Bermuda Dental Board Examination Packet

Dental Practitioner Exam

BERMUDA DENTAL BOARD
MINISTRY of HEALTH
CONTINENTAL BUILDING,
25 CHURCH STREET,
HAMILTON 12
P.O. Box HM 1195, Hamilton HM EX, Bermuda
Telephone: (441) 278-4900

Dear Candidate,

The Bermuda Dental Board examination is designed to give you, the candidate, an opportunity to demonstrate your skill and clinical judgment.

The grading for the practical examination is as follows you are awarded a 3 for SAT, 2 for ACC, 1 for SUB and a 0 for DEF. There are 14 areas for each procedure. You must achieve 28 points or more to pass a procedure and you must pass both anterior and posterior restoration procedures.

If at any time the directions seem unclear or you have questions regarding the format, terminology or criteria please ask.

We recognize that definitions and methods may differ between jurisdictions and we are open to considering other approaches when they are brought to us prior to the examination.

Also, at anytime during the examination, if you see a need to step outside of the criteria as listed SAT (satisfactory), please inform the examination committee prior to doing so. By doing this, we are able to see that you understand what is satisfactory and it may help your score.

Finally, there are a few critical errors that will result in an automatic failure. These are:

- Treating the wrong tooth or surface of the tooth
- A pulpal exposure
- Lack of clinical judgment or diagnostic skill
- A fractured restoration
- A restoration that debonds or moves
- Gross damage to the adjacent tooth
- Visibly open contact

The Bermuda Dental Board wishes to continually improve this examination process and feedback from you or your patient is welcomed. Your feedback or your patient's feedback will in no way affect the results of your examination.

Sincerely,
Dr. Ronda James
Chair, Bermuda Dental Board

1. Procedure for becoming registered in Bermuda as a dental services provider when an examination is required.

1. Apply to the Ministry of Health using the application form that can be downloaded from bermudadentalboard.org. Include with application originals or certified copies of Certificates, Diplomas and Licenses and evidence of liability insurance coverage. If Bermudian, skip steps 2&3.
2. If a work permit is required the Board will review your application and provide the employer of applicant with a letter of support and Form 11.
3. Once Work permit is granted the employer needs to notify the Dental Board.
4. With recognized documentation, the Dental Board will write to the Applicant with the dates and times for the qualifying examination.

The Permanent Secretary will be notified as to whether the applicant successfully passed the examination. The successful candidate will be issued a Registration Certificate in about 5 working days. Please note that applicants may not practice until the Registration Certificate is issued.

Inquiries regarding the progress of an application should be addressed Ms. Char-Lee Simons or Ms Thomas at the ministry.

2. Explanatory Notes

Eligibility to take Qualifying Examination: Graduates from accredited and recognized institutions. Must be Bermudian, PRC or have a Work Permit.

Examiners: Three Board members. When three members are not available than appropriately registered dental practitioner will be asked to fill in.

Testing Site: The examination will be conducted at the office of a Board Member. Applicant may contact the office where the exam will be given for inquires regarding the facilities and equipment.

The facility will provide:

- Gloves and mask but no protective eye wear or attire
- Operating Dental Unit
- Surface disinfectant
- Light curing unit
- Assistant approved by the Dental Board, the examinee is obligated to pay for the time of the assistant at a rate of $55 per hour.

3. Examination for Dentists

Part 1- Questions to be completed in 3 hours with a passing grade of 65%

Part 2- The practical exam consists of the preparation, filling and finishing a class II in the posterior and a Class III or IV in the anterior. Passing grade is 28 out of 42 points on both parts.

You may use whatever evidence based materials or aids that you are comfortable with and that will afford you a passing grade. The examination criteria sheets in this packet explain what you are being graded on for the practical.

2.1 Policy for Re-examination

When an applicant does not achieve a score of 65 in Part I or at least 28 points on both procedures in Part II, the Part failed must be retaken. The written is given first and requires a passing grade before the practical is given. The Act states that a candidate is not eligible to re-sit the examination for 6 months.

2.2 Standards of conduct during parts 1 or 2 of examination

Failure to adhere to these standards may result in failure to pass examination.

1. Any substantiated evidence of collusion, dishonesty, use of unwarranted assistance or intentional misrepresentation during registration or during the examination will result in failure of the examination.
2. All exercises of the examination shall be completed within the specified time frame.
3. No equipment, instruments or materials shall be removed from the examination site without written permission from the owner. Willful or careless damage of equipment at the testing site will result in failure and repairs or replacement costs must be paid by the candidate.
4. All required records from the examination must be turned in before examination is considered complete.
5. The candidate must perform only the treatment procedures assigned.

2.3 Standards for Clinical Examination Part 2

1. The candidate must complete **Health History** and establish a diagnosis and appropriate treatment plan for the patient. Misinformation or missing information that could endanger the patient, candidate, assistant or examiners will be cause for action including dismissal from the examination.
2. The candidate must behave in an **ethical and proper** manner. Patients shall be treated with proper concern for their safety and comfort.
3. **Universal precautions** and infection control procedures must be followed at all times.

4. The **patient selection** for the examination must provide the lesions required for this examination. Lesions must be **radiographically evident and extend into the dental layer**. Large carious lesions are inappropriate for this examination.
5. The candidate must adequately and **properly isolate** the restorative field with rubber or non-latex dental dam.
6. There was be **no evidence of unwarranted damage** to soft or hard tissue.
7. **In the case of equipment failure**, the site host examiner must be immediately notified so that it can be corrected.
8. When **local anesthetic** is required for the patient, the candidate is responsible for ensuring that the appropriate anesthetic is correctly administered in the proper dosage and recorded in the designated records. Inhalation and intravenous anesthetics are not permitted for the examination.
9. Appropriate **radiographs** must meet the requirements of the examination. Alteration to radiographs will result in failure of the examination. Pre-op radiographs will remain with the Board and examination papers along with post-op radiographs.
10. A **trained dental assistant** will be provided by the Board and paid for by the candidate. Bringing in an assistant is not an option.

4. Check out procedure:

In order to complete the examination process the following items must be provided to the examination committee. It is useful if you use the following list as a check off list and have the examiner that you give your forms initial items on lines provided.

_____Health history, treatment plan, anesthetic record and consent(2)

_____Pre-operative and Post-operative radiographs

_____Initialed Examination Flow sheets

_____Feedback Forms (Optional)

POSTERIOR COMPOSITE PREPARATION -INTERNAL AND EXTERNAL FORM

AXIAL WALLS AND PULPAL FLOOR

SAT	Preparation of the pulpal floor and axial walls is no deeper than 2.0mm
ACC	Preparation of the pulpal floor and axial walls is no deeper than 3.0 mm*
SUB	Preparation of the pulpal floor and axial walls is >3 but less than 4mm*
DEF	Preparation is greater than 4mm from the cavosurface margins.*

*If an extension of preparation is required , inform the examining committee BEFORE extending beyond "satisfactory" as defined above.

CARIES AND REMAINING MATERIAL

SAT	All caries and/or previous restorative material s are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

PREPARED SURFACES

SAT	All prepared surfaces are smooth, caries free and well-defined .
DEF	The prepared surfaces are irregular or ill-defined.

PROXIMAL CLEARANCE

SAT	Proximal contact is visibly open up to 1.5.
DEF	No proximal clearance visible or excessive clearance greater than 1.5mm.*

*If additional clearance is needed, inform the examining committee BEFORE extending beyond "satisfactory" as defined above.

OUTLINE SHAPE/CONTINUITY/EXTENSION

SAT	The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing with no sharp curves or angles.
SUB	The outline form is inappropriately overextended so that is compromises the remaining marginal ridge and or cusps. The outline is underextended and non-coalesced fissures remain which extend to the DEJ and are contiguous with the outline form.
DEF	The outline form is overextended so that it compromises, undermines and leaves unsupported remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the marginal ridge is 1.0 mm or less

CAVOSURFACE MARGIN

SAT	Cavosurface margins are beveled and terminate in sound natural tooth, free of previous restorative material, including sealants and decalcification.
DEF	Cavosurface margin includes unsupported enamel, or there is explorer penetrable decalcifiaction, or terminates on sealant or other restorative material.

CONDITION OF ADJACENT TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal, or recontouring of the tooth adjacent to the restoration.
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure adjacent to the restoration.
DEF	There is evidence of unwarranted or unnecessary removal , modification, or recontouring of tooth structure adjacent to the restoration. (enameloplasty)

EXAMINATION CRITERIA
POSTERIOR COMPOSITE FINISHED RESTORATION

MARGIN DEFICIENCY

SAT	There is no margin deficiency. There is no evidence of voids or open margins.
DEF	There is evidence of marginal deficiency to include pits and voids at the cavosurface margin, and /or there is an open margin.

MARGIN EXCESS AND GINGIVAL OVERHANG

SAT	There is no detectable marginal excess at the restoration-tooth interface either visually or with the tine of an explorer and doesn't catch when flossed.
DEF	There is evidence of excess at the restoration-tooth interface.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

INTERPROXIMAL CONTACT

SAT	Contact is present, visually closed and properly shaped. Definite, not excessive, resistance to floss.
ACC	Visually closed, adequate in size shape and position, little resistance to floss.
SUB	Visually closed, but deficient in size shape or position, little resistance or shreds floss.
DEF	No contact, visually open OR will not allow floss to pass through the contact.

CENTRIC/EXCURSIVE CONTACTS

SAT	With articulating paper, centric and excursive contacts are consistent in size, shape and intensity with contacts on other teeth within the quadrant.
SUB	With articulating paper, restoration is in hyper occlusion to other teeth in quadrant and requires adjustment.
DEF	There is gross hyperocclusion so that tooth is only one in contact OR there is no occlusion.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth , occlusal and marginal ridge anatomy.
DEF	The restoration does not reproduce the normal occlusal anatomy, marginal ridge anatomy, and would be expected to adversely affect tissue health.

CONDITION OF SOFT TISSUE

SAT	The soft tissue is free from damage or damage is consistent with procedure.
SUB	There is iatrogenic soft tissue damage inconsistent with procedure.
DEF	There is gross iatrogenic soft tissue damage inconsistent with pre-existing condition of the soft tissue and the procedure.

ANTERIOR CLASS III OR IV COMPOSITE PREPARATION -INTERNAL AND EXTERNAL FORM

AXIAL WALLS AND PULPAL FLOOR

SAT	Preparation of the pulpal floor and axial walls is no deeper than 2.0mm
ACC	Preparation of the pulpal floor and axial walls is no deeper than 3.0 mm*
SUB	Preparation of the pulpal floor and axial walls is >3 but less than 4mm*
DEF	Preparation is greater than 4mm from the cavosurface margins.*

*If an extension of preparation is needed, inform the examining committee BEFORE extending beyond "satisfactory" as defined above.

CARIES AND REMAINING MATERIAL

SAT	All caries and/or previous restorative material s are removed.
DEF	Caries or previous restorative material remains in the preparation or preparation is not extended to include caries.

PREPARED SURFACES

SAT	All prepared surfaces are smooth, caries free and well-defined .
DEF	The prepared surfaces are irregular or ill-defined.

PROXIMAL CLEARANCE

SAT	Proximal contact is visibly open up to 1.5.
DEF	No proximal clearance visible or excessive clearance greater than 1.5mm.*

*If additional clearance is needed, inform the examining committee BEFORE extending beyond "satisfactory" as defined above.

OUTLINE SHAPE/CONTINUITY/EXTENSION

SAT	The outline form includes all carious and non-coalesced fissures, and is smooth, rounded and flowing with no sharp curves or angles.
SUB	The outline form is inappropriately overextended so that is compromises the remaining marginal ridge and or cusps. The outline is underextended and non-coalesced fissures remain which extend to the DEJ and are contiguous with the outline form.
DEF	The outline form is overextended so that it compromises, undermines and leaves unsupported remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the marginal ridge is 1.0 mm or less

CAVOSURFACE MARGIN

SAT	Cavosurface margins are beveled and terminate in sound natural tooth, free of previous restorative material, including sealants and decalcification.
DEF	Cavosurface margin includes unsupported enamel, or there is explorer penetrable decalcifiaction, or terminates on sealant or other restorative material.

CONDITION OF ADJACENT TOOTH STRUCTURE

SAT	There is no evidence of unwarranted or unnecessary removal, or recontouring of the tooth adjacent to the restoration.
ACC	There is minimal evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure adjacent to the restoration.
DEF	There is evidence of unwarranted or unnecessary removal, modification, or recontouring of tooth structure adjacent to the restoration. (enameloplasty)

EXAMINATION CRITERIA
ANTERIOR CLASS III OR IV COMPOSITE FINISHED RESTORATION

MARGIN DEFICIENCY

SAT	There is no margin deficiency. There is no evidence of voids or open margins.
DEF	There is evidence of marginal deficiency to include pits and voids at the cavosurface margin, and /or there is an open margin.

MARGIN EXCESS AND GINGIVAL OVERHANG

SAT	There is no detectable marginal excess at the restoration-tooth interface either visually or with the tine of an explorer and doesn't catch when flossed.
DEF	There is evidence of excess at the restoration-tooth interface.

SURFACE FINISH

SAT	The surface of the restoration is uniformly smooth and free of pits and voids.
ACC	The surface of the restoration is slightly grainy or rough, but is free of significant pits and voids.
SUB	The surface of the restoration is rough and exhibits surface significant irregularities, pits or voids

INTERPROXIMAL CONTACT

SAT	Contact is present, visually closed and properly shaped. Definite, not excessive, resistance to floss.
ACC	Visually closed, adequate in size shape and position, little resistance to floss.
SUB	Visually closed, but deficient in size shape or position, little resistance or shreds floss.
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SAT	With articulating paper, centric and excursive contacts are consistent in size, shape and intensity with contacts on other teeth within the quadrant.
SUB	With articulating paper, restoration is in hyper occlusion to other teeth in quadrant and requires adjustment.
DEF	There is gross hyperocclusion so that tooth is only one in contact OR there is no occlusion.

ANATOMY/CONTOUR

SAT	The restoration reproduces the normal physiological proximal contours of the tooth , occlusal and marginal ridge anatomy.
DEF	The restoration does not reproduce the normal occlusal anatomy, marginal ridge anatomy, and would be expected to adversely affect tissue health.

CONDITION OF SOFT TISSUE

SAT	The soft tissue is free from damage or damage is consistent with procedure.
SUB	There is iatrogenic soft tissue damage inconsistent with procedure.
DEF	There is gross iatrogenic soft tissue damage inconsistent with pre-existing condition of the soft tissue and the procedure.

PATIENT HEALTH HISTORY

Patient Name:_____

Date of Birth:_____Today's date:_____

Name of Physician:_____

Is there a family history of any of the following?(Circle which ones apply)

Heart attack	Stroke	Dementia
Cancer	Arthritis	Diabetes
Bypass surgery	Artificial valves	Stents
Autoimmune disease	Loss of teeth	Other_____

Are you currently or in the past been treated for any of the following? (Circle which ones apply)

Heart attack	Stroke	Dementia
Cancer	Arthritis	Diabetes
Bypass surgery	Artificial valves	Stents
Autoimmune disease	Loss of teeth	Sleep apnea
High blood pressure	High cholesterol	Headaches
Thyroid problems	Kidney disease	Asthma
Hepatitis	Epilepsy	Other_____

Are you allergic to any medications or drugs? (Circle which applies) YES / NO If yes, please list:_____ _____

Are you Pregnant? (Circle which applies) YES / NO If yes, when is your due date?_____

Some drugs interact with local anesthetics and can put you at risk. Please list all medications and drugs that you are currently taking, especially anything taken in the last 24 hours.

_____

Do you have any disease, problem or condition not listed above that would pose a risk to your health and safety or others during the planned dental procedure?

_____

_____

I acknowledge that I understand and have answered these questions accurately and completely. I will not hold the Bermuda Dental Board responsible for any action taken or not taken because of errors I may have made when completing this form.

Patient Signature:_____Date signed:_____

PATIENT HEALTH HISTORY

Patient Name:_____

Date of Birth:_____Today's date:_____

Name of Physician:_____

Is there a family history of any of the following?(Circle which ones apply)

Heart attack	Stroke	Dementia
Cancer	Arthritis	Diabetes
Bypass surgery	Artificial valves	Stents
Autoimmune disease	Loss of teeth	Other_____

Are you currently or in the past been treated for any of the following? (Circle which ones apply)

Heart attack	Stroke	Dementia
Cancer	Arthritis	Diabetes
Bypass surgery	Artificial valves	Stents
Autoimmune disease	Loss of teeth	Sleep apnea
High blood pressure	High cholesterol	Headaches
Thyroid problems	Kidney disease	Asthma
Hepatitis	Epilepsy	Other_____

Are you allergic to any medications or drugs? (Circle which applies) YES / NO If yes, please list:_____ _____

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_____

_____

I acknowledge that I understand and have answered these questions accurately and completely. I will not hold the Bermuda Dental Board responsible for any action taken or not taken because of errors I may have made when completing this form.

Patient Signature:_____Date signed:_____

POSTERIOR RESTORATION TREATMENT PLAN

Candidate's Name_____**Date:**_____

Patient's Name _____**Assistant's Name** _____

Circle Type of Restoration and Tooth Number

MO DO MOD **Composite** **18 17 16 15 14 24 25 26 27 28**
48 47 46 45 44 34 35 36 37 38

ANESTHETIC RECORD		
Type(s) of Injection		
Anesthetic(s)		
Vasoconstrictor (Concentration)		
Quantity		
Examiner Initials (For Additional Anesthetic)		
PRETREATMENT MEDICATION:	**TYPE OF MEDICATION**	**DOSAGE**

SPECIAL COMMENTS TO EXAMINERS: *(Use ink. Please number each comment. Make sure examiner initials comments)*

_____
_____
_____
_____
_____
_____
_____

ANTERIOR RESTORATION TREATMENT PLAN

Candidate's Name_____**Date**_____

Patient's Name _____**Assistant's Name** _____

Circle Type of Restoration and Tooth Number

DL	**DF**	**ML**	**MF**	**13 12 11 21 22 23**
DIL	**DIF**	**MIL**	**MIF**	**43 42 41 31 32 33**

ANESTHETIC RECORD		
Type(s) of Injection		
Anesthetic(s)		
Vasoconstrictor (Concentration)		
Quantity		
Examiner Initials (For Additional Anesthetic)		
PRETREATMENT MEDICATION:	**TYPE OF MEDICATION**	**DOSAGE**

SPECIAL COMMENTS TO EXAMINERS: *(Use ink. Please number each comment. Make sure examiner initials comments)*

_____
_____
_____
_____
_____
_____
_____

Candidate: _____

DISCLOSURE STATEMENT & EXPRESS ASSUMPTION OF RISK
(PATIENT CONSENT FORM)

The Government of Bermuda through the Bermuda Dental Board requires all applicants for licensure to practice dentistry or dental hygiene in Bermuda to take part in a particular/clinical examination. This involves performing certain types of treatment on volunteer patients. You will receive this treatment free in return for your time given during the examination.

The Board wishes to make clear the person treating you during the examination is NOT licensed in Bermuda but is only an applicant for a license. The law requires the Board to admit to examination any qualified applicant who has been graduated from an approved dental school or college or from an approved school of dental hygiene. As such, neither the Board and/or its appointees or examiners has knowledge of the applicant's skill or competence, nor can they make any representation as to the applicant's skill or competence.

Therefore, the Board and/or its' appointees or examiners cannot and does not assume any responsibility or liability for the treatment you receive during the course of the examination, for any of the acts, omissions, or negligence committed by any such applicant and/or for any damages, injury or disability received or suffered by you. Also, the Board and/or its appointees or examiners assumes no duty or responsibility to notify any patient of poor treatment performed by any applicant.

IMPORTANT – LIMITATION OF LIABILITY

I, the undersigned verify that I have read and understand the above disclosure statement. I understand that the Bermuda Dental Board and/or its' appointees or examiners are not responsible for any of the acts, omissions, or negligence committed by any such applicant and/or for any damage, injury or disability received or suffered by me. Further, no representations or statements have been made by the Board and/or its' appointees or examiners to me about the skill or competence of any applicant or the result of treatment I will receive. I understand and agree that the Board and/or its' appointees or examiners will not be responsible for acts committed by the applicant or chairside assistant which may result in injury to me. I further understand that it is my responsibility to have an examination of my treatment checked by the Bermuda Dental Board to determine if it is satisfactory. I also understand that the Board and/or its' appointees or examiners will not be responsible for notifying me of faulty treatment performed by the applicant.

I, hereby consent to undergoing the treatment of _____ the nature and purpose of which have been explained to me by

Dr./Mr./Miss./Ms. _____.

Patient's Name _____ (Please Print)

Patient's Signature _____

Address _____

Witness: _____ Telephone Number: _____
(not the applicant) (not the applicant)

Candidate: _____

DISCLOSURE STATEMENT & EXPRESS ASSUMPTION OF RISK
(PATIENT CONSENT FORM)

The Government of Bermuda through the Bermuda Dental Board requires all applicants for licensure to practice dentistry or dental hygiene in Bermuda to take part in a particular/clinical examination. This involves performing certain types of treatment on volunteer patients. You will receive this treatment free in return for your time given during the examination.

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I, hereby consent to undergoing the treatment of _____ the nature and purpose of which have been explained to me by

Dr./Mr./Miss./Ms. _____.

Patient's Name _____ (Please Print)

Patient's Signature _____

Address _____

Witness: _____ Telephone Number: _____
(not the applicant) (not the applicant)

TREATMENT CONSENT FORM

DENTAL EXAMINATION

I, _____, authorize _____(applicant), a dental examinee and whomever the dental examinee may designate as an assistant or assistants, to perform upon myself the following dental procedure(s):

- ☐ **Posterior Preparation and Restoration**
- ☐ **Composite Preparation and Restoration**
- ☐ **Periodontal Measurements**
- ☐ **Oral Prophylaxis** (Scaling and Polishing)

I understand that the dental examinee may not be licensed. I further understand that such procedure(s) will be performed by the examinee as part of an examination conducted to determine the qualification of the dental examinee for licensure.

The nature and purpose of the dental procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the dental procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that some of the procedures may not be completed and I have been informed of the availability of services to complete treatment.

I consent to the making of appropriate radiographs (X-Rays) and dental examinations.

I understand that as a part of the dental procedure(s), it may be necessary to administer anesthetics and I consent to the use of such anesthetics by the dental examinee.

Dated this _____ day of _____, 20 ____

_____
Patient's Signature

_____
Patient's Address

_____
Patient's Address: Parish, Postal Code

_____
Patient's Phone Number

_____
Parent or Guardian's Signature (if patient is a minor)

TREATMENT CONSENT FORM

DENTAL EXAMINATION

I, _____, authorize _____(applicant), a dental examinee and whomever the dental examinee may designate as an assistant or assistants, to perform upon myself the following dental procedure(s):

- ☐ **Posterior Preparation and Restoration**
- ☐ **Composite Preparation and Restoration**
- ☐ **Periodontal Measurements**
- ☐ **Oral Prophylaxis** (Scaling and Polishing)

I understand that the dental examinee may not be licensed. I further understand that such procedure(s) will be performed by the examinee as part of an examination conducted to determine the qualification of the dental examinee for licensure.

The nature and purpose of the dental procedure(s) as well as the risks and possible complications have been explained to me. My questions with regard to the dental procedure(s) have been answered. I acknowledge that no guarantee or warranty has been made as to the results to be obtained. I understand that some of these procedures may not be completed and I have been informed of the availability of services to complete treatment.

I consent to the making of appropriate radiographs (X-Rays) and dental examinations.

I understand that as a part of the dental procedure(s), it may be necessary to administer anesthetics and I consent to the use of such anesthetics by the dental examinee.

Dated this _____ day of _____, 20 ____

_____
Patient's Signature

_____
Patient's Address

_____
Patient's Address: Parish, Postal Code

_____
Patient's Phone Number

_____
Parent or Guardian's Signature (if patient is a minor)

EXAMINATION FLOW SHEET

Posterior Class II Composite Restoration

Present to the examination committee the treatment plan with supporting radiographs along with health History and Letter of Consent.

Initials of examiners to start preparation:

_____ _____ _____

Preparation

Provide anesthetic, isolate the tooth or teeth to be treated and prepare the tooth or teeth for filling according to the criteria provided. *Note: if it becomes necessary to extend the preparation beyond satisfactory as described in the grading criteria, you want to recontour the adjacent surface or you expose the pulpal tissue– **STOP** and **get an examiner.** You will need to **explain** why and what steps you judge necessary. Fill in grey field below.

Reason to extend prep:_____

Initials of examiners for extensions of preparation if done (*see note above)

_____ _____ _____

Reason to recontour adjacent tooth/restoration:_____

Initials of examiners to recontour adjacent tooth/restoration

_____ _____ _____

Reason for pulp exposure:_____

Initials of examiners check of pulp exposure

_____ _____ _____

Initials of examiners for preparation grading

_____ _____ _____

Finished Restoration

Fill the preparation and finish according to the criteria provided.

Initials of examiners for final grading of restoration

_____ _____ _____

EXAMINATION FLOW SHEET

Anterior Class III or IV Composite Restoration

Present to the examination committee the treatment plan with supporting radiographs along with health History and Letter of Consent.

Initials of examiners to start preparation:

_____ _____ _____

Preparation
Provide anesthetic, isolate the tooth or teeth to be treated and prepare the tooth or teeth for filling according to the criteria provided. *Note: if it becomes necessary to extend the preparation beyond satisfactory as described in the grading criteria, you want to recontour the adjacent surface or you expose the pulpal tissue– **STOP** and **get an examiner.** You will need to **explain** why and what steps you judge necessary. Fill in grey field below.

Reason to extend prep:_____
Initials of examiners for extensions of preparation if done (*see note above)

_____ _____ _____
Reason to recontour adjacent tooth/restoration:_____
Initials of examiners to recontour adjacent tooth/restoration

_____ _____ _____
Reason for pulp exposure:_____
Initials of examiners check of pulp exposure

_____ _____ _____

Initials of examiners for preparation grading

_____ _____ _____

Finished Restoration
Fill the preparation and finish according to the criteria provided.

Initials of examiners for final grading of restoration

_____ _____ _____

FOLLOW UP FORM

Patient's name: _____

Patient's Address: _____

_____

Patient's Telephone number: _____

Tooth in Question: _____

Reason for Follow-Up: _____

What provisions have been made for the Follow-Up: _____

_____

Who will be handling the Follow-Up: _____

Was the patient informed that the follow up was necessary, and was financial responsibility clarified? _____

Applicant's signature: _____

Host examiner's signature: _____

FOLLOW UP FORM

Patient's name: _____

Patient's Address: _____

_____

Patient's Telephone number: _____

Tooth in Question: _____

Reason for Follow-Up: _____

What provisions have been made for the Follow-Up: _____

_____

Who will be handling the Follow-Up: _____

Was the patient informed that the follow up was necessary, and was financial responsibility clarified? _____

Applicant's signature: _____

Host examiner's signature: _____

Patient Feed Back

The Bermuda Dental Board is always looking for ways to improve the examination process. If you would like to make any suggestions or comments, please use the space below. Your comments will not affect the candidate's grade on the examination.

Name: (optional)_____

Patient Feed Back

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Name: (optional)_____

Candidate Feed Back

The Bermuda Dental Board is always looking for ways to improve the examination process. If you would like to make any suggestions or comments, please use the space below. Your comments will not affect your grade on the examination.

Name: (optional)_____