ subjects ~~or other subject matters~~ which relate ~~integrally~~ to the practice of dentistry, dental hygiene, or dental assisting which are intended to refresh and review, or update knowledge of new or existing concepts and techniques; and

25.3(3) It is conducted by individuals who have ~~special~~ education, training and experience ~~to be considered experts~~ concerning the subject matter of the program. The program must include a manual or written outline that substantively pertains to the subject matter of the program.

25.3(4) Activity types acceptable for continuing dental education credit may include:

a. Attendance at a ~~multiply~~ multiday convention-type meeting. A multiday, convention-type meeting is held at a national, state, or regional level and involves a variety of concurrent educational experiences directly related to the practice of dentistry. ~~Effective July 1, 2000, attendees shall receive three hours of credit with the maximum allowed six hours of credit per biennium. Prior to July 1, 2000, attendees received five hours of credit with the maximum allowed ten hours of credit per biennium. Four hours of credit shall be allowed for presentation of an original table clinic at a convention-type meeting as verified by the sponsor when the subject matter conforms with 25.3(7). Attendees at the table clinic session of a dental, dental hygiene, or dental assisting convention shall receive two hours of credit as verified by the sponsor.~~

~~*b.* Postgraduate study relating to health sciences shall receive 15 credits per semester.~~

~~*c.* Successful completion of Part II of the National Board Examination for dentists, or the National Board Examination for dental hygienists, if taken five or more years after graduation, or a recognized specialty examination will result in 15 hours of credit.~~

~~*d.* Self-study activities shall result in a maximum of 12 hours of credit per biennium. Activity may include television viewing, video programs, correspondence work or research or computer CD-ROM programs that are interactive and require branching, navigation, participation and decision making on the part of the viewer.~~

~~*e.* Original presentation of continuing dental education courses shall result in credit double that which the participant receives. Credit will not be granted for repeating presentations within the biennium. Credit is not given for teaching that represents part of the licensee's or registrant's normal academic duties as a full-time or part-time faculty member or consultant.~~

~~*f.* Publications of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting shall result in a maximum of 5 hours per article, maximum of 20 hours per biennium.~~

g. Credit may be given for other continuing education activities upon request and approval by

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the Iowa ~~board of~~ dental board ~~examiners~~.

25.3(5) Prior approval of activities. An organization or person, other than an approved sponsor, that desires prior approval for a course, program or other continuing education activity or that desires to establish approval of the activity prior to attendance shall apply for approval to the board at least 90 days in advance of the commencement of the activity ~~on a form provided by the board~~ using board-approved forms. The board shall approve or deny the application. ~~The application shall state the dates, subjects offered, total hours of instruction, names and qualifications of speakers and other pertinent information.~~ An application fee as specified in 650—Chapter 15 is required.

25.3(6) Postapproval of activities. A licensee or registrant seeking credit for attendance and participation in an educational activity which was not conducted by an approved sponsor or otherwise approved ~~may submit to the board, within 60 days after completion of such activity, its dates, subjects, instructors, and their qualifications, the number of credit hours and proof of attendance~~ shall apply for approval to the board using board-approved forms. Within 90 days after receipt of such application, the board shall advise the licensee or registrant in writing ~~by ordinary mail~~ whether the activity is approved and the number of hours allowed. All requests may be reviewed by the advisory committee on continuing education prior to final approval or denial by the board. ~~A licensee or registrant not complying with the requirements of this paragraph may be denied credit for such activity.~~ An application fee as specified in 650—Chapter 15 is required.

25.3(7) Subject matter acceptable for continuing dental education credit:

a. In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or course outlines shall clearly establish conformance with the following criteria:

(1) The subject matter is of value to dentistry and directly applicable to oral health care.

(2) The information presented enables the dental professional to enhance the dental health of the public.

(3) The dental professional is able to apply the knowledge gained within the professional capacity of the individual.

(4) The dental science courses include, but are not limited to, ~~those within the eight recognized dental specialty areas and~~ topics such as dental public health, endodontics, geriatric dentistry, hospital dentistry, oral diagnosis, oral and maxillofacial pathology, oral and maxillofacial radiology, oral rehabilitation oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics, ~~and~~ preventative dentistry and prosthodontics.

b. Acceptable subject matter includes, but is not limited to, courses in patient treatment record, medical conditions which may play a role in oral health, keeping, HIPAA, risk management, sexual boundaries, communication with patients, ~~and~~ OSHA regulations, Iowa jurisprudence and courses related to clinical practice. ~~A course on Iowa jurisprudence that has been prior approved by the board is also acceptable subject matter.~~

c. Unacceptable subject matter and activity types include~~s~~, but are not limited to, personal development, business aspects of practice, business strategy, financial management, marketing, sales, practice growth, personnel management, ~~government regulations,~~ insurance, collective bargaining, and ~~community service presentations~~ events where volunteer services are provided. While desirable, those subjects and activities are not applicable to dental skills, knowledge, and competence. Therefore, such courses will receive no credit toward renewal. The board may deny credit for any course.

Commented [BC[1]: May want to consider revising the wording here since volunteer services are technically applicable to dental skills; though, it does not necessarily increase skills or knowledge.

25.3(8) Inquiries relating to acceptability of continuing dental education activities, approval of sponsors, or exemptions should be directed to Advisory Committee on Continuing Dental Education, Iowa ~~Board of~~ Dental Board ~~Examiners~~, 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687.

[**ARC 8369B**, IAB 12/16/09, effective 1/20/10; **ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—25.4(153) Designation of continuing education hours. Continuing education hours shall be determined by the length of a continuing education course in "clock hours". For the purposes of calculating continuing education hours for renewal of a license, registration, qualification or permit,

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the following rules shall apply:

25.4(1) Licensees and registrants may claim continuing education credit for completion of the mandatory reporter training if completed in the current biennium.

a. Completion of training in the identification and reporting of abuse in children shall result in two hours credit.

b. Completion of training in the identification and reporting of abuse in dependent adults shall result in two hours of credit.

c. Completion of training in the identification and reporting of abuse in children and dependent adults as a combined course shall result in three hours of credit.

25.4(2) Credit hours awarded for certification in cardiopulmonary resuscitation (CPR) shall not exceed three continuing education hours per biennium.

25.4(3) Attendees of a multiday convention-type meeting, shall receive three hours of credit with the maximum allowed six hours of credit per biennium.

a. Four hours of credit shall be allowed for presentation of an original table clinic at a convention-type meeting as verified by the sponsor when the subject matter conforms with 25.3(7).

b. Attendees at the table clinic session of a dental, dental hygiene, or dental assisting convention shall receive two hours of credit as verified by the sponsor when the subject matter conforms with 25.3(7).

25.4(4) Postgraduate study relating to health sciences shall receive 15 credits per semester.

25.4(5) Successful completion of a specialty examination or the Dental Assisting National Board (DANB) shall result in 15 hours of credit.

25.4(6) Self-study activities shall result in a maximum of 12 hours of continuing education credit per biennium. Activity may include Internet-based coursework, television viewing, video programs, correspondence work or research, or computer CD-ROM programs that are interactive and require branching, navigation, participation and decision making on the part of the viewer. Internet-based webinars, which includes the involvement of an instructor and participants in real time and which allow for communication with the instructor through messaging, telephone or other means shall not be construed to be self-study activities.

25.4(7) Original presentation of continuing education dental education shall result in credit double that which the participants receives. Additional credit will not be granted for repeating presentations within the biennium. Credit is not given for teaching that represents part of the licensee's or registrant's normal academic duties as a full-time or part-time faculty member or consultant.

25.4(8) Publication of scientific articles in professional journals related to dentistry, dental hygiene, or dental assisting shall result in 5 hours of credit per article, maximum of 20 hours per biennium.

650—25.5(153) Extensions and exemptions.

25.5(1) *Illness or disability.* The board may, in individual cases involving physical disability or illness, grant an exemption of the minimum education requirements or an extension of time within which to fulfill the same or make the required reports. No exemption or extension of time shall be granted unless written application is made on forms provided by the board and signed by the licensee or registrant and a physician licensed by the board of medicine. Extensions or exemptions of the minimum educational requirements may be granted by the board for any period of time not to exceed one calendar year. In the event that the physical disability or illness upon which an exemption has been granted continues beyond the period granted, the licensee or registrant must reapply for an extension of the exemption. The board may, as a condition of the exemption, require the applicant to make up a certain portion or all of the minimum educational requirements.

25.5(2) *Other extensions or exemptions.* Extensions or exemptions of continuing education requirements will be considered by the board on an individual basis. Licensees or registrants will be exempt from the continuing education requirements for:

a. Periods that the person serves honorably on active duty in the military services;

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b. Periods that the person practices the person's profession in another state or district having a continuing education requirement and the licensee or registrant meets all requirements of that state or district for practice therein;

c. Periods that the person is a government employee working in the person's licensed or registered specialty and assigned to duty outside the United States;

d. Other periods of active practice and absence from the state approved by the board;

e. The current biennium renewal period, or portion thereof, following original issuance of the license.

f. For dental assistants registered pursuant to 650—20.7(153), the current biennium renewal period, or portion thereof, following original issuance of the registration.

650—25.6(153) Exemptions for inactive practitioners. A licensee or registrant who is not engaged in practice in the state of Iowa, residing in or out of the state of Iowa, may place the license or registration on inactive status by submitting a written renewal form and paying the required renewal fee. No continuing education hours are required to renew a license or registration on inactive status until application for reactivation is made. A request to place a license or registration on inactive status shall also contain a statement that the applicant will not engage in the practice of the applicant's profession in Iowa without first complying with all rules governing reactivation of inactive practitioners.

[**ARC 8369B**, IAB 12/16/09, effective 1/20/10]

650—25.4~~6~~7(153) Approval of sponsors.

25.-4~~6~~7(1) An organization or person not previously approved by the board, which desires approval as a sponsor of courses, programs, or other continuing education activities, shall apply for approval to the board stating its education history ~~for the preceding two years~~, including approximate dates, subjects offered, total hours of instruction presented, and names and qualifications of instructors. All applications shall be reviewed by the advisory committee on continuing education prior to final approval or denial by the board.

25.-4~~6~~7(2) Prospective sponsors must apply to the Iowa dental board using ~~a "Sponsor Approval Form"~~ board-approved forms in order to obtain approved sponsor status. An application fee as specified in 650—Chapter 15 is required. Board-approved sponsors must pay the biennial renewal fee as specified in 650—Chapter 15 and file a sponsor recertification record report biennially.

25.–4~~6~~7(3) The person or organization sponsoring continuing education activities shall make a written record of the Iowa licensees or registrants in attendance, maintain the written record for a minimum of five years, and submit the record upon the request of the board. The sponsor of the continuing education activity shall also provide proof of attendance and the number of credit hours awarded to the licensee or registrant who participates in the continuing education activity.

25.–4~~6~~7(4) Sponsors must be formally organized and adhere to board rules for planning and providing continuing dental education activities. Programs sponsored by individuals or institutions for commercial or proprietary purposes, especially programs in which the speaker advertises or urges the use of any particular dental product or appliance, may be recognized for credit on a prior approval basis only. When courses are promoted as approved continuing education courses which do not meet the requirements as defined by the board, the sponsor will be required to refund the registration fee to the participants. Approved sponsors may offer noncredit courses provided the participants have been informed that no credit will be given. Failure to meet this requirement may result in loss of approved sponsor status.

[**ARC 9218B**, IAB 11/3/10, effective 12/8/10; **ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—25.~~5~~8(153) Review of programs or sponsors. The board on its own motion or at the recommendation of the advisory committee on continuing education may monitor or review any continuing education program or sponsors already approved by the board. Upon evidence of significant variation in the program presented from the program approved, the board may disapprove

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all or any part of the approved hours granted to the program or may rescind the approval status of the sponsor.

650—25.6~~9~~(153) Hearings. In the event of denial, in whole or in part, of any application for approval of a continuing education program or credit for continuing education activity, the applicant, licensee, or registrant shall have the right, within 20 days after the sending of the written notification of the denial ~~by ordinary mail~~, to request a hearing which shall be held within 60 days after receipt of the request for hearing. The hearing shall be conducted by the board or a qualified hearing officer designated by the board. If the hearing is conducted by a hearing officer, the hearing officer shall submit a transcript of the hearing with the proposed decision of the hearing officer. The decision of the board or decision of the hearing officer after adoption by the board shall be final.

~~**650—25.7(153) Extensions and exemptions.**~~

~~**25.7(1)** *Illness or disability.* The board may, in individual cases involving physical disability or illness, grant an exemption of the minimum education requirements or an extension of time within which to fulfill the same or make the required reports. No exemption or extension of time shall be granted unless written application is made on forms provided by the board and signed by the licensee or registrant and a physician licensed by the board of medical examiners. Extensions or exemptions of the minimum educational requirements may be granted by the board for any period of time not to exceed one calendar year. In the event that the physical disability or illness upon which an exemption has been granted continues beyond the period granted, the licensee or registrant must reapply for an extension of the exemption. The board may, as a condition of the exemption, require the applicant to make up a certain portion or all of the minimum educational requirements.~~

~~**25.7(2)** *Other extensions or exemptions.* Extensions or exemptions of continuing education requirements will be considered by the board on an individual basis. Licensees or registrants will be exempt from the continuing education requirements for:~~

~~*a.* Periods that the person serves honorably on active duty in the military services;~~

~~*b.* Periods that the person practices the person's profession in another state or district having a continuing education requirement and the licensee or registrant meets all requirements of that state or district for practice therein;~~

~~*c.* Periods that the person is a government employee working in the person's licensed or registered specialty and assigned to duty outside the United States;~~

~~*d.* Other periods of active practice and absence from the state approved by the board;~~

~~*e.* The current biennium renewal period, or portion thereof, following original issuance of the license.~~

~~*f.* For dental assistants registered pursuant to 650—20.6(153), the current biennium renewal period, or portion thereof, following original issuance of the registration.~~

~~**650—25.8(153) Exemptions for inactive practitioners.** A licensee or registrant who is not engaged in practice in the state of Iowa, residing in or out of the state of Iowa, may place the license or registration on inactive status by submitting a written renewal form and paying the required renewal fee. No continuing education hours are required to renew a license or registration on inactive status until reinstatement. A request to place a license or registration on inactive status shall also contain a statement that the applicant will not engage in the practice of the applicant's profession in Iowa without first complying with all rules governing reinstatement of inactive practitioners.~~

~~[**ARC 8369B**, IAB 12/16/09, effective 1/20/10]~~

~~**650—25.9(153) Reinstatement of inactive practitioners.** Inactive practitioners shall, prior to engaging in the practice of dentistry, dental hygiene, or dental assisting in the state of Iowa, satisfy the following requirements for reinstatement:~~

~~**25.9(1)** Submit written application for reinstatement to the board upon forms provided by the board; and~~

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~~**25.9(2)** Furnish in the application evidence of one of the following:~~

~~*a.* The full-time practice of the profession in another state of the United States or the District of Columbia and completion of continuing education for each year of inactive status substantially equivalent in the opinion of the board to that required under the rules; or~~

~~*b.* Completion of a total number of hours of approved continuing education computed by multiplying 15 by the number of years the license has been on inactive status for a dentist or dental hygienist, up to a maximum of 75 hours for a dentist or dental hygienist, or by multiplying 10 by the number of years the registration has been on inactive status for a dental assistant, up to a maximum of 50 hours for a dental assistant; or~~

~~*c.* Successful completion of CRDTS or other Iowa state license or registration examination conducted within one year immediately prior to the submission of such application for reinstatement; or~~

~~*d.* The licensee or registrant may petition the board to determine the continuing education credit hours required for reinstatement of the Iowa license or registration.~~

~~*e.* Evidence that the applicant possesses a current certificate in a nationally recognized course in cardiopulmonary resuscitation. The course must include a clinical component.~~

~~**25.9(3)** Applications must be filed with the board along with the following:~~

~~*a.* Certification by the state board of dentistry or equivalent authority in which applicant has engaged in the practice of the applicant's profession that the applicant has not been the subject of final or pending disciplinary action.~~

~~*b.* Statement as to any claims, complaints, judgments or settlements made with respect to the applicant arising out of the alleged negligence or malpractice in rendering professional services as a dentist, dental hygienist, or dental assistant.~~

~~[**ARC 8369B**, IAB 12/16/09, effective 1/20/10; **ARC 9218B**, IAB 11/3/10, effective 12/8/10]~~

Commented [BC[2]: Intent is to move this section to IAC 650—Chapter 14 where renewal and reinstatements are addressed.

650—25.10(153) Noncompliance with continuing dental education requirements. It is the licensee's or registrant's personal responsibility to comply with these rules. The license or registration of individuals not complying with the continuing dental education rules may be subject to disciplinary action by the board or nonrenewal of the license or registration.

650—25.11(153) Dental hygiene continuing education. The dental hygiene committee, in its discretion, shall make recommendations to the board for approval or denial of requests pertaining to dental hygiene education. The dental hygiene committee may utilize the continuing education advisory committee as needed. The board's review of the dental hygiene committee recommendation is subject to 650—Chapter 1. The following items pertaining to dental hygiene shall be forwarded to the dental hygiene committee for review.

1. Dental hygiene continuing education requirements and requests for approval of programs, activities and sponsors.
2. Requests by dental hygienists for waivers, extensions and exemptions of the continuing education requirements.
3. Requests for exemptions from inactive dental hygiene practitioners.
4. Requests for reinstatement from inactive dental hygiene practitioners.
5. Appeals of denial of dental hygiene continuing education and conduct hearings as necessary.

These rules are intended to implement Iowa Code sections 147.10, 153.15A, and 153.39 and chapter 272C.

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CHAPTER 14
RENEWAL AND REINSTATEMENT

[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—14.1(147,153,272C) Renewal of license to practice dentistry or dental hygiene. A license to practice dentistry or a license to practice dental hygiene must be renewed prior to the expiration date of the license. Dental hygiene licenses expire on August 31 of every odd-numbered year. Dental licenses expire August 31 of every even-numbered year.

14.1(1) *Application renewal procedures.*

a. Renewal notice. The board office will send a renewal notice by regular mail or e-mail to each licensee at the licensee's last-known mailing or e-mail address.

b. Licensee and permit holder obligation. The licensee or permit holder is responsible for renewing the license or permit prior to its expiration. Failure of the licensee or permit holder to receive the notice does not relieve the licensee or permit holder of the responsibility for renewing that license or permit in order to continue practicing in the state of Iowa.

c. Renewal application form. Application for renewal must be made on forms provided by the board office. Licensees and permit holders may renew their licenses and permits online or via paper application.

d. Complete and timely filed application. No renewal application shall be considered timely and sufficient until received by the board office and accompanied by all material required for renewal and all applicable renewal and late fees. Incomplete applications will be not be accepted. For purposes of establishing timely filing, the postmark on a paper submittal will be used, and for renewals submitted online, the electronic timestamp will be deemed the date of filing.

14.1(2) *Application fee.* The appropriate fee as specified in 650—Chapter 15 of these rules must accompany the application for renewal. A penalty shall be assessed by the board for late renewal, as specified in 650—Chapter 15.

14.1(3) *Continuing education requirements.* Completion of continuing education in accordance with 650—Chapter 25 is required for renewal of an active license. However, licensees are exempt from the continuing education requirement for the current biennium in which the license is first issued.

14.1(4) *CPR certification.* In order to renew a license, an applicant must submit a statement:

a. Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a "hands-on" clinical component;

b. Providing the expiration date of the CPR certificate; and

c. Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

14.1(5) *Dental hygiene committee review.* The dental hygiene committee may, in its discretion, review any applications for renewal of a dental hygiene license and make recommendations to the board. The board's review is subject to 650—Chapter 1.

This rule is intended to implement Iowa Code section 147.10 and chapters 153 and 272C.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.2(153) Renewal of registration as a dental assistant. A certificate of registration as a registered dental assistant must be renewed biennially. Registration certificates shall expire on August 31 of every odd-numbered year.

14.2(1) *Renewal procedures.*

a. Renewal notice. The board office will send a renewal notice by regular mail or e-mail to each registrant at the registrant's last-known mailing address or e-mail address. The board will notify each registrant by mail or e-mail of the expiration of the registration certificate.

b. Registrant obligation. The registrant is responsible for renewing the registration prior to its expiration. Failure of the registrant to receive the notice does not relieve the registrant of the

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responsibility for renewing that registration in order to continue practicing in the state of Iowa.

c. Renewal application form. Registrants may renew their registration online or via paper application. Paper application for renewal must be made in writing on forms provided by the board office before the current registration expires.

d. Complete and timely filed application. No renewal application shall be considered timely and sufficient until received by the board office and accompanied by all material required for renewal and all applicable renewal and late fees. Incomplete applications will not be accepted. For purposes of establishing timely filing, the postmark on a paper submittal will be used, and for renewals submitted online, the electronic timestamp will be deemed the date of filing.

14.2(2) *Application fee.* The appropriate fee as specified in 650—Chapter 15 must accompany the application for renewal. A penalty shall be assessed by the board for late renewal, as specified in 650—Chapter 15.

14.2(3) *Continuing education requirements.* Completion of continuing education as specified in rule 650—20.11(153) and 650—Chapter 25 is required for renewal of an active registration. Failure to meet the requirements of renewal in the time specified by rule will automatically result in a lapsed registration.

14.2(4) *CPR certification.* In order to renew a registration, an applicant must submit a statement:

a. Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a "hands-on" clinical component;

b. Providing the expiration date of the CPR certificate; and

c. Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

This rule is intended to implement Iowa Code sections 147.10 and 153.39.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.3(136C,153) Renewal of dental assistant radiography qualification. A certificate of radiography qualification must be renewed biennially. Radiography qualification certificates shall expire on August 31 of every odd-numbered year.

14.3(1) *Renewal procedures.*

a. Renewal notice. The board office will send a renewal notice by regular mail or e-mail to each registrant at the registrant's last-known mailing address or e-mail address. The board will notify each registrant by mail or e-mail of the expiration of the radiography qualification.

b. Registrant obligation. The registrant is responsible for renewing the radiography qualification prior to its expiration. Failure of the registrant to receive the notice does not relieve the registrant of the responsibility for renewing that radiography qualification if the registrant wants to continue taking dental radiographs in the state of Iowa.

c. Renewal application form. Application for renewal must be made in writing on forms provided by the board office before the current radiography qualification expires. Registrants may renew their radiography qualification online or via paper application.

d. Complete and timely filed application. No renewal application shall be considered timely and sufficient until received by the board office and accompanied by all material required for renewal and all applicable renewal and late fees. Incomplete applications will not be accepted. For purposes of establishing timely filing, the postmark on a paper submittal will be used, and for renewals submitted online, the electronic timestamp will be deemed the date of filing.

14.3(2) *Application fee.* The appropriate fee as specified in 650—Chapter 15 must accompany the application for renewal. A penalty shall be assessed by the board for late renewal, as specified in 650—Chapter 15.

14.3(3) *Continuing education requirements.* In order to renew a radiography qualification, the dental assistant shall obtain at least two hours of continuing education in the subject area of dental radiography. Proof of attendance shall be retained by the dental assistant and must be submitted to the board office upon request.

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14.3(4) *CPR certification.* In order to renew a radiography qualification, an applicant must submit a statement:

a. Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a "hands-on" clinical component;

b. Providing the expiration date of the CPR certificate; and

c. Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

This rule is intended to implement Iowa Code chapters 136C and 153.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.4(147,153,272C) Grounds for nonrenewal. The board may refuse to renew a license, registration or radiography qualification on the following grounds:

14.4(1) After proper notice and hearing, for a violation of these rules or Iowa Code chapter 147, 153, or 272C during the term of the last license, registration or radiography qualification or renewal of license, registration or radiography qualification.

14.4(2) Failure to pay required fees.

14.4(3) Failure to obtain required continuing education.

14.4(4) Failure to provide a statement of current certification in cardiopulmonary resuscitation in a course that includes a clinical component.

14.4(5) Receipt of a certificate of noncompliance from the college student aid commission or the child support recovery unit of the department of human services in accordance with 650—Chapter 33 and 650—Chapter 34.

This rule is intended to implement Iowa Code section 153.23 and chapters 147, 252J, 261, and 272C.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.5(147,153,272C) Late renewal.

14.5(1) *Failure to renew license or permit.*

a. Failure to renew a dental or dental hygiene license or permit prior to September 1 following expiration shall result in a late fee in the amount specified in 650—Chapter 15 being assessed by the board in addition to the renewal fee.

b. Failure to renew prior to October 1 following expiration shall result in assessment of a late fee in the amount specified in 650—Chapter 15.

c. Failure of a license or permit holder to renew a license or permit prior to November 1 following expiration shall cause the license or permit to lapse and become invalid. A licensee or permit holder whose license or permit has lapsed and become invalid is prohibited from the practice of dentistry or dental hygiene until the license or permit is reinstated in accordance with rule 650—14.6(147,153,272C).

14.5(2) *Failure to renew registration.*

a. Failure to renew a dental assistant registration prior to September 1 following expiration shall result in a late fee in the amount specified in 650—Chapter 15 assessed by the board in addition to the renewal fee.

b. Failure to renew prior to October 1 following expiration shall result in assessment of a late fee in the amount specified in 650—Chapter 15.

c. Failure to renew a registration prior to November 1 following expiration shall cause the registration to lapse and become invalid. A registrant whose registration has lapsed and become invalid is prohibited from practicing as a dental assistant until the registration is reinstated in accordance with rule 650—14.6(147,153,272C).

14.5(3) *Failure to renew radiography qualification.* Failure to renew a radiography qualification prior to November 1 following expiration shall cause the radiography qualification to lapse and become invalid. A dental assistant whose radiography qualification is lapsed is prohibited from

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engaging in dental radiography until the qualification is reinstated in accordance with rule 650—14.7(136C,153).

This rule is intended to implement Iowa Code sections 147.10, 147.11, and 272C.2.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.6(147,153,272C) Reinstatement of a lapsed license or registration.

14.6(1) A licensee or a registrant who allows a license or registration to lapse by failing to renew may have the license or registration reinstated at the discretion of the board by submitting the following:

a. A completed application for reinstatement of a lapsed license to practice dentistry or dental hygiene or application for reinstatement of a lapsed registration on the form provided by the board.

b. Dates and places of practice.

c. A list of other states in which licensed or registered and the identifying number of each license or registration.

d. Reasons for seeking reinstatement and why the license or registration was not maintained.

e. Payment of all renewal fees past due, as specified in 650—Chapter 15, plus the reinstatement fee as specified in 650—Chapter 15.

f. Evidence of completion of a total of 15 hours of continuing education for each lapsed year or part thereof in accordance with 650—Chapter 25, up to a maximum of 75 hours. Dental assistants shall be required to submit evidence of completion of a total of 10 hours of continuing education for each lapsed year or part thereof in accordance with 650—20.12(153), up to a maximum of 50 hours.

g. If licensed or registered in another state, the licensee or registrant shall provide certification by the state board of dentistry or equivalent authority of such state that the licensee or registrant has not been the subject of final or pending disciplinary action.

h. A statement disclosing and explaining any disciplinary actions, investigations, claims, complaints, judgments, settlements, or criminal charges.

i. Evidence that the applicant possesses a current certificate in a nationally recognized course in cardiopulmonary resuscitation. The course must include a clinical component.

j. For reinstatement of a lapsed license, a completed fingerprint packet to facilitate a criminal history background check by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), including the fee for the evaluation of the fingerprint packet and the criminal history background checks by the DCI and FBI, as specified in 650—Chapter 15.

14.6(2) The board may require a licensee or registrant applying for reinstatement to successfully complete an examination designated by the board prior to reinstatement if necessary to ensure the licensee or registrant is able to practice the licensee's or registrant's respective profession with reasonable skill and safety.

14.6(3) When the board finds that a practitioner applying for reinstatement is or has been subject to disciplinary action taken against a license or registration held by the applicant in another state of the United States, District of Columbia, or territory, and the violations which resulted in such actions would also be grounds for discipline in Iowa in accordance with rule 650—30.4(153), the board may deny reinstatement of a license or registration to practice dentistry, dental hygiene, or dental assisting in Iowa or may impose any applicable disciplinary sanctions as specified in rule 650—30.2(153) as a condition of reinstatement.

14.6(4) The dental hygiene committee may, in its discretion, review any applications for reinstatement of a lapsed dental hygiene license and make recommendations to the board. The board's review of the dental hygiene committee recommendation is subject to 650—Chapter 1.

This rule is intended to implement Iowa Code sections 147.10, 147.11, and 272C.2.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.7(136C,153) Reinstatement of lapsed radiography qualification. A dental assistant who allows a radiography qualification to lapse by failing to renew may have the radiography qualification

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reinstated at the discretion of the board by submitting the following:

14.7(1) A completed application for reinstatement of the dental assistant radiography qualification.

14.7(2) Payment of the radiography reinstatement application fee and the current renewal fee, both as specified in 650—Chapter 15.

14.7(3) Proof of current registration as a dental assistant or proof of an active Iowa nursing license.

14.7(4) If the radiography qualification has been lapsed for less than four years, proof of two hours of continuing education in the subject area of dental radiography, taken within the previous two-year period.

14.7(5) If the radiography qualification has been lapsed for more than four years, the dental assistant shall be required to retake and successfully complete an examination in dental radiography. A dental assistant who presents proof of a current radiography qualification issued by another state and who has engaged in dental radiography in that state is exempt from the examination requirement.

This rule is intended to implement Iowa Code section 136C.3 and chapter 153.

[**ARC 0265C**, IAB 8/8/12, effective 9/12/12]

650—14.8 (153) Reactivation of inactive practitioners. Inactive practitioners shall, prior to engaging in the practice of dentistry, dental hygiene, or dental assisting in the state of Iowa, satisfy the following requirements for reactivation:

14.8(1) Submit written application for reactivation to the board upon forms provided by the board; and

14.8(2) Furnish in the application evidence of one of the following:

a. The full-time practice of the profession in another state of the United States or the District of Columbia and completion of continuing education for each year of inactive status substantially equivalent in the opinion of the board to that required under the rules; or

b. Completion of a total number of hours of approved continuing education computed by multiplying 15 by the number of years the license has been on inactive status for a dentist or dental hygienist, up to a maximum of 75 hours for a dentist or dental hygienist, or by multiplying 10 by the number of years the registration has been on inactive status for a dental assistant, up to a maximum of 50 hours for a dental assistant; or

c. Successful completion of CRDTS, WREB, SRTA or ADEX examination or registration examination conducted within one year immediately prior to the submission of such application for reactivation; or

d. The licensee or registrant may petition the board to determine the continuing education credit hours required for reactivation of the Iowa license or registration.

e. Evidence that the applicant possesses a current certificate in a nationally recognized course in cardiopulmonary resuscitation. The course must include a clinical component.

f. The board may require a licensee or registrant applying for reactivation to successfully complete an examination designated by the board prior to reactivation if necessary to ensure the licensee or registrant is able to practice the licensee's or registrant's prospective profession with reasonable skill and safety.

g. The dental hygiene committee may, in its discretion, review any applications for reactivation of an inactive dental hygiene license and make recommendations to the board. The board's review of the dental hygiene committee recommendation is subject to 650—Chapter 1.

14.8(3) Applications must be filed with the board along with the following:

a. Certification by the state board of dentistry or equivalent authority in which applicant has engaged in the practice of the applicant's profession that the applicant has not been the subject of final or pending disciplinary action.

b. Statement as to any claims, complaints, judgments or settlements made with respect to the applicant arising out of the alleged negligence or malpractice in rendering professional services as a dentist, dental hygienist, or dental assistant.

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From: Ruprecht,Axel [mailto:ARuprecht@dental.ufl.edu]
Sent: Friday, February 26, 2016 9:19 AM
To: Braness, Christel [IDB] <Christel.Braness@iowa.gov>
Subject: Appeal

February 25, 2016
Ms. Christel Braness
Program Planner
Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines IA 50309-4687

Dear Ms. Braness,

I am in receipt of your letter dated February 4, 2016, dealing with my Petition for Rule Waiver. I should like to appeal the ruling, specifically based upon a decision that I have not shown that, because of the special circumstances, application of the rule would impose undue hardship. As I stated in my petition, I am an oral and maxillofacial radiologist and have limited my practice to oral and maxillofacial radiology since 1973. I graduated from the University of Toronto with a DDS in 1968 and was licensed in Ontario, also in 1968. I subsequently interned for a year at the Toronto General and Toronto Western Hospitals, both teaching hospitals of the University of Toronto, finishing in 1969. During that time I successfully took the written examination of the National Dental Examining Board of Canada, which was not required. Upon completing my internship I entered the oral and maxillofacial radiology program at the University of Toronto, graduating in 1972 with an MScD. I moved to the University of Western Ontario as an assistant professor in oral radiology (as it was then called) in 1972. I practiced general dentistry for approximately one year while the late Dr. John Reid and I established our practice limited to oral radiology (Oral Radiology Consultants). I was also on staff at four hospitals in London, Ontario as an oral radiologist, and had an academic appointment in Medical Radiology at the University of Western Ontario.

In 1974 I received the Fellowship in the American Academy of Oral and Maxillofacial Radiology via an examination that was the forerunner to the American Board of Oral and Maxillofacial Radiology.

In 1975 I was recruited to the University of Saskatchewan, to become an associate professor of Oral Radiology and chair of the Department of Diagnosis and Oral Radiology and was licensed by the Province of Saskatchewan (not academic licensure). I was certified in the Province of Saskatchewan as a specialist in Oral Radiology. In the same year I was awarded (by examination) Fellowship in the Royal College of Dentists of Canada. Royal College Fellowships are the Canadian equivalent to Diplomate Status in Specialty Boards in the USA.

In 1977 I was certified in the Province of Ontario as a specialist in Oral Radiology.

In 1979 I was licensed in the neighboring Province of Alberta. I was also certified as an Oral and Maxillofacial Radiologist. At this point I had limited my practice to Oral and Maxillofacial Radiology for 6 years. I was a visiting Professor at the University of Alberta in Oral and Maxillofacial Radiology, and had been promoted to Professor at the University of Saskatchewan in Oral and Maxillofacial Radiology.

In 1981 I moved to Riyadh, Saudi Arabia to be Professor of Oral and Maxillofacial Radiology. I was licensed to practice in Saudi Arabia and certified as an Oral and Maxillofacial Radiologist by virtue of my being a Professor at the then only Dental College in the Kingdom, and based upon my Canadian and American credentials. Also in 1981 I became a Diplomate of the American Board of Oral and Maxillofacial Radiology.

In 1986 I joined the University of Marburg as Director of Oral and Maxillofacial Radiology and was licensed by the State of Hessen. While there I had to take and pass a course in radiation protection and hygiene, in order to be allowed to make radiographs.

In 1987 I was recruited to The University of Iowa to be Professor and Director of Oral and Maxillofacial Radiology. I remained in this position until I accepted the early retirement offer in 2015. At that point I had limited my practice to Oral and Maxillofacial Radiology for 42 years. From 2005 to 2015 I was Gilbert E. Lilly Professor of Diagnostic Sciences. For most of that time I was, and still am, the consultant in Oral and Maxillofacial Radiology to the Iowa Dental Association. Indeed I received an Outstanding Service Award from the Iowa Dental Association in 2005.

In 2015 I joined the University of Florida as Adjunct Professor of Oral and Maxillofacial Radiology from September 18, 2015 to December 18, 2015, at which point I became Professor of Oral and Maxillofacial Radiology, which I am today. In order to obtain my teaching permit I had to pass a Florida Jurisprudence examination.

I am also still Professor Emeritus of Oral and Maxillofacial Radiology, and of Radiology (as well Anatomy and Cell Biology) at the University of Iowa and still hold clinical privileges in Oral and Maxillofacial Radiology at the College of Dentistry and the University of Iowa Hospital and Clinics in the Department of Radiology.

I have now limited my practice to Oral and Maxillofacial Radiology for 43 years. I have never had a formal complaint or other action lodged against me in the three continents, four countries, and seven jurisdictions wherein I have practiced during that time.

I shall be returning to Iowa later this Spring.

I feel that to be required to take the CRDTS, WREB or ADEX examination in general dentistry, when I have limited my practice to Oral and Maxillofacial Radiology for the last 43 years, and when I have no intention of practicing general dentistry <u>would indeed impose an undue burden</u>. I am qualified by education and certification to be an Oral and Maxillofacial Radiologist. I realize that Iowa does not have a specialty license. Perhaps it should. I would be willing to sign a document that I would limit my practice to Oral and Maxillofacial Radiology.

I request the Iowa Dental Board reconsider its decision in regard to my petition.

Thanking you for your consideration of this appeal, I remain

Sincerely yours,

Axel Ruprecht D.D.S., M.Sc.D. F.R.C.D.(C), Dipl. A.B.O.M.R.
Clinical Professor of Oral and Maxillofacial Radiology

College of Dentistry
The University of Florida

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The only man to get all his work done by Friday was Robinson Crusoe.

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BEFORE THE IOWA DENTAL BOARD

Petition by Axel Ruprecht
18 Cherry Lane NE
Iowa City Iowa 52240
(319)-621-5577 }

for the waiver of 650 IAC-11.2(2)d, e} PETITION FOR WAIVER

relating to a waiver of the examination requirement license to practice Dentistry (limited to Oral and Maxillofacial Radiology)}

---

1. Petitioner's name, address, and telephone number. All communications concerning the petition can be directed to the address, phone, and e-mail address listed below.

Name: Axel Ruprecht
Address: 18 Cherry Lane NE
Iowa City IA 52240
Work Telephone: (352)-294-5576 until December 18, 2015
Home Phone: (319)-337-5044 not currently at this number
Cell phone, if desired: (319)-621-5577
Email: axel-ruprecht@uiowa.edu

2. I am requesting a waiver of 650 Iowa Administrative Code subrule 11.2(2)d.

3. I am requesting a waiver of 650 Iowa Administrative Code subrule 650 IAC-11.2(2)e, which requires documentation of passage of a regional clinical examination.

In lieu of above, I would like the board to accept the following: I am a graduate of the University of Toronto with a DDS (1968) and was subsequently licensed to practice Dentistry in Ontario (#6972) from 1968 to 1975. The license was based on passing a comprehensive set of examinations at the University of Toronto which covered 15 dental subjects on 5 examinations. I was a dental intern for one year at the Toronto General Hospital and Toronto Western Hospital 1968-1969. During this time I passed my National Dental Examining Board examination in 1968. I then entered the Oral Radiology program at the University of Toronto (1969-1972) and earned an MScD in December of 1972. During this time I passed the Part I Oral Radiology examination of the Royal College of Dentists of Canada in 1971. I then joined the faculty as Assistant Professor of Oral Radiology at the University of Western Ontario, in London Ontario, where I taught Radiology in the Faculty of Dentistry and Faculty of Medicine, and Dr. John Reid and I had a practice limited to Oral Radiology from 1972 to 1975. I was on staff as an oral radiologist at four London Hospitals, University Hospital, St. Joseph's Hospital, Victoria Hospital and Parkwood Hospital. In 1974 I passed the Fellowship examination of the American Academy of Oral and Maxillofacial Radiology (the forerunner of the American Board of Oral and Maxillofacial Radiology examination) and was awarded the FAAOMR. I also passed the

Part II Oral Radiology examination of the Royal College of Dentists of Canada in 1974 and was awarded the FRCD(C) in Oral Radiology in 1975. The Royal College examinations are the Canadian equivalent of Board examinations in the USA. There are sections for each of the recognized specialties, and thus my fellowship is Oral and Maxillofacial Radiology. In 1975 I moved to the University of Saskatchewan in Saskatoon, Saskatchewan, to become Associate Professor and Interim Chair (and then Chair) of the Department of Diagnosis and Oral Radiology. I was licensed to practice dentistry based upon my credentials (#1048), credentialed as an Oral Radiologist, and limited my practice to Oral Radiology. I practiced in Saskatchewan from 1975 to 1981. During this time I also took out my dental license and specialty certification in Alberta, and my specialty certification in Ontario (#470). In 1979 I was promoted to Professor. In 1981 I moved to Riyadh, Saudi Arabia to King Saud University as Professor of Oral and Maxillofacial Radiology from 1981-1986 and practiced during those 5 years. I was the only Oral and Maxillofacial Radiologist in Saudi Arabia for the first three years. In 1981 I became a Diplomate of the American Board of Oral and Maxillofacial Radiology. In 1986 I joined the University of Marburg as a radiologist for one year. While there I received a dental license from the Administrative Presidency in Giessen, Hessia, and a Certificate in Radiation Protection from the Bavarian Dental Board. In 1987 I moved to the University of Iowa where I spent 28 years as Professor and Director of Oral and Maxillofacial Radiology, and as Director of Advanced Education in Oral and Maxillofacial Radiology and received a faculty permit from the Iowa Dental Board to practice dentistry during that time, limiting my practice to Oral and Maxillofacial Radiology, and when Oral and Maxillofacial Radiology was recognized as the ninth dental specialty by the American Dental Association in 1999 I officially limited my practice to Oral and Maxillofacial Radiology in Iowa on the basis of my having become a Diplomate of the American Board of Oral and Maxillofacial Radiology (#42) in 1981. In August of 1991 I also became Professor of Radiology in the College of Medicine and was on clinical staff in Radiology, in the section of Neuroradiology at the University of Iowa Hospitals and Clinics. I have maintained a referral practice in Oral and Maxillofacial Radiology, first by myself, and then since about 2008 with Dr. V. Allareddy as Oral and Maxillofacial Radiology Consultants, based at The University of Iowa. From July 8, 2005 until June 30, 2015 I was Gilbert E. Lilly Professor of Diagnostic Sciences at The University of Iowa. I retired from The University of Iowa on July 1, 2015, but remain Emeritus Professor of Oral and Maxillofacial Radiology, of Radiology, and of Anatomy and Cell Biology. I was asked by the University of Florida to join the faculty for three months, September 18, 2015 to December 18, 2015 to teach and practice radiology. I was issued a teaching permit (#623) from the Florida State Board of Dentistry based upon my credentials and passing a jurisprudence examination. I am there now, but maintain my home in Iowa.

I should like to continue to practice Dentistry limited to Oral and Maxillofacial Radiology, as this will allow me to consult with dental practitioners in Iowa and continue to provide the service to the dental profession and public of Iowa that I have provided for the past 28 years.

_____.

(List specific training at accredited schools or other relevant information).

As stated above, I was enrolled in and graduated from the Oral Radiology program at the University of Toronto from September 1969 to December 1972.

(Below, list any additional relevant information)

I have been active in organized dentistry, mainly in Oral and Maxillofacial Radiology since entering the Toronto program.

I am a past president and still a member of the Canadian Academy of Oral and Maxillofacial Radiology, American Academy of Oral and Maxillofacial Radiology and American Board of Oral and Maxillofacial Radiology. I am also a member of the International Association of Dento Maxillo Facial Radiology, Iowa Radiological Society, American College of Radiology, and Radiological Society of North America, and a life member of the Iowa and American Dental Association and American Society of Head and Neck Radiology.

I have also been a consultant to the Iowa Dental Association in matters pertaining to radiology and radiation for many years, and was awarded the Outstanding Service Award in 2005 for this activity. I continue to be a consultant and have been asked to give an opinion to the IDA since coming to Florida.

4. Explain the relevant facts and reasons that the petitioner believes justify a waiver. Include in your answer all of the following:

a. Undue Hardship. I feel that having essentially limited my practice to Oral and Maxillofacial Radiology for over 40 years, and inasmuch as I would do so if I receive a waiver of the examination requirement, it would not be or value for me to have to take an examination in general dentistry, which I would not be practicing. To require that I take a clinical examination in general dentistry which I have not practiced in 41 years, having limited myself to Oral and maxillofacial Radiology would require my restudying and relearning an area of dentistry that it is not my intention to practice as I would be limited to Oral and Maxillofacial Radiology. And having been examined in Oral and Maxillofacial Radiology by the American Academy and Board of Oral and Maxillofacial Radiology and the Royal College of Dentists of Canada (section on Oral and Maxillofacial Radiology) and been found competent to practice Oral and Maxillofacial Radiology, and having been selected in the past by the Royal College as an Examiner in Oral and Maxillofacial Radiology 1976-1977 and 1994 to the present, and Chief Examiner in Oral and Maxillofacial Radiology from 1994 to 1999, and elected by my peers as a director of the American Board of Oral and Maxillofacial Radiology from 1988 to 1992 (which means that I was an examiner for that time), and having had my credentials, which include clinical practice in Oral and Maxillofacial Radiology examined for each academic and hospital appointment and promotion since 1972, and for clinical credentialing and re-credentialing on a regular basis, my qualifications to practice Oral and Maxillofacial Radiology are well established.

I have also never had a malpractice or similar complaint brought against me in my entire career.

b. Why Waiving the Rule Would Not Prejudice the Substantial Legal Rights of Any Person. Waiver of the rule would not prejudice the substantial legal rights of any person because there is no other Oral and Maxillofacial Radiologist in a similar position with my background. As such, at least as far as Oral and Maxillofacial Radiology is concerned I am in a unique position in Iowa. My being granted this waiver does not alter my relationship with the public or the dental profession. What I have done over the past 28 years in Iowa was done in such a way as to ensure the public health, safety and welfare. This would allow me to continue to provide the service in the same manner, with the public health, safety and welfare being always in the forefront, as would be expected of any practicing dental professional.

c. The Provisions of the Rule Subject to the Waiver are NOT Specifically Mandated by Statute or Another Provision of Law. Iowa Code Chapter 153 does not mandate the requirements of rule 650—11.2(2)d, e.

d. Substantially Equal Protection of the Public Health, Safety, and Welfare has been afforded by my previous 28 years of practice in Iowa, and my practice prior to this and subsequently in Florida.

The subrule that I am requesting a waiver from helps to ensure that I can continue to provide my specialized expertise to the dentists and physicians of Iowa and through them to their patients, the public of Iowa.

5. A history of prior contacts between the board and petitioner related to the regulated activity is as follows.

I have asked for clarification from the Board for my status as a dentist in Iowa when specialty recognition occurred. That is, when and how to officially limit my practice to Oral and Maxillofacial Radiology, once Oral and Maxillofacial Radiology was recognized as a dental specialty in 1999. I also asked the board for clarification with respect to the current protocol for requesting a waiver. I have never applied for any other waiver, and my only other interaction(s) related to my and The University of Iowa applying for my faculty Permit.

6. Information related to the board's action in similar cases: Inasmuch as I am the first Oral and Maxillofacial Radiologist to apply for this waiver, there are no similar cases. I am not applying as a foreign trained dentist because there is reciprocity between the accrediting commissions of

the USA and Canada, and as such, for all intents and purposes a Canadian and an American trained and educated dentist/oral and maxillofacial radiologist are considered as equivalent.

7. There is no other public agency or political subdivision that regulates dentistry in Iowa. Are there any public agencies or political subdivisions that would be affected by your request? If yes, please provide the name, address and other contact information below. ☐ Yes X No

8. I am not aware of any person or entity that would be adversely affected by the granting of a waiver in this case.

9. Provide the name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver, if any.

Dr. David C. Johnson,
Dean of Dentistry.
The University of Iowa-DSB N 308
801 Newton Rd.
Iowa City IA 52242-100
319-335-7144

Dr. Galen Schneider,
Executive Associate Dean of Dentistry.
The University of Iowa-DSB N 308
801 Newton Rd.
Iowa City IA 52242-1001
319-335-7146

Dr. Michael Kanellis,
Associate Dean of Clinics
College of Dentistry.
The University of Iowa-DSB N 308
801 Newton Rd.
Iowa City IA 52242-1001
319-335-7439
All at

10. I hereby authorize the Board to obtain any information relating to this waiver request from the individuals named herein. I will provide signed releases of information if necessary.

I hereby attest to the accuracy and truthfulness of the above information.

Petitioner's signature

September 25, 2015
Date

Braness, Christel [IDB]

From: Info <info@ndeb-bned.ca>
Sent: Wednesday, January 13, 2016 10:31 AM
To: Braness, Christel [IDB]
Subject: RE: National Board Examination

Dear Ms. Braness,

In response to your email dated January 8, 2016, we have provided information regarding NDEB certification in 1968 below.

The 1968 NDEB By-laws indicate that:
All candidates for examination of qualification under the Board must possess the following qualifications:

a) Hold a degree in dentistry from a school of dentistry approved by the Council on Education of the Canadian Dental Association at the time of graduation, such approval as of March 1948, or be certified by the Dean or registrar of a University as a bona fide senior year candidate of an approved dental school.
b) Hold an enabling certificate from a Canadian dental licensing body and

Effective January 1st, 1965, examinations shall consist of six examinations as follows:

a) Oral Diagnosis, Radiology and Treatment Planning.
b) Operative Dentistry, including fixed partial dentures.
c) Prosthodontics, including complete and partial removable dentures.
d) Orthodontics and Preventive Dentistry, including all phases of Paedodontics and Public Health Dentistry.
e) Oral Surgery, Anaesthesia and Endodontics.
f) Oral Medicine, including Clinical Therapeutics, Pathology and Periodontics.

Candidates qualifying for NDEB certificates must obtain a minimum passing mark of 75% on each examination paper and, in addition, each candidate must obtain an average of 75% of the aggregate marks.

Kind regards,

Leah Gunnell
Administrator, Credential Verification & Program Services

The National Dental Examining Board of Canada
Le Bureau national d'examen dentaire du Canada
80 Elgin Street, 2nd Floor
Ottawa, ON K1P 6R2
Tel: 613-236-5912
www.ndeb-bned.ca

From: Braness, Christel [IDB] [mailto:Christel.Braness@iowa.gov]
Sent: January-08-16 6:11 PM
To: Info
Subject: National Board Examination
Importance: High

The Iowa Dental Board is reviewing a request from someone who completed the written national board in Canada in 1968. Since the request specifically focuses on the examination(s), which he completed, I was wondering if it would be possible to get some information about the national examination. For example, what is the format of the examination, what information, in general, would have been covered in the examination and anything else which you think may be

helpful. The board needs to determine whether the examination offered in Canada would have been comparable to the examination offered in the United States. Any documentation, which you may have in this respect would be most helpful.

Thank you for your time.

Christel Braness, Program Planner
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | IDB Online Services

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Braness, Christel [IDB]

From: Info <info@ndeb-bned.ca>
Sent: Wednesday, January 13, 2016 10:50 AM
To: Braness, Christel [IDB]
Subject: RE: National Board Examination

Dear Ms. Braness,

They were six separate written examinations.

Kind regards,

Leah Gunnell
Administrator, Credential Verification & Program Services

The National Dental Examining Board of Canada
Le Bureau national d'examen dentaire du Canada
80 Elgin Street, 2nd Floor
Ottawa, ON K1P 6R2
Tel: 613-236-5912
www.ndeb-bned.ca

From: Braness, Christel [IDB] [mailto:Christel.Braness@iowa.gov]
Sent: January-13-16 11:36 AM
To: Info
Subject: RE: National Board Examination

I just had one last question, was this examination a written examination, or a patient-based, clinical examination? I just need to clarify that part.

Thank you again for your time.

Christel Braness, Program Planner
Iowa Dental Board
400 SW 8th St., Suite D
Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | IDB Online Services

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From: Info [mailto:info@ndeb-bned.ca]
Sent: Wednesday, January 13, 2016 10:31 AM
To: Braness, Christel [IDB] <Christel.Braness@iowa.gov>
Subject: RE: National Board Examination

Dear Ms. Braness,

Braness, Christel [IDB]

From: axel-ruprecht@mchsi.com
Sent: Sunday, January 10, 2016 9:32 AM
To: Braness, Christel [IDB]
Subject: Re: Copy of certificate

The format of the examination was 6 examinations that, as I recall, were 150 multiple choice questions each covering various disciplines. I just got back from a site visit to another Dental College and am going to need a few days to get this done, if you need it from the NDEB.

Rgds
Axel

----- Original Message -----
From: "Christel Braness [IDB]" <Christel.Braness@iowa.gov>
To: "Axel Ruprecht" <axel-ruprecht@uiowa.edu>, axel-ruprecht@mchsi.com
Sent: Friday, January 8, 2016 6:06:31 PM
Subject: RE: Copy of certificate

After discussing your request with the director, it looks like we may also need information, if possible, about the format of the examination and the information covered within the examination. If available, this would allow the Board to determine whether the national board offered in Canada is comparable to the examination offered in the United States. The concern is that without this information the Board may not be able to make an informed decision.

Staff will be distributing Board materials next Thursday, January 15, 2016. If you are able to get this information to me prior to that time, it will be included in the mailing. Information received after that date may be distributed to the Board on the date of the meeting; though, it will allow less time for review of the documentation. I will include the information forwarded to date for their review.

Let me know if you have any questions.

Christel Braness, Program Planner
Iowa Dental Board<http://www.dentalboard.iowa.gov/>
400 SW 8th St., Suite D
Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | IDB Online
Services<https://eservices.iowa.gov/PublicPortal/Iowa/IDB/common/index.jsp>

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From: Braness, Christel [IDB]
Sent: Friday, January 08, 2016 12:59 PM
To: 'Ruprecht, Axel' <axel-ruprecht@uiowa.edu>; 'axel-ruprecht@mchsi.com' <axel-ruprecht@mchsi.com>
Subject: RE: Copy of certificate

Rule Reference for Axel Ruprecht Waiver Request

650—11.2 (147,153) Dental licensure by examination.

11.2(1) Applications for licensure to practice dentistry in this state shall be made on the form provided by the board and must be complete and include required credentials and documents.

11.2(2) Applications for licensure must be filed with the board along with:

a. *Documentation of graduation from dental college.* Satisfactory evidence of graduation with a DDS or DMD from an accredited dental college approved by the board or satisfactory evidence of meeting the requirements specified in rule 650—11.4(153).

b. *Certification of good standing from dean or designee.* Certification by the dean or other authorized representative of the dental school that the applicant has been a student in good standing while attending that dental school.

c. *Evidence of good standing in each state where licensed.* If the applicant is a dentist licensed by another jurisdiction, the applicant shall furnish evidence that the applicant is a licensed dentist in good standing in those states in which the applicant is licensed.

d. *Documentation of passage of national dental examination.* Evidence of successful completion of the examination administered by the Joint Commission on National Dental Examinations. Any dentist who has lawfully practiced dentistry in another state or territory for five years may be exempted from presenting this evidence.

e. *Documentation of passage of a regional clinical examination.*

(1) Successful passage of CRDTS. Evidence of having successfully completed in the last five years the examination administered by the Central Regional Dental Testing Service, Inc. (CRDTS).

(2) Special transition period for dentists passing WREB or ADEX examination prior to September 1, 2011. An applicant who has successfully taken and passed the WREB or ADEX examination within the five years prior to September 1, 2011, may apply for licensure by examination by submitting evidence of successful completion of the WREB or ADEX examination.

f. *Explanation of any legal or administrative actions.* A statement disclosing and explaining any disciplinary actions, investigations, complaints, malpractice claims, judgments, settlements, or criminal charges, including the results of a self-query of the National Practitioners Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB).

g. *Payment of application, fingerprint and background check fees.* The nonrefundable application fee, plus the fee for the evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), as specified in 650—Chapter 15.

h. *Documentation of passage of jurisprudence examination.* Evidence of successful completion of the jurisprudence examination administered by the Iowa dental board.

i. *Current CPR certification.* A statement:

(1) Confirming that the applicant possesses a valid certificate from a nationally recognized course in cardiopulmonary resuscitation (CPR) that included a “hands-on” clinical component;

(2) Providing the expiration date of the CPR certificate; and

(3) Acknowledging that the CPR certificate will be retained and made available to board office staff as part of routine auditing and monitoring.

j. *Completed fingerprint packet.* A completed fingerprint packet to facilitate a criminal history background check by the DCI and FBI.

11.2(3) The board may require a personal appearance or any additional information relating to the character, education and experience of the applicant.

11.2(4) Applications must be signed and verified as to the truth of the statements contained therein.

This rule is intended to implement Iowa Code sections 147.3, 147.29, and 147.34.

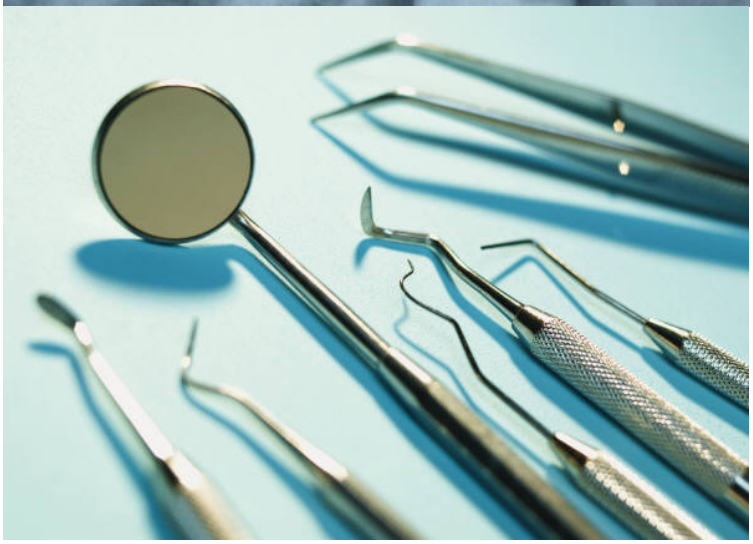
[**ARC 9218B**, IAB 11/3/10, effective 12/8/10; **ARC 9510B**, IAB 5/18/11, effective 6/22/11; **ARC 0265C**, IAB 8/8/12, effective 9/12/12]

Last Name	First Name	Rule/Subrule	Topic	Decision	Date of Ruling
Spanos	Dana	11.6(2)	Licensure by Credentials	Approved	12/20/2001
Spanos	Dana	11.5(2)"d"	WREB acceptance date	DENIED	12/20/2001
Heithoff	Abby	20.6(1)"b"	Dental Assistant Trainee	Approved	11/18/2002
Bednar	Matthew	22.4	Dental Radiology Training	DENIED	8/21/2003
Drennen	Pamela	22.4(3)	Dental Radiology Training	DENIED	9/9/2003
Confidential	2004-1(L)	22.5	Radiography Examination	DENIED	1/16/2004
Chowdhury	Jyoti	11.4(1)	Foreign Graduate	Approved	6/17/2004
Confidential	2004-2(SB)	11.2(2)"e"	Dental Examination for Licensure	DENIED	8/27/2004
Vargas	Kaaren	11.4(1)	Foreign Graduate	DENIED	6/17/2004
Confidential	2005-1(KC)	12.4(3)	Dental Hygiene Remedial Education	Approved	10/28/2005
Ptacek	Renee	22.4(3)	Dental Radiology Training	DENIED	10/28/2005
Confidential	2006-1(FB)	11.3(2)"e"	Licensure by Credentials	DENIED	5/12/2006
Weeks	Marsha	20.6(1)"b"	Dental Assistant Trainee	Approved	7/13/2006
Jennings	Adrienne	11.3(2)"e"	Licensure by Credentials	DENIED	9/14/2006
Karunagaran	Saravana	11.4(1)	Foreign Graduate	Approved	10/24/2006
Vargas	Kaaren	11.4(1)	Foreign Graduate	Approved	10/24/2006
Mahajan	Shrirang	11.4(1)	Foreign Graduate	DENIED	1/18/2007
Perry	Blake	11.2(2)"e"	Licensure by Examination - Exam Date	Approved	9/4/2007
Vargas	Marco	11.4(1)	Foreign Graduate	Approved	9/4/2007
Uribe	Juan M.	11.4(1)	Foreign Graduate	Approved	1/10/2008
Rouman	Marco	11.4(1)	Foreign Graduate	DENIED	11/20/2008
Ceraso	Gregory	29.5(1)	Moderate Sedation Permit, Facility Requirements	Approved	5/8/2009
Lopez	Bobbie	20.6(1)"b"(2)	Dental Assistant Trainee	Approved	5/8/2009
Gomez	Manual	11.4(1)	Foreign Graduate	DENIED	7/24/2009
Murray	Edward B.	29.4(9)	Moderate Sedation of Pediatric Patients	Approved	10/6/2010
Bansal	Ritu	11.4(1)	Foreign Graduate	Approved	10/15/2010
Humbert	Lewis A.	29.4(9)	Moderate Sedation of Pediatric & Medically-Compromised Patients	Approved	10/27/2010
Townsend	James D.	29.4(9)	Moderate Sedation of Pediatric & Medically-Compromised Patients	Approved	10/27/2010
Reno	Catherine	29.6(1)"a-b"	Nitrous Oxide Training	Approved	3/2/2011
Bunker	Cassie	22.4(3)	Dental Radiology Training	Approved	3/2/2011
Iowa Dental Foundation		13.3(3)"b",(1-8)	Temporary Permits for Volunteer Services at IMOM Events	Partial Approval, Partial Denial	9/27/2011
Krook	Bruce	51.34(2)	If disciplined, 1 year waiting period prior to reinstatement	DENIED	3/2/2012
Fatah	Walid	11.4(1)	Foreign Graduate	Approved	3/2/2012
Oestervemb	Niels	11.4(1)	Foreign Graduate	Approved	7/12/2012
Scott	Kelly	22.4(3)	Dental Radiology Training	Approved	10/25/2012
Khan	Shiza	11.4(1)	Foreign Graduate	Approved	10/25/2012
Doughman	Heidi	20.15	Expanded Functions	Approved	10/25/2012
Austin	Desirea	20.15	Expanded Functions	Approved	10/25/2012
Jensen	Ryan	12.1	Licensure by Examination	DENIED	5/9/2013
Habib	Amr	11.4(1)	Foreign Graduate	Approved	5/9/2014
Hussong	Ryan	29.5(1)	Moderate Sedation Permit, Facility Requirements	Approved	7/31/2014
Meyer	Mackenzie	11.7(1)b	Local Anesthesia Permit Requirements	Approved	1/22/2015

Last Name	First Name	Rule/Subrule	Topic	Decision	Date of Ruling
Martin	Jessie	22.4(3)	Dental Radiology Training	DENIED	1/22/2015
Houston	Gina	11.7(1)b	Local Anesthesia Permit Requirements	Approved	7/23/2015
Pike	Rebecca	11.7(1)b	Local Anesthesia Permit Requirements	Approved	8/13/2015
Ruprecht	Axel	11.2(2)"d-e"	Licensure by Examination, Exam Type	Requested More Information	
Ceraso	Gregory	29.5(1)	Moderate Sedation Permit	Approved	10/22/2015
Mahrt	SuzAnne	10.4(153)	Ownership of a practice by an RDH	Pending Board Review	

***Last Updated 1/7/2016**

PORTFOLIO EXAMINATION CANDIDATE HANDBOOK 2014/2015



Dental Board of California

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Chapter 1 – Introduction

This Candidate Handbook is designed to provide information for students who elect the Portfolio Examination pathway to initial dental licensure.

The purpose of this handbook is to provide candidates with detailed information about the Portfolio Examination ("Portfolio"). The handbook includes information about patient criteria; subject matter areas assessed by the examination, and standardized rating (grading) criteria.

Chapter 2 – Background

History

In January 2007, the Board initiated the process of re-evaluating the California Clinical Examination, and worked with the dental schools in California to explore alternative methods of assessing dental school students for initial dental licensure.

The Portfolio Examination was born out of the desire to eliminate the need to administer a stand-alone examination to those student candidates who met the requirements set by the Board. While this new type of assessment would exceed the present requirements for testing on actual patients, it is also based on achieving a required number of clinical experiences.

The plan was to require clinical experiences in oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics and periodontics. Competency would be demonstrated through series of standardized competency examinations to be developed by committees of faculty from California dental schools. Calibration, standardization, verification and cooperation are the important components of this new and novel approach to assessing candidates for initial licensure in California.

By July 2008, the Board commissioned an analysis of assessment methods prior to determining the Portfolio Examination as a viable pathway to qualify for licensure in California. Assembly Bill 1524, sponsored by the Dental Board of California, abolished the clinical and written examination administered by the Dental Board of California and replaced that examination with a Portfolio Examination of a candidate's competence to enter the practice of dentistry.

In 2009, committees of faculty from six dental schools began work on developing patient parameters and grading criteria for the standardized evaluation system. The faculty represented all six dental schools: University of California, Los Angeles; University of California, San Francisco; Loma Linda University; University of the Pacific; University of Southern California; and Western University of Health Sciences.

Premise

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences ***and*** clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for specific procedures in six subject areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

Distinguishing characteristics

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set forth by the Standards for Educational and Psychological Testing.

- *Second*, the Portfolio Examination is a *summative* assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.

- *Third*, it includes components of clinical examinations similar to other clinical examinations, *and*, is administered in a manner that is similar to other clinical

examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.

- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and their progress can be monitored beyond the scope of the clinical experiences or competency examinations.

- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.

- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.

- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.

- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.

- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.

- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

Development

The Portfolio Examination has been developed by psychometric consultants for the Dental Board of California in collaboration with committees of dental faculty knowledgeable in the six subject areas. The Portfolio Examination meets the Standards for Educational and Psychological Testing (1999) set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. The Standards are used as a benchmark by the measurement profession as the

psychometric standards for validating all examinations, including licensing and certification examinations.

Because the Portfolio Examination is a state licensure examination, it also meets legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

Chapter 3 – General Information

Summary of requirements

AGE	• At least 18 years old
IDENTIFICATION NUMBER	• School will request a Portfolio Candidate Identification number for each candidate.
APPLICATION	• Complete the Board "Application for Law and Ethics Examination. • Complete the Board "Application for Determination of Licensure Eligibility (Portfolio)"
REQUIREMENTS	• Successful completion of all competency examinations specified for the Portfolio Examination • Certification of good academic standing by the dean of the student's dental school attended by the applicant such that the applicant is expected to graduate from said dental school; no pending ethical issues • Minimum number of clinical experiences • NBDE Passing Results • Passing the Dentistry Law and Ethics Examination • Certification of Licensure (If licensed in another country) • Submission of fingerprints

Application for Licensure by Portfolio

Applicants must include the following information in the "Application for Determination of Licensure Eligibility (Portfolio)."

a) Full legal name.
b) United States social security number.
c) Address of residency.
d) Mailing address, if different from address of residency.
e) Date of birth.
f) Telephone number (home and/or cell phone.)
g) Gender of applicant
h) A 2" by 2" passport style photograph of the applicant.
i) Information as to whether the applicant has ever taken the California Law and Ethics written examination.
j) Information regarding applicant's education including dental education and postgraduate study.
k) Information regarding whether the applicant has any pending or had in the past any charges filed against a dental license or other healing arts license.
l) Information regarding any prior disciplinary action(s) taken against the applicant regarding any dental license or other healing arts license held by

the applicant including actions by the United States Military, United States Public Health Service or other federal government entity. “Disciplinary action” includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning or any other restriction or action taken against a dental license. If an applicant answers “yes” he or she must provide the date of the effective date of disciplinary action, the state where the discipline occurred, the date(s), charges convicted of, disposition and any other information required by the Board.

m) Information as to whether the applicant is currently the subject of any pending investigation by any governmental entity. If the applicant answers “yes” he or she must provide any additional information requested by the Board.

n) Information regarding any instances in which the applicant was denied a dental license, denied permission to practice dentistry, or denied permission to take a dental board examination. If the applicant answers “yes” he or she must provide the state or country where the denial took place, the date of the denial, the reason for denial, and any other information requested by the Board.

o) Information as to whether the applicant has ever surrendered a license to practice dentistry in another state or country. If the applicant answers "yes" additional information must be provided including state or country of surrender, date of surrender, reason for surrender, and any other information requested by the Board.

p) Information as to whether the applicant has ever been convicted of any violation of the law in this or any other state, the United States, or other country, omitting traffic infractions under $1,000 not involving alcohol, dangerous drugs, or controlled substances. For the purposes of this section, “conviction” means a plea or verdict of guilty or a conviction following a plea of nolo contendere or “no contest” and any conviction that has been set aside or deferred pursuant to Sections 1000 or 1203.4 of the Penal Code, including infractions, misdemeanors, and felonies;

q) Information as to whether the applicant is in default on a United State Department of Health and Human Services education loan pursuant to Sections 685 of the Code.

r) A certification, under the penalty of perjury, by the applicant that the information on the application is true and correct.

Applicant mailing address

All mail from the Board will be sent to the mailing address indicated on the application. If an applicant changes his or her address or wishes information be sent to another address, he or she must notify the Board, in writing, of the change. Failure to notify the Board of a change of address may prevent the applicant from receiving relevant information.

Certification of good standing

An application for Determination of Licensure Eligibility (Portfolio) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board will not

issue a license, until receipt of a certification letter from the dean of the school attended by the applicant, certifying the date the applicant graduated on school letterhead with the school seal.

Submission of Portfolio to the Board

A candidate must arrange with the school to have his or her completed Portfolio submitted to the Board. The earliest date that a student may submit their portfolio for review by the Board will be 90 days before graduation. The Portfolio will not reviewed by the Board until the "Application for Determination of Licensure Eligibility (Portfolio) has been received along with the required fee.

The Application and completed Portfolio may be submitted for review within 90 days of graduation. The latest date upon which an Application and completed Portfolio must be submitted for review will be no more than 90 days after graduation.

Issuance of license

The Board will review the submitted Portfolio materials to determine that it is complete and that the candidate has met the requirements. Once approved, the candidate will be sent an "Application for Issuance of License Number and Registration of Place of Practice".

Criminal background check

California law requires all applicants to undergo, a criminal background check. Fingerprints can be obtained by using Live Scan. A dental license will not be issued until clearance has been received from the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

Live Scan is available only in California, for either residents or visitors, and is more efficient than the Ink on Cards method. To use the Live Scan method, download the Live Scan form, complete it and take it to a Live Scan service location. The Live Scan service location will require you to pay a fee to process your prints. Fees for this service may vary. Your fingerprints will be taken electronically, without ink, and transmitted to the California DOJ and FBI. Finally, the DOJ/FBI will send their report to the Dental Board. Usually the report is received within seven days. There is a low rate of rejections with this method.

For a list of Live Scan locations and a copy of the live scan form you may visit the Board's website at: http://www.dbc.ca.gov/formspubs/form_livescan_dds.pdf or call (916) 263-2300.

Schools offering the Portfolio Examination

Students who engage in the Portfolio Examination process will take standardized competencies at the school in which they are enrolled. A list of dental schools is presented below:

Location	School
Loma Linda	Loma Linda University School of Dentistry 11092 Anderson Street Loma Linda, California 92350
Los Angeles	University of California, Los Angeles School of Dentistry 10833 Le Conte Avenue Los Angeles, California 90024
	University of Southern California Ostrow School of Dentistry 925 West 34th Street Los Angeles, California 90089
Pomona	Western University of Health Sciences College of Dental Medicine 309 East Second Street Pomona, California 91766
San Francisco	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143
	University of the Pacific Arthur A. Dugoni School of Dentistry 2155 Webster Street San Francisco, California 94115

Chapter 4 – Board policies

The following rules are in addition to any other examination rules set forth elsewhere in this guide and are adopted for the uniform conduct of the Portfolio Examination.

Radiographs

Radiographs for Portfolio competency examinations must be of diagnostic quality either digital or conventional.

Infection control

Candidates are responsible for maintaining all of the standards of infection control while treating patients. This includes the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by OSHA and the Dental Practice Act.

Use of local anesthetics

Local anesthetics must be administered according to school protocol and standards of care. The type and amount of anesthetics must be consistent with the patient's medical history and current condition.

Use of dental dams

Dental dams must be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations will be graded <u>without</u> the dental dam in place.

Personal protective equipment

Candidates must wear masks, gloves and eye protection during this section of the examination.

Patients of record

Candidates will provide clinical services upon patients of record of the dental school who fulfill the acceptable patient selection criteria for each of the Portfolio competency examinations.

Identification numbers

Candidates will be assigned by the Board an identification number to be used for all Portfolio competency examinations prior to completing any competency examination.

Patient treatment session time limits

Candidates will be allowed 3 hours, 30 minutes for each patient treatment session.

Chapter 5 – Overview

Definitions

CANDIDATE	A dental student who is taking the examination for the purpose of applying to the Board for licensure.
CASE	A dental procedure which satisfies the required clinical experiences
CLINICAL EXPERIENCES	Procedures, performed with or without faculty intervention, that the candidate must complete to the satisfaction of his or her clinical faculty prior to submission of his or her portfolio examination application. Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge and skill level to reliably demonstrate competency.
COMPETENCY EXAMINATION	A candidate's final assessment in a portfolio examination competency performed without faculty intervention and graded by competency examiners registered with the Board.
CRITICAL ERROR	A critical error is a gross error that is irreversible or may impact the patient's safety and wellbeing.
PATIENT MANAGEMENT	The interaction between patient and candidate from initiation to completion of treatment, including any post-treatment complications that may occur.
PORTFOLIO	The cumulative documentation of clinical experiences and competency examinations submitted to the Board.
PORTFOLIO COMPETENCY EXAMINERS	The dental school faculty examiner. The portfolio competency examiner must be a faculty member chosen by the school, registered with the Board, and must be trained and calibrated to conduct and grade the portfolio competency examinations.
SCHOOL	A Board-approved dental school located in California.

Demonstrations of clinical experience

Each candidate must complete at least the minimum number of clinical experiences in each competency prior to submission of their Portfolio to the Board. Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences must be performed on patients under the supervision of dental school faculty and must be included in the Portfolio submitted to the Board. Clinical experience may be obtained at the dental school clinic, an extramural dental facility or a mobile dental clinic approved by the Board.

Required elements

The Portfolio Examination must contain documentation of the minimum clinical experiences and document of clinical competency examination as follows:

- Documentation that provides proof of satisfactory completion of a final assessment in the competency examinations prescribed by the Board. ”Satisfactory proof” means the portfolio has been approved by the designated dental school faculty.

Satisfactory evidence the candidate has completed the clinical experiences prescribed by the Board.

- Certification from the dean of the qualifying dental school attended by the applicant to certify the applicant has graduated with no pending ethical issues;
- Certification from the dean certifying the candidate will graduate with no pending ethical issues.

Competency examinations vs. clinical experiences

A competency examination is performed without faculty intervention; however, completion of a successful competency examination may be counted as a clinical experience for the purposes of the Portfolio Examination.

Guidelines

- Candidates perform Portfolio competency examinations independently without faculty intervention.

- Schools have the option of using the same faculty to grade each competency examination.

- Each of the schools will have designated faculty as competency examiners and is responsible for administering the Board approved calibration course for competency examiners.

- Each competency examination will be graded by two (2) examiners.

- If a candidate fails a Portfolio competency examination three (3) times, the candidate cannot take the same Portfolio competency examination until remedial education has been completed.

- Readiness for Portfolio competency examinations is determined by clinical faculty.

Portfolio examiners

The Board has outlined a process for selection of dental school faculty who wish to serve as a Portfolio competency examiner.

a) At the beginning of each school year, the Dean at each school submits a letter verifying the Portfolio examiner meets the requirements of the Board and includes the names, credentials and qualifications of the dental school faculty to be approved by the Board as Portfolio examiners. Documentation of qualifications must include, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner, shall be a full-time or part-time faculty member of a Board-approved California dental school, have a minimum of one (1) year of previous experience in administering clinical examinations, and undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods. Portfolio competency examiners are required to attend Board-approved standardized calibration training sessions offered at their schools prior to administering a competency examination and annually thereafter.

b) In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.

c) The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

Scoring

Each Portfolio competency examination will be graded by two (2) independent competency examiners in accordance with the Board's standardized rating (grading) criteria on forms prescribed by the Board. The Portfolio Examination must be signed by the school faculty Portfolio competency examiners for the prescribed competency.

Patient safety

If the patient's well-being is put into jeopardy at any time during the examination, the examination will be terminated. The candidate fails the examination, regardless of performance on any other part of the examination.

Critical errors

A critical error is a gross error that is irreversible, and/or may impact patient safety and wellbeing. If a candidate commits a critical error, the candidate cannot proceed with the examination.

If the candidate makes a critical error at any point during a Portfolio competency examination, a score of "0" is assigned and the Portfolio competency examination is terminated immediately.

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

Within a given competency examination, a low rating in one area can be offset by a higher rating in another area.

- For Oral Diagnosis and Treatment Planning, Endodontics, and Periodontics, a rating of "2" (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

- For Direct Restoration and Indirect Restoration, a rating of "3" (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

- For Removable Prosthodontics, a rating of "3" (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

Scaled scores

- Ratings for each Portfolio competency examination based on a total of rating points, rather than an average of rating points.

- Total points for each Portfolio competency examination will be converted to scaled scores to place them on a common metric.

- A scaled score of 75 is considered a passing score for each Portfolio competency examination.

Compensatory model

Within a given competency examination, a low rating in one area can be compensated by a higher score in another area.

For example, a candidate who achieves a scaled score 76 from one examiner and 74 from another examiner will be credited for a scaled score 150 based on total points.

Likewise, a candidate who achieves a scaled score of 75 from one examiner and 75 from another examiner will be credited with a scaled score 150 based on total points.

Chapter 6 – Oral Diagnosis and Treatment Planning

Purpose

The competency examination for oral diagnosis and treatment planning (ODTP) is designed to assess the candidate's ability to identify and evaluate patient data and clinical findings; formulate diagnoses; and plan treatment interventions from a multidisciplinary perspective.

Clinical experiences

The documentation of oral diagnosis and treatment planning clinical experiences will include a minimum of twenty (20) patient cases.

Clinical experiences for ODTP include:

- Comprehensive oral evaluations,
- Limited (problem-focused) oral evaluations, and
- Periodic oral evaluation

Each examination, ODTP clinical experience requires medical and dental history, identified problem(s), diagnoses, treatment plans, and informed consent.

Overview

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:

  > Periodontics
  > Endodontics
  > Operative (direct and indirect restoration)
  > Fixed and removable prosthodontics
  > Orthodontics
  > Oral surgery

Patient parameters

- Maximum of ASA II as defined by the American Society of anesthesiologists (ASA) Physical Status Classification System.
- Missing or will be missing two or more teeth, NOT including third molars.
- At least moderate periodontitis with probing depths of 5 mm or more.

Scoring

Scoring points for oral diagnosis and treatment planning are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- **A score of 2 is acceptable; minimum competence**
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

Elements of the ODTP Portfolio

The oral diagnosis and treatment planning portfolio may include, but is not limited to the following:

a) Patient's Medical history must include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.

b) Patient's Dental history must include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.

c) Documentation of a comprehensive examination for dental treatment provided to patients includes:

(1) Interpretation of radiographic series
(2) Performance of caries risk assessment
(3) Determination of periodontal condition
(4) Performance of a head and neck examination, including oral cancer screening
(5) Screening for temporomandibular disorders
(6) Assessment of vital signs
(7) Performance of a clinical examination of dentition
(8) Performance of an occlusal examination

d) Documentation the candidate evaluated data to identify problems. The documentation of the data evaluation includes:

(1) Chief complaint
(2) Medical problem
(3) Stomatognathic problems
(4) Psychosocial problems

e) Documentation the candidate worked-up the problems and developed a tentative treatment plan. The documentation of the work-up and tentative treatment plan includes:

(1) Problem definition, e.g., severity/chronicity and classification

(2) Determination if additional diagnostic tests are needed
(3) Development of a differential diagnosis
(4) Recognition of need for referral(s)
(5) Pathophysiology of the problem
(6) Short term needs
(7) Long term needs
(8) Determination interaction of problems
(9) Development of treatment options
(10) Determination of prognosis
(11) Patient information regarding informed consent

f) Documentation the candidate developed a final treatment plan. The documentation includes:

(1) Rationale for treatment
(2) Problems to be addressed, or any condition that puts the patient at risk in the long term
(3) Determination of sequencing with the following framework:

- Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications
- Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology
- Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization
- Restorative: operative, fixed, removable prostheses, occlusal splints, implants
- Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching
- Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management

ODTP scoring criteria

FACTOR 1: MEDICAL ISSUES THAT IMPACT DENTAL CARE

4	3	2	1	0
• Identifies and evaluates all medical issues • Explains dental implications of systemic conditions • Identifies and assesses patient medications	• Misses one item that would NOT cause harm	• Misses two items that would NOT cause harm	• Misses more than two items that would cause potential harm	Critical errors include: • Misses medical or medication items that would cause potential harm

FACTOR 2: TREATMENT MODIFICATIONS BASED ON MEDICAL CONDITIONS

4	3	2	1	0
• Identifies all treatment modifications	• Misses one item that would NOT cause harm	• Misses two items that would NOT cause harm	• Misses more than two items that would cause potential harm	Critical errors include: • Misses treatment modifications that would cause potential harm

FACTOR 3: PATIENT CONCERNS/CHIEF COMPLAINT

4	3	2	1	0
• Identifies all patient concerns including chief complaint	• Identifies chief complaint but misses one patient concern	• Identifies chief complaint but misses two patient concerns	• Identifies chief complaint but misses more than two patient concerns	Critical errors include: • Chief complaint NOT identified

FACTOR 4: DENTAL HISTORY

4	3	2	1	0
• Identifies all parameters in dental history	• Misses one parameter in dental history	• Misses two parameters in dental history	• Misses more than two parameters in dental history	Critical errors include: • Neglects to address dental history

FACTOR 5: SIGNIFICANT RADIOGRAPHIC FINDINGS

4	3	2	1	0
• Identifies all radiographic findings	• Misses one radiographic finding that does NOT substantially alter treatment plan	• Misses two radiographic findings that do NOT substantially alter treatment plan	• Misses more than two radiographic findings that do NOT substantially alter treatment plan	Critical errors include: • Misses radiographic findings that substantially alters treatment plan

FACTOR 6: CLINICAL FINDINGS

4	3	2	1	0
• Identifies all clinical findings	• Misses one clinical finding that does NOT substantially alter treatment plan	• Misses two clinical findings that do NOT substantially alter treatment plan	• Misses more than two clinical findings that do NOT substantially alter treatment plan	Critical errors include: • Misses clinical findings that substantially alter treatment plan

FACTOR 7: RISK LEVEL ASSESSMENT

4	3	2	1	0
• Risk level (risk factors/indicators and protective factors) identified • Relevance of risk level identified	• Risk level and relevance of risk level identified but misses one item (risk factors/ indicators and protective factors)	• Risk level and relevance of risk level identified but misses two items (risk factors/indicators and protective factors)	• Risk level identified but misses more than two items (risk factors/indicators and protective factors) • Relevance of risk level NOT identified	Critical errors include: • Risk level NOT identified

FACTOR 8: NEED FOR ADDITIONAL DIAGNOSTIC TESTS/REFERRALS

4	3	2	1	0
• Prescribes/acquires all clinically necessary diagnostic test and referrals with comprehensive rationale	• Identifies need for clinically necessary diagnostic tests and referrals with limited rationale	• Identifies need for additional diagnostic tests and referrals without rationale	• Identifies need for additional diagnostic tests and referrals without rationale and prescribes non-contributory test or referrals	Critical errors include: • Does NOT identify clinically necessary diagnostic tests or referrals

FACTOR 9: FINDINGS FROM MOUNTED DIAGNOSTIC CASTS

4	3	2	1	0
• Casts and mounting reflect patient's oral condition • Identifies all diagnostic findings from casts	• Casts and mounting reflect patient's oral condition • Misses one diagnostic finding that does NOT substantially alter treatment plan	• Casts and mounting reflect patient's oral condition but misses two diagnostic findings that do NOT substantially alter treatment plan	• Casts and mounting reflect patient's oral condition but misses more than two diagnostic findings that do NOT substantially alter treatment plan	Critical errors include: • Casts and mounting do NOT reflect patient's oral condition • Misses diagnostic cast findings that substantially alter treatment plan

FACTOR 10: COMPREHENSIVE PROBLEM LIST

4	3	2	1	0
• All problems listed	• One problem NOT identified without potential harm to patient	• Two problems NOT identified without potential harm to patient	• Two or more problems NOT identified without potential harm to patient	Critical errors include: • Problems with potential for harm to patient NOT identified

FACTOR 11: DIAGNOSIS AND INTERACTION OF PROBLEMS

4	3	2	1	0
• All diseases correctly diagnosed • All interactions identified	• One missed diagnosis or interaction without potential harm to patient	• Two missed diagnoses or interactions without potential harm to patient	• More than two missed diagnoses or interactions without potential harm to patient	Critical errors include: • Missed diagnosis or interaction resulting in potential harm to patient

FACTOR 12: OVERALL TREATMENT APPROACH

4	3	2	1	0
• All treatment options identified within standard of care; provides rationale which is optimal	• All treatment options identified within standard of care; provides acceptable rationale	• All treatment options identified within standard of care and lacks sound rationale for treatment	• Incomplete treatment options and lacks sound rationale for treatment	Critical errors include: • Treatment options presented are NOT within standard of care

FACTOR 13: PHASING AND SEQUENCING OF TREATMENT

4	3	2	1	0
• Treatment optimally phased and sequenced	• Treatment phased correctly but one procedure out of sequence with no harm to patient	• Treatment phased correctly but two procedures out of sequence with no harm to patient	• Treatment NOT phased correctly but no potential harm to patient	Critical errors include: • Treatment NOT phased nor sequenced with potential harm to patient

FACTOR 14: COMPREHENSIVENESS OF TREATMENT PLAN

4	3	2	1	0
• Treatment plan addresses all problems • All treatment procedures are indicated	• One treatment procedure that is NOT indicated but will NOT result in harm to patient but treatment plan addresses all problems	• Two or more treatment procedures that are NOT indicated but reflect problem list but treatment plan addresses all problems	• Two or more treatment procedures that are NOT indicated and do NOT reflect problem list • Treatment plan is incomplete but does NOT cause harm to patient	Critical errors include: • Treatment plan is incomplete and causes potential harm to patient • Treatment procedures included that are NOT indicated resulting in harm to patient • Treatment procedures are missing from treatment plan resulting in harm to patient

FACTOR 15: TREATMENT RECORD

4	3	2	1	0
• Summarizes all data collected, diagnoses, and comprehensive rationale for treatment options • Documents presentation of risks and benefits of all treatment options	• Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options and provides limited rationale	• Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options but provides no rationale	• Summarizes all data collected, diagnoses, and treatment options, and documents presentation of risks and benefits only for preferred option	Critical errors include: • Does NOT summarize all data collected, diagnoses and/or treatment options • Does NOT document presentation of risks and benefits of all treatment options

Chapter 7 - Direct Restoration

Purpose

The competency examinations for direct restoration are designed to assess the candidate's independent ability to restore teeth with interproximal primary carious lesions to optimal form, function and esthetics.

Clinical experiences

The documentation of direct restorative clinical experiences includes a minimum of sixty (60) restorations.

The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including:

- Amalgams,
- Composites,
- Crown buildups,
- Direct pulp caps, and,
- Temporizations.

Overview

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, <u>and</u>,
  - > Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Any treatment modifications needed are consistent with the patient's medical history.

Patient parameters

Class II – Any permanent <u>posterior</u> tooth

Treatment needs to be performed in the sequence described in the treatment plan

- More than one test procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.
- Caries as shown on either of the two required radiographic images of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Tooth to be treated must be in occlusion.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Tooth with bonded veneer is not acceptable.

Class III/IV – Any permanent anterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- Caries as shown on the required radiographic image of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Carious lesions must involve the interproximal contact area.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Approach must be appropriate for the tooth.
- Tooth with bonded veneer is not acceptable.
- The lesion is not acceptable if it is in contact with circumferential decalcification.

Scoring

Scoring points for direct restorations are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- **A score of 3 is acceptable; minimum competence**
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

Elements of the Direct Restoration Portfolio

The Direct Restoration portfolio may include, but is not limited to the following:

a) Documentation of the candidate's competency to perform a class II direct restoration on a tooth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials.

   The case selection must be based on minimum direct restoration criteria for any permanent posterior tooth. The treatment performed should follow the sequence of the treatment plan(s). More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs.

   The tooth involved in the restoration must have caries which penetrate the dento-enamel junction and must be in occlusion. Proximal caries must be in contact with at least one adjacent tooth, a natural tooth surface or a permanent restoration; provisional restorations or removal partial dentures are not acceptable adjacent surfaces. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment.

b) Documentation of the candidate's competency to perform a class III/IV direct restoration on a tooth containing primary carious lesions to optimal forms, function and esthetics using composite restorative material. The case selected must be on any permanent anterior tooth and treatment needs to be performed in the sequence described in the treatment plan.

   More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs. The tooth involved in the restoration must have caries which penetrate the dento-enamel junction.

   The tooth to be restored must have an adjacent tooth to be able to restore a proximal contact. Proximal surface of the dentition adjacent to the proposed restoration must be natural tooth structure or a permanent restoration, provisional restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth involved in the restoration must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment. The lesion is not acceptable if it is in contact with circumferential decalcification. The approach must be appropriate for the tooth. Teeth with bonded veneers are not acceptable.

Direct Restoration scoring criteria

FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
• Obtains informed consent • Presents a comprehensive review of medical and dental history • Provides rationale for restorative procedure • Proposes initial design of preparation and restoration • Demonstrates full understanding of the procedure	• Slight deviation from optimal case presentation	• Moderate deviation from optimal case presentation	• Major deviation from optimal case presentation	• Multiple major deviations from optimal case presentation	• Critical errors in assessing patient's medical and/or dental history • Unable to justify treatment • Proposed treatment would cause harm to patient • Proposed treatment not indicated • Misses critical factors in medical and/or dental review that affect treatment or patient well being

FACTOR 2: OUTLINE AND EXTENSIONS

5	4	3	2	1	0
• Optimal outline and extensions such as: > Smooth, flowing > Does not weaken tooth > Includes the lesion > Breaks proximal contacts as appropriate > Appropriate cavosurface angles > Optimal treatment of fissures > No damage to adjacent teeth > Optimal extension for caries/ > decalcification > Appropriate extension requests	• Slight deviation(s) from optimal; minimal impact on treatment	• Moderate, clinically acceptable deviation(s) from optimal; minimal impact on treatment	• Major deviation from optimal such as: > Irregular outline > Outline weakens the tooth > Does not include the lesion > Contacts not broken where appropriate > Proximal extensions excessive > Inappropriate cavosurface angle(s) > Inappropriate treatment of fissures > Adjacent tooth requires major recontouring > Inappropriate extension requests	• Multiple major deviations from optimal including: > Irregular outline > Outline weakens the tooth > Does not include the lesion > Contacts not broken where appropriate > Proximal extensions excessive > Inappropriate cavosurface angle(s) > Inappropriate treatment of fissures > Adjacent tooth requires major recontouring > Inappropriate extension requests	• Critical errors in outline and extensions • Deviations from optimal that are irreversible and have a significant impact on treatment • Damage to adjacent tooth that requires restoration

FACTOR 3: INTERNAL FORM

5	4	3	2	1	0
• Optimal internal form such as: > Optimal pulpal and axial depth > Optimal wall relationships > Optimal axio-pulpal line angles > Optimal internal refinement > All previous restorative material removed > Optimal caries removal > Preparation is clean and free of fluids and/or debris > Appropriate liners and bases > Appropriate extension requests	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Excessive or inadequate pulpal or axial depth > Inappropriate wall relationships > Inappropriate internal line angles > Rough or uneven internal features > Previous restorative material present > Inappropriate caries removal > Fluids and/or debris present > Inappropriate handling of liners and bases > Inappropriate extension requests	• Multiple, major deviations from optimal including: > Excessive or inadequate pulpal or axial depth > Inappropriate wall relationships > Inappropriate internal line angles > Rough or uneven internal features > Previous restorative material present > Inappropriate caries removal > Fluids and/or debris present > Inappropriate handling of liners and bases > Inappropriate extension requests	• Critical errors from optimal internal form • Noncarious pulp exposure

FACTOR 4: OPERATIVE ENVIRONMENT

5	4	3	2	1	0
• Soft tissue free of unnecessary damage • Proper patient comfort/pain management • Optimal isolation • Correct teeth isolated • Dam fully inverted • Clamp stable with no tissue damage • No leakage • Preparation can be accessed and visualized	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal <u>such as</u>: > Incorrect teeth isolated > Dam not inverted, causing leakage that may compromise the final restoration > Clamp is not stable or impinges on tissue > Preparation cannot be accessed or visualized to allow proper placement of restoration > Major tissue damage	• <u>Multiple</u> major deviations from optimal <u>including</u>: > Incorrect teeth isolated > Dam not inverted, causing leakage that may compromise the final restoration > Clamp is not stable or impinges on tissue > Preparation cannot be accessed or visualized to allow proper placement of restoration > Major tissue damage	• Critical errors from optimal in operative environment • Gross soft tissue damage • Gross lack of concern for patient comfort

FACTOR 5: ANATOMICAL FORM

5	4	3	2	1	0
• Optimal anatomic form such as: > Harmonious and consistent with adjacent tooth structure > Interproximal contour and shape are proper > Interproximal contact area and position are properly restored > Contact is closed > Height and shape of marginal ridge is appropriate	• Slight deviation(s) from optimal	Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Inconsistent with adjacent tooth structure > Interproximal contour and shape are inappropriate > Height and shape of marginal ridge is inappropriate	• Multiple major deviations from optimal including: > Inconsistent with adjacent tooth structure > Interproximal contour and shape are inappropriate > Height and shape of marginal ridge is inappropriate	• Critical errors that require restoration to be redone

FACTOR 6: MARGINS

5	4	3	2	1	0
• Optimal margins • No deficiencies or excesses	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Open margin, submarginal, and/or excess restorative material	• Multiple major deviations from optimal	• Critical errors that require restoration to be redone

FACTOR 7: FINISH AND FUNCTION

5	4	3	2	1	0
• Optimal finish and function such as: > Smooth with no pits, voids or irregularities in restoration > Occlusion is properly restored with no interferences > No damage to hard or soft tissue	• Slight deviation(s) from optimal	Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Significant pits, voids or irregularities in the surfaces > Severe hyper-occlusion or hypo-occlusion > Moderate damage to hard or soft tissue	• Multiple major deviations from optimal	• Critical errors that require restoration to be redone • Procedure is not completed within allotted time • Unnecessary, gross damage to hard and soft tissue as related to finishing procedure

Chapter 8 - Indirect Restoration

Purpose

The competency examinations for indirect restoration are designed to assess the candidate's independent ability to restore teeth requiring an indirect restoration to optimal form, function and esthetics with a full or partial coverage ceramic, metal or metal-ceramic indirect restoration.

Clinical experiences

The documentation of indirect restorative clinical experiences will include a minimum of fourteen (14) restorations.

The restorations completed in the clinical experiences may be a combination of the following procedures:

> Inlays,
> Onlays,
> Crowns,
> Abutments,
> Pontics,
> Veneers,
> Cast posts,
> Overdenture copings, or
> Dental implant restorations.

Overview

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:
  > Ceramic restoration must be onlay or more extensive
  > Partial gold restoration must be onlay or more extensive
  > Metal ceramic restoration (PFM)
  > Full gold restoration
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management; candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Any treatment modifications needed must be consistent with the patient's medical history.

Patient parameters

- Treatment needs to be performed in the sequence described in the treatment plan
- Tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.
- Tooth must be in occlusal contact with a natural tooth or a permanent restoration. Occlusion with a full or partial denture is not acceptable.
- The restoration must include at least one cusp.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.
- The tooth must require an indirect restoration at least the size of an onlay or greater. The tooth cannot replace existing or temporary crowns.
- The candidate may not have performed any portion of the crown preparation in advance.
- Direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration (buildups) may be completed ahead of time, if needed.
- Restoration must be completed on the same tooth and same patient by the same candidate.
- Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.
- Teeth with cast post are not allowed.
- A facial veneer is not acceptable.

Scoring

Scoring points for indirect restoration are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- **A score of 3 is acceptable; minimum competence**
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

Elements of the Indirect Restoration Portfolio

The Indirect Restoration portfolio may include, but is not limited to the following:

a) Documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restorations. The treatment needs to be performed in the sequence in the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be in need of endodontic treatment. The tooth selected for restoration, must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of the onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

b) Documentation of the candidate's competency to complete a partial gold restoration must be an onlay or more extensive indirect restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

c) Documentation of the candidate's competency to perform a full gold restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

d) Documentation of the candidate's competency to perform a metal-ceramic restoration. The treatment must be performed in the sequence of the treatment

plan. The tooth must be asymptomatic with no pulpal or periapical pathosis: cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restorations must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient.

e) A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.

Indirect Restoration scoring criteria

FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
• Obtains informed consent • Presents a comprehensive medical and dental review • Provides rationale for restorative procedure • Proposes initial design of restoration • Provides method for provisionalization • Demonstrates full understanding of the procedure • Sequencing of treatment follows standards of care	• Slight deviations from optimal case presentation	• Moderate deviations from optimal case presentation	• Major deviation from optimal case presentation • Provides inappropriate justification for treatment • Sequencing of treatment does not follow standards of care	• Multiple major deviations from optimal case presentation	• Critical errors in assessing patient's medical and/or dental history • Unable to justify treatment • Proposed treatment would cause harm to patient • Proposed treatment not indicated • Misses critical factors in medical and dental review that affect treatment or patient well being

FACTOR 2: PREPARATION

5	4	3	2	1	0
• Meets all accepted criteria for optimal preparation: a) Occlusal /incisal reduction b) Axial reduction c) Finish lines d) Caries removal e) Pulpal protection f) Soft tissue management g) No damage to soft and hard tissues h) Resistance and retention i) Debridement	• Slight deviations from optimal; minimal impact on treatment	• Moderate, clinically acceptable deviations from optimal; minimal impact on treatment	• Major deviation from optimal but correctable without significantly changing the procedure	• Multiple major deviations from optimal preparation	• Critical errors that are irreversible and have a significant impact on treatment • Critical errors that require major modifications of the proposed treatment such as: a) Onlay that must change to full crown b) Overextension requiring crown lengthening

FACTOR 3: IMPRESSION

5	4	3	2	1	0
• Achieves optimal, clinically acceptable impression achieved in one attempt a) Impression extends beyond finish lines b) Detail of preparation and adjacent teeth captured accurately c) Free of voids in critical areas d) No aspect of impression technique that would result in inaccuracy e) Interocclusal record is accurate, if needed	• Achieves clinically acceptable impression in second attempt	• Achieves clinically acceptable impression more than two attempts	• Major deviation that require retaking impression <u>such as</u>: > Lack of recognition of unacceptable impression or interocclusal relationship	• <u>Multiple</u> major deviations from optimal in impression <u>including</u>: > Lack of recognition of unacceptable impression or interocclusal relationship	• failure to achieve a clinically acceptable impression after five (5) attempts • Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures

FACTOR 4: PROVISIONAL

5	4	3	2	1	0
• Meets all accepted criteria for optimal provisional: a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics	• Slight deviations from optimal have minimal impact on treatment	• Moderate deviations from accepted criteria have minimal impact on treatment	• Major deviation from optimal that can be corrected <u>such as</u>: > Lack of recognition of major deviation that can be corrected	• <u>Multiple</u> major deviations that have significant impact on treatment <u>including</u>: > Lack of recognition of major deviation that can be corrected	• Critical errors that are clinically unacceptable

FACTOR 5: CANDIDATE EVALUATION OF LABORATORY WORK

5	4	3	2	1	0
• Verifies that restoration meets all accepted criteria • Verifies errors in restoration and proposes changes, if needed	• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment	• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment	• Lack of recognition of major deviation from optimal that can be corrected	• Lack of recognition of multiple major deviations from optimal	• Critical errors that require restoration to be redone

FACTOR 6: PRE-CEMENTATION

5	4	3	2	1	0
• Meets all accepted criteria for pre-cementation: a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics i) Patient acceptance	• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment	• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment	• Lack of recognition of major deviation that can be corrected	• Lack of recognition of multiple major deviations from optimal	• Lack of recognition of critical errors which cannot be corrected

FACTOR 7: CEMENTATION AND FINISH

5	4	3	2	1	0
• Meets all accepted criteria for optimal cementation a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics i) All excess cement removed j) No unnecessary tissue trauma k) Appropriate postoperative instructions	• Slight deviations from optimal; minimal impact on treatment	• Moderate deviations from accepted criteria; minimal impact on treatment	• Major deviation from accepted that can be corrected	• Multiple major deviations from optimal	• Critical errors which require restoration to be redone • Procedure is not completed within allotted time • Unnecessary, gross damage to hard and soft tissue as related to finishing

Chapter 9 - Removable Prosthodontics

Purpose

The purpose of the competency examinations for removable prosthodontics are designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a prosthesis from diagnosis and treatment planning to delivery of the prosthetic device and post-insertion follow-up.

Clinical experiences

The documentation of removable prosthodontic clinical experiences must include a minimum of five (5) prostheses.

One of the five prostheses may be used as a Portfolio competency examination provided that it is completed in an independent manner with no faculty intervention.

A prosthesis is defined to include any of the following:

> Full denture,
> Partial denture (cast framework),
> Partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth),
> Immediate treatment denture, or,
> Overdenture retained by natural tooth or dental implants.

Overview

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient
    > Denture or overdenture for a single edentulous arch, or,
    > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture.
- No patient sharing; cannot split patients between candidates.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Any treatment modifications must be consistent with the patient's medical history.

- Case complexity cannot exceed the American College of Prosthodontics Class II for partially edentulous patients.

Patient parameters

Procedures must be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.

Scoring

Scoring points for removable prosthodontics are defined as follows:

- A score of 1 is unacceptable with gross errors
- A score of 2 is unacceptable with major errors
- **A score of 3 is minimum competence with moderate errors that do not compromise outcome**
- A score of 4 is acceptable with minor errors that do not compromise outcome
- A score of 5 is optimal with no errors evident

Elements of the Removable Prosthodontics Portfolio

a) Documentation the candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation must include, but is not limited to the following:

- Evidence the candidate obtained a patient history, (e.g. medical, dental and psychosocial).
- Evaluation of the patient's chief complaint.
- Radiographs and photographs of the patient.
- Evidence the candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).
- Evaluation of existing prosthesis and the patient's concerns.
- Evidence the candidate obtained and mounted a diagnostic cast.
- Evidence the candidate determined the complexity of the case based on ACP classifications.
- Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).
- Evidence the candidate analyzed the patient risks/benefits for the various treatment options.
- Evidence the candidate exercised critical thinking and made evidence based treatment decisions.

b) Documentation of the candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentations must include but is not limited to the following:

- Evidence the candidate developed a diagnosis and treatment plan for the removable prosthesis.
- Evidence the candidate obtained diagnostic casts.
- Evidence the candidate performed diagnostic wax-up/survey framework designs.
- Evidence the candidate performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.
- Evidence the candidate performed tooth modifications and/or survey crowns, when indicated.
- Evidence the candidate obtained master impressions and casts.
- Evidence the candidate obtained occlusal records.
- Evidence the candidate performed a try-in and evaluated the trial dentures.
- Evidence the candidate inserted the prosthesis and provided the patient with post-insertion care.
- Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

c) Documentation of the candidate's competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation must include, but is limited to the following:

- Evidence the candidate developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.
- Evidence the candidate educated the patient regarding the healing process, denture experience, and future treatment need.
- Evidence the candidate developed prosthetic phases which included surgical plans.
- Evidence the candidate obtained casts (preliminary and final impressions).
- Evidence the candidate obtained the occlusal records.
- Evidence the candidate did try-ins and evaluated trial dentures.
- Evidence the candidate competently managed and coordinated the surgical phase.
- Evidence the candidate provided the patient post insertion care including adjustment, relines and patient counseling.
- Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

d) Documentation of the candidate's competency to manage prosthetic problems. The documentation must include, but is not limited to the following:

- Evidence the candidate competently managed real or perceived patient problems.
- Evidence the candidate evaluated existing prosthesis.
- Evidence the candidate performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.
- Evidence the candidate made a determination if specialty referral was necessary.
- Evidence the candidate obtained impressions/records/information for laboratory use.
- Evidence the candidate competently communicated needed prosthetic procedure to laboratory technician.
- Evidence the candidate inserted the prosthesis and provided the patient follow-up care.
- Evidence the candidate performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).

e) Documentation the candidate directed and evaluated the laboratory services for the prosthesis. The documentation must include, but is not limited to the following:

- Complete laboratory prescriptions sent to the dental technician.
- Copies of all communications with the laboratory technicians.
- Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

Removable Prosthodontics scoring criteria

FACTOR 1: PATIENT EVALUATION AND DIAGNOSIS

5	4	3	2	1
• Evaluation and diagnosis is comprehensive and discriminating • Recognizes significant diagnostic implications of all findings	• Recognizes significant diagnostic implications but misses some findings that do NOT affect diagnosis	• Recognizes significant findings <u>but</u> there are errors in findings or judgment that do NOT compromise diagnosis	• Does NOT recognize significant findings or diagnostic implications • Diagnosis is jeopardized	• <u>Gross</u> errors in evaluation or judgment • <u>Gross</u> errors in diagnosis

FACTOR 2: TREATMENT PLAN AND SEQUENCING

5	4	3	2	1
• Presents/ formulates all treatment options and understands clinical nuances of each option • Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination • Performs risk-based analysis to present appropriate treatment options and prognosis • Demonstrates critical thinking as evidenced in steps in treatment plan • No errors in planning and sequencing	• Presents/formulates most treatment options and understands rationale of each option • Treatment plan is appropriate some contributing factors NOT considered • Minor errors that do NOT affect planning and sequencing	• Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis • Moderate errors that do NOT compromise planning and sequencing	• Does NOT address patient's chief complaint • Treatment plan NOT based on diagnosis • Major errors in evidenced based, critical thinking, risk-based, and prognostic assessment • Treatment sequence inappropriate	• Treatment plan NOT based on diagnostic findings or prognostic information • Treatment plan grossly inadequate • Treatment sequence grossly inappropriate

FACTOR 3: PRELIMINARY IMPRESSIONS

5	4	3	2	1
• Perform and recognize adequate capture of anatomy; free of distortions and voids	• Performs impression with minor errors that do NOT affect final outcome	• Performs impression with moderate errors that do NOT compromise final outcome	• Performs impression with major errors, or fails to recognize that final outcome is compromised	• Inadequate capture of anatomy or gross distortion/voids • Fails to recognize that subsequent steps are impossible

FACTOR 4: RPD DESIGN (IF APPLICABLE)

5	4	3	2	1
• Design demonstrates understanding of biomechanical and esthetic principles • Casts are surveyed accurately • Design is drawn with detail	• Design demonstrates understanding of biomechanical and esthetic principles with minor errors • Minor errors in cast survey and design	• Design is functional but includes rests, clasp assembly or major connector that are NOT first choices • Moderate errors in survey and design • Moderate errors in understanding of RPD design principles	• Demonstrates lack of understanding of biomechanical or esthetic principles • Major errors in cast survey and design	• Design is grossly inappropriate • Inaccurate survey • Illegible drawing

FACTOR 5: TOOTH MODIFICATION (IF APPLICABLE)

5	4	3	2	1
• Parallel guiding planes • Optimal size and location of rest preparations • Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane • Survey crowns as needed	• Minor deficiencies in tooth modification; RPD fit and service unaffected	• Moderate deficiencies in tooth modifications but no compromise in RPD fit and service	• Major errors in tooth modifications leading to compromised RPD fit and service • Tooth modifications may require restorations	• RPD abutment teeth are grossly over-prepared

FACTOR 6: BORDER MOLDING AND FINAL IMPRESSIONS

5	4	3	2	1
• Obtain optimal vestibular extension and peripheral seal • Perform and recognize adequate capture of anatomy • Impression free of distortions/voids	• Border molding and/or impression have minor errors that do NOT affect final outcome	• Border molding and/or impression have moderate deviations that do NOT compromise final outcome	• Border molding and/or impression have major errors that affect final outcome	• Border molding and/or impression do NOT adequately capture of anatomy or gross distortion/voids so that final outcome impossible

FACTOR 7: FRAMEWORK TRY-IN (IF APPLICABLE)

5	4	3	2	1
• Perform and recognize functional and occlusal adjustment • Complete seating of framework is achieved • Determine sequence for establishing denture-base support	• Minor deficiencies in ability to recognize and correct minor discrepancies in framework fit but do NOT affect RPD service	• Moderate deficiencies in ability to recognize or correct discrepancies in framework fit but no significant compromise to RPD service	• Major errors in framework fit NOT recognized • Errors in judgment regarding sequence of correction	• Gross errors in framework fit NOT recognized • Unable to determine sequence of correction

FACTOR 8: JAW RELATION RECORDS

5	4	3	2	1
• Smooth record bases with appropriate peripheral extensions/ thickness • Smoothly contoured wax rim establishes esthetic parameters • Vertical dimension is physiologically appropriate • Accurately captures centric relation • Relates opposing casts without interference	• Minor discrepancies in jaw relation records that do NOT adversely affect prosthetic service	• Moderate discrepancies in jaw relation records that do NOT compromise prosthetic service; records do NOT require repeating	• Major errors in jaw relation records that adversely affect prosthetic service; records should be redone	• Gross errors in jaw relation records with poor understanding and judgment; records should be redone

FACTOR 9: TRIAL DENTURES

5	4	3	2	1
• Recognizes optimal esthetic (midline, incisal length, tooth mold and shade, arrangement), occlusal (MIP=CR, VDO < VDR, bilateral posterior contact), speech and contour aspects of trial dentures • Deviations from the optimal are corrected or managed appropriately	• Minor deficiencies in ability to recognize and correct discrepancies in esthetics, vertical dimension, occlusion, phonetics and contour	• Moderate deficiencies in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which do NOT compromise final outcome	• Major errors in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which adversely affect final outcome	• Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome

FACTOR 10: INSERTION OF REMOVABLE PROSTHESIS

5	4	3	2	1
• Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following: > Tissue fit > Prosthetic support, stability and retention > RPD extension base tissue support > Vestibular extension and bulk > Occlusion; clinical remount required > Phonetics > Contours and polish > Patient home care instructions	• Minor discrepancies in judgment and/or performance of optimizing prosthesis fit and function; no adverse effect on prosthesis service	• Moderate discrepancies in judgment and performance of optimizing prosthesis fit/function; no compromise on prosthesis service	• Major errors in judgment and performance of optimizing prosthesis fit/function • Prosthesis service adversely affected; may require significant correction of prosthesis	• Gross errors in judgment and performance results in failure of prosthesis with no possibility to correct; prosthesis must be redone

FACTOR 11: POST-INSERTION (1 WEEK)

5	4	3	2	1
• Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis • Enroll patient in maintenance program • Demonstrate familiarity with common prosthesis complications and solutions	• Minor discrepancies in ability to evaluate and solve prosthesis problems; no effect on patient comfort and function	• Moderate discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function	• Major errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function	• Gross errors in ability to evaluate and solve prosthesis problems • Patient confidence is compromised

FACTOR 12: LABORATORY SERVICES FOR PROSTHESIS

5	4	3	2	1
• Prescription clearly communicates desired laboratory work and materials • Complies with infection control protocols between clinic and laboratory environments • Accurately evaluates laboratory work products	• Prescription, or management of laboratory services has minor errors that do NOT adversely affect prosthesis	• Prescription, or management of laboratory services has moderate discrepancies that do NOT compromise prosthesis	• Prescription, or management of laboratory services, has major errors that adversely affect prosthesis	• Prescription, or management of laboratory services has gross errors that result in prosthesis failure

Chapter 10 - Endodontics

Purpose

The purpose of the competency examination for endodontics is designed to assess the candidate's independent ability to demonstrate clinical skills in all aspects of a case from diagnosis to completion of conventional nonsurgical endodontic interventions.

Clinical experiences

The documentation of endodontic clinical experiences on patients must include five (5) canals or any combination of canals in three separate teeth.

Overview

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient's medical and dental history.
- Any treatment modifications must be consistent with the patient's medical history.

Patient parameters

- Any tooth to completion by the same candidate clinician on the same patient.
- Completed case means a tooth with an acceptable and durable coronal seal.

Scoring

Scoring points for endodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- **A score of 2 is acceptable; minimum competence**
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

Elements of the Endodontics Portfolio

The Endodontics portfolio must include, but is not limited to the following:

a) Documentation the candidate applied case selection criteria for endodontic cases. The Portfolio must contain evidence the cases selected met American Association of Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previously completed or initiated endodontic therapy.

- Candidate determines a diagnostic need for endodontic therapy.
- Candidate performs charting and diagnostic testing
- Candidate took and interpreted radiographs of the patient oral condition.
- Candidate made a pulpal diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the pulpal diagnosis was within approved parameters (within normal pulp, reversible pulpitis, irreversible pulpitis, necrotic pulp).
- Candidate makes a periapical diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the periapical diagnosis was within approved parameters (normal pulp, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, and chronic apical abscess).
- Evidence the candidate developed an endodontic treatment plan that included trauma treatment, management of emergencies and referrals when appropriate. An appropriate treatment may include an emergency treatment due to a traumatic dental injury or for relief of pain or acute infection. The endodontic treatment may be done at a subsequent appointment.

b) Documentation the candidate performed pretreatment preparation for endodontic treatment. Documentation must include, but is not limited to the following:

- Evidence the candidate competently managed the patient's pain.
- Evidence the candidate removed caries and failed restorations.
- Evidence the candidate determined the tooth restorability.
- Evidence the candidate achieved isolation with a dental dam.

c) The candidate competently performed access opening. Documentation must include, but is not limited to the following:

- Evidence the candidate created the indicated outline form.
- Evidence the candidate created straight line access.
- Evidence the candidate maintained structural integrity.
- Evidence the candidate completed un-roofing of pulp chamber.
- Evidence the candidate identified all canal systems.

d) Documentation the candidate performed proper cleaning and shaping techniques. Documentation must include, but is not limited to the following:

- Evidence the candidate maintained canal integrity.
- Evidence the candidate preserved canal shape and flow.
- Evidence the candidate applied protocols for establishing working length.
- Evidence the candidate demonstrated apical control.
- Evidence the candidate applied disinfection protocols.

e) Documentation the candidate performed proper obturation protocols. Documentation must include, but is not limited to evidence the candidate applied obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.

f) Documentation the candidate demonstrated proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height.

g) Documentation the candidate competently completed the endodontic case including evidence that the candidate achieved coronal seal to prevent re-contamination and the candidate created diagnostic, radiographic and narrative documentation.

h) Documentation the candidate provided recommendations for post-endodontic treatment, including evidence that the candidate recommended final restoration alternatives and provided the patient with recommendations for outcome assessment and follow-up.

Endodontics scoring criteria

FACTOR 1: PRETREATMENT CLINICAL TESTING AND RADIOGRAPHIC IMAGING

4	3	2	1	0
• Clinical tests and radiographic imaging completed and recorded accurately • Radiographic images are of diagnostic quality	• Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies	• Some clinical tests and radiographic images are lacking <u>but</u> diagnosis can be determined	• Some clinical tests and radiographic images are lacking <u>and</u> diagnosis is questionable	Critical errors <u>include</u>: • Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined • Radiographic images are missing or are NOT of diagnostic quality

FACTOR 2: ENDODONTIC DIAGNOSIS

4	3	2	1	0
• Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images	• Establishes correct pulpal and periapical diagnosis with accurate interpretation, <u>but</u> missing <u>one</u> clinical test and/or radiographic image	• Establishes correct pulpal and periapical diagnosis with adequate interpretation, <u>but</u> missing <u>multiple</u> clinical tests and radiographic images that do NOT impact diagnosis	• Establishes inaccurate pulpal or periapical diagnosis, <u>and</u> missing <u>multiple</u> clinical tests and radiographic images that impact diagnosis	Critical errors <u>include</u>: • Demonstrates lack of understanding of endodontic diagnosis • No clinical tests were done

FACTOR 3: ENDODONTIC TREATMENT PLAN

4	3	2	1	0
• Prognosis of treatment outcomes determined • Comprehensive evaluation of medical and dental history • Selects appropriate treatments based on clinical evidence • Understands complexities of the case such that all treatment risks identified • Informed consent obtained including alternative treatments	• Prognosis of treatment outcomes determined and adequate evaluation of medical and dental history • Selects appropriate treatment(s) • Significant treatment risks identified • Informed consent obtained	• Prognosis of treatment outcomes determined and minimal evaluation of one of the following: > Medical or dental history > Appropriate treatment(s) selected, > Most treatment risks identified, >Informed consent obtained	• Prognosis of treatment outcomes unclear • Inadequate evaluation of medical and dental history despite appropriate treatments selected • Key treatment risks NOT identified	Critical errors include: • Demonstrates lack of evaluation of relevant medical and dental history • Inappropriate treatment planning • No treatment risks identified • No informed consent obtained • Demonstrates inappropriate case selection • Prognosis of treatment outcomes NOT determined

FACTOR 4: ANESTHESIA AND PAIN CONTROL

4	3	2	1	0
• Thorough knowledge of technique and materials used • Monitors vital signs and patient response throughout anesthesia • Anesthesia administration effective	• Thorough knowledge of technique • Profound anesthesia achieved • Monitors patient response throughout anesthesia	• Can proceed with treatment without faculty assistance • Adequate anesthesia achieved	• Elements of anesthesia or pain control absent but patient care NOT compromised	Critical errors include: • Incorrect anesthetic technique • Inadequate pain control and patient care is compromised • Requires faculty assistance

FACTOR 5: CARIES REMOVAL, REMOVAL OF FAILING RESTORATIONS, EVALUATION OF RESTORABILITY, SITE ISOLATION

4	3	2	1	0
• Complete removal of visible caries • Removal of failing restoration • Establishes complete structural restorability • Achieves complete isolation with dental dam	• No visible caries and failing restorations removed • Establishes significant aspects of structural restorability and achieves effective isolation with dental dam	• No visible caries present • Establishes likely restorability and achieves adequate isolation with dental dam	• Caries removal compromised that potentially impacts procedure • Compromised coronal seal	Critical errors include: • Gross visible caries • Failing restoration present • Nonrestorable excluding medical indications • Ineffective isolation

FACTOR 6: ACCESS OPENING

4	3	2	1	0
• Optimum outline and access form with no obstructions • All canals identified • Roof and pulp horns removed	• Slight underextension of outline form but walls smooth but all canals identified and roof and pulp horns removed	• Moderate under- or overextension of outline form, minor irregularities for wall smoothness but all canals identified and roof and pulp horns removed	• Crown integrity compromised by overextension but tooth remains restorable • All canals identified but minor roof and pulp horns remain	Critical errors include: • Tooth is NOT restorable after access procedure or perforation • Structural compromise • Canal(s) missed or unidentified

FACTOR 7: CANAL PREPARATION TECHNIQUE

4	3	2	1	0
• Optimum canal length determination and preparation within 0.5-1.0 mm of radiographic apex • Maintenance of original canal position and integrity	• Adequate canal length determination and preparation within 1.5 mm short of radiographic apex • Mild deviations of original canal shape	• Acceptable canal length determination and preparation within 2 mm short of working length • Moderate deviations of original canal shape	• Canal length and preparation shorter than original working length • Canal length > 2 mm short or 1 mm long of radiographic apex • Severe deviations of original canal shape but treatable • Separated instrument that does NOT prevent canal preparation	Critical errors include: • Working length determination > 2 mm short or long of radiographic apex • Sodium hypochlorite accident • Canal perforated or NOT treatable • Separated instrument preventing canal preparation

FACTOR 8: MASTER CONE FIT

4	3	2	1	0
• Optimum cone fit and length verified within 0.5-1.0 mm of radiographic apex • Maintenance of canal position and integrity as demonstrated in cone fit	• Adequate cone fit and length verified within 1.5 mm short of radiographic apex • Mild deviations of original canal shape	• Acceptable cone fit and length verified within 2 mm short radiographic apex • Moderate deviations of original canal shape • Achieves tugback before lateral obturation	• Cone length determination > 2 mm short or long from radiographic apex • Cone fit > 2 mm short or > 1 mm long of radiographic apex	Critical errors include: • Master cone too small or too large and/or cone fit >2 mm short or long of radiographic apex

FACTOR 9: OBTURATION TECHNIQUE

4	3	2	1	0
• Achieves dense fill within 0.5-1.0 mm short of radiographic apex • None or minor overextension of sealer • No solid core material overextended	• Achieves dense fill within the apical two-thirds and less than 1.5 mm short of radiographic apex • Less than 1 mm of sealer extruded	• Achieves dense fill in apical third without voids • Solid core material 1.5- 2.0 mm short or 1 mm long of radiographic apex • 1-2 mm of sealer extruded	• Apical third has slight to moderate voids • Solid core material 2-3 mm short or 1-2 mm long • More than 2 mm of sealer extruded	Critical errors include: • Solid core material greater than 3 mm short or greater than 2 mm long of radiographic apex and/or significant voids throughout fill

FACTOR 10: COMPLETION OF CASE

4	3	2	1	0
• Optimum coronal seal placed prior to permanent restoration • Optimum evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes • Evidence of comprehensive and inclusive post-operative instructions	• Effective coronal seal placed prior to permanent restoration • Thorough evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes and evidence of post-operative instructions	• Acceptable durable coronal seal placed • Acceptable documentation; e.g., radiographs, clinical notes, assessment of outcomes and evidence of post-operative instructions	• Acceptable coronal seal placed with limited longevity • Evidence of incomplete documentation • Evidence of incomplete post-operative instructions	Critical errors include: • Poor coronal seal • Prognosis likely impacted by iatrogenic treatment factors • Improper or no documentation • No evidence of post-operative instruction

Chapter 11 - Periodontics

Purpose

The competency examinations for periodontics are designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a case from treatment planning to patient management.

Clinical experiences

The documentation of periodontal clinical experiences must include a minimum of twenty five (25) cases.
A periodontal experience must include, but is not limited to:

> An adult prophylaxis,
> Treatment of periodontal disease such as scaling and root planing,
> Any periodontal surgical procedure, and,
> Assisting on a periodontal surgical procedure when performed by a faculty or an advanced dental education candidate in periodontics

The combined clinical periodontal experience must include a minimum of five (5) quadrants of scaling and root planing procedures.

Overview

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan.
  - Part B. Calculus detection and effectiveness of calculus removal.
  - Part C. Periodontal re-evaluation.
- All three parts are to be performed on the <u>same</u> patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.

Patient parameters

a) Examination, diagnosis and treatment planning
   - Minimum twenty (20) natural teeth with at least 4 molars
   - At least one probing depth of 5 mm or greater must be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater
   - Full mouth assessment or examination
   - No previous periodontal treatment at the dental school, and no nonsurgical or surgical treatment within past 6 months

b) Calculus detection and periodontal instrumentation (scaling and root planing)

   - Minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar.
   - Third molars can be used but they must be fully erupted
   - At least one probing depth of 5 mm or greater must be present on at least two (2) of the teeth that require scaling and root planing.
   - Minimum of six (6) surfaces of clinically demonstrable subgingival calculus must be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus must be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual.
     If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

c) Re-evaluation

   - Candidate must have a thorough knowledge of the case
   - Candidate must perform at least two (2) quadrants of scaling and root planing on the patient being reevaluated
   - Candidate must perform at least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing should have been completed within an interval of 6 weeks or less.
   - Minimum twenty (20) natural teeth with at least four (4) molars
   - Baseline probing depth of at least 5 mm on at least four (4) of the teeth, excluding third molars

Scoring

Scoring points for periodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- **A score of 2 is acceptable; minimum competence**
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

Elements of the Periodontics Portfolio

a) Documentation the candidate performed a comprehensive periodontal examination. The comprehensive periodontal examination must include, but is not limited to the following:

(1) Evidence the candidate reviewed the patient's medical and dental history.
(2) Evidence the candidate evaluated the patient's radiographs.
(3) Evidence the candidate performed extra- and intra-oral examinations of the patient.
(4) Evidence the candidate performed comprehensive periodontal data collection.
- Evidence the candidate evaluated the patient's plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment, tooth mobility and furcations
- Evidence the candidate performed an occlusal assessment

b) Documentation the candidate diagnosed and developed a periodontal treatment plan. The documents must include:

(1) The candidate determined the periodontal diagnosis.
(2) The candidate formulated an initial periodontal treatment plan that demonstrated the candidate:

- Determined to treat or refer the patient.
- Discussed with patient the etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions.
- Determined non-surgical periodontal therapy.
- Determined need for re-evaluation.
- Determined recall interval.

c) Documentation the candidate performed nonsurgical periodontal therapy. The documents must include:

(1) Detected supra- and subgingival calculus
(2) Performed periodontal instrumentation:
- Removed calculus
- Removed plaque
- Removed stains

(3) Demonstrated that the candidate did not inflict excessive soft tissue trauma
(4) Demonstrated that the candidate provided the patient with anesthesia

d) Documentation the candidate performed periodontal re-evaluation. The documents must include:

(1) Evidence the candidate evaluated effectiveness of oral hygiene
(2) Evidence the candidate assessed periodontal outcomes:
- Reviewed the medical and dental history
- Reviewed the patient's radiographs
- Performed comprehensive periodontal data collections (e. g. , evaluation of plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility

(3) Evidence the candidate discussed with the patient his/her periodontal status as compared to the baseline, patient-specific oral hygiene instructions and modifications of specific risk factors
(4) Evidence the candidate determined further periodontal needs including the need for referral to a periodontist and periodontal surgery.
(5) Evidence the candidate established a recall interval for periodontal treatment.

Periodontics scoring criteria

FACTOR 1: REVIEW MEDICAL AND DENTAL HISTORY (Part A)

4	3	2	1	0
• Demonstrates complete knowledge and understanding of implications to dental care • Provides clear presentation of case	• Demonstrates complete understanding of implications to dental care but presentation could be improved	• Recognizes significant findings • Misses some information but minimal impact on patient care	• Recognizes medical conditions but fails to place in context of dental care • Unaware of medications or required precautions for dental appointment • Lack of information compromises patient care	Critical errors include: • Lacks current information • Endangers patient • Does NOT include vital signs • Leaves questions regarding medical or dental history unanswered • Does NOT identify need for medical consult

FACTOR 2: RADIOGRAPHIC FINDINGS (Part A)

4	3	2	1	0
• Identifies and interprets all radiographic findings	• Identifies and interprets significant radiographic findings	• Interprets radiographic findings with minor deviations that do NOT substantially alter treatment	• Misses significant radiographic findings	Critical errors include: • Grossly misinterprets radiographic findings • Fails to identify non-diagnostic radiographs • Presents with outdated radiographs

FACTOR 3: COMPREHENSIVE PERIODONTAL DATA COLLECTION (Part A - applies to one quadrant selected by examiner)

4	3	2	1	0
• Provides accurate assessment of all parameters in quadrant	• Deviations of pocket depth up to 1 mm • Correctly identifies all furcations • Correctly identifies all tooth mobility • Correctly identifies gingival recession • Correctly identifies areas with no attached gingiva	• Not more than one deviation of 2 mm or more in pocket depth • Correctly identifies Class II or III furcations involvement • Incorrectly identifies tooth mobility by one step in no more than one tooth • Over/underestimates gingival recession by ≤ 1 mm on any surface • Recognizes concept of clinical attachment level and differentiate from probing pocket depth	• More than one deviation of 2 mm or more in pocket depth • Fails to correctly identify Class II or III furcations involvement • Fails to identify areas with no attached gingiva • Overestimates Class 0 and 1 furcations • Over/underestimates tooth mobility by two steps on any tooth • Fails to correctly identify Grade 2 or 3 mobility • Over/underestimates gingival recession by more than 2 mm on any surface • Performs incomplete periodontal examination • Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth	Critical errors include: • Performs periodontal examination which has no diagnostic value • Provides inaccurate assessment of key parameters

FACTOR 4: EVALUATE PERIODONTAL ETIOLOGY/RISK FACTORS (Part A)

4	3	2	1	0
• Identifies all systemic, local etiologic and risk factors	• Misses one risk factor	• Misses two risk factors but treatment is NOT substantially impacted	• Misses risk factors which compromise treatment planning and patient care	Critical errors include: • Fails to identify all risk factors

FACTOR 5: COMPREHENSIVE PERIODONTAL DIAGNOSIS (Part A)

4	3	2	1	0
• Provides accurate and complete diagnosis based on comprehensive clinical examination and findings • Demonstrates comprehensive understanding of periodontal diagnosis	• Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case	• Differentiates between periodontal health, gingivitis and periodontitis • Makes acceptable diagnosis with minimal deviations from ideal but treatment NOT impacted	• Fails to diagnose periodontitis • Makes diagnosis with critical deviations from optimal • Provides a diagnosis which lacks rationale	Critical errors include: • Fails to make a diagnosis • Provides diagnosis which is grossly incorrect

FACTOR 6: TREATMENT PLAN (Part A)

4	3	2	1	0
• Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors	• Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any) • Provides adequate description of risks and benefits of treatment and alternatives	• Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome • Does NOT provide clear description of risks and benefits of treatment and alternatives	• Provides treatment plan which fails to address relevant factors which are likely to affect outcome • Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome	Critical errors include: • Provides clinically inappropriate treatment plan which could harm the patient

FACTOR 7: CALCULUS DETECTION (Part B)

4	3	2	1	0
• Demonstrates complete detection of all subgingival calculus present in quadrant(s)	• Incorrectly identifies absence or presence of one area of clinically demonstrable subgingival calculus	• Incorrectly identifies absence or presence two areas of clinically demonstrable subgingival calculus	• Misses three areas of clinically demonstrable subgingival calculus	Critical errors include: • Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus

FACTOR 8: EFFECTIVENESS OF CALCULUS REMOVAL (Part B)

4	3	2	1	0
• Demonstrates complete removal of all calculus plaque and stains from tooth surfaces • Does NOT cause any tissue trauma • Does NOT cause any patient discomfort	• Demonstrates complete removal of all other deposits except for stains in pits and fissures • Minimizes patient discomfort	• Misses one area of clinically demonstrable subgingival calculus • Demonstrates removal of all other deposits but some remaining minor stains on accessible surfaces • Provides sufficient pain management for treatment	• Misses two areas of clinically demonstrable subgingival calculus • Causes major tissue trauma • Leaves moderate plaque and supragingival calculus • Inadequate pain management	Critical errors include: • Misses three areas of clinically demonstrable subgingival calculus • Leaves heavy stain, plaque, supragingival calculus • No pain management

FACTOR 9: PERIODONTAL RE-EVALUATION (Part C)

4	3	2	1	0
• Identifies all clinical changes of periodontal condition and describes the biological basis of changes • Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction, and educates patient on the significance of plaque removal and periodontal disease treatment • Evaluates and determines all of the patient's specific periodontal needs with detailed rationale for further periodontal procedures	• Identifies all clinical changes of periodontal condition • Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures • Accurately assesses all of patient's oral hygiene problems • Provides oral hygiene instructions that addresses all of patient's needs • Evaluates and determines all of the patient's specific periodontal needs without detailed rationale	• Identifies most clinical changes of periodontal condition but fails to identify minor changes • Accurately assesses most of patient's oral hygiene problems • Provides oral hygiene instructions that only address most of the patient's needs • Evaluates and determines general needs for periodontal care including recall intervals and referral, if indicated	• Fails to identify persistent signs and symptoms of periodontal disease • Fails to present an oral hygiene plan • Makes recommendation for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs	Critical errors include: • Fails to recognize any clinical change in periodontal condition • Did NOT assess patient's oral hygiene care or needs • Has NOT evaluated and/or determined patient's periodontal needs • Fails to recognize need for referral

Chapter 12 – Checklist for submission of Portfolio to Dental Board of California

- ☐ Complete the Application for Determination of Licensure Eligibility (Portfolio)
- ☐ Complete the Law and Ethics Examination Eligibility
- ☐ Pay fees for application and examination
- ☐ Submit copy of LIVESCAN fingerprint form
- ☐ Submit original scorecard of NBDE examination passing results
- ☐ Complete Portfolio competency examinations
- ☐ Make arrangements for completion of the letter from the Dean's office certifying good academic standing and graduation
- ☐ Make arrangements with the school for the completed Portfolio to be sent to the Board.

Chapter 13 - Frequently Asked Questions

Q: Why did the Board decide to develop the Portfolio Examination alternative?

A: The Portfolio Examination is an initial licensure pathway that allows the Dental Board of California to delegate the administration of the clinical examination as legally mandated by the California State Business and Professions Code to the six (6) American Dental Association, Commission on Dental Accreditation (CODA) approved dental schools in California.

The Portfolio Examination offers candidates an option of completing a series of clinical competency examinations to be conducted during the clinical phase of dental education. The Portfolio clinical competency examinations will be administered under direct oversight by the Board and will utilize the psychometric (measurement) principles of standardization, calibration, and verification. After the examinations are completed and minimum clinical experiences are fulfilled, candidates will be granted a license to practice dentistry.

Currently, there are two pathways to initial dental licensure in California. One pathway is the clinical examination that is administered at the various dental schools within the state by WREB, a private examining group. A second pathway involves completion of a postdoctoral residency program in either Advanced Education in General Dentistry (AEGD) or General Practice Residency (GPR).

Q: How does this alternative compare to the other options for obtaining initial dental licensure?

A:

Portfolio Examination	Licensure by WREB	Licensure by Residency
Portfolio Competency examination completed with patients of record during your final year of dental school.	Must pass WREB examination.	Must complete a one year general practice residency (GPR)or advanced education in general residency program (AEGD)
Application/Examination fee of $350.00.	Application fee of $100.00 plus cost of WREB examination.	Application fee of $100.00 plus cost of residency program of 1 year.
Must complete the California Law and Ethics written examination.	Must complete the California Law and Ethics written examination.	Must complete the California Law and Ethics written examination.
Must complete the National Board Dental Examination.	Must complete the National Board Dental Examination.	Must complete the National Board Dental Examination.

Q: How was the Portfolio Examination developed?

A: The Portfolio Examination has been developed by dental school faculty of the six Board approved dental schools under the guidance of psychometric (measurement) consultants and in accordance with psychometric standards.

The Portfolio Examination consists of sequential candidate evaluation and passing a competency examination performed on patients of record in each of the following areas:

a) Oral Diagnosis and Treatment Planning
b) Direct Restoration
c) Indirect Restoration
d) Removable Prosthodontics
e) Endodontics
f) Periodontics

The six (6) competency examinations of the Portfolio Examination process will be evaluated by dental school faculty who have been calibrated according to grading criteria set forth by the Board.

Q: How were the minimum clinical experiences determined?

A: All six (6) dental schools agreed to minimum clinical experiences that their candidates will achieve to enable them to submit their Portfolio Examination to the Board.

These minimum clinical experiences are common requirements, and are within the individual school requirements for graduation. Consequently, a candidate will still need to meet all academic requirements for that dental school for graduation, allowing for academic autonomy of individual dental schools.

The competency components of the Portfolio Examination may be taken prior to completion of clinical experiences at the discretion of the dental school in which the candidate is enrolled.

Q: What procedures are in place for Board oversight?

A: In order to ensure public safety, the Board will maintain oversight of the process with dentist consultants contracted to the Board. Moreover, the Board will continue to maintain authority over this process and perform periodic audits of Portfolio competency examination results at each school.

Q: Why not use Objective Structured Clinical Examinations (OSCE) for maximum standardization?

A: The schools and the Board chose to have candidates provide services to actual patients rather than manikins so that they are confident that candidates can provide services in actual clinical settings during the normal course of treatment. For example, candidates would be performing procedures and understand the consequences of their procedures on actual tissue and structures rather than cadaver teeth and artificial tissue.

Q: What are the advantages of the Portfolio Examination?

A: First, the Portfolio Examination costs a fraction of what it costs to participate in other pathways to licensure (WREB, postdoctoral residency programs).

Second, the candidate can perform the required competency components throughout their dental school tenure utilizing normal standards of patient care while insuring patient protection in the process.

Third, the procedures are performed on patients of record at the individual dental schools, ensuring that follow-up care can be obtained if necessary for those involved with this process. The pressure of acquiring patients is alleviated, as the competency components can be performed at any time during the final year of dental school. This allows for public protection and safety, minimizing the potential exposure of the patient involved in the current “snapshot” examination process.

Q: What is different about the Portfolio competency examinations compared with my school’s competency examinations?

A: The Portfolio Examination is much broader based and is standardized across schools. The Portfolio requires minimum clinical experiences in six domains plus successful completion of standardized competency examinations in six subject areas to be performed on patients of record during the normal course of treatment: Oral Diagnosis and Treatment Planning, Direct Restoration, Indirect Restoration, Removable Prosthodontics, Endodontics and Periodontics. All procedures require an “on demand” level of acceptable clinical performance.

Q: What if I decide that the Portfolio Examination pathway is not for me?

A: If you choose not to participate in the Portfolio pathway, you can still acquire your license by taking the WREB or participating in a postdoctoral residency program in general dentistry (GPR or AEGD).

Q. Do I have to complete the minimum number of clinical experiences <u>before</u> attempting a Portfolio competency examination?

A. You can take a Portfolio competency examination once clinical faculty has approved your readiness for the examination regardless of the number of clinical experiences you have completed.

Q. When can I begin taking the Portfolio competency examinations?

A. You can begin taking Portfolio competency examinations as soon as your Clinic Director determines your readiness. Most students will take their Portfolio competency examinations in their final year of dental school; however, students may take them earlier at the discretion of the Clinic Director.

Q. Can the registrar of my dental school certify that I will graduate on my application?

A. No, only the Dean of your dental school can certify that you will graduate and are in good standing.

Q. How soon will I know the results of a given Portfolio competency examination?

A. Your results should be given immediately following completion of a Portfolio competency examination.

Q. What should I do if I fail a Portfolio competency examination?

A. You will need to make arrangements with the Portfolio competency examiner to retest. If you have failed a Portfolio competency examination three times, you will need to complete remedial education before retesting.

Q. Who will submit the completed Portfolio Examination after I have completed my minimum clinical experiences and Portfolio competency examinations?

A. Your dental school will submit the completed portfolio. You will need to verify with your school that your application is on file with the Board or submit your application and fee with the Portfolio.

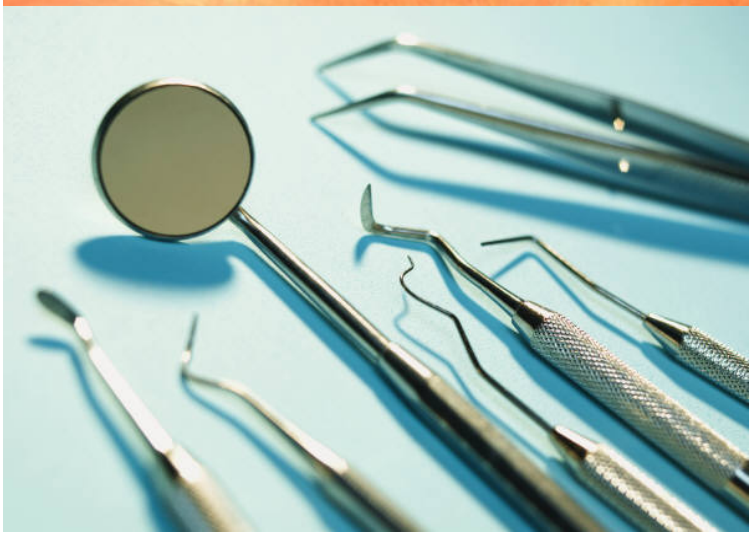
Q. What if I decide that the Portfolio Examination pathway is not for me?

A. If a candidate chooses not to utilize the Portfolio pathway, he/she can still acquire their license by taking WREB or completing a postdoctoral residency program.

Q. Can my application fee be refunded if I decide that I no longer want to participate in the Portfolio pathway?

A. Application fees are non-refundable and cannot be transferred to another licensure pathway.

PORTFOLIO EXAMINATION EXAMINER TRAINING MANUAL 2014/2015



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Chapter 1 – Introduction

This Examiner Training Manual is designed to provide information for examiners who will assess candidates' competencies in standardized competency examinations.

The manual includes detailed information about the Portfolio Examination ("Portfolio") and its evaluation system including patient criteria, subject matter areas assessed by the examination and grading criteria. Designated Portfolio examiners from each of the six dental schools are expected to follow the standardized procedures and rating (grading) criteria set forth in this manual.

Chapter 2 – Background

Premise

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences ***and*** clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for in six subject matter areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

Distinguishing characteristics

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set for by the Standards for Educational and Psychological Testing.

- *Second*, the Portfolio Examination is a *summative* assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.

- *Third*, it includes components of clinical examinations similar to other clinical examinations, and, is administered in a manner that is similar to other clinical examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.

- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and their progress can be monitored beyond the scope of the clinical experiences or competency examinations.

- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.

- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.

- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.

- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.

- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.

- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

Summative assessment

As mentioned earlier, the Portfolio Examination is considered a summative assessment to make an overall judgment about a candidate's fitness to practice independently. This means that candidates perform clinical procedures without faculty intervention unless there are patient safety issues.

Development

The Portfolio Examination has been developed by psychometric consultants for the Dental Board of California in collaboration with committees of dental faculty knowledgeable in the six subject areas. The Portfolio Examination meets the Standards for Educational and Psychological Testing (1999) set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. The Standards are used as a benchmark by the measurement profession as the psychometric standards for validating all examinations, including licensing and certification examinations.

Because the Portfolio Examination is a state licensure examination, it also meet legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

Chapter 3 – Overview of Portfolio

Summary of requirements

AGE	• At least 18 years old
IDENTIFICATION NUMBER	• School will request a Portfolio Candidate Identification number.
APPLICATION	• Complete the Board "Application for Law and Ethics Examination. • Complete the Board "Application for Determination of Licensure Eligibility (Portfolio)"
REQUIREMENTS	• Successful completion of all competency examinations specified for the Portfolio Examination • Certification of good academic standing by the dean of the dental school attended by the candidate such that the candidate is expected to graduate from said dental school; no pending ethical issues • Minimum number of clinical experiences • NBDE Passing Results • Passing the Dentistry Law and Ethics Examination • Certification of Licensure (If licensed in another country) • Submission of fingerprints

Certification of good standing

An application for determination of licensure eligibility (Portfolio) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board will not issue a license, until receipt of a certification letter from the dean of the school attended by the applicant, certifying the date the applicant graduated on school letterhead with the school seal.

Submission of Portfolio to the Board

A candidate must arrange with the school to have his or her completed Portfolio submitted to the Board. The earliest date that a candidate may submit his/her portfolio for review by the Board will be determined by each individual school. The Portfolio will not reviewed by the Board until the "Application for Determination of Licensure Eligibility (Portfolio) has been received along with the required fee.

The Application and completed Portfolio may be submitted for review within 90 days of graduation. The latest date upon which an Application and completed Portfolio may be submitted for review shall be no more than 90 days after graduation.

Issuance of license

The Board will review the submitted Portfolio materials to determine that it is complete and that the candidate has met the requirements. Once approved, the candidate will be sent an "Application for Issuance of License Number and Registration of Place of Practice". A license will be issued in 7-10 days once the completed application and required fee has been received by the Board.

Demonstrations of clinical experience

Each candidate must satisfactorily complete at least the minimum number of clinical experiences in the competencies prior to submission of their portfolio to the Board. (Competency examinations may be taken prior to completion of clinical experiences at the discretion of the dental school in which the candidate is enrolled.) Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge and skill level to reliably demonstrate competency.

Competency Examination	**Minimum Required Experiences**
Oral Diagnosis and Treatment Planning (ODTP)	20
Direct Restorations (DR)	60
Indirect Restorations (IR)	14
Removable Prosthodontics (RP)	5
Endodontics (E)	5
Periodontics (P)	25

All clinical experiences must be performed on patients under the supervision of dental school faculty and must be included in the portfolio submitted to the Board. Clinical experience may be obtained at the dental school clinic, any extramural dental facility or a mobile dental clinic approved by the Board.

Portfolio competency examinations vs. clinical experiences

A competency examination is performed without faculty intervention; however, completion of a successful competency examination may be counted as a clinical experience for the purposes of the Portfolio Examination at the discretion of the dental school at which the candidate is enrolled.

Guidelines

- Candidates perform Portfolio competency examinations independently without faculty intervention.
- Schools have the option of using the same faculty to grade each competency examination.
- Each of the schools will designate faculty as competency examiners and is responsible for administering the Board approved calibration course for said examiners.
- Each competency examination will be graded by two (2) examiners.
- If a candidate fails a Portfolio competency examination three times, the candidate cannot take the same Portfolio competency examination until remediation has been completed.
- Readiness for Portfolio competency examinations may be determined by clinical faculty.

Portfolio examiners

The Board has outlined a process for selection of dental school faculty who wish to serve as a Portfolio examiner. Each Portfolio examiner will undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods.

a) At the beginning of each school year, each school submits the names, credentials and qualifications of the dental school faculty to be appointed by the Board as Portfolio examiners. Documentation of qualifications must include but is not limited to, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner.

b) In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.

c) The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

Portfolio examiner calibration

Each Portfolio examiner will undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods.

a) Calibration of Portfolio examiners shall be conducted at least annually.

b) Portfolio examiners will receive hands-on calibration sessions with feedback on their performance.

c) Hands-on calibration sessions will include, but are not limited to, an overview of the rating process, examples of rating errors, examples of how to complete the grading forms, several sample cases in each of the competency domains, and ongoing feedback to individual examiners.

d) All Portfolio examiners will be trained and calibrated to use the same rating (grading) criteria.

e) Calibration sessions will be conducted on an ongoing basis, with the expectation that examiners participating in the Portfolio Examination process will have opportunity to participate in Portfolio competency examinations conducted at schools other than their own.

Scoring

Each Portfolio competency examination will be graded by two (2) independent competency examiners in accordance with the Board's standardized rating (grading) criteria on forms prescribed by the Board. The Portfolio Examination must be signed by the school faculty Portfolio examiner for the prescribed competency.

Patient safety

If the patient's well-being is put into jeopardy at any time during the examination, the examination will be terminated. The candidate fails the examination, regardless of performance on any other part of the examination.

Critical errors

A critical error is a gross error that is irreversible, may impact patient safety and well-being. If a candidate commits a critical error, the candidate cannot proceed with the examination.

If the candidate makes a critical error at any point during a Portfolio competency examination, a score of "0" is assigned and the Portfolio competency examination is terminated immediately.

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

- For Oral Diagnosis and Treatment Planning, Endodontics, and Periodontics, a rating of "2" (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

- For Direct Restoration and Indirect Restoration, a rating of "3" (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

- For Removable Prosthodontics, a rating of "3" (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

Scaled scores

- Ratings for each Portfolio competency examination based on a total of rating points, rather than an average of rating points.

- Total points for each Portfolio competency examination will be converted to scaled scores to place them on a common metric.

- A scaled score of 75 is considered a passing score for each Portfolio competency examination.

- Staff will be designated by each dental school to convert total points for each Portfolio competency examination to scaled scores. This activity will be performed independent of the examiners.

Compensatory model

Within a given competency examination, a low rating in one area can be compensated by a higher score in another area.

For example, a candidate who achieves a scaled score 76 from one examiner and 74 from another examiner will be credited for a scaled score 150 based on total points.

Likewise, a candidate who achieves a scaled score of 75 from one examiner and 75 from another examiner will be credited with a scaled score 150 based on total points.

Chapter 4 – Board policies

The following rules are in addition to any other examination rules set forth elsewhere in this guide and are adopted for the uniform conduct of the Portfolio examination.

Radiographs

Radiographs for Portfolio competency examinations must be of diagnostic quality either digital or conventional.

Infection control

Candidates are responsible for maintaining all of the standards of infection control while treating patients. This includes the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by OSHA and the Dental Practice Act.

Use of local anesthetics

Local anesthetics must be administered according to school protocol and standards of care. The type and amount of anesthetics must be consistent with the patient's health and other factors.

Use of dental dams

Dental dams must be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations will be graded <u>without</u> the dental dam in place.

Personal protective equipment

Candidates must wear masks, gloves and eye protection during this section of the examination.

Patients of record

Candidates will provide clinical services upon patients of record who fulfill the patient selection criteria for each of the six types of Portfolio competency examinations.

Identification numbers

Candidates will be assigned by the Board an identification number to be used for all Portfolio competency examinations prior to completing any competency examination.

Patient treatment session time limits

Candidates will be allowed 3 hours, 30 minutes for each patient treatment session.

Chapter 5 – Documentation

Grading worksheets

Each Portfolio examiner is expected to complete all sections in the rating (grading) worksheet with the following information:

CANDIDATE ID#	This number is the identification number that the Board assigns to each student participating in the Portfolio Examination pathway.
PATIENT CHART#	This number corresponds to the chart number associated with a patient who is receiving treatment at a given dental school clinic.
TOOTH#	This number corresponds to the tooth or teeth numbers associated with the treatment site.
FINAL SCORE	The total number of points for all scoring factors from two (2) examiners.
FACTOR SCORE	Each factor within a competency examination should receive a score, e.g., 1, 2, 3, 4, etc.
COMMENTS	Any noteworthy comments justifying the factor score rating.
DATE	The date that competency examination was administered.
EXAMINER SIGNATURE	The signature of the Portfolio examiners who administered a given factor (subsection) of the Portfolio competency examination.

Example of a rating (grading) worksheet

Candidate ID #

Factor Scores

Tooth number

Patient Chart #

Final Score

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
ORAL DIAGNOSIS/TREATMENT PLANNING COMPETENCY EXAM

Candidate ID# 14532 **Candidate Name: _____**	**Patient's Chart #: 9085**
<u>Factor 1: Medical issues that impact dental care</u> – Score [3] **[4] –** Identifies and evaluates all medical issues; Explains dental implications of systemic conditions; Identifies and assesses patient's medications. **[3] –** Misses <u>one</u> item that would NOT cause harm. **[2] –** Misses <u>two</u> items that would NOT cause harm. **[1] –** Misses <u>more than two</u> items that would NOT cause harm. **[0] – Critical errors –** • Misses medical or medication issues that would cause harm. **Comments:** (Comments justifying the rating provided) **Date:** 10/12/14 **Examiner signature:** Mary Jones, DDS	**<u>Factor 2: Treatment modifications based on medical conditions</u> –** **Score [3]** **[4] –** Identifies all treatment modifications. **[3] –** Misses <u>one</u> item that would NOT cause harm. **[2] –** Misses <u>two</u> items that would NOT cause harm. **[1] –** Misses <u>more than two</u> items that would NOT cause potential harm. **[0] – Critical errors-** • Misses treatment modifications that would cause potential harm. **Comments:** (Comments justifying the rating provided) **Date:** 10/12/14 **Examiner signature:** Mary Jones, DDS

Summary of competency examinations

The Summary of Competency Examinations is a required document submitted to the Board as proof of completion of the Portfolio Competency Examination. The Summary can be completed after the rating (grading) worksheets have been compiled for a given candidate.

DENTAL BOARD OF CALIFORNIA
PORTFOLIO EXAMINATION
SUMMARY OF COMPETENCY EXAMINATIONS

Candidate ID# 14532

Competency Examination	Scaled Score	Status	Date Completed
Oral Diagnosis and Treatment Planning	152	P	12/12/12
Direct Restoration	150	P	12/13/12
Indirect Restoration	168	P	9/3/12
Removable Prosthodontics	153	P	12/15/12
Endodontics	178	P	10/9/12
Periodontics	150	P	11/20/12

Highest scaled score is 200
Scaled score of 150 or above is passing

I, _____, hereby attest that the information provided in the Summary is true and correct.

Signature of Dean _____

Date _____

Chapter 6 – Oral Diagnosis and Treatment Planning

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Oral Diagnosis and Treatment Planning, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

ODTP grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:

  > Periodontics
  > Endodontics
  > Operative (direct and indirect restoration)
  > Fixed and removable prosthodontics
  > Orthodontics
  > Oral surgery

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
ORAL DIAGNOSIS/TREATMENT PLANNING COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____
Factor 1: Medical issues that impact dental care – Score [ ] **[4] –** Identifies and evaluates all medical issues; Explains dental implications of systemic conditions; Identifies and assesses patient's medications. **[3] –** Misses one item that would NOT cause harm. **[2] –** Misses two items that would NOT cause harm. **[1] –** Misses more than two items that would NOT cause harm. **[0] – Critical errors –** • Misses medical or medication items that would cause potential harm. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 2: Treatment modifications based on medical conditions – Score [ ]** **[4] –** Identifies all treatment modifications. **[3] –** Misses one item that would NOT cause harm. **[2] –** Misses two items that would NOT cause harm. **[1] –** Misses more than two items that would NOT cause harm. **[0] – Critical errors-** • Misses treatment modifications that would cause potential harm. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 3: Patient concerns/chief complaint – Score [ ] **[4]** – Identifies all patient concerns including chief complaint. **[3] –** Identifies chief complaint but misses one patient concern. **[2] –** Identifies chief complaint but misses two patient concern. **[1] –** Identifies chief complaint but misses more than two patient concerns. **[0] – Critical errors –** • Chief complaint not identified. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 4: Dental history – Score [ ]** **[4] –** Identifies all parameters in dental history. **[3] –** Misses one parameter in dental history. **[2] –** Misses two parameters in dental history. **[1] –** Misses more than two parameters in dental history. **[0] – Critical errors –** • Neglects to address dental history. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 5: Significant radiographic findings – Score [ ] **[4] –** Identifies all radiographic findings. **[3] –** Misses one radiographic finding that does NOT substantially alter treatment plan. **[2] –** Misses two radiographic findings that do NOT substantially alter treatment plan. **[1] –** Misses more than two radiographic findings that do NOT substantially alter treatment plan. **[0] – Critical findings –** • Misses radiographic findings that substantially alter treatment plan. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 6: Clinical findings – Score [ ]** **[4] –** Identifies all clinical findings. **[3] –** Misses one clinical findings that does NOT substantially alter treatment plan. **[2] –** Misses two clinical findings that do NOT substantially alter treatment plan. **[1] –** Misses more than two clinical findings that do NOT substantially alter treatment plan. **[0] – Critical errors –** • Misses clinical findings that substantially alter treatment plan. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 7: Risk level assessment – Score [ ] **[4] –** Risk level (risk factors/indicators and protective factors) identified; Relevance of risk level identified. **[3] –** Risk level and relevance of risk level identified but misses one item. (risk factors/indicators and protective factors) **[2] –** Risk level and relevance of risk level identified but misses two items. (risk factors/indicators and protective factors) **[1] –** Risk level identified but misses more than two items (risk factors/indicators and protective factors); Relevance of risk level NOT identified. **[0] – Critical errors –** • Risk level NOT identified. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 8: Need for additional diagnostic tests/referrals – Score [ ]** **[4] –** Prescribes/acquires all clinically necessary diagnostic tests and referrals with comprehensive rationale. **[3] –** Identifies need for clinically necessary diagnostic tests and referrals with limited rationale. **[2] –** Identifies need for additional diagnostic tests and referrals without rationale. **[1] –** Identifies need for additional diagnostic tests and referrals without rationale and prescribes non-contributory tests or referrals. **[0] – Critical errors –** • Does NOT identify clinically necessary diagnostic tests or referrals. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 9: Findings from mounted diagnostic casts – Score [ ] **[4] –** Casts and mounting reflect patient's oral condition; Identifies all diagnostic findings from casts. **[3] –** Casts and mounting reflects patient's oral condition; Misses one diagnostic finding that does NOT substantially alter treatment plan. **[2] –** Casts and mounting reflect patient's oral condition but misses two diagnostic findings that do NOT substantially alter treatment plan. **[1] –** Casts and mounting reflect patient's oral condition but misses more than two diagnostic findings that do NOT substantially alter treatment plan. **[0] – Critical errors** – • Casts and mounting do NOT reflect patient's oral condition. • Misses diagnostic cast findings that substantially alter treatment plan. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 10: Comprehensive problem list – Score [ ]** **[4] –** All problems listed. **[3] –** One problem NOT identified without potential harm to patient. **[2] –** Two problems NOT identified without potential harm to patient. **[1] –** Two or more problems NOT identified without potential harm to patient. **[0] – Critical errors –** • Problems with potential harm to patient NOT identified. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 11: Diagnosis and interaction of problems – Score [ ] **[4] –** All diseases correctly diagnosed; All interactions identified. **[3] –** One missed diagnosis or interaction without potential harm to patient. **[2] –** Two missed diagnoses or interactions without potential harm to patient. **[1] –** More than two missed diagnoses or interactions without potential harm to patient. **[0] – Critical errors –** • Missed diagnosis or interaction resulting in potential harm to patient. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 12: Overall treatment approach – Score [ ]** **[4] –** All treatment options identified within standard of care; Provides rationale which is optimal. **[3] –** All treatment options identified within standard of care; Provides acceptable rationale. **[2]** – All treatment options identified within standard of care and lacks sound rationale for treatment. **[1] –** Incomplete treatment options and lacks sound rationale for treatment. **[0] – Critical errors –** • Treatment options presented are NOT within standard of care. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 13: Phasing and sequencing of treatment – Score [ ] **[4] –** Treatment optimally phased and sequenced. **[3] –** Treatment phased correctly but one procedure out of sequence with no harm to patient. **[2] –** Treatment phased correctly but two procedures out of sequence with no harm to patient. **[1] –** Treatment NOT phased correctly but no potential harm to patient. **[0] – Critical errors –** • Treatment NOT phased nor sequenced correctly with potential harm to patient. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 14: Comprehensiveness of treatment plan – Score [ ]** **[4] –** Treatment plan addresses all problems; All treatment procedures are indicated. **[3] –** One treatment procedure that is NOT indicated but will NOT result in harm to patient but treatment plan address all problems. **[2] –** Two or more treatment procedures that are NOT indicated but reflect problem list; but treatment plan addresses all problems. **[1] –** Two or more treatment procedures that are NOT indicated and do NOT reflect problem list; Treatment plan is incomplete but does not cause harm to patient. **[0] – Critical errors-** • Treatment plan is incomplete and causes potential harm to patient. • Treatment procedures included that are NOT indicated resulting in harm to patient. • Treatment procedures are missing from treatment plan resulting in harm to patient. **Comments:** **Date:** _____ **Examiner signature:** _____ **ODTP**

Factor 15: Treatment record – **Score [ ]** **[4] –** Summarized all data collected, diagnoses, and comprehensive rationale for treatment options; Documents presentation of risks and benefits or all treatment options. **[3] –** Summarized all data collected, diagnoses, and treatment options; Documents presentation of risks and benefits of all treatment options and provides limited rationale. **[2] –** Summarized all data collected, diagnoses and treatment options; Documents presentation of risks and benefits of all treatment options but provides no rationale. **[1] –** Summarized all data collected, diagnoses and treatment options; And documents presentation of risks and benefits only for preferred option(s). **[0] – Critical errors –** • Does NOT summarize all data collected, diagnoses and/or treatment options. • Does NOT document presentation of risks and benefits or all treatment options. **Comments:** **Date:** _____ **Examiner signature:** _____	**ODTP**

Chapter 7 – Direct Restoration

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Direct Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

Direct Restoration grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, and,
  - > Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient’s medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient’s medical and dental history.
- Medical conditions must be managed appropriately.

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
DIRECT RESTORATION COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____ **Tooth #:** _____ **Restoration type:** _____
<u>Factor 1: Case presentation</u> – **Score [ ]** **[5] –** Obtains informed consent; Presents a comprehensive review of medical and dental history; Provides rationale for restorative procedure; Proposes initial design of preparation and restoration; Demonstrates full understanding of the procedure. **[4] –** <u>Slight</u> deviation from optimal case presentation. **[3] –** <u>Moderate</u> deviation from optimal case presentation. **[2] –** <u>Major</u> deviation from optimal case presentation. **[1] –** <u>Multiple</u> deviations from optimal case presentation. **[0] – Critical errors –** • Critical errors in assessing patient's medical and/or dental history. • Unable to justify treatment. • Proposed treatment would cause harm to patient. • Proposed treatment not indicated. • Misses critical factors in medical and/or dental review that affect treatment of patient's well being. **Comments:** **Date:** _____ **Examiner signature:** _____	**DR**

Factor 2: Outline and extensions – **[5] –** Optimal outline and extensions such as: Smooth flowing; Does not weaken tooth; Includes the lesion; Breaks proximal contact as appropriate; Appropriate cavosurface angles; Optimal treatment of fissures; No damage to adjacent teeth; Optimal extension for caries; Decalcification; Appropriate extension requests. **[4] –** Slight deviation(s) from optimal minimal impact on treatment. **[3] –** Moderate clinically acceptable deviation(s) from optimal minimal impact on treatment. **[2] –** Major deviations from optimal such as**;** Irregular outline; Outline weakens the tooth; Does not include the lesion; Contacts not broken where appropriate; Proximal extensions excessive; Inappropriate cavosurface angle(s); Inappropriate treatment of fissures; Adjacent tooth requires major recontouring; Inappropriate extension requests. **[1] –** Multiple major deviations from optimal including: Irregular outline; Outline weakens the tooth; Does not include the lesion; Contacts not broken where appropriate; Proximal extensions excessive; Inappropriate cavosurface angle(s); Inappropriate treatment of fissures; Adjacent tooth requires major recontouring; Inappropriate extension requests.	**Factor 2: Outline and extensions – Continued** **Score [ ]** **[0] – Critical errors –** • Critical errors in outline and extensions. • Deviations from optimal that are irreversible and have a significant impact on treatment. • Damage to adjacent tooth that requires restoration. **Comments:** **Date:**_____ **Examiner signature:** _____ **DR**

Factor 3: Internal form – Score [ ]	**Factor 4: Operative environment – Score [ ]**
[5] – Optimal internal form such as: Optimal pulpal and axial depth; Optimal wall relationships; Optimal axio-pulpal line angles; Optimal internal refinement; All previous restorative material removed; Optimal caries removal; Preparation is clean and free of fluids and/or debris; Appropriate liners and bases; Appropriate extension requests. **[4] –** Slight deviation(s) from optimal **[3] –** Moderate, clinically acceptable deviation(s) from optimal. **[2] –** Major deviation from optimal such as: Excessive or inadequate pulpal or axial depth; Inappropriate wall relationships; Inappropriate internal line angles; Rough or uneven internal features; Previous restorative material present; Inappropriate caries removal; Fluids and/or debris present; Inappropriate handling of liners and bases; Inappropriate extension requests. **[1] –** Multiple major deviations from optimal including: Excessive or inadequate pulpal or axial depth; Inappropriate wall relationships; Inappropriate internal line angles; Rough or uneven internal features; Previous restorative material present; Inappropriate caries removal; Fluids and/or debris present; Inappropriate handling of liners and bases; Inappropriate extension requests.. **[0] – Critical errors –** • Critical errors from optimal internal form. • Noncarious pulp exposure. **Comments:** **Date:** _____ **Examiner signature:** _____	**[5] –** Soft tissue free of unnecessary damage; Proper patient comfort/pain management; Optimal isolation; Correct teeth isolation; Dam fully inverted; Clamp stable with no tissue damage; No leakage; Preparation can be accessed and visualized. **[4] –** Slight deviation(s) from optimal. **[3] –** Moderate, clinically acceptable deviation(s) from optimal. **[2] –** Major deviation from optimal such as: Incorrect teeth isolated; Dam not inverted, causing leakage that may compromise the final restoration; Clamp is not stable or impinges on tissue; Preparation cannot be accessed or visualized to allow proper placement of restoration; Major tissue damage. **[1] –** Multiple deviations from optimal including: Incorrect teeth isolated; Dam not inverted, causing leakage that may compromise the final restoration; Clamp is not stable or impinges on tissue; Preparation cannot be accessed or visualized to allow proper placement of restoration; Major tissue damage. **[0] – Critical errors –** • Critical errors from optimal in operative environment. • Gross soft tissue damage. • Gross lack of concern for patient comfort. **Comments:** **Date:** _____ **Examiner signature:** _____ **DR**

Factor 5: Anatomical form: - Score [ ] **[5] –** Optimal anatomic form such as: Harmonious and consistent with adjacent tooth structure; Interproximal contour and shape are proper; Interproximal contact area and position are properly restored; Contact is closed, floss passes though with resistance; Height and shape of marginal ridge is appropriate. **[4] –** Slight deviation(s) from optimal. **[3] –** Moderate, clinically acceptable deviation(s) from optimal. **[2] –** Major deviation from optimal such as: Inconsistent with adjacent tooth structure; Interproximal contour and shape are inappropriate; Height and shape of marginal ridge is inappropriate. **[1] –** Multiple major deviations from optimal including: Inconsistent with adjacent tooth structure; Interproximal contour and shape are inappropriate; Height and shape of marginal ridge is inappropriate. **[0] – Critical errors –** • Critical errors that require restoration to be redone. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 6: Margins: - Score [ ]** **[5] –** Optimal margins with no deficiencies or excesses. **[4] –** Slight deviation(s) from optimal. **[3] –** Moderate, clinically acceptable deviation(s) from optimal. **[2] –** Major deviation from optimal such as: Open margin; Subgingival and/or excess restorative material. **[1] –** Multiple major deviations from optimal. **[0]** – Critical errors – • Critical errors that require restoration to be redone. **Comments:** **Date:** _____ **Examiner signature:** _____ **DR**

Factor 7: Finish and function: - **Score [ ]** **[5] –** Optimal finish and function such as: Smooth with no pits, voids or irregularities in restoration; Occlusion is properly restored with no interferences; No damage to hard or soft tissue. **[4] –** Slight deviation(s) from optimal. **[3] –** Moderate, clinically acceptable deviation(s) from optimal. **[2] –** Major deviation from optimal such as: Significant pits, voids or irregularities in the surfaces; Severe hyper-occlusion or hypo-occlusion; Moderate damage to hard or soft tissue. **[1] –** Multiple major deviations from optimal. **[0] – Critical errors –** • Critical errors that require restoration to be redone. • Procedure is not completed within allotted time. • Unnecessary, gross damage to hard and soft tissue as related to finishing procedure. **Comments:** **Date:** _____ **Examiner signature:** _____	**DR**

Chapter 8 – Indirect Restoration

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Indirect Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

Indirect Restoration grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:

  > Ceramic restoration must be onlay or more extensive
  > Partial gold restoration must be onlay or more extensive
  > Metal ceramic restoration (PFM)
  > Full gold restoration

- Requires a case presentation for which the proposed treatment is appropriate for patient’s medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management; candidate must be familiar with the patient’s medical and dental history.
- Medical conditions must be managed appropriately.

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
INDIRECT RESTORATION COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____ **Tooth #:** _____**/Type of Restoration**_____ **Final Score:** _____
Factor 1: Case presentation – Score [ ] **[5] –** Obtains informed consent; Presents a comprehensive medical and dental review; Provides rationale for restorative procedure; Proposes initial design of restoration; Provides method for provisionalization; Demonstrates full understanding of the procedure; Sequencing of treatment follows standards of care. **[4] –** Slight deviation from optimal case presentation. **[3] –** Moderate deviations from optimal case presentation. **[2] –** Major deviation from optimal case presentation; Provides inappropriate justification for treatment; Sequencing of treatment does not follow standards of care. **[1] –** Multiple major deviations from optimal case presentation. **[0] – Critical errors –** • Critical errors in assessing patient's medical and/or dental history. • Unable to justify treatment. • Proposed treatment would cause harm to patient. • Proposed treatment not indicated. • Misses critical factors in medical and dental review that affect treatment or patient well being. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 2: Preparation – Score [ ]** **[5] –** Meets all accepted criteria for optimal preparation: Occlusal/incisal reduction; Axial reduction; Finish lines; Caries removal; Pulpal protection; Soft tissue management; No damage to soft and hard tissue; Resistance and retention; Debridement. **[4] –** Slight deviations from optimal; minimal impact on treatment. **[3] –** Moderate, clinically acceptable deviations from optimal; minimal impact on treatment. **[2] –** Major deviation from optimal but correctable without significantly changing the procedure. **[1] –** Multiple major deviations from optimal preparation. **[0] – Critical errors –** • Critical errors that are irreversible and have a significant impact on treatment. • Critical errors that require major modifications of the proposed treatment such as: ❖ Onlay that must change to full crown. ❖ Overextension requiring crown lengthening. **Comments:** **Date:** _____ **Examiner signature:** _____ **IR**

Factor 3: Impression – Score [ ]	Factor 4: Provisional – Score [ ]
[5] – Achieves optimal, clinically acceptable impression in one attempt; Impression extends beyond finish line; Detail of preparation and adjacent teeth captured accurately; Free of voids in critical areas; No aspect of impression technique that would result in inaccuracy; Interocclusal record is accurate, if needed. **[4] –** Achieves clinically acceptable impression in second attempt. **[3] –** Achieves clinically acceptable impression more than two attempts. **[2] –** Major deviation that requires retaking impression such as: • Lack of recognition of unacceptable impression or interocclusal relationship. **[1] –** Multiple major deviations from optimal in impression including: • Lack of recognition of unacceptable impression or interocclusal relationship. **[0] – Critical errors –** • failure to achieve a clinically acceptable impression after five (5) attempts • Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures. **Comments:** **Date:** _____ **Examiner signature:** _____	**[5] –** Meets all acceptable criteria for optimal provisional: Occlusal form and function; Proximal contact; Axial contour; Marginal fit; External surface smooth and polished without pits, voids or debris; Optimal internal adaptation; Retention; Esthetics. **[4] –** Slight deviations from optimal with minimal impact on treatment. **[3] –** Moderate deviations from accepted criteria have minimal impact on treatment. **[2] –** Major deviation from optimal that can be corrected such as: Lack of recognition of major deviation that can be corrected. **[1] –** Multiple major deviations that have significant impact on treatment including: Lack of recognition of major deviation that can be corrected. **[0] - Critical errors –** • Critical errors that are clinically unacceptable. **Comments:** **Date:** _____ **Examiner signature:** _____ **IR**

Factor 5: Student evaluation of laboratory work – Score [ ] **[5] –** Verifies that restoration meets all accepted criteria; Verifies errors in restoration and proposes changes, if needed. **[4] –** Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment. **[3] –** Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment. **[2] –** Lack of recognition of a major deviation from optimal that can be corrected. **[1] –** Lack of recognition of multiple major deviations from optimal. **[0] – Critical errors –** • Critical errors that require restoration to be redone. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 6: Pre-cementation – Score [ ]** **[5] –** Meets all accepted criteria for pre-cementation: Occlusal form and function; Proximal contact; Axial contours; Marginal fit; External surface smooth and polished without pits, voids, or debris; Optimal internal adaptation; Retention; Esthetics; Patient acceptance. **[4] –** Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment. **[3] –** Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment. **[2] –** Lack of recognition of major deviation that can be corrected. **[1] –** Lack of recognition of multiple major deviations from optimal. **[0] – Critical errors –** • Lack of recognition of critical errors which cannot be corrected. **Comments:** **Date:** _____ **Examiner signature:** _____ **IR**

Factor 7: Cementation and finish – **Score [ ]** **[5] –** Meets all accepted criteria for optimal cementation: Occlusal form and function; Proximal contact; Axial contours; Marginal fit; External surfaces smooth and polished without pits, voids, or debris; Optimal internal adaptation; Retention; Esthetics; All excess cement removed; No unnecessary tissue trauma; Appropriate postoperative instructions. **[4] –** Slight deviations from optimal; minimal impact on treatment. **[3] –** Moderate deviations from accepted criteria; minimal impact on treatment. **[2] –** Major deviation from accepted that can be corrected. **[1] –** Multiple major deviations from optimal. **[0] – Critical errors –** • Critical errors which require restoration to be redone. • Procedure is not completed within allotted time. • Unnecessary, gross damage to hard and soft tissue as related to finishing. **Comments:** **Date:** _____ **Examiner signature:** _____	**IR**

Chapter 9 – Removable Prosthodontics

Minimum competence level of performance

- The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.
-
- For Removable Prosthodontics, a rating of “3” (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

Removable Prosthodontics grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient
    - > Denture or overdenture for a single edentulous arch, or,
    - > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture.
- No patient sharing; cannot split patients between candidates.
- Requires patient management. Candidate must be familiar with patient’s medical and dental history.
- Medical conditions must be managed appropriately.
- Case complexity is not a criteria.

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
REMOVABLE PROSTHODONTICS COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____ **Final Score:** _____ **Type of prosthesis:** _____
Factor 1: Patient evaluation and diagnosis – Score [ ] **[5] –** Evaluation and diagnosis is comprehensive and discriminating; Recognizes significant diagnostic implications of all findings. **[4] –** Recognizes significant diagnostic implications but misses some findings that do NOT affect diagnosis. **[3] –** Recognized significant findings but there are errors in findings or judgment that do NOT compromise diagnosis. **[2] –** Does NOT recognize significant findings or diagnostic implications; Diagnosis is jeopardized. **[1] – Critical errors –** • Gross errors in evaluation or judgment. • Gross errors in diagnosis. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 2: Treatment plan and sequencing – Score [ ]** **[5] –** Presents/formulates all treatment options and understands clinical nuances of each option; Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination; Performs risk-based analysis to present appropriate treatment options and prognosis; Demonstrates critical thinking as evidenced in steps in treatment plan; No errors in planning and sequencing. **[4] –** Presents/formulates most treatment options and understands rationale of each option; Treatment plan is appropriate some contributing factors NOT considered; Minor errors that do NOT affect planning and sequencing. **[3] –** Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis; Moderate errors that do NOT compromise planning and sequencing. **[2] –** Does NOT address patient's chief complaint; Treatment plan NOT based on diagnosis; Major errors in evidence based, critical thinking, risk-based, and prognostic assessment; Treatment sequence inappropriate. **[1] – Critical errors –** • Treatment plan NOT based on diagnostic findings or prognostic information. • Treatment plan grossly inadequate. • Treatment sequence grossly inappropriate. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Factor 3: Preliminary impressions – Score [ ] **[5] –** Perform and recognize adequate capture of anatomy; Free or distortions and voids. **[4] –** Performs impression with minor errors that do NOT affect final outcome. **[3] –** Performs impression with moderate errors that do NOT compromise final outcome. **[2] –** Performs impression with major errors; or fails to recognize that final outcome is compromised. **[1] – Critical errors –** • Inadequate capture of anatomy or Gross distortion/voids. • Fails to recognize that subsequent steps are impossible. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 4: RPD design (if applicable) – Score [ ]** **[5] –** Design demonstrates understanding of biomechanical and esthetic principles; Casts are surveyed accurately; Design is drawn with detail. [**4] –** Design demonstrates understanding of biomechanical and esthetic principles with minor errors; Minor errors in cast survey and design. **[3] –** Design is functional but includes rests, clasp assembly or major connector that is NOT first choice; Moderate errors in survey and design; Moderate errors in understanding of RPD design principles. **[2] –** Demonstrates lack of understanding of biomechanical or esthetic principles; Major errors in cast survey and design. **[1] – Critical errors –** • Design is grossly inappropriate. • Inaccurate survey. • Illegible drawing. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Factor 5: Tooth modification (if applicable) – Score [ ]	**Factor 6: Border molding and final impression – Score [ ]**
[5] – Parallel guiding planes; Optimal size and location of rest preparations; Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane; Survey crowns as needed. **[4] –** Minor deficiencies in tooth modification; RPD fit and service unaffected. **[3] –** Moderate deficiencies in tooth modifications; But NO compromise in RPD fit and service. **[2] –** Major errors in tooth modifications leading to compromised RPD fit and service; Tooth modifications may require restorations. **[1] – Critical errors** – • RPD abutment teeth are grossly over-prepared. **Comments:** **Date:** _____ **Examiner signature:** _____	**[5] –** Obtain optimal vestibular extension and peripheral seal; Perform and recognize adequate capture of anatomy; Impression free of distortions/voids. **[4] –** Border molding and/or impression have minor errors that do NOT affect final outcome. **[3] –** Border molding and/or impression have moderate deviations that do NOT compromise final outcome. **[2] –** Border molding and/or impression have major errors that affect final outcome. **[1] – Critical errors –** • Border molding and/or impression do NOT adequately capture of anatomy. • Gross distortion/voids so that final outcome is impossible. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Factor 7: Framework try-in (if applicable) – Score [ ] **[5] –** Perform and recognize functional and occlusal adjustments; Complete seating of framework is achieved; Determine sequence for establishing denture-base support. **[4] –** Minor deficiencies in ability to recognize and correct minor discrepancies in framework fit; but do NOT affect RPD service. **[3] –** Moderate deficiencies in ability to recognize or correct discrepancies in framework fit; but no significant compromise to RPD service. **[2] –** Major errors in framework fit NOT recognized; Errors in judgment regarding sequence of correction. **[1] – Critical errors –** • Gross errors in framework fit NOT recognized. • Unable to determine sequence of correction. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 8: Jaw relation records – Score [ ]** **[5] –** Smooth record bases with appropriate peripheral extensions/thickness; Smoothly contoured wax rim establishes esthetic parameters; Vertical dimension is physiologically appropriate; Accurately captures centric relation; Relates opposing casts without interference. **[4] –** Minor deficiencies in jaw relation records that do NOT adversely affect prosthetic service. **[3] –** Moderate discrepancies in jaw relation records that do NOT compromise prosthetic service; Records do NOT require repeating. **[2] –** Major errors in jaw relation records that adversely affect prosthetic service; Records should be redone. **[1] – Critical errors –** • Gross error in jaw relations records with poor understanding and judgment. • Records should be redone. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Factor 9: Trial dentures – Score [ ] **[5] –** Recognized optimal esthetics (midline, incisal length, tooth mold and shade, arrangement); Occlusal (MIP=CR, VDO < VDR, bilateral posterior contact); Speech and contour aspects of trial denture; Deviations from the optimal are corrected or managed appropriately. **[4] –** Minor deficiencies in ability to recognize and correct discrepancies in esthetics; Vertical dimension; Occlusion; Phonetics; and contour. **[3] –** Moderate deficiencies in ability to recognize or correct discrepancies in esthetics; Vertical dimension; Occlusion; and phonetics which do NOT compromise final outcome. **[2] –** Major errors in ability to recognize or correct discrepancies in esthetics; Vertical dimension; Occlusion and phonetics which adversely affect final outcome. **[1] – Critical errors –** • Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 10: Insertion of removable prosthesis – Score [ ]** **[5] –** Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following: • Tissue fit. • Prosthetic support, stability and retention. • RPD extension base tissue support. • Vestibular extension and bulk. • Occlusion; clinical remount required. • Phonetics. • Contours and polish. • Patient home care instructions. **[4] –** Minor discrepancies in judgment and/or performance of optimizing prosthesis fit and function; No adverse effect on prosthesis service. **[3] –** Moderate discrepancies in judgment and performance of optimizing prosthesis fit/function; No compromise on prosthesis service. **[2] –** Major errors in judgment and performance of optimizing prosthesis fit/function; prosthesis service adversely affected; May require significant correction or prosthesis. **[1] – Critical errors –** • Gross errors in judgment and performance results in failure of prosthesis with no possibility to correct; Prosthesis must be redone. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Factor 11: Post insertion (1 week) – Score [ ] **[5] –**Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis; Enroll patient in maintenance program; Demonstrate familiarity with common prosthesis complications and solutions. **[4] –**. Minor discrepancies in ability to evaluate and solve prosthesis problems; no affect on patient comfort and function. **[3] –** Moderate discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function. **[2] –**.Major errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function. **[1] –** Gross errors in ability to evaluate and solve prosthesis problems; patient confidence is compromised **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 12: Laboratory services – Score [ ]** **[5] –** Prescription clearly communicates desired laboratory work and materials; Complies with infection control protocols between clinic and laboratory environments; Accurately evaluates laboratory work products. **[4] –**. Prescription, or management of laboratory services has minor errors that do NOT adversely affect prosthesis. **[3] –** Prescription, or management of laboratory services has moderate discrepancies that do NOT compromise prosthesis. **[2] –** Prescription, or management of laboratory services, has major errors that adversely affect prosthesis. **[1] –**Prescription, or management of laboratory services has gross errors that result in prosthesis failure. **Comments:** **Date:** _____ **Examiner signature:** _____ **RP**

Chapter 10 – Endodontics

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales. For Endodontics, a rating of "2" (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

Endodontics grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
ENDODONTICS COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____ **Tooth #:** _____ **Final Score:** _____
Factor 1: Pretreatment clinical testing and radiographic imaging – Score [ ] **[4] -** Clinical tests and radiographic imaging completed and recorded accurately; radiographic images are of diagnostic quality. **[3] –** Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies. **[2] –** Some clinical tests and radiographic images are lacking but diagnosis can be determined. **[1] –** Some clinical tests and radiographic images are lacking and diagnosis is questionable. **[0] – Critical errors -** • Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined. • Radiographic images are missing or are NOT of diagnostic quality **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 2: Endodontic diagnosis – Score [ ]** **[4] –** Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images. **[3] –** Establishes correct pulpal and periapical diagnosis with accurate interpretation, but missing one clinical test and/or radiographic image. **[2] –** Establishes correct pulpal and periapical diagnosis with adequate interpretation, but missing multiple clinical tests and/or radiographic images that do NOT impact diagnosis. **[1] -** Establishes inaccurate pulpal or periapical diagnosis, and missing multiple clinical tests and radiographic images that impact diagnosis. **[0] – Critical errors –** • Demonstrates lack of understanding of endodontic diagnosis. • No clinical tests were done. **Comments:** **Date:** _____ **Examiner signature:** _____ **E**

Factor 3: Endodontic treatment plan – Score [ ]

[4] – Prognosis of treatment outcomes determined; Comprehensive evaluation of medical and dental history; Selects appropriate treatments based on clinical evidence; Understands complexities of the case such that all treatment risks identified; Informed consent obtained including alternative treatments.

[3] – Prognosis of treatment outcomes determined and adequate evaluation of medical and dental history; Selects appropriate treatment(s); Significant treatment risks identified; Informed consent obtained.

[2] – Prognosis of treatment outcomes determined and minimal evaluation of one of the following:

- Medical or dental history
- Appropriate treatment(s) selected
- Most treatment risks identified
- Informed consent obtained

[1] – Prognosis of treatment outcomes unclear; Inadequate evaluation of medical and dental history despite appropriate treatment selected; Key treatment risks NOT identified.

[0] – Critical errors –

- Demonstrates lack of evaluation of relevant medical and dental history.
- Inappropriate treatment planning.
- No treatment risks identified.
- No informed consent obtained.
- Demonstrates inappropriate case selection.
- Prognosis of treatment outcomes NOT determined.

Comments:

Date:_____

Examiner signature: _____

Factor 4: Anesthesia and pain control – Score [ ]

[4] – Thorough knowledge of technique and materials used; Monitors vital signs and patient response throughout anesthesia; Anesthesia administration effective.

[3] – Thorough knowledge of technique; Profound anesthesia achieved; Monitors patient response throughout anesthesia.

[2] – Can proceed with treatment without faculty assistance; Adequate anesthesia achieved.

[1] – Elements of anesthesia or pain control absent but patient care NOT compromised.

[0] – Critical errors –

- Incorrect anesthetic technique.
- Inadequate pain control and patient care compromised.
- Required faculty assistance.

Comments:

Date: _____

Examiner signature:

_____

E

Factor 5: Caries removal, removal of failing restorations, evaluation of restorability and site isolation – Score [ ] **[4] –** Compete removal of visible caries; Removal of failing restoration; Establishes complete structural restorability; Achieves complete isolation with dental dam. **[3] –** No visible caries and failing restorations removed; Establishes significant aspects of structural restorability and achieves effective isolation with dental dam. **[2] –** No visible caries present; Establishes likely restorability and achieves adequate isolation with dental dam. **[1] –** Caries removal compromised that potentially impacts procedure; Compromised coronal seal. **[0] – Critical errors –** • Gross visible caries • Failing restoration present • Non-restorable excluding medical indications • Ineffective isolation **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 6: Access opening – Score [ ]** **[4] –** Optimum outline and access form with no obstructions; All canals identified; Roof and pulp horns removed. **[3] –** Slight under-extension of outline form but walls smooth but all canals identified and roof and pulp horns removed. **[2] –** Moderate under- or over-extension of outline form; Minor irregularities for wall smoothness but all canals identified and roof and pulp horns removed. **[1] –** Crown integrity compromised by over-extension but tooth remains restorable; All canals identified but minor roof and pulp horns remain. **[0] – Critical errors –** • Tooth is NOT restorable after access procedure or perforation. • Structural compromise. • Canal(s) missed or unidentified. **Comments:** **Date:** _____ **Examiner signature:** _____ **E**

<u>Factor 7: Canal preparation technique</u> – Score [ ]

[4] – Optimum canal length determination and preparation within 0.5-1.0 mm of radiographic apex; Maintenance of original canal position and integrity.

[3] – Adequate canal length determination and preparation within 1.5 mm short of radiographic apex; Mild deviations of original canal shape.

[2] – Acceptable canal length determination and preparation within 2.0 mm short of working length; Moderate deviations of original canal shape.

[1] – Canal length and preparation shorter than original working length; Canal length >2.0 mm short or 1.0 mm long of radiographic apex; Severe deviations of original canal shape but treatable; Separated instrument that does NOT prevent canal preparation.

[0] – Critical errors –

- Working length determination >2.0 mm short or long of radiographic apex.
- Sodium hypochlorite accident.
- Canal perforated or NOT treatable.
- Separated instrument preventing canal preparation.

Comments:

Date: _____

Examiner signature:

_____

<u>Factor 8: Master cone fit</u> – Score [ ]

[4] – Optimum cone fit and length verification within 0.5-1.0 mm of radiographic apex; Maintenance of canal position and integrity as demonstrated in cone fit.

[3] – Adequate cone fit and length verified within 1.5 mm short of radiographic apex; Mild deviations of original canal shape.

[2] – Acceptable cone fit and length verified within 2.0 mm short of radiographic apex; Moderate deviations of original canal shape; Achieves tugback before lateral obturation.

[1] – Cone length determination >2.0 mm short or long from radiographic apex; Cone fit >2.0 mm short or >1.0 mm long of radiographic apex.

[0] – Critical errors –

- Master cone too small.
- Master cone too large.
- Master cone fit >2.0 mm short or long of radiographic apex.

Comments:

Date : _____

Examiner signature:

_____

E

Factor 9: Obturation technique – Score [ ]	**Factor 10: Completion of case – Score [ ]**
[4] – Achieves dense fill within 0.5 - 1.0 mm short of radiographic apex; None or minor over-extension of sealer; No solid core material over-extended. **[3] –** Achieves dense fill within the apical two-thirds and less than 1.5 mm short of radiographic apex; Less than 1.0 mm of sealer extruded. **[2] –** Achieves dense fill in apical third without voids; Solid core material 1.5 - 2.0 mm short or 1.0 mm long of radiographic apex; 1.0 - 2.0 mm of sealer extruded. **[1] –** Apical third has slight to moderate voids; Solid core material 2.0 - 3.0 mm short or 1.0 - 2.0 mm long; More than 2.0 mm of sealer extruded. **[0] – Critical errors –** • Solid core material greater than 3 mm short or greater than 2 mm long of radiographic apex. and/or • Significant voids throughout fill. **Comments:** **Date:** _____ **Examiner signature:** _____	**[4] –** Optimum coronal seal placed prior to permanent restoration; Optimum evidence of documentation (e.g., radiographs, clinical notes, assessment of outcomes); Evidence of comprehensive and inclusive post-operative instructions. **[3] –** Effective coronal seal placed prior to permanent restoration; Thorough evidence of documentation (e.g., radiographs, clinical notes, assessment of outcomes) <u>and</u> evidence of post-operative instructions. **[2] –** Acceptable durable coronal seal placed; Acceptable documentation (e.g., radiographs, clinical notes, assessment of outcomes <u>and</u> evidence of post-operative instructions. **[1] –** Acceptable coronal seal placed with limited longevity; Evidence of incomplete documentation; Evidence of incomplete post-operative instructions. **[0] – Critical errors –** • Poor coronal seal. • Prognosis likely impacted by iatrogenic treatment factors. • Improper or no documentation. • No evidence of post-operative instructions. **Comments:** **Date:** _____ **Examiner signature:** _____ **E**

Chapter 11 – Periodontics

Minimum competence level of performance

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Periodontics, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

Periodontics grading worksheet

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

Overview

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan
  - Part B. Calculus detection, effectiveness of calculus removal
  - Part C. Periodontal re-evaluation
- Ideally, all three parts are to be performed on the same patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.

DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION
PERIODONTICS COMPETENCY EXAM

Candidate ID# _____ **Candidate Name:** _____	**Patient's Chart #:** _____ **Final Score:** _____
Factor 1: Review of medical and dental history (Part A) – Score [ ] **[4] –** Demonstrates complete knowledge and understanding of implications to dental care; Provides clear presentation of case. **[3] –** Demonstrates complete understanding of implications to dental care but presentation could be improved. **[2] –** Recognized significant findings: Misses some information but minimal impact on patient care. **[1] –** Recognized medical conditions but fails to place in context of dental care; Unaware of medications or required precautions for dental appointment; Lack of information compromises patient care. **[0] – Critical errors –** • Lacks current information. • Endangers patient. • Does NOT include vital signs. • Leaves questions regarding medical or dental history unanswered. • Does NOT identify need for medical consult. **Comments:** **Date:** _____ **Examiner signature:** _____	**Factor 2: Radiographic findings (Part A) – Score [ ]** **[4] –** Identifies and interprets all radiographic findings. **[3] –** Identifies and interprets significant radiographic findings. **[2] –** Interprets radiographic findings with minor deviations that do NOT substantially alter treatment. **[1] –** Misses significant radiographic findings. **[0] – Critical errors –** • Grossly misinterprets radiographic findings. • Fails to identify non-diagnostic radiographs. • Presents with outdated radiographs. **Comments:** **Date:** _____ **Examiner signature:** _____ **P**

Factor 3: Comprehensive periodontal data collection (Part A – Applies to one quadrant selected by examiner) – Score [ ] **Quadrant: _____** **[4] –** Provides accurate assessment of all parameters in quadrant. **[3] –** Deviations of pocket depth up to 1 mm; Correctly identifies all furcations; Correctly identifies all tooth mobility; Correctly identifies gingival recession; Correctly identifies area with no attached gingiva. **[2] –** Not more than one deviation of 2 mm or more in pocket depth; Correctly identifies Class II or III furcation involvements; Incorrectly identifies tooth mobility by one step in no more than one tooth; Over/under-estimates gingival recession by ≤ 1 mm on any surface; Recognizes concept of clinical attachment level and differentiate from probing pocket depth. **[1] –** More than one deviation of 2 mm or more in pocket depth; Fails to correctly identify Cass II or III furcation involvement; Fails to identify areas with no attached gingiva; Overestimates Class 0 and 1 furcations; Over/under-estimates tooth mobility by two steps on any tooth; Fails to correctly identify Grade 2 or 3 mobility; Over/under-estimates gingival recession by more than 2 mm on any surface; Performs incomplete periodontal examination; Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth. **[0] – Critical errors –** • Performs periodontal examination which has no diagnostic value. • Provides inaccurate assessment of key parameters. **Comments:** **Date: _____** **Examiner signature:** **_____**	**Factor 4: Evaluate periodontal etiology/risk factors (Part A) – Score [ ]** **[4] –** Identifies all systemic, local etiologic and risk factors. **[3] –** Misses one risk factor. **[2] –** Misses two risk factors but treatment is NOT substantially impacted. **[1] –** Misses risk factors which compromise treatment planning and patient care. **[0] – Critical errors –** • Fails to identify all risk factors. **Comments:** **Date: _____** **Examiner signature:** **_____** **P**

Factor 5: Comprehensive periodontal diagnosis (Part A) – Score [ ]	**Factor 6: Treatment plan (Part A) – Score [ ]**
[4] – Provides accurate and complete diagnosis based on comprehensive clinical examination and findings; Demonstrates comprehensive understanding of periodontal diagnosis. **[3] –** Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case. **[2] –** Differentiates between periodontal health, gingivitis and periodontitis; Makes acceptable diagnosis with minimal deviations from ideal but treatment is NOT impacted. **[1] –** Fails to diagnose periodontitis; Makes diagnosis with critical deviations from optimal; Provides a diagnosis which lacks rationale. **[0] – Critical errors –** • Fails to make a diagnosis. • Provides diagnosis which is grossly incorrect. **Comments:** **Date:** _____ **Examiner signature:** _____	**[4] –** Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors. **[3] –** Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any); Provides adequate description of risks and benefits or treatment and alternatives. **[2] –** Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome; Does NOT provide clear description of risks and benefits of treatment and alternatives. **[1] –** Provides treatment plan which fails to address relevant factors which are likely to affect outcome; Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome. **[0] – Critical errors –** • Provides clinically inappropriate treatment plan which could harm the patient. **Comments:** **Date:** _____ **Examiner signature:** _____ **P**

Factor 7: Calculus detection (Part B) – Score [ ] **Quadrant: _____** **[4] –** Demonstrates complete detection of all subgingival calculus present in quadrant(s). **[3] –** Incorrectly identifies absence or presence of one area of clinically demonstrable subgingival calculus. **[2] –** Incorrectly identifies absence or presence of two areas of clinically demonstrable subgingival calculus. **[1] –** Misses three areas of clinically demonstrable subgingival calculus. **[0] – Critical errors –** • Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus. **Comments:** **Date: _____** **Examiner signature:** _____	**Factor 8: Effectiveness of calculus removal (Part B) – Score [ ]** **[4] –** Demonstrates complete removal of all calculus plaque and stains from tooth surfaces; Does NOT cause any tissue trauma; Does NOT cause any patient discomfort. **[3] –** Demonstrates complete removal of all other deposits except for stains in pits and fissures; Minimizes patient discomfort. **[2] –** Misses one area of clinically demonstrable subgingival calculus; Demonstrates removal of all other deposits but some remaining minor stains on accessible surfaces; Provides sufficient pain management for treatment. **[1] –** Misses two areas of clinically demonstrable subgingival calculus; Causes major tissue trauma; Leaves moderate plaque and supragingival calculus; Inadequate pain management. **[0] – Critical errors –** • Misses three areas of clinically demonstrable subgingival calculus. • Leaves heavy stains, plaque, and supragingival calculus. • No pain management. **Comments:** **Date: _____** **Examiner signature:** _____ **P**

Factor 9: Periodontal re-evaluation (Part C) – Score [ ]	**Factor 9: Periodontal re-evaluation (continued)**
[4] – Identifies all clinical changes of periodontal condition and describes the biological basis of changes; Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction and educates patient on the significance of plaque removal and periodontal disease treatment; Evaluates and determines all of the patient's specific periodontal needs with detailed rationale for further periodontal procedures. **[3] –** Identifies all clinical changes of periodontal condition; Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures; Accurately assesses all of patient's oral hygiene problems; Provides oral hygiene instructions that addresses all of patient's needs; Evaluates and determines all of the patient's specific periodontal needs without detailed rationale. **[2] –** Identifies most clinical changes of periodontal condition but fails to identify minor changes; Accurately assesses most of patient's oral hygiene problems; Provides oral hygiene instructions that only address most of the patient's needs; Evaluates and determines general needs for periodontal care including recall intervals and referral, if indicated. **[1] –** Fails to identify persistent signs and symptoms of periodontal disease; Fails to present an oral hygiene plan; Makes recommendations for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs. **[0] – Critical errors –** • Fails to recognize any clinical change in periodontal condition. • Did NOT assess patient's oral hygiene care or needs. • Has NOT evaluated and/or determined patient's periodontal needs. • Fails to recognize need for referral.	**Comments:** **Date:** _____ **Examiner signature:** _____ **P**

Appendix A – Common rating errors

Common rating errors

Rating errors are systematic biases which may affect the examiner's ability to provide a fair and objective evaluation of candidates. By applying the established grading criteria systematically, rating errors can be avoided. Basically, examiners should use their professional judgment in applying the grading criteria for each grading factor and rate the candidates' performance accordingly.

1. FIRST IMPRESSIONS. First impressions can have a lasting and troublesome effect on the evaluation process. During the first few minutes of the examination, the examiner may form a favorable or unfavorable impression of the candidate. The end result is that the examiner may distort or ignore various aspects of candidates' performance.

2. HALO/HORN EFFECT. Halo or horn effect is a broader example of the type of influence which occurs during first impressions. Halo refers to positive overgeneralization based on a positive aspect of performance. Horn refers negative overgeneralization based on a negative aspect of performance. Thus, if the candidate exhibits good or poor performance for one grading factor, the ratings for all factors are distorted.

3. STEREOTYPING. Stereotyping refers to unfair bias towards a candidate without being aware of the bias. Examiners should be aware of individual differences of candidates rather than generalizations about a group of people.

4. SIMILARITY EFFECTS. Similarity effects are the tendency of examiners to rate candidates more favorably if because the candidates perform tasks in the same style or use the same process as they do.

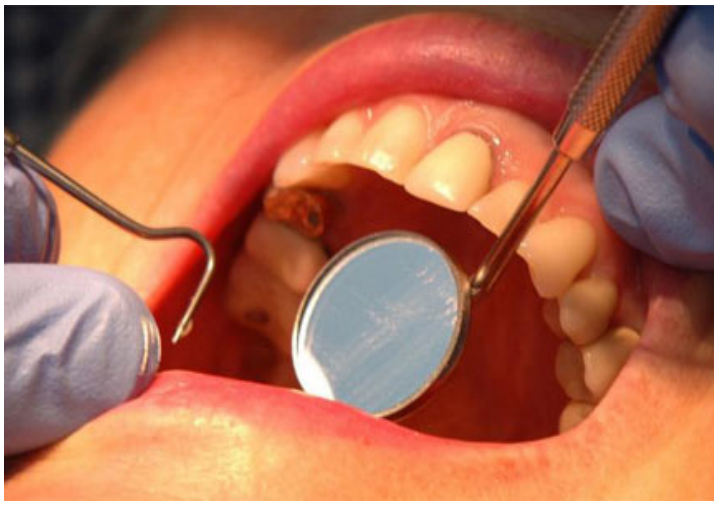
5. CONTRAST EFFECTS. Contrast effects are the result of evaluating the candidate relative to other candidates rather than applying the established grading criteria.

6. CENTRAL TENDENCY. Central tendency is the inclination to "play it safe" and rate candidates in the middle.

7. NEGATIVE AND POSITIVE LENIENCY. Leniency (level) error is the tendency of an examiner to rate candidates too low or too high on a consistent basis.

8. FRAME OF REFERENCE. Frame of reference error occurs when examiners compare candidate performance to their personal standards of care.

PORTFOLIO EXAMINATION AUDIT PROCESS 2015/2016



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Chapter 1 – Introduction

Purpose of audit process

This Audit Process is designed to serve multiple purposes. First it will provide information for auditors who will conduct site visits on behalf of the Dental Board of California (Board). The purpose of the site visits is to determine if the participating dental schools are following the procedures established for the evaluation and calibration system set forth by the Board for the Portfolio Examination. Second, it will provide information on which participating dental schools can conduct a self-assessment of its adherence to the Board's examination procedures. Third, it will provide a protocol for collecting documentation that will serve as validity evidence for the examination.

During an audit, in-depth information is obtained about the administrative and psychometric aspects of the portfolio examination, much like the accreditation process. An audit team comprised of faculty from the dental schools and persons designated by the Board would verify compliance with accepted professional testing standards, e.g., Standards for Educational and Psychological Testing, as well as verifying that the portfolios have been implemented according to the goals of the portfolio process.

Applicable psychometric standards

Standard 3.15 of the Standards for Educational and Psychological Testing[1] state:

"When using a standardized testing format to collect structured behavior samples, the domain, test design, test specifications and materials should be documented as for any other test. Such documentation should include a clear definition of the behavior expected of the test takers, the nature of expected responses, and any materials or directions that are necessary to carry out the testing." (p. 46)

Role of the Board

The Board has several responsibilities with regard to the audit:

- Oversight of audit process
- Establishment of grading standards necessary for public protection

[1] American Educational Research Association, American Psychological Association, & National Council on Measurement in Education (1999). Standards for Educational and Psychological Testing. Washington, DC: Author.

- Developing audit protocols and criteria for assessing schools' compliance with the evaluation system and calibration process
- Hands-on training for auditors in the evaluation system
- Selecting auditors who can maintain the independence between themselves and the Portfolio Examination process

Role of the audit team

The audit team is responsible for verification of the examination process, examination results, collection and evaluation of specific written documentation which respond to a set of standardized audit checklist, and summarizing the findings in a written report. A site visit can be conducted to verify portfolio documentation and clear up unresolved questions.

The audit team would be comprised of persons who can remain objective and neutral to the interests of the school being audited. The audit team should be knowledgeable of subject matter, psychometric standards, psychometrics and credentialing testing.

The audit team should be prepared to evaluate the information provided in a written report to the Board that documents the strengths and weaknesses of each school's administrative process.

Documentation for validity evidence

Each student will have a portfolio of completed, signed rating (grade) sheets which provide evidence that clinical competency examinations in the six areas of practice have been successfully completed.

In addition to the signed grade worksheets and summary of candidates' competency examinations, the following content specific documentation should be provided at the time of the audit site visit:

ORAL DIAGNOSIS AND TREATMENT PLANNING	• Full workup of case
DIRECT RESTORATION	• Restorative diagnosis and treatment plan • Preoperative radiographs, e.g., original lesion in Class II, III, IV
INDIRECT RESTORATION	• Restorative diagnosis and treatment plan • Preoperative radiographs
REMOVABLE PROSTHODONTICS	• Removable prosthodontic diagnosis and treatment plan • Preoperative radiographs illustrating treatment condition
ENDODONTICS	• Endodontic diagnosis and treatment plan • Preoperative radiographs of treatment site • Postobturation radiographs of treatment site

PERIODONTICS	• Periodontal diagnosis and treatment plan • Charted pocket readings • Preoperative radiographs including subgingival calculus • Follow-up report

It is anticipated that auditors will be presented with a representative sample of documentation from the candidate competency examination.

Schedule for audits

The Board will conduct audits of the Portfolio competency instructors and examinations every two years (biennially).

Chapter 2 – School Audit Information

RESOURCES	• Who is responsible for training dental school staff to assign final scaled scores and prepare final score reports and other required documentation to the Board? • What quality control procedures are in place to ensure that the final scaled scores and score reports are accurate?
TRAINING AND CALIBRATION OF EXAMINERS	• Who is responsible for the Calibration Training of Board-approved Portfolio examiners?
TEST SECURITY	• Are procedures in place to permit auditors to view patient information for the purposes of the audit? • Are procedures in place to maintain the security of the Portfolio examination materials before, during and after each competency examination? • Are procedures in place to maintain security of final scoring procedures and final scores?
QUALITY OF DOCUMENTATION	• Is the quality of the documentation consistent with accepted standards of care for each type of competency examination? • Are comments routinely available on the grading worksheets to justify an examiner's ratings?
PERFORMANCE STATISTICS	• Are procedures in place to produce reliability statistics for Portfolio examiners? • Are procedures in place to maintain pass/fail statistics for all factors?
INCIDENT REPORTS	• Are procedures in place to handle incidents that may arise during the implementation of competency examinations of the Portfolio Examination?
UNSUCCESSFUL CANDIDATES	• What procedures are in place for candidates who fail a competency examination and who wish to pursue the Portfolio Examination pathway to initial licensure?

Chapter 3 – Portfolio Audit Checklist

The audit checklist will be used to determine the standardization of the candidate portfolios at each dental school and must be completed prior to the ending of the site visit.

Portfolio Examination Audit Checklist

Candidate Name: _____

Candidate ID #: _____

Review of Applicant Portfolio			
Oral Diagnosis and Treatment Planning (ODTP)			
Clinical Experiences			
Does the portfolio include documentation of ODTP for a minimum of twenty (20) cases?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required fifteen (15) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ *(After three (3) failed attempts remedial education is required.)*		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Does the treatment plan include at least three (3) of the following six (6) disciplines? Mark all that apply: ☐ Periodontics ☐ Endodontics ☐ Operative (direct and indirect restoration ☐ Fixed and removable prosthodontics ☐ Orthodontics ☐ Oral Surgery	Y	N	Comments:
Patient Parameters			
• Maximum of ASA II • Missing or will be missing two or more teeth, not including third molars • At least moderate periodontitus (probing depth of 5 mm or more)	*Informational Only*		

Portfolio Examination Audit Checklist

Elements of ODTP Portfolio			
Does the medical history include: - Evaluations of past illness and conditions, hospitalizations and operations - Allergies - Family history - Social history - Current illnesses and medications and their effect on dental condition	Y	N	Comments:
Does the dental history include: - Age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts	Y	N	Comments:
Documentation of a comprehensive examination for dental treatment provided to patients?	Y	N	Comments:
Documentation the candidate evaluated data to identify problems?	Y	N	Comments:
Documentation the candidate worked up the problems and developed a tentative treatment plan?	Y	N	Comments:
Documentation the candidate developed a final treatment plan?	Y	N	Comments:
Was this a full workup of the case?	Y	N	Comments:
Direct Restoration			
Clinical Experiences			
Does the portfolio include documentation of Direct Restoration clinical experiences for a minimum of sixty (60) restorations?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required seven (7) scoring factors for the Class II amalgam or composite; maximum one slot preparation?	Y	N	Comments:

Portfolio Examination Audit Checklist

Does the portfolio contain completed grade sheets in the required seven (7) scoring factors for the Class II amalgam or composite or Class III or IV composite?	Y	N	Comments:
How many attempts did the candidate take in order to pass each of the portfolio competency examinations?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Class II Any permanent posterior tooth • More than one test procedure can be performed on a single tooth • Caries a shown on either of the two required radiograph of an unrestored proximal surface must extend to or beyond the dento-enamel junction • Tooth treated must be in occlusion • Must have adjacent tooth to be able to restore proximal contact • Tooth must be asymptomatic with no pulpal or periapical pathology • Tooth with bonded veneer not acceptable Class III/IV Any permanent anterior tooth *(optional)* • Treatment needs to be performed in the sequence described in the treatment plan • Caries shown on radiograph image of an unrestored proximal surface must extend to or beyond dento-enamal junction • Carious lesions must involve the interproximal contact area • Must have adjacent tooth to be able to restore proximal contact • Tooth must be asymptomatic with no pulpal or periapical pathology • Tooth with bonded veneer not acceptable	*Informational Only*		

Portfolio Examination Audit Checklist

Elements of Direct Restoration			
Includes documentation of the candidate's competency to perform a class II direct restoration on a tooth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials?	Y	N	Comments:
Includes documentation of the candidate's competency to perform a class III/IV direct restoration on a tooth containing primary carious lesions to optimal forms, function and esthetics using composite restorative material?	Y	N	Comments:
Was there a restorative diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs, E.g., original lesion in Class II, III, IV?	Y	N	Comments:
Indirect Restoration			
Clinical Experiences			
Does the portfolio include documentation of Indirect Restoration clinical experiences for a minimum of fourteen (14) restorations?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required seven (7) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Was the treatment performed in the sequence described in the treatment plan?	Y	N	Comments:

Portfolio Examination Audit Checklist

Was the tooth asymptomatic with no pulpal or periapical pathosis?	Y	N	Comments:
Was the tooth in occlusal contact with a natural tooth or permanent restoration?	Y	N	Comments:
Does the restoration include at least one cusp?	Y	N	Comments:
Is there an adjacent tooth in order to restore proximal contact?	Y	N	Comments:
Did the candidate perform any portion of the crown in advance?	Y	N	Comments:
Direct restoration materials which are placed to contribute to the retention and resistance form of the final restoration (build-ups) may be completed ahead of time if needed.	*Informational only*		
Was the restoration completed in the same tooth on the same patient by the same candidate?	Y	N	Comments:
Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of existing crown.	*Information only*		
Elements of Indirect Restoration			
Includes documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restoration? The treatment needs to be performed in the sequence in the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be in need of endodontic treatment. The tooth selected for restoration, must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of the onlay or greater. The tooth selected cannot replace existing or temporary crowns.	Y	N	Comments:

Portfolio Examination Audit Checklist

Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.			
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes documentation of the candidate's competency to complete a partial gold restoration must be an onlay or more extensive indirect restoration? The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.	Y	N	Comments:
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes documentation of the candidate's competency to complete a full gold restoration? The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel	Y	N	Comments:

surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.			
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes documentation of the candidate's competency to complete a metal-ceramic restoration? The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis: cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restorations must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient.	Y	N	Comments:
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.	*Informational only*		
Was there a restorative diagnosis and treatment plan?	Y	N	Comments:

Portfolio Examination Audit Checklist

Were there preoperative radiographs?	Y	N	Comments:
Removable Prosthodontics			
Clinical Experiences			
Does the portfolio include documentation of removable prosthodontics clinical experiences for a minimum of five (5) prostheses?	Y	N	Comments: *One of which may be used for the portfolio competency examination.*
Competency Examination			
Does the portfolio contain completed grade sheets in the required scoring factors for the prosthodontic performed?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Procedures may be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.	*Informational only*		
Elements of Removable Prosthodontics			
Includes documentation of the candidate's competency to: • Develop a diagnosis • Determined treatment options and prognosis for the patient to receive a removable prosthesis	Y	N	Comments:
Includes documentation of the candidate's competency to successfully restore edentulous spaces with removable prostheses?	Y	N	Comments:

Portfolio Examination Audit Checklist

Includes documentation of the candidate's competency to successfully manage tooth loss transitions with immediate or transitional prostheses?	Y	N	Comments:
Includes documentation of the candidate's competency to successfully manage prosthetic problems?	Y	N	Comments:
Includes documentation of the candidate's competency to successfully direct and evaluate the laboratory services for the prostheses?	Y	N	Comments:
Was there a removable prosthodontic diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs illustrating the treatment condition?	Y	N	Comments:
Endodontics			
Clinical Experiences			
Does the portfolio include documentation of Endodontic clinical experiences for a minimum of five (5) canals or any combination of canals in three separate teeth?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required ten (10) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Any tooth to completion by the same candidate on the same patient. Completed case is defined as a tooth with an acceptable and durable coronal seal.	*Information only*		

Portfolio Examination Audit Checklist

Elements of Endodontics			
Includes documentation of the candidate's competency in applied case selection criteria for endodontic cases?	Y	N	Comments:
Includes documentation of the candidate's competency to perform pretreatment preparation for endodontic treatment?	Y	N	Comments:
Includes documentation of the candidate's competency in performing access openings?	Y	N	Comments:
Includes documentation of the candidate's competency in performing proper cleaning and shaping techniques?	Y	N	Comments:
Includes documentation of the candidate's competency in performing proper obturation protocols?	Y	N	Comments:
Includes documentation of the candidate's competency in demonstrating proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height?	Y	N	Comments:
Includes documentation that the candidate competently completed the endodontic case including evidence that the candidate achieved coronal seal to prevent re-contamination and the candidate created diagnostic, radiographic and narrative documentation?	Y	N	Comments:
Includes documentation of the candidate's competency in providing recommendations for post endodontic treatment, including evidence that the candidate recommended final restoration alternatives and provided the patient with recommendations for outcome assessment and follow-up?	Y	N	Comments:
Was there an endodontic diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs of the treatment site?	Y	N	Comments:
Were there postobturation radiographs of the treatment site?	Y	N	Comments:

Portfolio Examination Audit Checklist

Periodontics			
Clinical Experiences			
Does the portfolio include documentation of periodontal clinical experiences for a minimum of twenty five (25) cases?	Y	N	Comments:
Competency Examination			
Did the combined clinical experience include a minimum of five (5) quads of scaling and root planing procedures?	Y	N	Comments:
Does the portfolio contain completed grade sheets in the required nine (9) Scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Has the case been scored in the following three (3) parts? ☐ Part A Review medical and dental history, radiographic findings, comprehensive periodontal date collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan ☐ Part B Calculus detection, effectiveness of calculus removal ☐ Part C Periodontal re-evaluation	Y	N	*In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.*
Patient Parameters			
Examination, diagnosis and treatment planning • Minimum twenty (20) natural teeth with at least 4 molars • At least one probing depth of 5 mm or greater must be present on at least four (4) of the teeth, excluding third molars, with at least two of	*Informational only*		

these teeth with clinical attachment loss of 2 mm or greater • Full mouth assessment or examination • No previous periodontal treatment at this institution, and no nonsurgical or surgical treatment within past 6 months	
Calculus detection and periodontal instrumentation (scaling and root planning • Minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar. • Third molars can be used but they must be fully erupted • At least one probing depth of 5 mm or greater must be present on at least two (2) of the teeth that require scaling and root planing. • Minimum of six (6) surfaces of clinically demonstrable subgingival calculus must be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus must be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual. If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.	*Informational only*
Re-evaluation • Candidate must be able to demonstrate a thorough knowledge of the case • Candidate must perform at least two (2) quadrants of scaling and root planing on the patient being reevaluated • Candidate must perform at least two	*Informational only*

documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing should have been completed within an interval of 6 weeks or less. • Minimum twenty (20) natural teeth with at least four (4) molars • Baseline probing depth of at least 5 mm on at least four (4) of the teeth, excluding third molars			
Elements of Periodontics			
Includes documentation that the candidate competently performed a comprehensive periodontal examination?	Y	N	Comments:
Includes documentation that the candidate competently diagnosed and developed a periodontal treatment plan that documents the following: ☐ The candidate determined the periodontal diagnosis ☐ The candidate formulated an initial periodontal treatment plan that demonstrated the following: o Determined to treat or refer patient o Discussed with patient the etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient specific oral hygiene instructions o Determined non-surgical periodontal therapy o Determined need for re-evaluation o Determined recall interval	Y	N	Comments:
Includes documentation that the candidate competently performed nonsurgical periodontal therapy that he/she: ☐ Detected supra and subgingival calculus ☐ Performed periodontal instrumentation • Removed calculus • Removed plaque • Removed stains	Y	N	Comments:

Portfolio Examination Audit Checklist

☐ Demonstrated that the candidate did not inflict excessive soft tissue trauma ☐ Demonstrated that the candidate provided the patient with anesthesia			
Includes documentation that the candidate competently performed a periodontal re-evaluation?	Y	N	Comments:
Was there a periodontal diagnosis and treatment plan?	Y	N	Comments:
Were there charted pocket readings?	Y	N	Comments:
Was there preoperative radiographs?	Y	N	Comments:
Was there a follow-up report?	Y	N	Comments:

Portfolio Examination Audit Checklist

Narrative (Please print legibly or type. Additional sheets may be attached as necessary)		
Auditors Printed Name:	**Date**	**Signature of Auditor**

Expanded Functions
Frequently Asked Questions
Approved By the Iowa Dental Board: 4/29/16

Overview: This document answers frequently asked questions about expanded functions. Expanded functions may be performed by registered dental assistants and licensed dental hygienists who have completed Board-approved training. They are broken into Level 1 and Level 2 procedures. Training for Level 1 procedures must consist of the following:

(1) An initial assessment to determine the base entry level of all participants in the program. At a minimum, all participants must meet established requirements before beginning expanded function training;
(2) A didactic component;
(3) A laboratory component, if necessary;
(4) A clinical component, which may be obtained under the personal supervision of the participant's supervising dentist while the participant is concurrently enrolled in the training program; and
(5) A postcourse competency assessment at the conclusion of the training program.

Training for Level 2 procedures is only available through the University of Iowa.

Iowa Administrative Code 650-20.4 establishes the requirements for registered dental assistants to provide expanded functions. Iowa Administrative Code 650-10.3(8) establishes the requirements for licensed dental hygienists to provide expanded functions.

1. Who is eligible to train for Level I Expanded Functions Procedures?
Registered dental assistants and licensed dental hygienists are eligible to train in expanded functions as outlined below.

Registered Dental Assistants:
To be eligible for expanded functions training, a registered dental assistant meet at least one of the following requirements:

1. Be a graduate of an ADA-accredited dental assistant program; or
2. Be currently certified by the Dental Assisting National Board (DANB); or
3. Have at least one year of clinical practice as a registered dental assistant; or
4. Have at least one year of clinical practice as a dental assistant in a state that does not require registration.

Licensed Dental Hygienists:
Any licensed dental hygienist is eligible to train for Level 1 procedures.

2. Is a dental assistant trainee eligible for Level I Expanded Functions Procedures?
No. A dental assistant trainee is not eligible to train in Level 1 procedures.

***3. What are the education and training requirements to become an expanded functions provider*?**
All expanded function training must be prior-approved by the Board. See question 15 for more information.

4. Which courses are acceptable for Level 1 training?
Courses which have been reviewed and approved by the Board are acceptable for Level 1 training. More information regarding Board approved courses can be found at http://www.dentalboard.iowa.gov/practitioners/dental-assistants/xfinfo.html.

5. Do I have to train in all Level I Expanded Functions Procedures or can I pick and choose?
You may choose to train in any one or several of the expanded function duties in order to become a basic expanded function provider. However, to become a Certified Level 1 Provider, you must successfully complete the training for all Level I Expanded Function Procedures and provide verification of the completion of Level 1 procedures (see attached sample Documentation of Training).

6. What documentation do I need to verify that I have completed all of the Level 1 Expanded Functions Procedures?
The Board has a sample documentation form available, or you may develop your own form to maintain documentation. At minimum, the course trainer/teacher needs to sign off on each function, verifying the completion of each function that was successfully completed. A signed certificate of completion is an acceptable form of documentation.

Both the supervising dentist and registered dental assistant or dental hygienist shall be responsible for maintaining in each office of practice documentation of successful completion of the Board-approved training.

7. Can I become a Level I Certified Provider, if I have completed training through multiple trainers?
Yes, provided you have documentation of all training provided.

8. If I have trained in all Level I Expanded Functions Procedures, do I need a formal certificate which verifies my status as a Level 1 Certified Provider?
No. It is the responsibility of the Level 1 dental hygienist or registered dental assistant to obtain and maintain documentation of completion for each function. If you have documentation that you have completed training in all functions, you are considered to be a Level 1 Certified Provider.

9. Do I need to register my Level I status with the Board?
No. The supervising dentist and registered dental assistant or dental hygienist shall be responsible for maintaining in each office of practice documentation of successful completion of the Board-approved training.

10. Can I be awarded continuing education credit for training in expanded functions?
Yes. Board-approved courses are eligible for continuing education credit. The course trainer/teacher can verify the number of continuing education credits that have been approved.

11. What examinations are required for Level 1 Expanded Functions Procedures?
Both pre and post-tests are required for Level 1 procedures.

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12. Who is eligible for Level 2 Expanded Function Procedures?
Certified Level 1 Providers who have completed training in all Level 1 procedures. In order to be eligible to train for Level 2 procedures, you must first become a Certified Level 1 Provider.

13. What are the differences in Level 1 Expanded Function Procedures for registered dental assistants and dental hygienists?
Per Board rules, there are some distinctions in Level 1 Expanded Function Procedures between dental assistants and dental hygienists as some functions are already included in the dental hygiene scope of practice. There are 5 Level 1 procedures for dental hygienists and 11 Level 1 procedures for dental assistants. Please review the list of Level 1 functions below and note the differences.

Dental Hygienists Level 1 procedures:

1. Taking occlusal registrations for purposes other than mounting study casts;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases and bonding systems for restorative purposes; and
5. Taking final impressions.

Registered Dental Assistants Level 1 procedures:

1. Taking occlusal registrations;
2. Placement and removal of gingival retraction;
3. Fabrication and removal of provisional restorations;
4. Applying cavity liners and bases, desensitizing agents, and bonding systems;
5. Placement and removal of dry socket medication;
6. Placement of periodontal dressings;
7. Testing pulp vitality;
8. Monitoring of nitrous oxide inhalation analgesia;
9. Taking final impressions;
10. Removal of adhesives (hand instrumentation only); and
11. Preliminary charting of existing dental restorations and teeth.

14. Does Level 1 include placement of a provisional restoration?
No. A Level 1 dental hygienist or registered dental assistant can *only* fabricate or remove a provisional restoration. The placement of a provisional restoration is not a permitted function.

15. Can a hygienist take an expanded function course on those procedures which are already included in the scope of practice, such as the monitoring of nitrous oxide?
Yes, but it is not required in order for a hygienist to become a Certified Level 1 Provider.

16. If I took expanded function training as a dental assistant, and later become a dental hygienist, do my expanded function credentials carry-over, or do I have to re-train?
They carry-over. If you change professions, from a dental assistant to a dental hygienist, your expanded function credentials are valid, as long as you continue to maintain documentation of all training provided. You do not have to re-train.

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17. What do I need to submit to become a Board-approved provider of Level 1 expanded functions training?
The following items must be submitted for Board consideration:

1. Expanded Functions Prior Approval Form
2. Detailed course description for each function
3. Course outline for each function which clearly shows the following:
    a. Breakout of hours spent on each topic area
    b. A didactic component
    c. A laboratory component, if necessary
    d. A clinical component
4. An initial assessment to determine base entry level of participants (pre-test)
5. A postcourse competency assessment (post-test)

18. What level of supervision is required for expanded function procedures?
Per Board rules, the below supervision levels are required for expanded function procedures:

Dental Hygienists:
A dental hygienist may only perform expanded function procedures which are delegated by and performed under the supervision of a dentist. The taking of occlusal registrations for purposes other than mounting study casts may be performed under general supervision; all other expanded function procedures shall be performed under direct supervision.

Dental Assistants:
Dental assistants may only perform expanded function procedures which are delegated by and performed under the direct supervision of a dentist.

19. Can dental hygienists and dental assistants take the same course(s)?
Yes. Dental hygienists and dental assistants can take the same course(s).

20. Do I need to renew or complete ongoing courses to maintain my expanded functions training?
No. There are currently no requirements for renewal of expanded functions training.

21. Where do I go to receive Level 2 training?
Level 2 training will be provided by the College of Dentistry at the University of Iowa, but it is currently under development. More information on the Level 2 training will be posted on the Board website once the Level 2 training is available.

In order to be eligible to start Level 2 training the applicant must first pass an entrance exam, which will be administered by the University of Iowa.

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IOWA DENTAL BOARD STANDING COMMITTEES

Updated 7/29/15

Dental Hygiene Committee (DHC)	Date Appointed
Mary Kelly, R.D.H., Chair	**2011**
Nancy Slach, R.D.H.	2012
Tom Jeneary, D.D.S.	2015
**mandated by statute*	

Anesthesia Credentials Committee (ACC)	Date Appointed
Kaaren Vargas, D.D.S., Chair (Board Member)	**2012**
John Frank, D.D.S.	2013
Richard Burton, D.D.S.	prior to 2012
Steven Clark, D.D.S.	prior to 2012
Kurt Westlund, D.D.S.	prior to 2004
Doulgas Horton, D.D.S.	prior to 2004
Gary Roth, D.D.S.	prior to 2004
Jonathan DeJong, D.D.S., Alternate	*July, 2015*
**mandated by rule*	

Continuing Education Advisory Committee (CEAC)	Date Appointed
Lori Elmitt, Chair (Board Member)	***2012***
Steven Fuller, D.D.S. (Board Member)	2013
Marijo Beasler, R.D.H.	2009
Will McBride, D.D.S.	July, 2015
Sarah Stream, R.D.A.	July, 2015
Kristee Malmberg, R.D.A.	prior to 2006
Sara Schlievert, R.D.H.	July, 2015
**mandated by rule*	

Iowa Practitioner Review Committee (IPRC)	Date Appointed
Richard Rips, D.D.S., Chair	**2011**
Gordon Anderson, II, IADC, Vice Chair	**2010**
DeAnn Decker, IADC	2013
Sheila Rogers, CADC, CCGC	2013
Jill Stuecker, IDB Executive Director	2014
James Gallagher, MD, FAPA	July, 2015
**mandated by rule*	

Licensure/Registration Committee (L&RC)	Date Appointed
Kaaren Vargas, D.D.S., Chair	***2012***
Tom Jeneary, D.D.S.	2013
Diane Meier	2008
**mandated by rule*	

Dental Assistant Registration Committee (DARC)	Date Appointed
George North, D.D.S., Chair	***Est. 2003***
Terri Deal, DMACC DA Program Director	2015
Stephany Anderson, DA	2015
Tom Jeneary, D.D.S. (Board Member)	2013
Steven Fuller, D.D.S. (Board Member)	2011
Steven Bradley, D.D.S. (Board Member)	2010
Diane Meier (Board Member)	2008
**created by Board*	

Executive Committee (EC)	Date Appointed
Steven Bradley, D.D.S., Chair	***2012***
Steven Fuller, D.D.S., Vice-Chair	2013
Kaaren Vargas, D.D.S., Secretary	2013
Mary Kelly, R.D.H.	2012
**created by Board*	

Expanded Functions Committee (EFC)	Date Appointed
Nancy Slach, R.D.H., Chair (Board Member)	***2013***
Tom Jeneary, D.D.S. (Board Member)	2013
Jane Slach, R.D.A.	2013
Elaine Peterson, R.D.A.	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Michael Kanellis, D.D.S.	2013
Jeff Chaffin, D.D.S.	July, 2015
**created by Board*	

IOWA DENTAL BOARD STANDING COMMITTEES

IOWA DENTAL BOARD AD HOC COMMITTEES

Examination Review Committee (ERC)	***Date Appointed***
P.T. Grimes, D.D.S., Chair	***2008***
Steven Fuller, D.D.S. (Board Member)	2012
David Holmes, D.D.S.	prior to 2006
Michael Kanellis, D.D.S.	prior to 2006
Deena Kuempel, D.D.S.	prior to 2006
**ad hoc, created by Board*	

Skilled Care Facility Task Force	***Date Appointed***
Michael Kanellis, D.D.S., Chair	***2013***
Steven Bradley, D.D.S. (Board Member)	2013
Mary Kelly, R.D.H. (Board member)	2013
Eileen Cacioppo, R.D.H.	2013
Howard Cowen, D.D.S.	2013
Lori Elmitt (Board Member)	2013
Jane Slach, R.D.A.	2013
Beth Jones	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Maria Fuller, D.D.S.	2013
**ad hoc, created by Board*	

Dental Hygiene Committee Purpose Statement

The Dental Hygiene Committee is established in Iowa Code Section 153.33. The committee shall have the authority to adopt recommendations regarding the practice, discipline, education, examination, and licensure of dental hygienists and shall carry out duties as assigned by the board. The committee shall have no regulatory or disciplinary authority with regard to dentists, dental assistants, dental lab technicians, or any other auxiliary dental personnel (subsection 2).

The board shall ratify recommendations of the committee at the first meeting of the board following adoption of the recommendations by the committee, or at a meeting of the board specifically called for the purpose of board review and ratification of committee recommendations. The board shall decline to ratify committee recommendations only if the board makes a specific finding that a recommendation exceeds the jurisdiction or expands the scope of the committee beyond the authority granted in subsection 2, creates an undue financial impact on the board, or is not supported by the record (subsection 3).

Current Members	***Date Appointed***
Mary Kelly, R.D.H., Chair	***2011***
Nancy Slach, R.D.H.	2012
Tom Jeneary, D.D.S.	2015

Additional Information

Number of Members: 3, established in Iowa Code

Frequency of Meetings: Once per quarter, or as needed

Number of Vacancies: None

Method of Appointment: The 2 dental hygiene members of the board are automatically members. The dentist member shall be elected to the committee annually by a majority vote of board members. The dentist member must have supervised and worked in collaboration with a dental hygienist for a period of at least 3 years immediately preceding election to the committee.

Term Limits: None

Mode of Meeting: Typically in person; teleconferences on occasion

Staff Coordinator: Christel Braness

**mandated by statute*

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Anesthesia Credentials Committee Purpose Statement

The Anesthesia Credentials Committee is established in Iowa Administrative Code 650--Chapter 29. The committee is tasked with reviewing requests related to the issuance and renewal of moderate sedation and general anesthesia permits.

Current Members	***Date Appointed***
Kaaren Vargas, D.D.S., Chair (Board Member)	***2012***
John Frank, D.D.S.	2013
Richard Burton, D.D.S.	prior to 2012
Steven Clark, D.D.S.	prior to 2012
Kurt Westlund, D.D.S.	prior to 2004
Doulgas Horton, D.D.S.	prior to 2004
Gary Roth, D.D.S.	prior to 2004
Jonathan DeJong, D.D.S., Alternate	*July, 2015*

Additional Information

Number of Members: No fewer than 7. According to IAC 650--29.10 this committee shall be chaired by a member of the board and shall include at least 6 additional members who are licensed dentists. At least 4 committee members shall hold deep sedation/gederal anesthesia or moderate sedation permits.

Frequency of Meetings: Once per quarter, or more frequently as needed
Number of vacancies: 0
Method of Appointment: Appointed by the board. The board chairperson shall appoint the committee chair.
Term Limits: None
Mode of Meeting: Typically by teleconference; occassionally in-person
Staff Coordinator: Christel Braness

**mandated by rule*

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Continuing Education Advisory Committee Purpose Statement

The Continuing Education Advisory Committee is a committee established in IAC 650--25.1 to review and make recommendations on requests for continuing education courses, or other continuing education-related issues, as requested.

Current Members	*Date Appointed*
Lori Elmitt, Chair (Board Member)	***2012***
Steven Fuller, D.D.S. (Board Member)	2013
Marijo Beasler, R.D.H.	2009
Will McBride, D.D.S.	July, 2015
Sara Schlievert, R.D.H.	July, 2015
Sarah Stream, R.D.A.	July, 2015
Kristee Malmberg, R.D.A.	prior to 2006

Additional Information

Number of Members: 7. The committee is established in IAC 650--25.1. Must consist of 1 member of the board, 2 licensed dentists with expertise in the area of professional continuing education, 2 licensed dental hygienists with expertise in the area of professional continuing education, and 2 registered dental assistants with expertise in the area of professional continuing education.

Frequency of Meetings: Once every 6-8 weeks, or as needed
Number of Vacancies: 0
Method of Appointment: Appointed by the board. The board chairperson shall appoint the committee chair.
Term Limits: None
Mode of Meeting: Typically by teleconference; occassionally in-person
Staff Coordinator: Christel Braness, Angela Davidson

**mandated by rule*

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Iowa Practitioner Review Committee Purpose Statement

The Iowa Practitioner Review Committee (IPRC) is established in Iowa Administrative Code 650--Chapter 35 to evaluate, assist, and monitor the recovery, rehabilitation, or maintenance of dentists, hygienists, or assistants who self-report impairments. The IPRC is both an advocate for the health of a practitioner and a means to protect the health and safety of the public.

Current Members	***Date Appointed***	***Date Reappointed***	***Term Expires***
Richard Rips, D.D.S., Chair	***2011***	2014	4/30/2017
Gordon Anderson, II, International Alcohol and Drug Counselor, Vice Chair	2010	2013	4/30/2016
DeAnn Decker, International Alcohol and Drug Counselor	2013		4/30/2016
Sheila Rogers, Certified Alcohol and Drug Counselor, Certified Compulsive Gambling Counselor	2013		4/30/2016
Jill Stuecker, Executive Director	2014		N/A
James Gallagher, MD, FAPA	July, 2015		4/30/2018
Vacant: Public Member			

Additional Information

Number of Members: Not specified in rule
Frequency of Meetings: Once per quarter
Number of Vacancies: 1, the committee wishes to have a psychiatrist or psychologist
Method of Appointment: The chairperson of the board shall appoint the members of the IPRC. Membership may include but is not limited to: executive director of the board, 1 practitioner who has remained free of addiction for no less than 2 years following successful completion of a board-approved recovery program, 1 physician/counselor with expertise in substance abuse/addiction treatment program, 1 psychiatrist or psychologist, and 1 public member. The committee shall elect a chairperson and vice chairperson annually at the last meeting closest to April 30. They will both serve 1 year terms beginning on May 1.

Term Limits: Committee members, except the executive director, shall be appointed for 3 year terms which begin on May 1 and terminate on April 30

Mode of Meeting: In-person
Staff coordinator: Angie Davidson
**mandated by rule*

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Licensure/Registration Committee Purpose Statement

The licensure/registration committee is responsible for reviewing and recommending appropriate action concerning applications for: Permanent licensure as a dentist in cases where former disciplinary action or criminal history has been reported and meets the criteria for review; Resident dental licenses or faculty permits in cases where the applicants are foreign trained; Reinstatement in cases where the practitioner has been out of practice for 5 or more years, to determine if additional examination(s) are required prior to reinstatement; Dental assistant registrations, radiography qualifications, reinstatements who have a criminal history; Dental assistant reinstatements for examination recommendations over five years, not covered in existing rules.

Current Members	***Date Appointed***
Kaaren Vargas, D.D.S., Chair	***2015***
Tom Jeneary, D.D.S.	2013
Diane Meier	2008

Additional Information

Number of Members: 3. This committee requires appointments of board members due the confidential nature of the material (4 members could result in a tie, and 5 or more would establish a quorum of the board so it must be 3).

Frequency of Meetings: By email or as needed

Number of Vacancies: None

Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None

Mode of Meeting: By email or in person

Staff Coordinator: Janet Arjes, Christel Braness

**mandated by rule*

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Dental Assistant Registration Committee Purpose Statement

The Dental Assistant Registration Committee was created by the board to review issues relating to dental assistants. The committee monitors policies around the registration and reinstatement process; testing; expanded functions and other issues as needed. The committee also reviews items as requested by the board.

Current Members	***Date Appointed***
George North, D.D.S., Chair	***Est. 2003***
Terri Deal, DMACC Dental Assistant Program Director	2015
Stephany Anderson, Registered Dental Assistant	2015
Tom Jeneary, D.D.S. (Board Member)	2013
Steven Fuller, D.D.S. (Board Member)	2011
Steven Bradley, D.D.S. (Board Member)	2010
Diane Meier (Board Member)	2008

Additional Information

Number of Members: At board chairperson's descretion
Frequency of Meetings: As needed
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None
Mode of Meeting: In person and by teleconference
Staff Coordinator: Janet Arjes
**created by Board*

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Executive Committee Purpose Statement

The Executive Committee is a subset of the board available to the executive director for support and guidance.

Current Members	***Date Appointed***
Steven Bradley, D.D.S., Chair	***2012***
Steven Fuller, D.D.S., Vice-Chair	2013
Kaaren Vargas, D.D.S., Secretary	2013
Mary Kelly, R.D.H.	2012

Additional Information

Number of Members: At board chairperson's descretion. The executive committee should have at least a chair, vice-chair and secretary.
Frequency of Meetings: Once per quarter
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Board chairperson serves as committee chair.
Term Limits: None
Mode of Meeting: In person or by phone as needed
Staff Coordinator: Jill Stuecker
**created by Board*

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Examination Review Committee Purpose Statement

The Examination Review Committee is an hoc committee established to review and discuss matters related to the licensing examinations accepted by the board.

Current Members	***Date Appointed***
P.T. Grimes, D.D.S., Chair	***2008***
Steven Fuller, D.D.S. (Board Member)	2012
David Holmes, D.D.S.	prior to 2006
Michael Kanellis, D.D.S.	prior to 2006
Deena Kuempel, D.D.S.	prior to 2006

Additional Information

Frequency of Meetings: Has not met in several years
Number of Members: At board chairperson's descretion
Number of vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.
Term Limits: None
Mode of Meeting:
Staff Coordinator: Jill Stuecker

**ad hoc, created by Board*

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Expanded Functions Committee Purpose Statement

The Expanded Functions Committee was created by the Board and is tasked with reviewing and making recommendations to the Board on expanded function courses.

Current Members	***Date Appointed***
Nancy Slach, R.D.H., Chair (Board Member)	***2013***
Tom Jeneary, D.D.S. (Board Member)	2013
Jane Slach, R.D.A.	2013
Elaine Peterson, R.D.A.	2013
Lynn Curry, D.D.S.	2013
Steven Thies, D.D.S.	2013
Michael Kanellis, D.D.S.	2013
Jeff Chaffin, D.D.S.	July, 2015

Additional Information

Number of Members: 7
Frequency of Meetings: As needed
Number of Vacancies: 0
Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.
Term Limits: None
Mode of Meeting: In person and by teleconference
Staff Coordinator: Janet Arjes, Christel Braness

**ad hoc, created by Board*

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Skilled Care Facility Task Force Purpose Statement

The Skilled Care Facility Task Force is an ad hoc task force created to discuss and review concerns related to dental health care access of residents of skilled care facilities. The task force was tasked with reviewing options related to these individuals and how to best address access to dental health care.

Current Members	***Date Appointed***	
Michael Kanellis, D.D.S., Chair	***2013***	michael-kanellis@uiowa.edu
Steven Bradley, D.D.S. (Board Member)	2013	sbradley@netins.net
Mary Kelly, R.D.H. (Board member)	2013	marykellyrdh@msn.com
Eileen Cacioppo, R.D.H.	2013	ECacioppo@aol.com
Howard Cowen, D.D.S.	2013	howard-cowen@uiowa.edu
Lori Elmitt (Board Member)	2013	lorielmitt@msn.com
Jane Slach, R.D.A.	2013	Jane.Slach@kirkwood.edu
Beth Jones	2013	bjones@deltadentalia.com
Lynn Curry, D.D.S.	2013	curry4596@msn.com
Steven Thies, D.D.S.	2013	srthis@qwestoffice.net
Maria Fuller, D.D.S.	2013	mftooth@yahoo.com

Additional Information

Number of Members: At board chairperson's descretion

Frequency of Meetings: Task Force has not met in approximately 1 year.

Number of Vacancies: 0

Method of Appointment: Appointed by board chairperson. Committee chair also appointed by board chairperson.

Term Limits: None

Mode of Meeting: Meet in person and by teleconference as appropriate

Staff Coordinator: Phil McCollum

**ad hoc, created by Board*

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***This is an external committee**

CRDTS Steering Committee	*Appointed:*
Steven Bradley, D.D.S.	

CRDTS Examination Review Committees	*Appointed:*
Kaaren Vargas, D.D.S. - Dental Examinations	
Mary Kelly, R.D.H. - Hygiene Examinations	

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2017 Dental Board Meeting Dates

January 26-27, 2017

April 27-28, 2017

May 18, 2017 – Teleconference, Thursday at 7am

July 13-14, 2017

October 12-13, 2017