

# GUIDELINES

for the

# Certification Process

American Board of Prosthodontics

Revised-----February 20, 2008

Effective -----April 6, 2008

[www/prosthodontics.org/abp](http://www/prosthodontics.org/abp)

## Table of Contents

Mission Statement of the American Board of Prosthodontics.....	4
Goals of the American Board of Prosthodontics .....	4
History of American Board of Prosthodontics .....	4
Definitions	
Removable Prosthodontics .....	6
Fixed Prosthodontics .....	6
Implant Prosthodontics .....	6
Maxillofacial Prosthetics .....	6
General Statement of Purpose .....	7
Certification for the Specialty of Prosthodontics .....	7
Limited Practice.....	7
Educationally Qualified.....	7
Board Eligible.....	7
Duration of Eligibility .....	8
Diplomate .....	8
Role of the Board and Examiners in Evaluation Process .....	8
Validity and Reliability of Criterion Based Evaluations .....	9
Required Qualifications for Examination.....	10
Application Procedures .....	10
Fees.....	11
The Examination .....	11
Description of Section A Written Examination.....	12
Description of Section B Patient Presentation and Oral Examinations .....	14

Description of Parts 2, 3 and 4 Patient Presentations .....	17
Format for Parts 2, 3 and 4 Presentation .....	18
Grading of Section B Parts 2, 3 and 4 .....	21
Description of Section C Scenario Based Oral Examinations .....	22
Application Renewal .....	23
Re-examination.....	23
Appeals Process .....	22
Annual Fee .....	24
Revocation of Certificate.....	24
Continued Proficiency (Recertification).....	24
General Information .....	25
Criterion Statements for Parts 2, 3 and 4 Patient Presentations .....	26
Criterion Statements for Parts 3 and 4 Oral Examinations .....	54
Past Presidents American Board of Prosthodontics .....	55

## **MISSION STATEMENT**

### The American Board of Prosthodontics

The mission of the American Board of Prosthodontics is to certify individuals who have demonstrated special knowledge and skills in prosthodontics. The Board also seeks to certify those who are committed to life-long learning and a lifetime of ethical practices, who value the doctor/patient relationship, who respect those with philosophical, cultural or physical differences and who are committed to the advancement of prosthodontics.

The American Board of Prosthodontics recognizes its responsibility to the profession and to the public and accepts this responsibility through the administration of an examination designed to identify individuals with the knowledge, skills and attributes deemed important to those who will be called Diplomates of the American Board of Prosthodontics.

## **GOALS**

### The American Board of Prosthodontics

1. Assure that Diplomates meet certain knowledge and skill criteria and issue certificates to these individuals indicating they have met the established criteria. Bylaws, Article II, Section 1 and Article VIII, Section 1.
2. Assure that Diplomates maintain continued proficiency in prosthodontics. Bylaws, Article VIII, Section 4.
3. Provide the public and profession with information regarding individuals who are Board Certified. Bylaws, Article I, Section 2; Article XII, Sections 1 and 2.
4. Encourage the specialty to advance itself through Board certification.

## **HISTORY**

### The American Board of Prosthodontics

The American Board of Prosthodontics was incorporated on February 21, 1947, in the State of Illinois. Following preliminary organizational efforts by the Academy of Denture Prosthetics (now the Academy of Prosthodontics), the Board, at the request of the American Dental Association, was established as the specialty certifying body for prosthodontics. The following nine founder board members were duly elected from the membership of the Academy of Denture Prosthetics during the annual session at Miami, Florida in October 1946: Drs. C. J. Stansbury, R. H. Kingery, O. M. Dresden, Bert L. Hooper, David McLean, F. C. Elliot, I. R. Hardy, C. O. Boucher, and R. M. Tench. There were 64 members of the Board representing the Academy of Denture Prosthetics(now the Academy of Prosthodontics), American Denture Society (now the American Prosthodontic Society), and the Pacific Coast Society of Prosthodontics.

The first Board examination was given in 1949 and included written essays and oral and clinical components during a one-week session. To be eligible for the certifying examination prior to January 1, 1964, the applicant had to present evidence either of prosthodontic training or of having spent 10 years in the practice of dentistry with special interest in prosthodontics. Thereafter, formal educational requirements included a Master of Science degree in prosthetic dentistry or the equivalent from an American Dental Association-approved or provisionally approved dental school.

In 1951, Canadian dentists became eligible for certification. After Board approval of several hospital residency and internship programs in prosthodontics during 1952, successful candidates from these programs and others established since were adjudged to have satisfied the requirements for examination. On January 1, 1954, the eligibility requirements were changed to include formal educational experiences such as a Master of Science degree in prosthetic dentistry or its equivalent from a dental school approved or provisionally approved by the American Dental Association. Minor changes in examination procedures were made in the ensuing years, and in 1957, the Board accepted the responsibility for examining candidates in fixed prosthodontics.

The written part of the examination was changed from an essay to an objective form in 1960, and consideration was given to dividing the week-long examination into two separate parts. Additional study of the phased procedure culminated in application of the concept in 1962. Also during 1962, the American Dental Association House of Delegates changed the eligibility requirements for Board candidates by making mandatory two years of formal advanced education in prosthodontics for individuals applying after January 1, 1965. From 1962 to 1987, a Phase I examination consisting of the written, oral and patient presentation parts was given each February, followed in June by Phase II which consisted of clinical and oral parts. In 1987 the Phase I oral examination was lengthened to one hour to include the patient presentation, the broad areas of prosthodontics, and the related basic and applied sciences. The Phase II oral examination was eliminated.

At the request of the Federation of Prosthodontic Organizations and the American Academy of Maxillofacial Prosthetics in 1967, the Board, with American Dental Association sanction, accepted the responsibility for including maxillofacial prosthetics as a component area of prosthodontics for competency certification. In 1974, provision was made for candidates to elect to take the clinical examination in maxillofacial prosthetics.

Recognizing the growing complexity of the prosthodontic specialty and the need for a broader Board membership base, the Academy of Denture Prosthetics (now the Academy of Prosthodontics), in 1972, relinquished sponsorship of the Board in favor of the Federation of Prosthodontic Organizations.

In 1987, the American Dental Association mandated that prosthodontics would be recognized as a single specialty including fixed, removable, and maxillofacial prosthetics and that advanced educational programs in prosthodontics must provide education and training in all of these areas. Recognizing a need for a more comprehensive examination to reflect these changes in the standards for Advanced Education in Prosthodontics, the Board, in 1990, announced significant changes in the examination format to more accurately evaluate candidates' knowledge and clinical proficiency in all aspects of Prosthodontics (fixed prosthodontics, removable partial prosthodontics, complete denture prosthodontics, maxillofacial prosthetics, implant prosthodontics, and occlusion). Following a transition year during 1991, the Phase I examination was expanded from one half day to a full day. The oral and patient presentation parts were expanded and moved to the Phase II examination and the onsite clinical examination was discontinued. An additional written examination covering clinical prosthodontics was also incorporated into the Phase II examination.

In 1988, the Federation of Prosthodontic Organizations designated the American College of Prosthodontists as the sponsoring organization of the Board within the structure of the Federation of Prosthodontic Organizations. In 1992, the Federation of Prosthodontic Organizations designated and the ADA Council on Dental Education recognized the American College of Prosthodontists as the sponsoring organization for the specialty of prosthodontics and the sponsor of the American Board of Prosthodontics.

To simplify describing the examination, the various parts were numbered from 1 to 5 in 1993. The Part 1 examination is a half-day comprehensive written examination. Parts 2, 3 and 4 consist of evaluating 3 patient treatments that include oral examinations of the candidate. The candidate makes a slide presentation of the patient treatment for Parts 3 and 4. The Part 5 examination was a three (3) hour examination which was incorporated into the Part 1 examination in 1996 by increasing the size and scope of the Part 1 examination.

To provide more flexibility for candidates to complete the examination process, recent additional modifications have been made. In 1996 candidates were given the option of taking the Part 1 written examination during the 3rd year of their prosthodontic training program, prior to establishing board eligibility. Additionally, in 2003 candidates were given the option of performing all patient treatments (Parts 2, 3, and 4) during their training program and the possibility of taking one of the patient presentation examinations during the February examination period in their final year of training.

In 2006 computer based testing was initiated to allow candidates to take the written examination closer to their homes using one of various testing centers across the country.

In 2008 substantive changes were made to the oral examination process. To minimize confusion during the transition period the various parts of the examination were renamed. Effective for 2008, Section A remains as the former Part I written examination given in April of each year at remote testing centers near the candidate's home. Section B includes the oral patient presentation examinations (formerly Parts 2, 3 and 4). Section C includes the Scenario Based Examinations that replace one of the oral patient presentation examinations. During a transition period of several years candidates have the choice of whether to take all 3 parts of Section B (the former parts 2, 3 and 4) or whether to take two of the oral patient presentation examinations plus Section C (three 1/3 hour scenario based oral examinations for a total of 1 hours).

The primary objective of the American Board of Prosthodontics continues to be the determination of the proficiency of eligible candidates who desire certification in prosthodontics.

## **DEFINITIONS**

Prosthodontics is that branch of dentistry pertaining to the restoration and maintenance of oral function, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

Removable Prosthodontics is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures for edentulous or partially edentulous patients by artificial substitutes that are removable from the mouth.

Fixed Prosthodontics is that branch of prosthodontics concerned with the replacement and/or restoration of teeth by artificial substitutes that are not removable from the mouth.

Implant Prosthodontics is that branch of prosthodontics concerned with the replacement of teeth and contiguous structures by artificial substitutes partially or completely supported and/or retained by alloplastic implants.

Maxillofacial Prosthetics is that branch of prosthodontics concerned with the restoration and/or replacement of stomatognathic and associated facial structures by artificial substitutes that may or may not be removed.

## **GENERAL STATEMENT OF PURPOSE**

The American Board of Prosthodontics

The American Board of Prosthodontics was organized by the Academy of Denture Prosthetics at the request of the American Dental Association for the following purposes:

To advance the science and art of prosthodontics by encouraging its study and improving its practice.

To determine the eligibility of candidates within the regulations for qualification for examination.

To conduct examinations to determine the proficiency of applicants for certification as Diplomates.

To grant and issue Diplomate certificates to successful candidates.

To maintain a roster of Diplomates for the general information of the public, the dental and medical professions, dental schools, and health agencies.

## **CERTIFICATION FOR THE SPECIALTY OF PROSTHODONTICS**

By the authority of the American Dental Association and its Council on Dental Education, certificates may be issued by the American Board of Prosthodontics, which will attest to an applicant's knowledge, ability and proficiency in the specialty of prosthodontics.

Any dentist who meets the qualifications as set forth in this document may become a candidate for certification by making formal application to the American Board of Prosthodontics. The American Board of Prosthodontics will not discriminate against any person because of race, color, religion, sex, national origin, ancestry, age, marital status or handicaps. Please note that language is not a physical disability for testing purposes.

Diplomates of the American Board of Prosthodontics are expected to announce and limit their practice to prosthodontics.

Limited Practice—Dentists who have successfully completed an advanced prosthodontic education program which is accredited by the Commission on Dental Accreditation may ethically limit their practice to prosthodontics, subject to individual state guidelines.

Educationally Qualified—An individual is considered Educationally Qualified after the successful completion of an advanced educational prosthodontic program which is accredited by the Commission

on Dental Accreditation. However, an individual is not Board Eligible unless his/her application has been submitted to and approved by the Board and his/her eligibility has not expired.

**Board Eligible**—Sometimes there is confusion regarding the use of the phrase board eligible. Individuals are not board eligible upon completion of their advanced education program in prosthodontics. Individuals are educationally qualified upon completion of a program which is accredited by the Commission on Dental Accreditation. They become board eligible only when their application for certification has been submitted to and approved by the Board.

Dentists trained in Canada are eligible for certification by the American Board of Prosthodontics under the same rules governing candidates from the United States, except that Canadian dentists must present to the Board evidence of parallel qualifications in Canada in all categories required for candidates trained in the United States.

**Duration of Eligibility**—The period of Board eligibility begins on the date when the individual's application is accepted and approved by the Board and is extended to the candidate for six (6) consecutive years. However, Board eligibility status will be forfeited if the Part I written examination is not taken within two (2) years of eligibility. Although eligibility may be re-established by re-application, all phases of the examination must be successfully completed within six (6) years of initial eligibility. No re-applications are acceptable after this six (6) year period unless, upon consultation with the applicant, the Board determines that unusual extenuating circumstances warrant an extension of the duration of eligibility. Graduate students/residents taking Part I during a prosthodontic training program will not be considered Board eligible until formal application for eligibility is made to the Board. Board eligibility of 6 years begins only after formal application to and acceptance by the Board. Successful completion of the Section A Written Examination is not time dependent and does not expire.

Graduate students/residents wishing to take one of the patient presentation examinations (Section B-Part 2, 3, or 4) during the final year of training must apply for and receive notice of eligibility prior to taking the examination during February of the final year of training. The 6 year period of eligibility begins on the date eligibility is awarded, during the third year of training.

**Diplomate**—Any dentist who has successfully met the requirements of the Board for certification and remains in good standing.

## **ROLE OF THE BOARD AND ITS EXAMINERS IN THE EVALUATION PROCESS**

An examiner has been described as one who works in examining records or people and who tests by careful questioning in order to find out the knowledge, skill and qualifications of a candidate. Since its inception, the primary objective of the Board has been, and will continue to be, the protection of the public through determination of the competency of eligible candidates who desire certification as specialists in prosthodontics. The Board is an examining and certifying body. It remains independent from political issues and is not directly responsible for the education of the candidates. It has been, and will continue to be the position of the Board, that candidates be examined by the current standards approved by the Commission on Dental Accreditation for advanced education programs in prosthodontics. The Board is not static or unchanging. Changes occur, however, only after a great deal



of study and thought. The Board strives to be fair and objective in all its relationships with candidates. It abides by the rules which are in effect, but seeks to modify the guidelines and examining procedures whenever it appears that such changes could benefit those it serves: the public, the profession, the specialty, the certified diplomates, and the candidates seeking diplomate status.

## **VALIDITY AND RELIABILITY OF CRITERION BASED EXAMINATIONS**

Individuals knowledgeable in testing have emphasized that any system of evaluation must be objective if it is to be considered valid and reliable. The Board has always strongly advocated eliminating subjectivity in its certification process. Its dedication to improving the examinations will be ongoing. Criterion-based evaluation has been presented as a method of increasing the validity and reliability of an examination. The Board devoted a great deal of effort during the early 1980's to developing criterion statements for the different oral examination phases of its certification process. In February, 1985 the first criterion-based oral examination was conducted to evaluate the performance of one candidate in the Part 2 (now Section B) patient presentation. During this initial experience, both the traditional and criterion-based methods were used in the evaluation of the candidate's performance. Using both methods the Board could make a paired comparison of the two and judge the efficacy of the new system. The criterion statements developed by the Board for the patient presentation included: records, the narrative, fixed prosthodontics, removable partial prosthodontics, maxillofacial prosthetics, and occlusion. Each member of the Board was requested to evaluate the candidate's performance in each of the areas using the criterion statements. The criteria were written as objective descriptions of acceptable, marginal, or unacceptable levels of skill or performance. In selected areas the acceptable and unacceptable levels were further divided into two subsets. To evaluate a candidate's performance at a specific task, the Board member selected the category (acceptable, marginal, or unacceptable) in which the criterion statement best matched the candidate's skill at performing the examined task. The Board member then checked the appropriate numerical value on the candidate's score sheet: (acceptable 1 or 2, marginal 3 or unacceptable 4 or 5).

In the initial evaluation of the criterion-based examination, the Board examiners experienced agreement or near agreement in almost every category. As a result of this early effort, the Board adopted the process of a criterion-based examination for use in all phases of the examination.

The specific criterion statements for the Section B Oral Presentation Examinations (formerly Parts 2, 3 and 4) of the certification process appear at the end of this document. An explanation is also provided on how the Board uses the scores received by each candidate to determine pass/fail outcomes. This document represents the Board's efforts to date and is subject to change. The Board reserves this "right to change" as its responsibility to those it serves. The purpose in publishing this material is to better inform any and all persons who are interested in the certification process, and it is hoped that it will assist candidates in preparing for the examinations.

The contents of this document remain the property of the Board. Its duplication and/or reproduction is prohibited without the written consent of the Board.

## **REQUIRED QUALIFICATIONS FOR EXAMINATION**

A candidate for examination by the American Board of Prosthodontics must:

1. Have satisfactory moral and ethical standing in the dental profession.
2. Show evidence of satisfactory completion (or anticipated completion) of advanced education in Prosthodontics as defined in the American Dental Association document entitled Requirements for Advanced Specialty Education Programs in Prosthodontics.

Advanced education in a recognized specialty area of dentistry may be offered on either a graduate or postgraduate basis.

- a. A graduate program is a planned sequence of advanced courses leading to a master's or doctoral degree granted by a recognized and accredited educational institution.
  - b. A postgraduate program is a planned sequence of advanced courses that leads to a certificate of completion in a specialty recognized by the American Dental Association or Canadian Dental Association. The level of specialty-area instruction in the graduate and postgraduate programs must be comparable.
3. Meet the requirements to be Board Eligible.

Upon submitting an application, (which must include certified evidence of the successful completion of an accredited program in advanced Prosthodontics) and all other certified documents required by the application and having such applications approved by the Board, a candidate for certification becomes Board eligible.

## **APPLICATION PROCEDURES**

Requests for information or application forms should be directed to the Executive Director of the American Board of Prosthodontics ([ttaylor@nso.uchc.edu](mailto:ttaylor@nso.uchc.edu)).

After having answered all questions and submitted all data requested, (to include either "certified true copies" or university copies certified by the registrar of completion of advanced education in prosthodontics or a letter from the program director stating that the applicant is expected to complete the training program within the expected time frame), the applicant must mail the application form back to the Executive Director. The candidate must include the application fee with the completed form. The fee is not refundable, either in the event of acceptance or rejection by the Board.

NOTE: Incomplete forms will not be considered by the Board. If any item is left blank or is not answered completely, a clearly detailed statement should be made setting forth the reason the information is not available. All transcripts, certificates, or diplomas must be notarized copies.

After the Executive Director has reviewed the completed application, the candidate will be informed of their eligibility status and of the date and place of the next examination.

## **FEES**

There is an application for certification fee plus a fee for each part of the examination. The appropriate fees must accompany each application. The examination fee schedule is as follows: Application for Certification fee \$200, the Computer Based Section A (formerly Part1) \$375, Section B (formerly Parts 2,3,4) \$250 each, Section C scenario exams (1 fee for the entire Section C exam) \$250. Re-examination fees will be the same for subsequent applications. The appropriate fee must be paid to the Executive Director at the time the candidate, in writing, signifies they intend to take a portion of the examination. All fees must be paid in United States currency.

## **THE EXAMINATION**

The examination shall include the principles and procedures of fixed prosthodontics, occlusion, removable prosthodontics, implant prosthodontics, maxillofacial prosthetics, and related arts and sciences. It shall consist of a computer based examination, patient presentations, and oral examinations. The examination is conducted in three sections. Any section may be taken in any order.

The Section A Written (formerly Part 1) Examination is a computer based examination given during the month of April each year at 200 PearsonVUE professional testing centers located regionally in the 48 contiguous United States. Information on the computer based testing process can be found at *www.MeasurementResearch.com*. Here one can find answers to frequently asked questions about computer based testing and a demonstration test which shows the item format and how to answer questions.

The application deadline for the Section A Written Examination is 90 days in advance of the examination date. The candidate may take this examination in the third year of their prosthodontic training program, prior to establishing Board eligibility. An individual whose prosthodontic education extends beyond 3 years may take Section A in their third year. The program director must certify that the candidate is in the 3rd year of the program.

Section B Patient Presentation Oral Examinations (formerly Parts 2-4) are candidate generated patient presentations that include oral examination. Board eligible candidates may take any or all of the Section B parts in any order, at either the February or autumn examinations. The application deadline for Section B examinations is 30 days in advance of the examination date.

Graduate student/resident candidates may take one of the Section B Patient Presentation Oral Examinations (Part 2, 3, or 4) during the February examination period of the third year of training in addition to the written Section A Written Examination. Patient treatments presented may have been performed during the training program. At least one of the patient presentations Section B must include implant prosthodontics.

The candidate should be aware that the entire examination must be completed within 6 consecutive years from the date Board eligibility was initially approved.

English is the official language of the American Board of Prosthodontics.

Candidates may utilize digital photographs and radiographs provided no alterations of the images have been performed with the exception of peripheral cropping. Any alteration will result in automatic failure of the candidate. A signed statement that no alteration has occurred must be included with each patient presentation.

## **DESCRIPTION OF THE SECTION A WRITTEN EXAMINATION**

Section A is a criterion-referenced examination that is constructed through the coordinated efforts of Board Members and Psychometric Experts who provide information on the measurement characteristics of the items and /or test. The computer based examination is given at regional testing centers. Some of the questions (items) are chosen or modified from a bank of test items catalogued by subject area. New items are written for the examination by Board members each year. Questions are also solicited from training program directors. These items are reviewed by the Board and those approved are added to the question bank.

The Criterion-referenced Examination is written to measure the knowledge and skills of qualified candidates. The items are evaluated to ascertain that they measure what they purport to measure, are appropriate for prosthodontic candidates, minimize the amount of test error and are coherent in style and format. Those questions not meeting accepted criteria are either discarded or rewritten. A test score from a criterion referenced test is a measure of how well a candidate performs in relation to the test items rather than the performance of other candidates.

The content of the examination is based upon the Standards for Advanced Specialty Education Programs in Prosthodontics and is updated to reflect changes in those standards. There are “must” statements in the didactic curriculum section of the standards that require in-depth understanding and familiarity levels of knowledge in specific areas. The distribution of knowledge levels within the standards is reflected in the number of questions from each area, weighted from in-depth to familiarity. The current standards emphasize the following didactic areas:

Instruction must be provided at the in-depth level in each of the following:

- Fixed prosthodontics
- Implant prosthodontics
- Occlusion
- Removable prosthodontics

Instruction must be provided at the understanding level in each of the following:

- Applied pharmacology
- Biomaterials
- Craniofacial anatomy and physiology
- Diagnostic radiology
- Geriatrics
- Infection control
- Implant placement including surgical and post-surgical management
- Maxillofacial prosthetics
- Medical emergencies
- Oral pathology
- Preprosthetic surgery; including surgical principles and procedures

Prosthetic patient classification systems such as the Prosthetic Diagnostic Index (ACP Classification systems) for edentulous, partially edentulous and dentate patients.

Research methodology

Temporomandibular disorders and orofacial pain

Instruction must be provided at the familiarity level in each of the following:

Behavioral sciences

Biostatistics

Craniofacial growth and development

Endodontics

Ethics

Immunology

Intraoral photography

Oral microbiology

Orthodontics

Periodontics

Practice management

Risk assessment for oral disease

Sleep disorders

Scientific writing

Teaching methodology

Wound healing

In addition to these areas, questions from current prosthetic literature and other related areas will complete the questions for the computer based examination. Candidates are given 4 hours to complete the examination.

#### Scoring the Computer Based Examination

The examination is constructed using standard psychometric methods. The test is designed by the Board and its measurement consultants to identify those candidates who are capable of meeting acceptable cognitive ability based on the Commission on Dental Accreditation's Accreditation Standards for advanced Specialty Education Programs in Prosthetics. The Board established the criterion referenced standard based upon acceptable cognitive ability. Board Members do not know candidates scores prior to final determination of the pass level.

## **DESCRIPTION OF SECTION B**

Section B shall consist of 3 patient presentation and oral examination sessions of approximately one hour each in length. The oral presentation examinations are described as Parts 2, 3 and 4. The examinations will cover the patient presentation, general prosthetics and related dental sciences.

Successful completion of this part of the examination will require acceptable performance by the candidate in all three of these categories. Currently the candidate may elect to take all 3 of the Section B examinations to fulfill the certification process (in addition to successful completion of Section A) or may elect to take any two of the oral patient presentation examinations plus the Section C scenario based oral examinations to complete the certification process.

## **DESCRIPTION OF PARTS 2, 3 AND 4**

These parts consist of oral and image presentations by the candidate of patients he/she has treated. One of the presentations (Part 2) will consist of a removable partial denture treatment with 2 crowns for which all laboratory work excluding the fabrication of the RPD framework has been performed by the candidate, a fixed prosthodontic patient treatment (Part 3) and the other will consist of a removable prosthodontic patient treatment (Part 4). Each presentation is scheduled for approximately one hour with the candidate being allowed an uninterrupted 20 minutes to present the patient's treatment and the remaining time is devoted to questioning by a team of examiners. Candidates must be prepared to defend their diagnosis, prognosis, treatment planning, treatment and maintenance based upon evidence based dentistry.

If possible, a different team of examiners will evaluate each patient presentation. The oral examinations are tape recorded. The Parts 3 and 4 patients cannot receive the same combination of treatment as the patient presented in Part 2.

The patient treatments will serve as the primary focus of the oral examination. However, questioning may include principles and concepts of the broad scope of prosthodontics.

Part 2: Removable Partial Prosthodontic Treatment consisting of a removable partial denture prosthesis for either arch and the fabrication of at least two crowns that restore either natural teeth or implants in either arch. It is not required that the fixed restorations serve as abutments for the removable partial denture prosthesis.

Candidates are required to perform all clinical prosthodontic and laboratory procedures for the Part 2 patient (regardless of whether the treatment was performed during residency training or after completion of residency training) with one exception: Services of a dental laboratory technician may be employed to fabricate the removable partial denture framework, following a properly executed written work authorization. A copy of the Part 2 work authorization form must be included with the patient presentation. A form (provided by the Board at the time of examination) attesting to the completion of all procedures by the candidate must be signed by the candidate. Violation of this requirement will lead to disqualification of the candidate from this part of the examination. The candidate is responsible for and will be evaluated on the quality of diagnosis, treatment planning and care provided to the patient including restorative/prosthodontic procedures performed by other dentists. Candidates must be prepared to defend their diagnosis, prognosis, treatment planning, treatment and maintenance based upon evidence based dentistry.

Part 3: Fixed Prosthodontic Treatment (no removable prostheses) consisting of either

- 1) A fixed reconstruction that includes at least twenty (20) fixed units that restore the articulating surfaces of the teeth.
- 2) A fixed reconstruction of both arches that includes one complete arch (the articulating surfaces of all anterior and posterior teeth must be restored in that arch) and a minimum of six (6) fixed restored units in the opposing arch.

Fixed partial dentures may be supported by implants, but a minimum of eight (8) natural teeth must be restored as part of the total treatment for either option.

The candidate should seriously consider replacement of all foundation restorations and should be prepared to justify foundation material selected.

Part 4: Removable Prosthodontic Treatment consisting of any of the following:

- 1) Complete denture opposing a complete denture
- 2) Complete denture or overdenture opposing an overdenture. Overdentures may be supported and/or retained by natural teeth or implant abutments.
- 3) Complete denture or overdenture opposing a removable partial denture, an implant-supported fixed complete denture, or implant-supported fixed partial denture(s).
- 4) Complete or partial denture obturator prosthesis opposing a complete denture, removable or fixed partial denture(s), or an implant prosthesis.

## **FORMAT FOR PARTS 2, 3 AND 4 PRESENTATIONS**

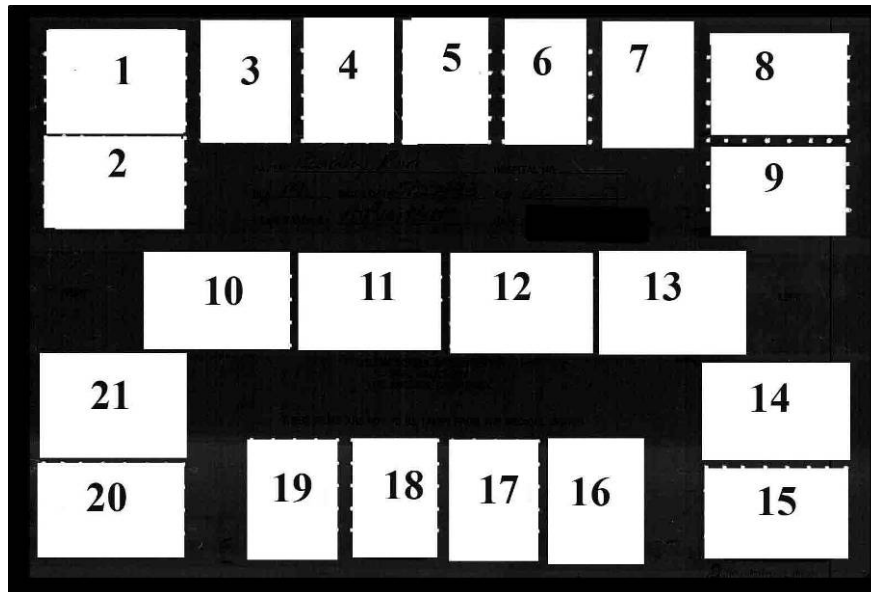
A verbal and visual presentation shall be given by the candidate. A maximum of 20 minutes will be allowed for the presentation.

Aspects of therapy must be presented in the following order:

1. History and chief complaint
2. Clinical findings
3. Diagnosis
4. Treatment plan
5. Treatment
6. Completed treatment
7. Prognosis

A maximum of 44 color images may be presented for each treatment. Only one image may be presented per slide. Digital projection is the method of presentation. An LCD projector, screen and radiograph view box will be provided by the Board. The candidate must bring his/her own laptop computer to the examination for projection along with any connection adapters required by that computer type to make it compatible with standard LCD projectors. Candidates may bring their own LCD projector. It is the candidate's responsibility to insure that their laptop computer presentation is compatible with standard commercially available LCD projectors. Technical difficulties with projection are the responsibility of the candidate to rectify. Failure to project images satisfactorily will disqualify the candidate from taking the examination during that examination period. The use of multiple

projectors is not permitted. Candidates must provide the Board with a CD-ROM with the required images labeled as above. A set of periapical and bitewing radiographs of all post-treatment teeth and implants present in the mouth of the treated patient must be handed in upon completion of Part 2. A complete full mouth periapical series (including bitewings) of original post-treatment radiographs must also be handed in upon completion of Part 3. The CD-ROM and radiographs become the property of the Board and may be used for future examination material. If digital radiographs are submitted (pre-op and post-op) for parts 2 and/or 3, each individual digital radiographic image will be submitted as a separate digital file. Those individual images must be labeled as shown in the following illustration.



Slides for the Part 2 and 3 treatments must clearly show at least:

*Pre-treatment:*

- Teeth in maximum intercuspation (frontal and lateral views)
- Lateral views in laterotrusion and mediotrusion
- Teeth in protrusion (frontal and lateral views)
- Occlusal views of maxilla and mandible
- Complete mouth periapical and bitewing radiographs
- Panoramic radiograph (for patient treatments begun in 2007 or later)  
(For the Part 2 presentation, if the patient is edentulous in one arch the maximum intercuspation and laterotrusion, mediotrusion, and protrusion images should be taken with the pre-existing complete denture prosthesis in place. If the patient presented with no complete denture prosthesis these images are not required.)

*Treatment:*

- Tooth preparations (occlusal view)
- Tooth preparations (frontal and lateral view), (for patient treatments performed in 2006 and later)
- Provisional restorations (frontal and lateral views)



- Final impressions

*Post-Treatment*

- Same as pre-treatment

Slides for the removable treatment must clearly show at least:

- *Pre-Treatment:*
- Occlusal views of maxillary and mandibular edentulous or partially edentulous ridges.
- Anterior view of maxillary and mandibular ridges at approximate occlusal vertical dimension
- Complete mouth periapical or panoramic radiographic series

*Treatment:*

- Border molded impression trays (tissue surface)(for patient treatments begun after February, 2008)
- Impressions (tissue surface)
- The technique and materials used to record maxillomandibular relationships (frontal and lateral views)
- Wax trial denture on articulator (5 slides)
  - frontal view
  - lateral views
  - occlusal views

*Post-Treatment:*

- Occlusal views of maxillary and mandibular arches without the prosthesis, if implants or natural teeth are present
- Tissue surfaces of completed prostheses
- Prostheses in place, teeth in maximum intercuspation (frontal and lateral views)
- Lateral views in laterotrusion and mediotrusion
- Teeth in protrusion (frontal and lateral views)
- Full face frontal and full face profile views with both the existing and new prostheses in occlusion. The Patient's eyes must be blocked out.
- Frontal view of full face smile. The patient's eyes must be blocked out.

The following casts/dies will be presented.

*Removable Partial and Fixed Treatment:*

- Pre- and post-treatment mounted casts
- Articulated casts with diagnostic wax patterns.
- Working casts/dies

*Removable Treatment:*

- Pre-treatment mounted casts of edentulous or partially edentulous ridges at occlusal vertical dimension
- Post-treatment mounted casts of completed prostheses
- Duplicate master casts
- Working casts/dies for any fixed restorations used in conjunction with the removable treatment

For the removable treatment, a copy of the medical history and examination form will be presented.

Mounted periapical pre-treatment and post-treatment radiographs of the complete mouth will be presented for the Fixed Treatment. A pre-treatment panoramic radiograph must also be presented for patient treatments started in 2007 or later. The post-treatment radiographs will become property of and will be retained by the Board. Mounted periapical and/or panoramic pre-treatment radiographs of the complete mouth will be presented for the removable treatment. Post treatment radiographs of all implants associated with the Removable Treatment will be presented by the candidate and will become property of and will be retained by the Board.

Laboratory technicians may be used to aid in fabrication of prostheses for the Part 3 and 4 treatments, but candidates must have a thorough understanding of laboratory procedures and are responsible for the outcome of laboratory procedures in the completed treatment. Laboratory work authorization forms will be presented for both the fixed and removable treatments.

### **GRADING OF SECTION B- PARTS 2, 3 AND 4**

After all the candidates have been examined, the Board will meet in executive session to evaluate each candidate. The candidate's names are read by the Executive Director and each Team of examiners have the opportunity to request that a particular candidate's evaluation be deferred until later in the session for grading. Following this initial process, a written vote is taken for each candidate, except those that have been deferred. The votes are collected, tabulated and recorded for each candidate. The candidates for whom evaluation was deferred are then considered by the Board. A brief report is presented by the two Examiners of the Board who conducted the oral examination. Patient presentation materials are reviewed by each Examiner of the Board. After completing this review process, each Board Examiner judges the performance of the candidate against the criterion statements and a secret ballot vote is taken for the candidate.

It is a matter of Board policy that the successful completion of Parts 2, 3 and 4 requires acceptable performance by the candidate in all three categories: (1) patient presentation, (2) general prosthodontics, and (3) related dental sciences. After counting of the written ballots, the majority rule is applied and a candidate is judged to have passed or failed on that basis. All patient treatment presentations are graded according to the written criteria of the appropriate evaluation form. The evaluation forms have both major and minor categories. The major categories are those that can be graded on a numerical scale of 1 to 5 whereas the minor categories are those that can only receive grades between 2 and 4. A failure in the patient presentation occurs when the candidate receives any of the following grades: one (1) number 5 grade in any major category; two (2) number 4 grades in any major category; or four (4) number 4 grades in any of the categories. No candidate can be judged to have failed the examination by only one Examiner of the Board.

A candidate who presents an adequate patient treatment for the Part 2, 3, and/or 4 examinations but performs unsatisfactorily on the oral examination will be required to successfully complete a one hour repeat oral examination on general prosthodontics and related sciences. This examination will be given at a future examination date.

## **SECTION C EXAMINATION (Begins November, 2008) (SCENARIO BASED ORAL EXAMINATIONS)**

The scenario examinations consist of three 20 minute oral examinations in which two examiners present scenarios to the candidate and ask questions structured to assist in the evaluation of the candidate's depth and breadth of knowledge in prosthodontics and related disciplines and sciences. The three 20 minute examinations must be completed during a one day period. Candidates will be scored based upon their performance in all three examinations combined. A poor performance in one of the scenario examinations will not, by itself, cause failure of the entire section.

## **APPLICATION RENEWAL**

Board eligibility commences with the acceptance of a completed application by the Board. A graduate student or resident taking only the Section A written examination while a student/resident is not considered Board eligible until s/he has completed formal training in an accredited prosthodontic program and formally applies to the American Board for eligibility. Successful completion of Section A of the Examination as a student/resident does not by itself signify eligibility. Formal application to the Board is still required.

Graduate student /resident candidates who elect to take one of the patient presentation examinations (Part 2, 3, or 4) during February of the third year of training must have applied for and been granted eligibility prior to the examination and will continue to be eligible for a period of six years from the date of initial award of eligibility

Approved applications are valid for two (2) years and the new applicant is Board Eligible only during this time. At least one part of the examination must be taken during this two year period or Board eligibility is forfeited. Taking one part of the examination automatically extends Board eligibility for the remainder of the total six (6) year period. For those who successfully complete Section A during their training program, eligibility commences with formal application to the Board for the remaining parts (6 years). Candidates may request consideration for an extension in writing from the Board when there are extenuating circumstances.

## **RE-EXAMINATION**

Should a candidate fail all or any part(s) of the examination, s/he may apply at any time for re-examination and pay the appropriate fee for each part. If the candidate is unsuccessful in one or two parts, they can be reexamined in that part(s) only at a subsequent Board examination. Relative to the examination, Section B candidates that present an acceptable patient presentation but perform an unacceptable oral examination will be required to successfully complete a one hour repeat oral examination on general prosthodontics and related dental sciences. This examination will be given at a subsequent Board examination. A failure on any patient presentation will require that the candidate present a new patient treatment or retreatment of the same patient at a subsequent examination.

If the candidate fails any part of the examination three (3) times, Board eligibility is permanently forfeited and may not be re-established except under unusual extenuating circumstances which the Board may determine.

## **APPEALS PROCESS**

The American Board of Prosthodontics has a formal appeals process for administrative or scoring concerns only. There are no appeals for examination content or performance. Details are available upon request from the Executive Director of the Board.

## **ANNUAL FEE**

Holders of certificates from the American Board of Prosthodontics are required to pay an annual fee as determined by the Board. Annual fees are payable to the Executive Director of the Board on or before January 1 of each year.

The American Board of Prosthodontics issues time-limited certificates of eight (8) years duration.

Certification will be revoked if the annual fee is six (6) months delinquent. Payment is the responsibility of the Diplomate. Delinquent diplomates will receive a final registered letter from the executive director approximately one month prior to the six month delinquent date. Delinquent diplomates will not be listed in the roster as published in the Journal of Prosthetic Dentistry and the Journal of Prosthodontics. Nor will they be listed in the ABP website.

## **REVOCAION OF CERTIFICATE**

The American Board of Prosthodontics shall have the power, jurisdiction, and right to decide or determine whether evidence or information placed before it is sufficient to constitute grounds for suspension or revocation of any certification issued by the Board.

## **CONTINUED PROFICIENCY (RECERTIFICATION)**

The issuance of the original certificate shall not preclude periodic re-examination should the Board decide such procedure to be necessary to maintain desirable standards for the specialty of

prosthodontics. All active diplomates will be required to undergo a process of continued proficiency (recertification). The following is an outline for the continued proficiency process.

I. Certificates of diplomate status are issued for eight (8) year periods.

II. Continued Proficiency Mechanism

A. Continuing education

Attainment of at least forty (40) points in an eight (8) year period will be required by all diplomates except those in a Life Diplomate status. A maximum of 10 (10) points per year will be allowed toward the total of forty (40) points. Points may be accumulated in the following ways:

1. Attendance at a scientific session sponsored by a major prosthodontic organization (one point per day).
2. Other courses, conferences and meetings applicable to prosthodontics preferably "CERP" approved (one point per day).
3. Publications in peer reviewed journals (not to include abstracts), (two points per publication).\*
4. Prosthodontic book chapters - (one point per chapter).\*
5. Professional lectures given and study club activities related to prosthodontics (one point per day).\*

\* A maximum of sixteen (16) points in an eight (8) year period may be credited from publications, lectures and study group activities. Activities of a 1/2 day will earn 1/2 point (three hours equals 1/2 point).

Continuing education activity will be reported yearly on the registration form. All diplomates will be responsible for maintaining updated documentation of their continuing education activity. A percentage of randomly chosen diplomates will be requested to furnish documentation to the Board relating to their continuing education activities.

B. Self Assessment

A self assessment on recent prosthodontic advances will be prepared by the American Board of Prosthodontics. The self assessment can be requested on the annual registration form beginning in 1998. A package of questions with score card will be mailed to the diplomates requesting the self assessment. The completed score card will be mailed back to the executive director of the Board, logged and scored. The results, with correct answers and references, will be sent back to the diplomate.

C. At least one (1) documented self assessment is required in the eight (8) year certification period.

Summary

To become recertified following the eight (8) year period of certification a diplomate must:

1. Complete 40 points of continuing education.
2. Complete at least one (1) self-assessment.
3. Monitor their progress toward continued proficiency on a yearly basis.

## **GENERAL INFORMATION**

Inquiries concerning the activities of the American Board of Prosthodontics as well as information regarding applications and examinations for certification should be addressed to the Executive Director. [TTAYLOR@NSO.UCHC.EDU](mailto:TTAYLOR@NSO.UCHC.EDU) .

## **CRITERION STATEMENTS FOR SECTION B PATIENT PRESENTATION PART 2**

### **RECORDS**

Preoperative Radiographs, Casts, Dies and Photographs

- **Acceptable**  
Preoperative radiographs are originals, properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.
- **Marginal**  
Radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements though with less than ideal contrast and sharpness.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Articulation instrument is inadequately programmed or inappropriately used. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

## Postoperative Radiographs, Casts, Dies and Photographs

- **Acceptable**  
Postoperative radiographs are originals properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.
- **Marginal**  
Postoperative radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements with less than ideal contrast and sharpness.
- **Unacceptable (any one of following constitutes unacceptability)**  
Postoperative radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” seriously compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

## **NARRATIVE**

### History and Clinical Examination

- **Acceptable**  
History records chief complaint, an account of current problems, past history of dental and general health, family history, personal history and a review of systems. Clinical examination includes a general survey of patient condition, examination of the head and neck, examination of soft tissues of the mouth, and detailed information gained from a comprehensive dental examination.
- **Marginal**  
History is adequate though in depth coverage of some elements is marginal. Clinical examination is adequate though some aspects of the examination are marginally covered.
- **Unacceptable (any one of the following constitutes unacceptability)**  
History is poorly organized and fails to elicit pertinent information. Omissions compromise the formulation of an accurate diagnosis. Clinical examination is deficient resulting in a lack of needed diagnostic information.

### Diagnosis/Treatment Plan

- **Acceptable**  
Diagnosis is appropriate and supported by a thorough systemic method of identifying oral disease. Treatment plan is well organized and chronologically sequenced to prevent and correct oral disease.
- **Acceptable**  
Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment plan is organized and chronologically sequenced to prevent and correct oral disease.

- **Marginal**  
Diagnosis is adequate though method used to formulate it is questionable. Treatment plan is marginally adequate but not well organized.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Diagnosis is incomplete or inappropriate and is not supported by clinical findings. Treatment plan is inappropriate. Treatment plan is poorly organized and improperly sequenced.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Diagnosis is clearly incomplete or inappropriate and is not supported by clinical findings. Treatment plan is grossly inappropriate or inadequate with errors in content and sequencing. Teeth have been inappropriately extracted and/or restored.

## **FIXED PROSTHODONTICS/ NATURAL TEETH**

### Overall Design Concept

- **Acceptable**  
All basic components of accepted design concepts have been considered and optimally applied.
- **Acceptable**  
All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- **Marginal**  
Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Some of the basic components of accepted design concepts have not been addressed.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

### Abutment Preparation

- **Acceptable**  
Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Finish line design and location are optimal for the preparation. Finish of the preparation displays finesse.
- **Acceptable**  
Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Finish line design and location are generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.
- **Marginal**  
Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Finish line design or location is questionable. Finish of the preparations is marginally adequate.



- Unacceptable (any one of the following constitutes unacceptability)  
Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate, adjacent teeth damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.
- Unacceptable (any one of the following constitutes unacceptability)  
Reduction, retention, resistance form, finish line design, and the finish of the preparations are grossly inadequate. Gross undercuts present. Teeth have been prepared that did not need restoration. Existing restorations that have obvious deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

#### Pontic(s)

- Acceptable  
Pontic form, tissue relationship, and axial contour are well designed.
- Marginal  
Form, contour and tissue relationship are marginally acceptable.
- Unacceptable (any one of the following constitutes unacceptability)  
Gross inadequacies in pontic form, tissue relationships and contours.

#### Other Restorative Procedures

- Acceptable  
Restorative material is appropriate to situation in which employed; margins as well adapted; physiologic contours achieved; and post(s) appropriate in length and design.
- Marginal  
Restorative materials, margin adaptation, contours or post length and design are marginally acceptable.
- Unacceptable (any one of the following constitutes unacceptability)  
Restorative material is inappropriate to the situation in which employed; margins are poorly placed or adapted; contours are poor and may be pathogenic; post length and design are inappropriate to situation.

#### Esthetics

- Acceptable  
Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved.
- Marginal  
Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable.
- Unacceptable (any one of the following constitutes unacceptability)  
Restoration is grossly different from natural teeth. Result is unnatural with undesirable appearance.

#### Completed Restorations

- Acceptable

Restoration is physiologically compatible and well integrated with other elements of care.

- **Acceptable**  
Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- **Marginal**  
Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Future damage to surrounding tissues is likely to occur. Integration with other elements of care is lacking.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Damage has occurred to surrounding tissues. Gross neglect of integration with other elements of care is evident.

## **FIXED PROSTHODONTICS/IMPLANTS**

### Overall Design Concept

- **Acceptable**  
All basic components of accepted design concepts have been considered and optimally applied.
- **Acceptable**  
All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- **Marginal**  
Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Some of the basic components of accepted design concepts have not been addressed.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

### Abutments

- **Acceptable**  
An appropriate number of implants of proper length have been well placed in the edentulous area and appear to be physiologically compatible.
- **Acceptable**  
An appropriate number of implants with generally adequate length have been placed in the edentulous area and appear to be physiologically compatible.
- **Marginal**  
The number, length, placement of the implants is marginal but they appear to be physiologically compatible.

- Unacceptable (any one of the following constitutes unacceptability)  
The number, length, placement of the implants is unacceptable and that may affect their physiologic compatibility.
- Unacceptable (any one of the following constitutes unacceptability)  
The number, length, distribution of the implants is unacceptable and/or the implants appear to not be physiologically compatible.

#### Pontics

- Acceptable  
Pontic form, tissue relationship, and axial contours are well designed. Presentation accurately shows these areas.
- Marginal  
Form, contour, tissue relationship, presentation are marginally acceptable.
- Unacceptable  
Gross inadequacies in pontic form, tissue relationships, contours, and presentations.

#### Esthetics

- Acceptable  
Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved. Presentation clearly shows the required details.
- Marginal  
Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable. Presentation marginal.
- Unacceptable (any one of the following constitutes unacceptability)  
Restoration is grossly different from the natural teeth. Result is unnatural with undesirable appearance. Presentation unacceptable.

#### Completed Restoration(s)

- Acceptable  
Prosthesis is properly contoured and finished and well integrated with other elements of care.
- Acceptable  
Prosthesis is generally properly contoured, finished and integrated with other elements of care.
- Marginal  
Prosthesis contour, finish or integration with other elements of care is marginal.
- Unacceptable (any one of the following constitutes unacceptability)  
Prosthesis contour, finish, integration with other elements of care is unacceptable.
- Unacceptable (any one of the following constitutes unacceptability)  
Prosthesis contour, finish, integration with other elements of care is grossly unacceptable.

## **REMOVABLE PARTIAL PROSTHODONTICS**

#### Overall Design Concept

- Acceptable  
All basic components of accepted design concepts have been considered for both the edentulous and dentate areas.

- **Acceptable**  
All basic components of accepted design concepts have been addressed for both the edentulous and the dentate areas. The method in which one or more of these components have been used may be controversial.
- **Marginal**  
Most basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed might be justified upon oral examination.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Some basic components of accepted design concepts have not been addressed for both the edentulous and the dentate areas.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Most basic components of accepted design concepts have not been addressed for both the edentulous and the dentate areas. Those components not addressed cannot be justified in the light of current knowledge.

#### Direct Retainer Assembly Selection

- **Acceptable**  
An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
- **Marginal**  
The type, number, and placement of most direct retainer assemblies are adequate, but at least one direct retainer is inappropriate in type and/or placement.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The type, number, size, placement of direct retainer assemblies are unacceptable.

#### Rest(s)

- **Acceptable**  
Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- **Marginal**  
Most of the occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Most of the occlusal, cingulum, or incisal rests have been improperly prepared or improperly placed to provide optimal support for the prosthesis.

#### Retention/Reciprocation

- **Acceptable**  
Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.
- **Marginal**  
Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.
- **Unacceptable (any one of the following constitutes unacceptability)**

Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability. The size, contour, location or material used for the reciprocating and retentive components is/are unacceptable for the type of prosthesis.

#### Indirect Retainer(s)

- **Acceptable**  
An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.
- **Marginal**  
An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line or is less than optimal from a rest seat position/preparation standpoint.
- **Unacceptable (any one of the following constitutes unacceptability)**  
An indirect retainer(s) has not been placed to resist rotation of the prosthesis around the fulcrum line. The size of the indirect retainer is inadequate or is less than optimal from a rest seat position/preparation standpoint.

#### Major Connector Selection/Placement/Size

- **Acceptable**  
The major connector selection is appropriate, it is appropriately placed and appears to be rigid. It is of the type that would provide maximum stabilization and support to the prosthesis and remaining oral structures.
- **Acceptable**  
The major connector selection is appropriate, it is placed within the scope of acceptable principles and it appears to be rigid. It is of the type that will provide adequate stabilization and support to the prosthesis and remaining oral structures.
- **Marginal**  
The major connector is acceptable, it appears to be rigid, but the placement and selection are questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Aspects of major connector selection, placement and/or rigidity are inadequate.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Aspects of major connector selection, placement and/or rigidity are grossly inadequate.

#### Base(s) Coverage/Contour

- **Acceptable**  
The denture bases are extended and contoured properly within physiologic limits in order to give maximum stability and support to the prosthesis.
- **Marginal**  
The extent of the bases is marginally acceptable and the contour is questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The bases are grossly over or under extended and the contour is inadequate.

#### Esthetics

- **Acceptable**

The selection, color and position of the teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

- Marginal

The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.

- Unacceptable (any one of the following constitutes unacceptability)

- The selection, color and position of the teeth are not correct. There is poor orofacial support (in insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.

#### Denture Finish and Contour

- Acceptable

Resin exhibits no porosity. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish.

- Marginal

Resin exhibits minor areas of porosity. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonably acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished.

- Unacceptable (any one of the following constitutes unacceptability)

Resin is porous throughout. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces modified by grinding are rough. Denture or denture teeth have been fractured and not repaired or inadequately repaired.

#### Abutment Restoration(s)

- Acceptable

The abutment restorations have good margin integrity and are of the proper material and contour to permit ideal placement of the retainer assemblies.

- Acceptable

The abutment restorations have good margin integrity and are of the proper material, but the contours might be less than ideal for the chosen retainer assemblies.

- Marginal

The abutment restorations lack some margin integrity and the material used and/or contours are less than ideal for proper placement of the retainer assemblies.

- Unacceptable (any one of the following constitutes unacceptability)

The abutment restorations lack some areas of margin integrity and the material used and/or contours are inadequate for the retainer assemblies selected.

- Unacceptable (any one of the following constitutes unacceptability)

The abutment restorations show major areas lacking margin integrity and the material used and/or the contours are totally inadequate for the retainer assemblies chosen.

## **COMPLETE DENTURE/ OVERDENTURE PROSTHODONTICS**

### Overdenture/Natural Teeth Abutment Preparations (without copings)

- **Acceptable**  
Reduction is optimal. Contours are smooth with no undercuts. Occlusal or incisal restorations sealing the root canal and tooth surfaces are smooth and polished. Margins are supragingival with no ledging.
- **Acceptable**  
Reduction is generally adequate though not optimal. Occlusal or incisal restoration sealing the root canal are generally smooth and polished. Margins are supragingival with areas slightly roughened.
- **Marginal**  
Reduction is marginally acceptable with abutment(s) being over or under reduced. Occlusal or incisal restorations sealing the root canal and abutment surface are not smooth. Margins are mostly supragingival though some are subgingival.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Abutments have been over or under prepared to an extent that will compromise treatment outcome. Occlusal or incisal restorations and abutment surfaces are rough and poorly contoured. Significant portions of the margins are subgingival leaving marginal gingiva unsupported.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Abutments are grossly over or under reduced decidedly compromising treatment outcome. Abutment restorations and surfaces are very rough and poorly contoured. Most margins are subgingival resulting in unsupported marginal gingiva.

### Overdenture/Natural Teeth Abutment Preparations (for copings)

- **Acceptable**  
Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Margin design is optimal for the preparation. Finish of the preparation displays finesse.
- **Acceptable**  
Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Margin design is generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.
- **Marginal**  
Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Margin design is questionable. Finish of the preparations is marginally adequate.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Margin design is inappropriate. Preparation finish is inadequate.
- **Unacceptable (any one of the following constitutes unacceptability)**

Reduction, retention, resistance form, margin design, finish of the preparations.

#### Completed Overdenture Abutment Restorations

- Acceptable  
Restoration is physiologically compatible and well integrated with other elements of care.
- Acceptable  
Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- Marginal  
Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
- Unacceptable (any one of the following constitutes unacceptability)  
Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.
- Unacceptable (any one of the following constitutes unacceptability)  
Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

#### Occlusal Scheme

- Acceptable  
The occlusal scheme developed conforms to and demonstrates an acceptable technique.
- Marginal  
The occlusal scheme developed follows an acceptable technique. The candidate's understanding of the principles and concepts of the technique is marginal.
- Unacceptable (any one of the following constitutes unacceptability)  
The occlusal scheme developed does not follow an acceptable technique.

#### Centric Relation/Maximum Intercusation

- Acceptable  
Centric occlusion position and maximum intercuspation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed in centric occlusion.
- Acceptable  
Centric occlusion contacts demonstrate minor variations which could be improved with minor occlusal adjustment.
- Marginal  
Centric occlusion contacts show minor variations which are within the range of occlusal adjustment but will require a remount to correct.
- Unacceptable (any one of the following constitutes unacceptability)  
Centric occlusion and maximum intercuspation are not coincidental. Occlusal variations are present that cannot be corrected by conservative means.
- Unacceptable (any one of the following constitutes unacceptability)  
Centric occlusion and maximum intercuspation are not coincidental. Gross occlusal variations exist. Discrepancies cannot be corrected by conservative means.

#### Esthetics

- Acceptable



The selection, color and position of the anterior teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.

- **Acceptable**  
The selection, color and position of the anterior teeth could be improved esthetically. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.
- **Marginal**  
The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The selection, color and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The selection, color, and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics created are poor.

#### Denture Finish and Contour

- **Acceptable**  
Dentures exhibit no porosity. Tissue surfaces are free of sharp edges, nodules, and voids. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish. Thickness of the palate of the maxillary denture is uniform and approximately 2.5 mm.
- **Marginal**  
Dentures demonstrate minor areas of porosity. Tissue surfaces are mostly free of sharp edges but some nodules are apparent. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonably acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished. Thickness of maxillary denture palate is not uniform and is too thick or too thin.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Dentures contain porosity throughout. Tissue surfaces contain many resin nodules or sharp resin fins. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces modified by grinding are rough. Maxillary denture palate is grossly too thick or too thin or palate is irregular with thin and thick areas. Denture or denture teeth have been fractured and not repaired or inadequately repaired.

## OCCLUSION

- **Acceptable**

Centric relation and maximum intercuspation are coincident. Occlusal contacts are harmonious in centric relation and eccentric positions. The occlusal plane and type of teeth selected (material and cusp form) enhance the stability of the prosthesis.

- **Acceptable**  
Occlusal contacts are generally harmonious in centric relation and eccentric positions, but minor discrepancies exist.
- **Marginal**  
Occlusal contacts are compromised in either centric relation or eccentric positions. The choice of teeth and position of the occlusal plane is questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Centric relation and maximum intercuspation may not coincide. Occlusion has major discrepancies. Occlusal contacts may be lacking in centric relation. Undesirable eccentric contacts may be present. Occlusion is likely to be a pathogenic factor or create instability.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Centric relation and maximum intercuspation do not coincide. Occlusion has gross discrepancies. Numerous occlusal errors in centric relation/eccentric positions would likely create major instability.

### **PROGNOSIS**

- **Acceptable**  
Prognosis is realistic, based on an appropriate diagnosis, a well organized treatment plan and appropriate treatment.
- **Marginal**  
Prognosis is reasonable though slightly optimistic.
- **Unacceptable**  
Prognosis is not realistic.

### **WORK AUTHORIZATION FORM(S)**

- **Acceptable**  
All pertinent information is present and clearly described.
- **Marginal**  
Information is generally adequate but some aspects are marginally covered.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Pertinent information has not been written, information is confusing, incomplete or no form was used.

### **CRITERION STATEMENTS FOR PATIENT PRESENTATION PARTS 3 AND 4**

## **RECORDS**

### Preoperative Radiographs, Casts, Dies, Slides

- **Acceptable**  
Preoperative radiographs are originals, properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical “cut off.” Casts are clean, securely mounted and accurately reproduce the oral structures. Casts are free of any elements which would introduce error. Slides are properly exposed and exhibit the required information. All required views are present.
- **Marginal**  
Radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Slides are adequate but exposure and portrayal of required information could be improved. All required views are present.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement and apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Articulation instrument inadequately programmed or inappropriately used. Slides are improperly exposed or fail to exhibit the required information. Required views are missing.

### Postoperative Radiographs, Casts, Dies, Slides

- **Acceptable**  
Postoperative radiographs are originals properly mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted, and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Slides are properly exposed and exhibit the required information. All required views are present.
- **Marginal**  
Postoperative radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Slides are adequate but exposure and portrayal of required information could be improved. All required views are present.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Postoperative radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement and apical “cut off” seriously compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Slides are improperly exposed or fail to exhibit the required information. Required views are missing.

## **MEDICAL HISTORY/EXAMINATION FORM USED FOR REMOVABLE PROSTHODONTIC TREATMENT**

- **Acceptable**

All pertinent information has been collected and recorded accurately.

- **Marginal**  
Information is generally adequate but some aspects are marginally covered.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Pertinent information has not been collected, not recorded accurately or no form was used.

## **PATIENT PRESENTATION**

### **History and Clinical Examination**

- **Acceptable**  
History records chief complaint, and account of current problems, past history of dental and general health, family history, personal history, and a review of systems. Clinical examination includes a general survey of patient condition, examination of the head and neck, examination of the soft tissues of the mouth, and detailed information gained from a comprehensive dental examination.
- **Marginal**  
History is adequate though in depth coverage of some elements is marginal. Clinical examination is adequate though some aspects of the examination are marginally covered.
- **Unacceptable (any one of the following constitutes unacceptability)**  
History is poorly organized and fails to elicit pertinent information. Omissions compromise the formulation of an accurate diagnosis. Clinical examination is deficient resulting in a lack of needed diagnostic information.

### **Diagnosis and Treatment Planning**

- **Acceptable**  
Diagnosis is appropriate and supported by a thorough, systematic method of identifying oral disease. Treatment Plan is well organized and chronologically sequenced to prevent and correct oral disease.
- **Acceptable**  
Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment Plan is organized and chronologically sequenced to prevent and correct oral disease.
- **Marginal**  
Diagnosis is adequate though method used for formulating it is questionable. Treatment Plan is marginally adequate but not well organized.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Diagnosis is inappropriate and is not supported by clinical findings. Treatment Plan is poorly organized and improperly sequenced. Patient could benefit by referral to another specialist.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Diagnosis is clearly inappropriate and is not supported by clinical findings. Treatment Plan is grossly inadequate with errors in content and/or sequencing. Teeth have been inappropriately prepared, restored and/or extracted. Teeth that should have been treated were not. Patient should have been referred to another specialist.

## **FIXED PROSTHODONTICS**

## Overall Design Concept

- Acceptable  
All basic components of accepted design concepts have been considered and optimally applied.
- Acceptable  
All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- Marginal  
Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)  
Some of the basic components of accepted design concepts have not been addressed.
- Unacceptable (any one of the following constitutes unacceptability)  
Most basic components of accepted design concepts have not been addressed. Those components not addressed cannot be justified in the light of current knowledge.

## Abutment Preparation

- Acceptable  
Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Finish line design and location are optimal for the preparation. Finish of the preparation displays finesse.
- Acceptable  
Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Finish line design and location are generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.
- Marginal  
Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Finish line design or location is questionable. Finish of the preparations is marginally adequate.
- Unacceptable (any one of the following constitutes unacceptability)  
Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate, adjacent teeth damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.
- Unacceptable (any one of the following constitutes unacceptability)  
Reduction, retention, resistance form, finish line design, and the finish of the preparations are grossly inadequate. Gross undercuts present. Teeth have been prepared that did not need restoration. Existing restorations that have obvious deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

## Other Restorative Procedures

- Acceptable  
Restorative material is appropriate to situation in which employed; margins are well adapted; physiologic contours achieved; and post appropriate in length and design (if employed).
- Marginal

Restorative materials, marginal adaptation, contours, post length and design, are marginally acceptable.

- Unacceptable (any one of the following constitutes unacceptability)  
Restorative material is inappropriate to the situation in which employed; margins are poorly placed or adapted; contours are poor and may be pathogenic; post length and design are inappropriate to the situation.

#### Provisional Restorations

- Acceptable  
The provisional restorations are esthetic, well contoured, show proper fit, show proper occlusion, and are not irritating to the tissues.
- Marginal  
The provisional restorations are generally acceptable but differences exist in esthetics, occlusion, contour, and tissue reaction.
- Unacceptable (any one of the following constitutes unacceptability)  
The provisional restorations are poorly contoured, unesthetic, lack proper fit, are irritating to the tissues, and lack adequate occlusion.

#### Pontics

- Acceptable  
Pontic form, tissue relationship, and axial contours are well designed.
- Marginal  
Form, contour, tissue relationship, are marginally acceptable.
- Unacceptable  
Gross inadequacies in pontic form, tissue relationships, contours.

#### Esthetics

- Acceptable  
Restoration blends with adjacent natural teeth. Form and color are well developed. Natural appearance is achieved.
- Marginal  
Esthetic result is acceptable but definite differences exist between natural teeth and restoration. Esthetic result is less than desirable.
- Unacceptable (any one of the following constitutes unacceptability)  
Restoration is grossly different from the natural teeth. Result is unnatural with undesirable appearance.

#### Completed Restorations

- Acceptable  
Restoration is physiologically compatible and well integrated with other elements of care.
- Acceptable  
Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- Marginal  
Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.

- Unacceptable (any one of the following constitutes unacceptability)  
Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.
- Unacceptable (any one of the following constitutes unacceptability)  
Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

## **REMOVABLE PARTIAL PROSTHODONTICS**

### Overall Design Concept

- Acceptable  
All basic components of accepted design concepts have been considered for both the edentulous and dentate areas.
- Acceptable  
All basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. The method in which one or more of these components have been used may be controversial.
- Marginal  
Most basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed have been justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)  
Some basic components of accepted design concepts have been addressed for both the edentulous and dentate areas. Those components not addressed cannot be justified in the light of current knowledge.
- Unacceptable (any one of the following constitutes unacceptability)  
Most basic components of accepted design concepts have not been addressed for both the edentulous and dentate areas.

### Direct Retainer Assembly Selection

- Acceptable  
An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
- Marginal  
The type, number, and placement of most direct retainer assemblies are acceptable, but at least one direct retainer is unacceptable in type and/or placement.
- Unacceptable (any one of the following constitutes unacceptability)  
The type, number, and placement of most direct retainer assemblies are unacceptable.

### Rest(s)

- Acceptable  
Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- Marginal  
Most of the occlusal, cingulum, and incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.

- Unacceptable (any one of the following constitutes unacceptability)  
Most of the occlusal, cingulum, or incisal rests have been improperly placed to provide optimal support for the prosthesis.

#### Retention/Reciprocation

- Acceptable  
Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.
- Marginal  
Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.
- Unacceptable (any one of the following constitutes unacceptability)  
Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components is unacceptable for the type of prosthesis.

#### Indirect Retainer(s)

- Acceptable  
An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.
- Marginal  
An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation.
- Unacceptable (any one of the following constitutes unacceptability)  
An indirect retainer(s) has not been placed to resist rotation of the prosthesis around the fulcrum line.

#### Major Connector Selection/Placement/Size

- Acceptable  
The major connector selection is appropriate, it is appropriately placed and appears to be rigid. It is of the type that would provide maximum stabilization and support to the prosthesis and remaining oral structures.
- Acceptable  
The major connector selection is appropriate, it is placed within the scope of acceptable principles and it appears to be rigid. It is of the type that will provide adequate stabilization and support to the prosthesis and remaining oral structures.
- Marginal  
The major connector selection is appropriate, it appears to be rigid, but the placement and selection are questionable.
- Unacceptable (any one of the following constitutes unacceptability)  
Aspects of major connector selection, placement and/or rigidity are not adequate.
- Unacceptable (any one of the following constitutes unacceptability)  
Aspects of major connector selection, placement and/or rigidity are grossly inadequate.



### Base(s) Coverage/Contour

- **Acceptable**  
The denture bases are extended and contoured properly within physiologic limits in order to give maximum stability and support to the prosthesis.
- **Marginal**  
The extent of the bases is marginally acceptable and the contour is questionable.
- **Unacceptable**  
The bases are grossly over or under extended and the contour is inadequate.

### Abutment Restoration(s)

- **Acceptable**  
The abutment restorations have good marginal integrity and of the proper material and contour to permit ideal placement of the retainer assemblies.
- **Acceptable**  
The abutment restorations have good marginal integrity and are of proper material, but the contours might be less than ideal for the chosen retainer assemblies.
- **Marginal**  
The abutment restorations lack some marginal integrity and the material used and/or contours are less than ideal for proper placement of the retainer assemblies.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The abutment restorations lack some areas of marginal integrity and the material used and/or contours are inadequate for the retainer assemblies selected.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The abutment restorations show major areas lacking in marginal integrity and the material used and/or the contours are totally inadequate for the retainer assemblies chosen.

## **IMPLANT PROSTHODONTICS**

### Abutments

- **Acceptable**  
An adequate number of implants of proper length have been well distributed in the edentulous area and they appear to be physiologically compatible.
- **Acceptable**  
An adequate number of implants with generally adequate length have been distributed in the edentulous area and they appear to be physiologically compatible.
- **Marginal**  
The number, length, distribution of the implants is marginal but they appear to be physiologically compatible.

- Unacceptable (any one of the following constitutes unacceptability)  
The number, length, distribution of the implants is unacceptable and that may affect their physiologic compatibility.
- Unacceptable (any one of the following constitutes unacceptability)  
The number, length, distribution of the implants is unacceptable and the implants appear to not be physiologically compatible.

#### Overall Design Concept

- Acceptable  
All basic components of accepted design concepts have been considered and optimally applied.
- Acceptable  
All basic components of accepted design concepts have been addressed but some aspect of the design may be considered controversial.
- Marginal  
Most basic components of accepted design concepts have been addressed and those not addressed have been justified upon oral examination.
- Unacceptable (any one of the following constitutes unacceptability)  
Some of the basic components of accepted design concepts have been addressed. Those components not addressed cannot be justified in the light of current knowledge.
- Unacceptable (any one of the following constitutes unacceptability)  
Most basic components of accepted design concepts have not been addressed.

#### Complete Prosthesis

- Acceptable  
Prosthesis is properly contoured and finished and well integrated with other elements of care.
- Acceptable  
Prosthesis is generally properly contoured, finished and integrated with other elements of care.
- Marginal  
Prosthesis contour, finish or integration with other elements of care is marginal.
- Unacceptable (any one of the following constitutes unacceptability)  
Prosthesis contour, finish, integration with other elements of care is unacceptable.
- Unacceptable (any one of the following constitutes unacceptability)  
Prosthesis contour, finish, integration with other elements of care is grossly unacceptable.

## **COMPLETE DENTURES/OVERDENTURES**

#### Overdenture/Natural Teeth Abutment Preparations (without copings)

- Acceptable  
Reduction is optimal. Contours are smooth with no undercuts. Occlusal or incisal restorations sealing the root canal and tooth surfaces are smooth and polished. Margins are supragingival with no ledging. Casts clearly document all of these requirements.
- Acceptable  
Reduction is generally adequate though not optimal. Occlusal or incisal restoration sealing the root canal are generally smooth and polished. Margins are supragingival with areas slightly roughened. Casts clearly document these requirements.

- **Marginal**  
Reduction is marginally acceptable with abutment(s) being over or under reduced. Occlusal or incisal restorations sealing the root canal and abutment surface are not smooth. Margins are mostly supragingival though some are subgingival. Casts marginally document requirements.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Abutments have been over or under prepared to an extent that will compromise treatment outcome. Occlusal or incisal restorations and abutment surfaces are rough and poorly contoured. Significant portions of the margins are subgingival leaving marginal gingiva unsupported. Casts do not document requirements.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Abutments are grossly over or under reduced decidedly compromising treatment outcome. Abutment restorations and surfaces are very rough and poorly contoured. Most margins are subgingival resulting in unsupported marginal gingiva.

#### Overdenture/Natural Teeth Abutment Preparations (for copings)

- **Acceptable**  
Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Margin design is optimal for the preparation. Finish of the preparation displays finesse.
- **Acceptable**  
Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Margin design is generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.
- **Marginal**  
Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Margin design is questionable. Finish of the preparations is marginally adequate.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Preparation is over or under reduced. Retention and resistance form is lacking or ill-defined. Margin design is inappropriate. Preparation finish is inadequate.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Reduction, retention, resistance form, margin design, and/or finish of the preparations are grossly inadequate.

#### Completed Overdenture Abutment Restorations

- **Acceptable**  
Restoration is physiologically compatible and well integrated with other elements of care.
- **Acceptable**  
Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.
- **Marginal**  
Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.
- **Unacceptable (any one of the following constitutes unacceptability)**

Integration with other elements of care is lacking. Future damage to surrounding tissues may occur.

- Unacceptable (any one of the following constitutes unacceptability)  
Gross neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

#### Maxillary Impression

- Acceptable  
The flanges extend into the vestibule without impinging on movable tissue. The surface of the impression accurately reproduces the anatomy of the supporting tissues. The posterior extension of the impression includes the hamular notches and the posterior junction of the hard and soft palate.
- Acceptable  
The border extensions are generally acceptable. There are some localized areas of over extension that can be corrected. The impression records the anatomy of the supporting tissues. The posterior extension includes the anatomic guides.
- Marginal  
Some of the border extensions are generally acceptable with local areas of over- or under extension. The impression records the anatomy of the tissues. The posterior extension of the impression includes the anatomic guides. Some voids present in impression. The border extensions are generally acceptable, with localized areas of over- or under extension. The impression records the anatomy of the tissues. There are some voids.
- Unacceptable (any one of the following constitutes unacceptability)  
The border extensions are generally over- or under extended with the potential for loss of stability and/or retention. The impression lacks detail, and there are several voids.
- Unacceptable (any one of the following constitutes unacceptability)  
The border extensions are grossly under- or overextended. The tissue registered by the impression lacks detail. There are voids and/or distortions evident.

#### Mandibular Impression

- Acceptable  
The flanges extend into the vestibule without impinging on movable tissue. The tray covers, but does not extend beyond the retromolar pads. The surface of the impression contacting the supporting oral mucosa accurately reproduces the anatomy of these tissues. The impression material is evenly distributed in the impression tray.
- Acceptable  
The border extensions are generally acceptable. There are also some localized areas that are overextended, but the conditions are correctable with minor alterations. The impression records the anatomy of the tissues. The impression material is evenly distributed in the impression tray.
- Marginal  
The border extensions are generally acceptable, with local areas of over or under extension. The retromolar pads are only partially covered. The impression records the anatomy of the tissues. The impression material is evenly distributed in the impression tray; however, there are a few small voids.
- Unacceptable (any one of the following constitutes unacceptability)  
The border extensions are generally over or under extended, with the potential for loss of stability and/or retention. The tray does not contact the retromolar pads. The impression lacks

tissue detail, and there are several voids. The impression material is unevenly distributed in the impression tray.

- Unacceptable (any one of the following constitutes unacceptability)  
The border extensions are grossly under or overextended. The tissues registered lack detail. The impression material is unevenly distributed in the impression tray, and there are several areas where the tray has distorted tissue.

#### Maxillomandibular Relationship Records

- Acceptable  
The methods used to establish centric relation records follow acceptable techniques. Casts are properly poured, trimmed, and mounted. Record bases properly contoured. Mounted casts clearly show these requirements.
- Marginal  
The methods used to establish centric relation records follow acceptable techniques. Casts show minor discrepancies which would be correctable with minor adjustments on the finished denture.
- Unacceptable (any one of the following constitutes unacceptability)  
The methods used to establish centric relation records do not follow acceptable technique. Casts show major discrepancies. Record bases are unacceptable.

#### Wax Trial Dentures

- Acceptable  
The prosthetic teeth have been optimally arranged for function and esthetics and the wax is nicely contoured and very smooth.
- Acceptable  
The prosthetic teeth are arranged for good function and esthetics and the wax is properly contoured and smooth.
- Marginal  
The tooth arrangement is marginal and/or the wax contours and smoothness lack finesse.
- Unacceptable (any one of the following constitutes unacceptability)  
The teeth are not acceptably arranged for function, esthetics. The wax contours, smoothness are unacceptable.
- Unacceptable (any one of the following constitutes unacceptability)  
There are gross discrepancies in tooth arrangement, waxing.

#### Cuspless Tooth Arrangements

##### Centric Occlusion/Maximum Intercuspatation

- Acceptable  
Centric occlusion and maximum intercuspation are coincidental. Occlusal contacts of the posterior teeth are bilateral and simultaneous when closing the articulator in the centric occlusion position. Similar relationships are demonstrated in the mouth.

##### Marginal

Centric occlusion and maximum intercuspation are quite close to being coincidental. The occlusal contacts observed in centric occlusion demonstrate minor deflections which are within the correctable range. Similar relationships are shown in the mouth.

- Unacceptable (any one of the following constitutes unacceptability)

Centric occlusion and maximum intercuspation are not coincidental. The occlusal contacts are grossly deflective. Correction will require resetting the teeth.

#### Bilateral Cross-Tooth, Cross-Arch

#### Balanced Articulation

#### Centric Occlusion/Maximum Intercuspation

- **Acceptable**  
Centric occlusion and maximum intercuspation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed on the articulator in centric occlusion. A similar relationship is also shown in the mouth.
- **Marginal**  
Centric occlusion and maximum intercuspation are coincidental. The occlusal contacts demonstrate minor deflections which are within the correctable range. A similar relationship is shown in the mouth.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Centric occlusion and maximum intercuspation are not coincidental. The occlusal contacts are grossly deflective. Correction will require resetting the teeth.

#### Occlusal Vertical Dimension

- **Acceptable**  
The patient demonstrates an acceptable interocclusal distance in a closed position and a normal physiologic rest position.
- **Acceptable**  
The patient demonstrates an interocclusal distance that is less than ideal (slightly open with interocclusal space remaining or slightly closed).
- **Marginal**  
The patient demonstrates an interocclusal space that is considered to be closed 2 to 3 millimeters anteriorly.
- **Unacceptable (any one of the following constitutes unacceptability)**  
No interocclusal space or open occluding vertical dimension.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Patient is excessively open or excessively closed.

#### Centric Relation/Maximum Intercuspation

- **Acceptable**  
Centric occlusion position and maximum intercuspation are coincidental. The occlusal contacts of the posterior teeth are bilateral and simultaneous when closed in centric occlusion.
- **Acceptable**  
Centric occlusion contacts demonstrate minor variations which could be improved with minor occlusal adjustment.
- **Marginal**  
Centric occlusion contacts show minor variations which are within the range of occlusal adjustment but will require a remount to correct.
- **Unacceptable (any one of the following constitutes unacceptability)**

Centric occlusion and maximum intercuspation are not coincidental. Occlusal variations are present that cannot be corrected by conventional means.

- Unacceptable (any one of the following constitutes unacceptability)  
Centric occlusion and maximum intercuspation are not coincidental. Gross occlusal variations exist. Discrepancies cannot be corrected by conventional means.

#### Esthetics

- Acceptable  
The selection, color and position of the anterior teeth complement the total occlusal scheme and provide orofacial support and esthetics. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.
- Acceptable  
The selection, color and position of the anterior teeth could be improved esthetically. The occlusal scheme developed includes the correct vertical and horizontal placement of the teeth.
- Marginal  
The selection, color and position of the anterior teeth could be improved. The orofacial support is minimal or slightly excessive. The esthetics developed would benefit from some changes. The occlusal scheme may or may not include discrepancies in the vertical and horizontal placement of the teeth.
- Unacceptable (any one of the following constitutes unacceptability)  
The selection, color and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics are poor. The vertical and/or horizontal placement of the teeth is incorrect and may encourage denture instability.
- Unacceptable (any one of the following constitutes unacceptability)  
The selection, color, and position of the anterior teeth are not correct. There is poor orofacial support (insufficient or excessive), and the esthetics created are poor.

#### Denture Finish and Contour

- Acceptable  
Dentures exhibit no porosity. Tissue surfaces are free of sharp edges, nodules, and voids. Polished surfaces are free of scratches, plaster inclusions, and are properly contoured and highly polished. Stippling, if present, is smooth and appropriately positioned. Denture base color is appropriate for the patient. Modified occlusal surfaces of denture teeth have been restored to a high polish. Thickness of the palate of the maxillary denture is uniform and approximately 2.5 mm.
- Marginal  
Dentures demonstrate minor areas of porosity. Tissue surfaces are mostly free of sharp edges but some nodules are apparent. Polished surfaces of dentures contain minor scratches and blemishes. A few plaster inclusions are apparent. Denture polished surface is over or under contoured. Denture base color is reasonable acceptable for the patient. Occlusal surfaces of modified denture teeth are not polished. Thickness of maxillary denture palate is not uniform and is too thick or too thin.
- Unacceptable (any one of the following constitutes unacceptability)  
Dentures contain porosity throughout. Tissue surfaces contain many resin nodules or sharp resin fins. Polished surfaces of denture have numerous scratches and blemishes. There are retained plaster or stone inclusions. Denture facial contours are grossly over contoured or severely flattened. Color of denture base is inappropriate for the patient. Denture teeth occlusal surfaces

modified by grinding are rough. Maxillary denture palate is grossly too thick or too thin or palate is irregular with thin and thick areas. Denture or denture teeth have been fractured and not repaired or inadequately repaired.

## **MAXILLOFACIAL PROSTHETICS**

### Overall Design Concept

- **Acceptable**  
All basic components of accepted design concepts have been considered for both the defect and the non-defect areas.
- **Acceptable**  
All basic components of accepted design concepts have been addressed for both the defect and the non-defect areas. The method in which one or more of these components have been used may be controversial.
- **Marginal**  
Most basic components of accepted design concepts have been addressed for both the defect and the non-defect area. Those components not addressed might be justified upon oral examination.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Some basic components of accepted design concepts have been addressed for both the defect and the non-defect areas. Those components not addressed cannot be justified in the light of current knowledge.
- **Unacceptable (any one of the following constitutes unacceptability)**  
All basic components of accepted design concepts have not been addressed for both the defect and the non-defect areas.

### Direct Retainer Assembly Section

- **Acceptable**  
An acceptable number of direct retainer assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.
- **Marginal**  
The type, number, and placement of most direct retainer assemblies are acceptable, but at least one direct retainer is unacceptable in type and/or placement.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The type, number, and placement of most direct retainer assemblies is unacceptable.

### Rest(s)

- **Acceptable**  
Occlusal, cingulum, or incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- **Marginal**  
Most of the occlusal, cingulum, and incisal rests have been properly prepared and placed to provide optimal support for the prosthesis.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Most of the occlusal, cingulum, or incisal rests have been improperly placed to provide optimal support for the prosthesis.



### Retention/Reciprocation

- **Acceptable**  
Reciprocating and retentive components of all direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are proper for the type of prosthesis.
- **Marginal**  
Reciprocating and retentive components of some direct retainers have been acceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components are marginal for the type of prosthesis.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Reciprocating and retentive components of most direct retainers have been unacceptably placed to provide tooth stability while the prosthesis is placed and removed. The material used and the contour of the reciprocating and retentive components is unacceptable for the type of prosthesis.

### Indirect Retainer(s)

- **Acceptable**  
An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.
- **Marginal**  
An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line.
- **Unacceptable (any one of the following constitutes unacceptability)**  
An indirect retainer(s) has not been placed to resist rotation around the fulcrum line.

### Major Connector Selection/Placement

- **Acceptable**  
The major connector appears to be rigid and appropriately placed. It is of the type that would give maximum stabilization and support to the prosthesis and remaining oral structures.
- **Marginal**  
The major connector is marginally acceptable. It appears to be rigid, but the placement and selection are questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The major connector appears not to be rigid and its placement and selection are questionable.

### Base(s) Coverage/Contour (Non-defect area, if present)

- **Acceptable**  
The bases in the non-defect area/areas are extended and contoured properly within physiological limits in order to give maximum stability and support to the prosthesis.
- **Marginal**  
The extent of the bases in the non-defect area or areas is marginally acceptable and the contour is questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The bases are grossly over or under extended and the contour is inadequate.

#### Obturator Extension/Contour

- Acceptable  
The extent and contour of the bases in the defect areas are appropriate.
- Marginal  
The extent of the bases in the non-defect area or areas is marginally acceptable and the contour is questionable.
- Unacceptable (any one of the following constitutes unacceptability)  
The extent and contour of the bases are inadequate.

#### Design

- Acceptable  
The design and materials used are appropriate for the type of defect to be obturated.
- Acceptable  
The design and materials used are generally adequate but not optimal for the type of defect to be obturated.
- Marginal  
The design and materials used are marginally acceptable for the type of defect to be obturated.
- Unacceptable (any one of the following constitutes unacceptability)  
The design is overly or under simplified and the materials used are inappropriate for the type of defect to be obturated.
- Unacceptable (any one of the following constitutes unacceptability)  
The design and materials used are grossly inadequate for the type of defect to be obturated.

#### Abutment Restoration(s)

- Acceptable  
The abutment restorations have good marginal integrity and are of the proper material and contour to permit ideal placement of the retainer assemblies.
- Acceptable  
The abutment restorations have good marginal integrity and are of proper material, but the contours might be less than ideal for the chosen retainer assemblies.
- Marginal  
The abutment restorations lack some marginal integrity and the material used and/or contours are less than ideal for proper placement of the retainer assemblies.
- Unacceptable (any one of the following constitutes unacceptability)  
The abutment restorations lack some areas of marginal integrity and the material used and/or the contours are inadequate for the retainer assemblies selected.
- Unacceptable (any one of the following constitutes unacceptability)  
The abutment restorations show major areas lacking in marginal integrity and the material used and/or the contours are totally inadequate for the retainer assemblies chosen.

## **OCCLUSION**

- **Acceptable**  
Centric occlusion and maximum intercuspation are coincident. Occlusal contacts are harmonious in centric occlusion and eccentric positions. The occlusal plane and type of teeth selected (material and cusp form) enhance the stability of the prosthesis.
- **Acceptable**  
Occlusal contacts are generally harmonious in centric occlusion and eccentric positions, but minor discrepancies exist.
- **Marginal**  
Occlusal contacts are compromised in either centric occlusion or eccentric positions. The choice of teeth and position of the occlusal plane is questionable.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Centric occlusion and maximum intercuspation may not coincide. Occlusion has major discrepancies. Occlusal contacts may be lacking in centric occlusion. Undesirable eccentric contacts may be present. Occlusion may create instability for the prosthesis.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Centric occlusion and maximum intercuspation do not coincide. Occlusion has gross discrepancies. Numerous occlusal errors in centric occlusion and eccentric positions would likely create major instability for the prosthesis(es).

## **PROGNOSIS**

- **Acceptable**  
Prognosis is realistic, based on an appropriate diagnosis, a well organized treatment plan and appropriate treatment.
- **Marginal**  
Prognosis is reasonable though optimistic.
- **Unacceptable**  
Prognosis is not realistic.

## **WORK AUTHORIZATION FORM(S)**

- **Acceptable**  
All pertinent information is present and clearly described.
- **Marginal**  
Information is generally adequate but some aspects are marginally covered.
- **Unacceptable (any one of the following constitutes unacceptability)**  
Pertinent information has not been written, information is confusing, incomplete or no form was used.

**CRITERION STATEMENTS FOR  
ORAL EXAMINATION  
PARTS 2, 3 AND 4**

- **Acceptable**  
The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates a superior understanding of the broad scope of Prosthodontics.
- **Acceptable**  
The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates an adequate understanding of the broad scope of Prosthodontics.
- **Marginal**  
The candidate responds adequately to questioning associated with the patient presentation. The candidate understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate's understanding of the broad scope of Prosthodontics is marginal.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The candidate's response to questioning associated with the patient presentation is not adequate. Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of Prosthodontics is not adequate.
- **Unacceptable (any one of the following constitutes unacceptability)**  
The candidate's response to questioning associated with the patient presentation is not adequate. The candidate's patient presentation is technically poor and he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of Prosthodontics is not adequate.

## AMERICAN BOARD OF PROSTHODONTICS PRESIDENTS

1947-1948	* Dr. Bert L. Hooper
1948-1952	* Dr. Claude J. Stansbery
1952-1953	* Dr. Carl O. Boucher
1953-1954	* Dr. Richard H. Kingery
1954-1955	* Dr. Harold L. Harris
1955-1956	* Dr. Vincent R. Trapozzano
1956-1957	* Dr. Roland D. Fisher
1957-1958	* Dr. Muller M. DeVan
1958-1959	Dr. S. Howard Payne
1959-1960	* Dr. Daniel H. Gehl
1960-1961	* Dr. Alvin H. Grunewald
1961-1962	* Dr. Bertram H. Downs
1962-1963	* Dr. Gilbert P. Smith
1963-1964	* Dr. Charles H. Jamieson
1964-1965	* Dr. Jack Werner
1965-1966	* Dr. Lynn O. Dirksen
1965-1967	* Dr. Frank M. Lott
1967-1968	Dr. Heinz O. Beck
1968-1969	Dr. J. Eugene Ziegler
1969-1970	* Dr. Arthur L. Roberts
1970-1971	Dr. Samuel E. Guyer
1971-1972	* Dr. Gustave J. Perdigon
1972-1973	Dr. Robert B. Lytle
1973-1974	* Dr. Arthur E. Aull, Jr.
1974-1975	* Dr. Chester K. Perry
1975-1976	Dr. John E. Rhoads
1976-1977	Dr. William R. Laney
1977-1978	* Dr. Ernest B. Nuttall
1978-1979	Dr. Davis Henderson
1979-1980	* Dr. I. Kenneth Adisman
1980-1981	* Dr. Milton H. Brown
1981-1982	Dr. Kenneth D. Rudd
1982-1983	* Dr. Roland W. Dykema
1983-1984	* Dr. Thomas A. Curtis
1984-1985	Dr. Jack D. Preston
1985-1986	Dr. Douglas C. Wendt
1986-1987	Dr. Arthur O. Rahn
1987-1988	* Dr. William H. Pruden, II
1988-1989	Dr. Brien R. Lang
1989-1990	Dr. William D. Culpepper
1990-1991	Dr. Ronald P. Desjardins
1991-1992	Dr. Kenneth A. Turner
1992-1993	Dr. Robert M. Morrow
1993-1994	Dr. James W. Schweiger

1994-1995  
1995-1996  
1996-1997  
1997-1998  
1998-1999  
1999-2000  
2000-2001  
2001-2002  
2002-2003  
2003-2004  
2004-2005  
2005-2006  
2006-2007

\* Deceased

Dr. Ronald D. Woody  
Dr. Howard M. Landesman  
\* Dr. Robert Staffanou  
Dr. Richard J. Grisius  
Dr. Charles J. Goodacre  
Dr. Edward J. Plekavich  
Dr. Thomas D. Taylor  
Dr. David W. Eggleston  
Dr. Robert J. Cronin  
Dr. Steven A. Aquilino  
Dr. Carl J. Andres  
Dr. Stephen D. Campbell  
Dr. John R. Agar