UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

Department of Comprehensive Dentistry

Advanced Education in General Dentistry

Program Information

2025-2026

University of Maryland
School of Dentistry
650 W. Baltimore Street
Baltimore, MD 21201
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I. GENERAL INFORMATION

A. INTRODUCTION

The Advanced Education in General Dentistry (AEGD) Program is a postdoctoral educational program accredited by the American Dental Association's Commission on Dental Accreditation (CODA). Rooted in a longstanding tradition of excellence in dental education, the program is designed to provide advanced clinical training and academic enrichment beyond the scope of pre-doctoral education. It emphasizes the integration of applied basic and behavioral sciences, recognizing oral health as an essential and interactive component of overall health.

The program prepares residents to deliver comprehensive oral health care to a diverse patient population, including individuals with complex medical and dental needs. Through a curriculum that promotes clinical excellence, ethical practice, and interdisciplinary collaboration, residents gain proficiency in all areas of general dentistry, including restorative dentistry, prosthodontics, periodontics, endodontics, oral surgery, and implantology.

The AEGD program offers multiple tracks tailored to meet the evolving interests and career goals of our residents. These tracks are supported by a technologically advanced clinical environment and a faculty committed to mentorship and innovation. The program maintains a strong orientation toward private practice, equipping graduates with the skills necessary for successful, independent practice in a dynamic healthcare landscape.

There are close relationships with organized dentistry, including the Maryland State Dental Association (MSDA), Maryland State Board of Dental Examiners (MSBDE), the Academy of General Dentistry (AGD), and the American Dental Education Association (ADEA). These partnerships enhance the educational experience and foster professional development through networking, continuing education, and advocacy.

Graduates of the program emerge as competent, confident clinicians prepared to provide high-quality, patient-centered care and to contribute meaningfully to the dental profession.

B. UMB Core Values, UMSOD mission and AEGD vision

UMB Core Values
Respect and Integrity, Well-Being and Sustainability, Equity and Justice, and Innovation and Discovery

University of Maryland School of Dentistry's Vision:
Good oral health is integral to general health and quality of life. We will achieve preeminence through excellence and innovation in education, patient care, research, public service, and global engagement.

University of Maryland School of Dentistry's Purpose:
Advancing Oral Health - Improving Lives

AEGD vision
Aligned with the University of Maryland, Baltimore (UMB) core values and the University of Maryland School of Dentistry (UMSOD) mission and vision, the Advanced Education in General Dentistry (AEGD) program is firmly centered on excellence in patient care. The program is guided by a dedicated curriculum that integrates residents' professional aspirations with current market demands, ensuring that program outcomes are consistent with the standards set forth by the Commission on Dental Accreditation (CODA).

C. THE PURPOSE AND GOALS

a. One-Year Program Goals and Objectives

The goals of the **one-year program** should include preparation of the graduate to:

- Act as a primary care provider for individuals and groups of patients. This includes providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; directing health promotion and disease prevention activities and using advanced dental treatment modalities.
- Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.
- Manage the delivery of oral health care by applying concepts of patient and practice management and quality improvement that are responsive to a dynamic health care environment.
- Function effectively and efficiently in multiple health care environments within interdisciplinary health care teams.
- Apply scientific principles to learning and oral health care. This includes using critical thinking, evidence or outcomes-based clinical decision-making and technology-based information retrieval systems.
- Utilize the values of professional ethics, lifelong learning, patient centered care, adaptability, and acceptance of cultural diversity in professional practice.
- Understand the oral health needs of communities and engage in community service.

b. Two-Year Program Goals and Objectives

The two-year AEGD program incorporates all the goals and objectives of the one-year program and is designed to expand the educational opportunities offered by:

- Gaining experience in managing highly complex comprehensive dental care;
- Improving clinic management skills;
- Pursuing areas of individual concentration, e.g.: temporomandibular disorders & facial pain, anesthetics & sedation, oral pathology, CAD-CAM, etc;
- *Providing residents with an interdisciplinary graduate foundation in the biological and clinical sciences for careers in dental research and/or education and the practice of dentistry;
    - ***Gaining teaching experience, performing original research and earning an optional Master of Science degree if indicated.**

      * This is only the Master's tract. Not all Year II residents are enrolled in Master's coursework or do research.

D. RESPONSIBILITIES

a. Duties of the resident

Each resident shall:

- Provide professional comprehensive care and treatment to assigned patients;
- keep a complete record of activity in the Program, by maintaining a Portfolio.
- Maintain at all times the highest professional conduct with respect to patients, faculty and support staff.
- Consult with faculty members when arriving at a diagnosis and treatment plan.
    - Do not begin treatment before asking for start for faculty
    - Never dismiss pt without final check of faculty
    - Produce and approve appointment notes on time
- Function under the supervision and guidance of the teaching staff.
- Develop the ability to assume increasing independence. As a result, a greater amount of responsibility will be placed on your clinical judgment as the year progresses.
- Manage all treatment plans for assigned patients, maintain primary responsibility for discussing treatment cost with each patient, and utilize one of the acceptable protocols for the collection of all fees (see Clinic Manual).
- Assume responsibility for following your patient's financial accounts; render treatment only after payment is assured.
- Attend all regular and special program meetings.
- Review and sign the Attendance & leave Policy.
- Review and follow Policies of the Clinic Manual, Medical Emergencies, Infection Control and OSHA policies (http://dental-umaryland.smartcatalogiq.com/en/Clinic-Manual/Clinic-Manual.Select "Current Students", then, Policies – Clinic Manual.
- Residents are assigned an email address & a unique axium provider number. Both are used as a means of communication. Residents should check their emails & axium messages on daily basis.
- Read and understand UMSOD Academic Due Process Policy found on page 9 of the manual.
- Read and understand the UMSOD Resident Grievance Policy (https://dental-umaryland.smartcatalogiq.com/-/media/Institution/University-of-Maryland-School-of-Dentistry/Policies/Grievance%20Policy_updated%2002132020.pdf)
- Residents will participate in all academic activities.
- Review and sign all campus policies
- Maintain a clean clinical space, including personal operatory, lounge and laboratory.
- Operate in a team-work mindset
- Do not leave early if patient is missing
- Present all didactic assigned presentations/seminars
- Arrive before 8am to plan the day, as patient must be sitting in the operative chair at 8am sharp
- Respect lunch and end time at the clinic floor for staff

Notes: [1]In order to achieve the above, a personal camera and computer are strongly recommended for each resident. The program has an intraoral camera to aid in case documentation.

[2]Each resident will receive on Articulator, must be kept in good conditions and returned after the completion of the AEGD program.

b. The teaching staff responsibilities

- Be fully aware of the philosophy and objectives of the AEGD Program.
- Present seminars, lectures, conferences, HandOn and journal clubs; attend treatment planning seminars, and engage in other research and service.
- Review of patient's records assigned to residents to assure their accuracy and comprehensiveness. Provide electronic signatures to verify the record entries and perform Case Complete Audits.
- Discuss patient evaluation, treatment planning, management, complications, and outcomes of all cases with residents.
- Supervise residents in clinical sessions, pre-approve extractions, removable deliveries and fixed cementations.
- Serve as a role model by being involved in the active treatment of patients.
- Attend all staff meetings scheduled that involve them.

F. LEAVE POLICY

Residents are granted the following Holidays: Independence Day, Labor Day, Thanksgiving Break, Winter Break, Dr. King's Birthday, Spring Break, Memorial Day, and Juneteenth. In addition, the residents are allowed 10 excused absence days.

The policy for excused absences for a maximum of ten (10) days, counted as 8 hours/day, include and are limited to:

- Illness with a doctor's note
- COVID-19 illness or quarantine
- Hospitalization
- Religious holidays with one-month advanced notice to course directors
- Death in the family
- Family emergencies
- Interview days
- Presentation at approved professional and/or research meetings
- Personal and vacation leave

Requests for personal days shall be submitted in writing, for approval, to the Director **AT LEAST FOUR WEEKS** in advance of the anticipated dates (unless an emergency situation exists). *If approved*, it is the responsibility of the resident taking leave to do the following:

- Any missed time past the **TEN** (10) days of allowable leave will need to be made up before receiving a certificate.
- Leave is given on first come, first served basis as clinic must remain operational at all times.
- Make sure that no conflicting assignments exist, and all assigned duties are completed (i.
- Notify the business staff/ receptionists concerning patient scheduling.
- Promptness and attendance are critical to maintaining schedules. Repeated tardiness and/or absences will not be tolerated and will be deducted from your annual leave allowance.
- No leave will be granted during transition periods, i.e. July, August, May & June, unless in exceptional emergency situations.

Sick or late (notification)

Residents should notify by e-mail Drs. Eisner and Arossi, the Office Manager (Wendy Gilden (410-706-4428) and Stephanie Horne (410-706-4156), and the Program Administrative Specialist (Danielle Ellington – 410 706 0844) if they are going to be late or out sick.

G. TUITION

Stipends vary from year-to-year and are discussed during the interview process. Students graduating from a US or Canadian CODA accredited school do not pay tuition and fees. All other applicants are responsible for their tuition and fees. Tuition for the Master's program is charged to the master track resident.

H. PRACTICE PRIVILEGES AND OTHER ACTIVITIES OUTSIDE THE PROGRAM

Residents who graduated from a US or Canadian CODA accredited school and have obtained a license to practice dentistry in the state of Maryland from the State Board of Dental Examiners are permitted to work outside the program (Moonlighting). Permission must be approved by the Program Director. Liability insurance for outside work is the responsibility of the Resident.

H. ADVANCED EDUCATION IN GENERAL DENTISTRY FACULTY AND STAFF

2025-2026

FACULTY

Dr. Adam Eisner, Director - General Dentist
Dr. Guilherme Arossi, General Dentist
Dr. Qoot Alkhubaizi, General Dentist
Dr. Douglas Barnes, General Dentistry
Dr. Jeffrey Behar, General Dentist
Dr. Mark Keiser, Periodontist

Dr. Harvey Cohen, General Dentist
Dr. Charles Doring, General Dentist
Dr. Marvin Leventer, Dental Anesthesiology
Dr. Darianna Masih, General Dentist
Dr. David Mazza, General Dentist
Dr. Gilbert Palmieri, General Dentist
Dr. John Powers, General Dentist
Dr. Mohammad Shahegh, General Dentist
Dr. Nahid Shahry, General Dentist
Dr. Victor Siegel, General Dentist
Dr. Dennis Stiles, General Dentist
Dr. Bradley Trattner, Endodontist
Dr. Ian Walker, Endodontist
Dr. Mehdi Zamani, General Dentist

DENTAL HYGIENE
Linda Finlay, RDH

DENTAL ASSISTANTS
Armentia Davis (Supervisor and Clinic Coordinator)

Latonya Owens
Lauren Wilson
Kaylarae Wilson

STAFF

Wendy Gilden, RDH, Office Manager
Stephanie Horne, Treatment Coordinator
Danielle Ellington, Administrative Program Specialist

FRONT DESK
Jamilla Couch
Taylor Epkins
Sarah Montgomery
Linda Williamson, Insurance Coordinator

I. Advanced Education in General Dentistry 2025-2026 AEGD Residents and Diamond Scholars

Year I

Dr. Jennifer Flores	University of Maryland School of Dentistry	2025
Dr. Shoshana Garfield	University of Maryland School of Dentistry	2025
Dr. Kee Hyun (Sean) Kwak	University of Maryland School of Dentistry	2025
Dr. Emily Mills	University of Maryland School of Dentistry	2025
Dr. Yuliana Alzate	Universidad de Antioquia Medellin, Columbia	2014
Dr. Monsurat Ojikutu	University of Lagos, Nigeria	2006
Dr. Gabriela Quezada	Universidad de San Martin, Peru	2006
Dr. Sanjeev Soni	Buddha Institute of Dental Sciences, India	1995

Year II

Dr. Balsam Alhwaidi	University of Baghdad	2014
Dr. Ramisa Chamgordani	Islamic Azad University	2010
Dr. Mohammed Estaitia	University of Sharjah	2020

Diamond Scholars

Ms. Sara Abdelwahab	University of Maryland School of Dentistry	2026
Ms. Isabel Zats	University of Maryland School of Dentistry	2026
Ms. Katelyn Park	University of Maryland School of Dentistry	2026

6/17/03

J. Academic Due Process Policy

Advanced Dental Education (ADE) Programs
University of Maryland School of Dentistry

All matters of professional ethics and conduct that involve ADE students will be referred to the Judicial Board of the Dental School for adjudication. The ethical and conduct standards for student enrolled in ADE programs are identical to the standards of conduct for students enrolled in the pre-doctoral and dental hygiene programs. Judicial Board matters are not governed by the policy contained in this document. An Advanced Dental Education student who believes he or she has been harassed on the basis of his/her sex shall be referred to the UMB Policy on Sexual Harassment of Students, VI-1.20(B).

Academic Standards

A. Students in ADE Programs are expected to maintain high levels of academic success. Academic dismissal from an ADE Program can result from failure to achieve a Program's requirements or failure to meet minimal levels of academic achievement as they are defined in the *Catalog of the Baltimore College of Dental Surgery*. Clinical competence in all areas of patient management and treatment constitutes a vital sector of academic achievement. A student must maintain a B (3.0) or better overall average to remain in good standing. If the student's performance falls below this level of performance, he/she will be placed on academic probation during the following semester. In the event that the student's overall average remains below a 3.0 at the end of the semester of probation, he/she will be dismissed from the Program. All failing and incomplete grades must be rectified before a certificate is conferred.

B. Faculty will provide feedback to students in all matters related to didactic and clinical performance. This feedback can be oral or written, but must be in writing, at appropriate intervals, as determined by each Program's accreditation standards noted under "Evaluation." Program directors will ensure that each ADE student receives a copy of the Program's Accreditation Standards as part of the program orientation for new residents.

Unsatisfactory Performance

A. Unsatisfactory performance in knowledge, skills, clinical competence and/or patient management may be documented in several ways, and corrective actions or sanctions can range from oral or written counseling to dismissal from the Program. The process for such actions is as follows:

1. Initial notification of a deficiency/problem can be addressed orally by the program director or the faculty identifying the problem. After so doing, a dated notation will be placed in the student's file by the program director.

2. Should the problem continue, or new problems develop, the student will be sent a letter or counseling form by the program director, identifying the deficiency/deficiencies and required actions to be taken by the student to correct the deficiency/deficiencies. A time period for correcting the deficiency/deficiencies will be specified. A copy of the counseling form will be kept in the program or course director's file, and a copy will be sent to the Assistant Dean for Research and Graduate Studies. The student should acknowledge receipt of the letter or counseling form by signing the original and returning it to the program director. The letter or counseling form will be placed in the student's file. The student should keep the copy for future reference.

3. Should student performance still not improve, the program director, or program's designate acting in (his/her) stead, will notify the student in writing that he/she will be placed on academic probation. Actions required of the student and a timeline (not exceeding those of academic probation noted above) to correct the deficiency/deficiencies will be detailed in the letter. The student must sign the letter, keep a copy for his/her files and return the original letter to the program director, who will place the letter in the student's file. Copies will be sent to the department chair and the Assistant Dean for Research and Graduate Studies.

4. If the student fails to rectify the deficiency/deficiencies in the time specified, the program director, in consultation with the program faculty, will recommend dismissal from the program to the department chair, the Assistant Dean for Research and Graduate Studies, and the Advanced Dental Graduate Education (ADGE) Committee. The ADGE Committee will review the recommendation for dismissal.

Review

A. The student will be given the opportunity to be heard by the ADGE Committee on the recommendation for dismissal by offering his/her own statements, and, if appropriate, testimony of witnesses and presentation of evidence. The ADGE Committee may choose to call for further testimony and documents. Hearsay evidence is admissible only if corroborated. Any irrelevant or unduly repetitive evidence will be excluded. If the student fails to appear for his/her hearing without good cause, he/she will be deemed to have waived his/her right to meet with the ADGE Committee.

B. Following its review and any subsequent meetings, the ADGE Committee will conduct its deliberation and make a decision on the basis of a majority vote. If the ADGE Committee determines that the student should be dismissed, the recommendation will be forwarded to the Dental School's Faculty Council for action. In the case of dismissal decisions, the Assistant Dean for Research and Graduate Studies will notify the student in writing that s/he has been dismissed from the Program.

C. The Assistant Dean for Research and Graduate Studies shall maintain the documentary evidence from the hearing for at least 4 years from the date of the hearing. The student may obtain a copy of the record upon paying the cost of reproduction.

Appeals Process

A. In the event that the student elects to appeal the dismissal decision, the student may not take part in any academic or clinical activities of the program until and unless action on the appeal reverses the decision for dismissal.

B. If the student disputes the dismissal, he/she may contact the Program Director within five business days of notification of dismissal for informal discussion. Should the student remain dissatisfied, the student may file a formal appeal.

C. A student wishing to file a formal appeal of a dismissal decision must initiate the appeal process regarding dismissal from the Program within 10 business days of receiving the written notification. The appeal must be submitted in writing to the Assistant Dean for Research and Graduate Studies. The written appeal must include: the decision the student is appealing; the specific ground for the appeal (only newly discovered evidence or lack of due process); and the academic status that the student is requesting. The student may present and prioritize more than one alternative to dismissal from the Program.

D. The Assistant Dean for Research and Graduate Studies will review the appeal and designate a three-person Appeals Panel. Faculty who have been substantially involved in this or any other decision or actions against the student prior to dismissal are excluded from the Panel. Where possible and practical, the Panel will consist of three members of the full-time faculty. The Assistant Dean for Research and Graduate Studies will appoint one of these three as Chairperson of the Appeals Panel.

E. The Chairperson will then schedule a meeting with the members of the Panel within 5 business days when possible or practical. The Panel will determine whether the student's written appeal meets the criteria outlined in C. and report their decision in writing to the Assistant Dean for Research and Graduate Studies. Should the Panel determine that an appeal lacks the required evidence, the appeal will be denied. In these circumstances, there is no further appeal.

F. If the Panel determines that newly discovered information, not originally considered by the ADGE Committee does exist, then the matter should be referred back to the ADGE Committee for reconsideration.

G. If the Panel determines that there was a failure of due process, an appeal on the record will be heard. The decision of this Panel will be final. The student and the Assistant Dean for Research and Graduate Studies will be notified of the decision in writing.

Approved by Dental School Faculty Council: April 8, 2003
Approved by University Counsel: June 19, 2003
Approved by Dean: June 30, 2003

II. CLINIC INFORMATION

A. PROFESSIONAL LIABILITY

Professional Liability is provided by the program and is **only for patient care provided in the school**.

B. COMMUNICATION POLICY

- Residents are required to provide a contact number (cell phone number is preferred).
- A program What's App chat group will be created for all the residents and paid faculty
- A MS Teams site is available for the program.
- Residents must be present on the clinic floor in an easily reachable position, and must notify the front desk if they are away from the clinic area for more than 10 minutes.
- Residents will be provided with a University of Maryland e-mail address which will become the official e-mail address for Program communication.
- Residents should review their University of Maryland e-mail account and Axium messages at least once a day and Friday afternoon before leaving work. E-mail will be the primary source of non-urgent communication.
- Individual questions or topics should be addressed directly to the Faculty, when appropriate, or to the course director, when necessary.
- Group questions or topics should be brought to the course director by the Chief resident.
- Communications from residents to other graduation schools should follow the standard procedure within the UMSOD policy. In out-of-ordinary situations, the communication should be pre-authorized by the course director

C. EMERGENCIES POLICY

During office hours

- Please direct your patients to contact the front desk and/or the business office, Ms. Gilden (410.706.4428) or Ms. Horne (410-706-4156), to handle all "emergency" related visits
- The preference is for each provider to see their own emergencies, however; our program is expected to support emergencies of all SOD patients

After hours

- Provide the afterhours emergency phone number **(443-827-5011**), Ms**. Cheryl Patucci** handles all SOD after hours phone calls.
- Any AEGD related emergencies will be scheduled on the AEGD schedule.
- Any school-wide related emergencies will be scheduled on AEGD in the event of a respective
- clinic closure
- In the event that a patient with an emergency is scheduled on your chair, Ms. Patucci
- forwards an email/Axium message to the provider, faculty and business manager.

Scheduling of emergency patients

- If emergency patient is assigned to a resident, any Resident or Diamond Scholar will see the patient if there is an opening.

- Emergency patients will be given any empty slot in the appointment schedule with any available resident.
- If there is no empty slot, the patient will be assigned to the first available resident who will see the patient.

D. OPERATING HOURS FOR AEGD CLINIC

- Patient appointments are Monday – Thursday 8:00 am to 4:00 pm, Friday 8:00 am – 12:00 pm. Residents are required to arrive by 7:30 am and not to depart until 4:30 pm.

  Friday 1:00-1:30 Administrative time

- **CLINIC Schedule on most days**

  First Patient – 8 am to 9:30 am
  Second Patient – 9:30 am to 11 am
  Third Patient – 11 am to 12 noon

  LUNCH – 12 pm to 1 pm

  Fourth Patient – 1 pm to 2:30 pm
  Fifth Patient – 2:30 pm to 4 pm

E. TREATMENT PLANS

- All treatment plans must be reviewed by an attending faculty and signed by the patient before any restorative treatment can begin.
- In treatment planning cases, especially if they are complex, residents must first collect all necessary data (EOE/IOE, odontogram, periochart, FMX, Panoramic and CBCT as needed, intra-oral pictures), including mounted diagnostic casts. Sometimes, diagnostic wax-ups may be required, and patient will be charged for it if the wax-up is done by a dental lab. There will be no charge to the patient if the wax-up is done by the resident.
- Format for treatment planning is discussed on pages 31-34.
- Residents are expected to have a treatment plan written out **before** approaching an attending faculty for evaluation. By presenting the case in such a manner, a more meaningful discussion will emerge. Always bring mounted casts, clinical pictures, updated x-rays and progress notes for treatment planning.
- A sequenced treatment plan should be written after final attending approval and discussion.
- All treatment plans must be entered into Axium and swiped by attending faculty.
- When a comprehensive treatment is completed and prior to entering the patient into the recall system, a record review audit and case complete audit must be performed.
- UNI Lab produces high-end esthetic porcelain crowns and veneers, thus, there is an extra fee for esthetic cases using this lab. There is a policy of one esthetic case extra-lab fee waive each resident per year
- The extra-fee for gold crowns will take place according to the lab
- If the resident decides to send the patient to the lab for shade selection, there will be an extra-fee

F. MEDICAL CONSULTS

For medically compromised patients where dental treatment plans will need to be altered due to patient condition, a medical consult form must be filled out. Residents will send the information request via the patient to the medical doctor. The patient will then return the form to the resident and it will be added to the patient's dental chart. Any **ASA III (Severe systemic issues) and IV (Severe**

systemic issues that may affect life or death) patient requires a medical consult and medical clearance prior to dental treatment.

When residents are phoning medical doctors for patient consults, it is advised that the resident prepare in advance what to say. In general, the resident should include the following:

- Identify yourself (DDS, Dental Resident at UMSOD) and your patient.
- State the known health condition of the patient.
- Describe the dental procedures planned. Medical doctors tend not to have a detailed understanding of these procedures; thus, account the details of the surgery, the extent of bleeding predicted, the intended local anesthetic or medication to be used, and/or the possible effects of the dental treatment on the patient.
- Specifically ask the information required from the medical doctor. Examples: *"Should antibiotic prophylaxis be administered prior to dental therapy?" "Is the use of epinephrine in the local anesthetic contraindicated?"* Avoid asking too general a question like, *"Is there anything that should concern me about the patient?"*
- Document discussion in the *Progress Notes* of the patient's record and ask for written documentation from the patient's physician.

G. MEDICAL UPDATES

Medical updates must be completed in the Electronic Patient Record at every appointment and must be approved by a faculty member. It should be resident's customary question to ask about any changes in patient's medical condition at every visit, and a new B.P. should be taken and recorded in the chart. **IF MEDICAL UPDATES ARE NOT COMPLETED, THE RESIDENT WILL BE "LOCKED OUT" OF AXIUM THE NEXT DAY.**

H. DENTAL HYGIENE

An integral part of the AEGD family are the hygienists; they provide oral care instructions, prophylaxis treatment, scaling and root planing, debridements, fluoride treatments and placement of Arestin. These services are available via (1) completed prescribed treatment plans and/or (2) appointed recall visits with the hygienist. Treatment plans are to be comprised of full mouth probings and chartings and radiographs annually.

Performing hygiene checks is an important element of your educational and training experience. Residents are *expected* to develop the skill for pausing mid-treatment with their patients and performing a hygiene check for another patient who is seeing the hygienist. Our hygienists review their daily schedule and determine their hygiene examination needs.

From July to December, we expect hygiene check performed by a resident to be reviewed by an attending faculty. From December to June, residents to engage faculty if findings are present. At the start of each day, hygienists will note her examination needs on the white board, which is located on the clinic floor and approach the attending faculty/chief resident who will assign residents to perform the examinations on that day.

Hygiene visits can commence prior to or in conjunction with restorative appointments. At completion of the hygiene visit, patients schedule their follow up recall at the front desk. Please encourage your patients to maintain their recall visits. There are also hygiene products available for application or by

prescription for purchase via the clinic and the School Store. The School store does not accept insurance plans.

IT IS THE RESPOSIBILITY OF THE PROVIDER TO MAKE A DIAGNOSIS, PROVIDE THE APPROPRIATE TREATMENT CODES AND SUBMIT APPROPRIATE PRE-AUTHORIZATION PRIOR TO THE PATIENT SEEING THE HYGIENIST.

I. AEGD DENTAL ASSISTANTS

Listed below are items that dental assistants will provide on every day basis:

I. **Chair Setup** – complete setup for your first patient of the day (cassette, medicaments, disposable handles, etc.). This can only be accomplished with schedules posted and procedures noted. During the course of the day, residents could be expected to clean-up and setup their own chairs.

II. **Chairside Assisting** – There is not an assistant for each resident, (assistant to resident ratio is 1 assistant:4 residents). Assistants will be able to help residents during the critical part of the procedure. (Mixing and placing of amalgams, mixing impression materials, placing of composites, etc.). Surgeries always have first priority.

III. **Exams** – If a resident is doing screening on any day, the assistant in that zone will help with the charting. The resident will be expected to take the necessary radiographs.

IV. **Radiographs** – Residents will take all necessary images.

V. **Rubber Dam** – The assistants and Faculty are asking the residents to use the rubber dam whenever they can. This will help the resident during the procedure, especially when they won't have an assistant available.

VI. **Become Familiar with Layout**

J. TREATMENT COORDINATOR

The Treatment Coordinator (PCC) provides patient support services that are both efficient and caring.

1. Acts as a patient advocate, acquainting patients with policies and procedures relevant to their care and helping them navigate the system as necessary. Provides excellent customer service to internal and external calls regarding information, treatment and special needs. Responds to patient concerns and forwards concerns to the program director as necessary.
2. Provides individualized coordination of care; when necessary, reviews chart to monitor patient clinical progress.
3. Assesses outcomes of care; analyze complaints to determine trends. Surveys patient via questionnaires; resolve complaints.
4. Assists students with patient management.

K. PRODUCTION REPORT

This report is given monthly to the resident to monitor procedures completed by ADA codes. The resident is responsible for maintaining the record in their portfolio. (See page 35.)
This can be printed in the Personal Planner in Axium, by clicking on My Production Tab.

UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

L. EXPOSURE REPORTING MANAGEMENT PROTOCOL – BALTIMORE CAMPUS

If an exposure has or may have occurred:

1) STOP and IMMEDIATELY remove item responsible for exposure to prevent a DOUBLE exposure
   - Note if item is visibly bloody
2) Remove PPE and set aside gloves for checking later if a glove breach is not obvious (SOD nurse can help with this)
3) Wash all wounds with soap and water, and flush exposed mucous membranes with cool water
   - Do not force wounds to bleed
4) DO NOT dismiss source patient/stop patient from leaving (if possible)
5) Prepare to report the incident, make note of patient medical history, risk factors and have patient ID #
6) Report incident to your attending faculty (student/resident), or department supervisor (staff)
7) Report exposure to an SOD nurse; the most efficient way to do so is to use the emergency pager system
   - To place an emergency page:
     - Call 6-8128 or 410-706-8128
     - When Vocera answers, say "URGENT BROADCAT EMERGENCY TEAM"
     - Nurse(s) will respond to your area within a few minutes **(page again, if no response in 3-5 minutes)***

   *** If unable to contact SOD nurse:**
   - **Individuals, NOT on staff at UMMC -** Phone the University of Maryland Immediate Care, Bloodborne Pathogen Exposure Hotline **(BBPE Hotline) at 667-214-1886**; if using an SOD phone, dial 9 first. **This is a general on-call line:** Leave message and phone number for the hotline to call back (*note: clinic wall phones cannot receive incoming calls).* **DO NOT go to the Emergency Room without a referral from the BBPE Hotline.**
   - **Individuals ALSO ON STAFF at UMMC - Page the UMMC Needlestick Hotline from a personal cell phone or SOD office (clinic wall phones cannot receive return calls**): **Dial 8-2337** (*410-328-2337, if using a cell phone*) and follow the voice prompts (Enter ID# 7845)
8) Complete the required forms **(all incident details must be provided to an SOD nurse as soon as possible)**

Required Injury Reporting *Forms (give to an SOD nurse as soon as possible after completion)*:

1) **Student/Resident, Staff, Employee and Volunteer forms will be provided by a SOD nurse, or can be located in bins on SOD nurses' office doors in labeled packets (rooms 1326, 2318, 3322, or 4317)**

- Employees can also find injury report documents online *(always report details to SOD nurse as well)*

Students	Employees* (Staff and Faculty)	Volunteers
1) U of MD SOD Occupational Exposure Incident Report 2) Adverse Incident Report *(done by SOD nurse)*	**1)** First Report of Injury (needed for medical follow-up) **2)** Accident Witness Statement **(indicate if no witness)** **3)** Supervisor's report of Injury ***department must fax to corporate or state EHS within 3 days (copy to SOD nurse), unless done online** 4) U of MD SOD Occupational Exposure Incident Report 5) Adverse Incident Report (done by SOD nurse)	1) U of MD SOD Occupational Exposure Incident Report 2) JE Authorization Form (required to receive treatment at U of MD Immediate Care ***(signed by Mark Sutter - rm 5201)*** 3) Adverse Incident Report *(done by SOD Nurse)*

  - State forms: http://www.ehs.umaryland.edu/Insurance/Workers_Comp/index.htm
  - Corporate forms: **FDSP Associate injury report forms are not available online**

*** Never refer to an incident report in the EPR, record incident facts only**

Revised: 03/03/2022

M. Medical Emergency Response Protocol

a. For Immediate Life-threatening Emergencies or Behavioral Incidents:

1. **Call 911** (alerts Baltimore City 911 Center)
   - Give your exact location to the 911 operator
   - Indicate if an ambulance is needed or officers for behavior incident
2. **Using an SOD wall phone, dial extension 6-8128**, Vocera Genie answers, say "**URGENT BROADCAST – EMERGENCY TEAM**"
3. Send someone to front lobby to help direct emergency personnel
4. If no SOD emergency response team member is available, faculty or senior resident take charge, and report incident using incident form in bin on nurses doors *(room 1326, 2318, 3322, or 4317)*

- **Before Responders Arrive**:

1. If bodily fluids present and/or victim is coughing, don the appropriate PPE where available
2 The first responder will act as "captain" and direct interventions until a more qualified or experienced individual arrives to take over that role.
    A. Position victim so as to protect from further injury on the floor or in a dental chair.
    B. If campus police have been called to send an ambulance, designate a person to alert the guard in the atrium lobby, and to assist the EMTs to the location of the emergency.
    C. Bring or have someone bring the Emergency Cart/Oxygen tank into the room/quad (located outside clinic prep area or in some side hallways off main corridors).
        (1) Start oxygen with a nasal cannula for oxygen support at 2-4 L/min, or with a non-rebreather mask, or if the patient is distressed due to shortness of breath, at 10-15L/min (make sure bag attached to the non-rebreather mask inflates).
        (2) **Provide treatment if trained**; **DO NOT wait for emergency responders, if basic life support is needed** (See basic CPR instructions from the AHA in the front of white emergency binders on top of red Emergency Cart if necessary).

c. For **non-life-threatening Emergencies**, or for BP / glucometer check, etc.

1. **Using an SOD wall phone, dial extension 6-8128**, Vocera Genie answers, SAY the first and last name of the person OR say what you need, followed by the word "nurse"
    - **EXAMPLE, SAY…**
        - Call Nurse
        - Call Blood Pressure nurse
        - Call Glucose nurse
        - Call Exposure nurse
        - Call Oral Surgery nurse
        - Call Swallowed Object nurse

Revised: 06/06/2023

N. LABORATORIES

a. PROFESSIONAL LABS

- Friendship, Empire, Uni Lab and Mahwah dental labs handle the School of Dentistry's fixed, removable and implant prosthodontic cases.
- Uni may be used for involved esthetic cases. **AN ADDITIONAL FEE MUST BE CHARGED TO THE PATIENT IF THIS PREMIER LAB IS USED.** Review the AEGD Laboratory Fee Protocol work sheet for instructions.

b. DDX/AXIUM LAB FORM

- Please make sure all required information fields are completed in the prescription draft in order for the fourth-floor lab to approve and create a case. Prescriptions must be swiped by the attending faculty and Business staff.
- Confirm with the office manager to ensure that a minimum of 50% payment was made by the patient prior to sending out the case. The lab will not process the case without this information, nor will they do so without the patient's name and axiUm number.
- Any laboratory form involving new technology products and an alternative laboratory should be approved by the Director.
- For lab cases either milled in house, use code D2999.3 (In-house) D2999.4 (Lab) to denote a digital case. For lab cases sent to labs via Sirona Connect or 3Shape Unite, a DDX lab slip AND the plataform lab slip for the case MUST be created, with clear indication of its connection.

c. DENTAL LAB CASES

- All lab work for AEGD department is submitted to the School of Dentistry's in-house lab to be routed to an outside lab.
- The AEGD department uses the Henry Schein's DDX Lab Tracking Program. Lab prescriptions must be completed in the Electronic Patient Record. All cases must be approved by an attending faculty member before going to the dental labs.
- **All Complex Cases Should Have Mounted Models For Diagnosis And Treatment Planning Purposes.**
- For the **first three months of the program** you are expected to mount your own cases. When using a semi-adjustable articulator ensure that the type/name of articulator is indicated on the prescription. After that, mounting will be at the **discretion of the faculty**.
- **In select cases**, residents are expected to ditch and mount beyond the 3-month period.
- All impressions, wax and metal try-in's must be disinfected before going to the labs and indicated on prescription form.
- For PFM bridges, always perform a framework try-in prior to adding porcelain.
- For single crown cases, ensure that your bite registration is sent with the lab case, and specify the type of articulator you'd like your case to be mounted on (hinge or semi-adjustable articulator+ brand).
- For multiple crowns & bridge cases, a custom tray must be fabricated by the resident for the final impression.
- **Do not** use triple trays for impressions to fabricate prostheses on terminal teeth, bridges & survey crowns.
- Preliminary casts for removable dentures must be surveyed and mounted (if required) by the resident prior to design. **Master impressions must be poured by the resident, surveyed and designed prior to shipment to the lab**. If not, it will be returned by the lab.

- Cases that are ready to be sent to the lab, should be placed in appropriate lab boxes and left on the lab cart inside the clinic conference room #2313.
- All DDX lab drafts must be swiped by a faculty member prior to being sent to the lab.
- Fixed, Remo and Ortho lab cases are delivered and picked up once a day at approximately 9 a.m.
- Incoming lab cases are signed in; then placed in the resident's designated location in the wall hanging storage units in the AEGD hallway, or they may be hand delivered to the resident.
- To speed up having your case returned to you as quickly as possible, please be sure to include the date of return. Also, start your day count for your case to be returned on the next working day. Don't forget to exclude holidays and clinic closings.
- Mr. William King is the School of Dentistry's Prosthodontics Lab Supervisor.
- Place patient axiUm number on all study models. **DO NOT USE PATIENT NAMES DUE TO HIPAA REGS.**
- Check your lab shelf at least twice a day, every day for returned lab cases for dies that need to be trimmed, MD Bridge designs, RPD designs, etc.
- Prepare for patients who may need lab work at their next appointment by checking your patient schedule, and their charts at least 2 days prior to their next appointment.

d. INFECTION CONTROL

- Note that impressions **MUST** be properly disinfected and bagged prior to delivery to the labs. The laboratory form must be labeled "disinfected".
- Remove gloves and wash hands **BEFORE** entering the lab area.

e. TIME REQUIRED

- Both fixed and removable cases require pre-set working days depending on the complexity of the case. Rushing cases may not be possible, so schedule the patient accordingly: (Laboratory time requirements are posted within the AEGD clinic).
- For large restorative cases, which require frequent visits, it is recommended to schedule multiple appointments for the patient to ensure completion of the case within the duration of the residency

f. REMAKE POLICIES

- Remakes must be approved and signed by the Director and the office manager before the case can be sent back to the lab. This is to verify the need for the re-make and to determine financial responsibility for the remake.
- It is advised to remake impressions if remaking crown/bridge cases so as to avoid repeating the same error.
- All items from the first case must be returned to the lab, including the models and rejected restorations.
- Make a note of the exact reason for the remake, this constitutes part of quality assurance.

O. RESTORATIVE MATERIALS AND EQUIPMENT USED IN THE AEGD CLINIC

COMPOSITE
TPH 3 Spectra
Surefil SDR Flow
Fluorocore II

GLASS IONOMERS
Fuji 9
Vitrebond

BONDING AGENTS
Prime and Bond Elect
ClearFil SE Bond
Prime&Bond NT + Activator
Scotchbond universal

BLEACHING SOLUTIONS
In Office: *Zoom
Home Treatment: Night White Excel (10% ; 16%; 22%)

TEMPORARY CROWN MATERIAL
Acrylic: Jet & Alike
BisAcryl: Integrity
Inlays: Telio onlay

CEMENTING SYSTEMS
A. Without Bonding
Duralon
Fuji Cem
B. With Bonding
Relyx Universal

DESENSITIZING AGENTS
Gluma

POST AND CORE MATERIAL
ParaPost

THEMOSTATIC SOLUTIONS
Hemodent
Visco Stat Plus

IMPRESSION MATERIAL
Alginate
Aquasil PVS system

BITE REGISTRATIONS
Duralay
Regisil

RELINE MATERIALS
GC Reline (soft)
Coe-Soft (soft)
Coe-Comfort (soft)
UfiGel (hard C)

TEMPORARY CEMENTS
Duralon
Temp Grip
Cavit

ENDO SUPPLIES
Ept, EndoIce
Apexlocator (RootZX)
Brassler Endosequence ESX
Dycal
MTA
$CaOH_2$

IMPLANTS
3i Implant (restorative)
ITI (Straumann) (restorative & surgical)
Nobel Biocare (restorative & surgical)

MISCELLANEOUS
Nobel Biocare (membranes – resorbable and non-resorbable)
Nobel Biocare bone graft
Sutures (non-resorbable - PTFE, Nylon)
Digital Scan Body ELOS for Nobel
Digital Scan body Dentsply/Sirona
Diode Laser (Biolase – Epic X)
Prime Mill and MCXL
Ceramic Oven (DS Speedfire and Ivoclar CERAMAT)
Omni Vac Machine
3-D Printer, Wash and Cure Units (Sprint Ray)
Air Abrasion Unit - RONDOflex Plus 360 by Kavo
Intra-oral scanners (3 Shape Trios, Cerec Omnicam)

FINISHING AND POLISHING
COMPOSITE
Soflex discs
Enhance
PoGo

ACRYLIC
Acrylic polishing kit – rubber point straight nose

CERAMIC and HYBRID CAM BLOCKS
Lithium-dissilicate (e-max; Tessera)
Zirconia (Chairside Zirconia)
Hybrid composite (LAVA Ultimate)
PMMA (Telio)

RESTORATIVE BAND SYSTEMS
Toflemire band
Palodent 360
Omni-matrix
Poliester matrix
Garrison / Palodent seccional matrix

P. Complementary equipment

a. Air abrasion devices

An air abrasion unit is available and it can be moved into the clinic as required. Unless familiar with the apparatus, a resident's first use should be under close supervision of an attending faculty who is comfortable with the equipment.

c. Some of the many applications for air abrasion are:

a. Removal of stains
b. Preparation of pit and fissures prior to sealants
c. Preparation of cavity preps that are small, including cervical abrasion sites
d. Micro-etching for composite repairs
e. But, **NOT** for amalgam removal

b. Clinical camera

There are two conventional clinical cameras available for documenting cases (CanonEOS Rebel T6i, with macro lens 100mm; 15-55mm and circular flash). Additionally, there are two USB intra-oral cameras for further documentation. Images for these are planned through Axium and stored directly in INFINITT.

c. Digital dentistry systems

The AEGD clinic has different digital dentistry workflow.

Restorative procedures (inlays, onlays, crowns, 3-unit bridges) can be produced (hybrid composite blocks, glass-ceramic blocks and zirconia blocks) by using a chairside workflow, using the Dentsply/Sirona CEREC Intra-oral scanner (2 PrimeScans and 3 Omnicams), in-house production using the Dentsply/Sirona milling machines (2 Primemills and 2 MCXL), followed by sintering/crystallization/glazing in one of the ceramic ovens (Dentsply/Sirona Speedfire or Ivoclar Ceramat). Additionally, cases can be scanned (using CEREC IOS or 3Shape IOS) and sent to external lab fabrication using the Dentsply/Sirona Cerec portal or the 3Shape Unite portal.

Digital waxing can be produced by acquiring a file from any IOS and designing in Autodesk Meshmixer (each operative station has the software) or in 3Shape Unite.

Nightguards can be designed in 3Shape Unite.

Surgical implant guides can be designed using 3Shape Unite or Nobel-biocare DTX implant plan.

All designed products can be 3d-printed in-house using a SprintRay ProS95 dental printer.

Training will be provided before the resident can use the system.

Q. **DOCUMENTATION AND CHARTS**

Patient Chart Entries:

1. The program mandates the use of Axium **Visit Forms** for patients visits
2. Any additional notes can be placed in Template Notes using the Assessment/Treatment/Evaluation/Next Appointment **(ATEN)** system.

Standardized Format for Progress Notes

A standardized format for Progress Notes will be used for all patient record entries, except for Oral Surgery that already uses a standardized SOAP note. The "data elements" and "examples" of the Progress Note format are shown below.

Data Elements of Progress Note

A: Assessment – reason for visit; pt. health/medical management considerations; consent

T: Treatment – concise and detailed description of procedures performed and medications

E: Evaluation – appraisal of treatment; patient's reaction to treatment; extenuating circumstances

N: Next Visit – specific plans for next visit

Examples of Progress Note

Date

A: Patient presents for tx of occlusal caries on #19; no Changes in med. hx. since 1/15/99; pt. understands risks of today's tx and reaffirms consent.

T: Mandibular block with 1.8 cc 2% Xylocaine; 1:100,000 epi.; rubber dam; #19 occlusal caries removal, $CaOH_2$ (Dycal), Vitrebond, amalgam (Contour) restoration.

E: Patient apprehensive as usual regarding local anesthesia; deep caries approaching pulp, but no exposure; patient advised that tooth could need endodontic therapy; treatment completed.

N: 6 month recall, check for caries progression on mesial of #3 by radiograph.

Date

A: Patient presents for SC/RP of ULQ; reports new RX, nifedipine for hypertension; BP right arm sitting: 145/80; pt. understands risks of today's tx and reaffirms consent; plaque score: 65%.

T: Reinforced home care instructions, showed patient literature on gingival hyperplasia associated with nifedipine; local infiltration in area of #14 with 0.5ml of 2% Xylocaine with 1:100,000 epi.; ultrasonic

removal of gross calculus followed by hand curette scaling and root planning; irrigated DL pocket of #14 with sterile saline.

E: Patient understands risk for hyperplasia, showed extra motivation to follow home care; 7mm pocket DL #14 difficult to complete instrumentation due to furcation; revaluation required.

N: Next visit 10/27/99: URQ SC/RP, whole mouth polish and fluoride; check tissue response and finish RP of distal furcation #14 before starting URQ.

Faculty Electronic Swipe Approval

1. At the end of each appointment period, all clinical services rendered during the appointment must be recorded in the Notes section of the electronic patient record (Axium). This section must have an electronic signature by the instructor supervising the student during the appointment period. An entry in Axium must be made for each appointment.
2. Using the **ATEN** system of chart entries, the following information should be listed in the continuation notes: 1) date, 2) department, 3) tooth number, 4) diagnosis, 5) treatment listing all restorative materials (with brand names following each in parenthesis), 6) use of rubber dam, 7) appropriate remarks and/or post-operative instructions listed under E (Evaluation). Standard accepted abbreviations maybe used. Residents and attending faculty must approved the EPR entries together.

Faculty electronic signature

1. All Daily Treatment Records **MUST** have an electronic signature (SWIPE) before the end of the day. Treatment Plans should have two signatures: patient and attending faculty before treatment can begin.
2. Prescriptions for narcotic-based medications must be signed by a Maryland licensed dentist who has a DEA number.
3. Electronic Prescriptions for the laboratory work must be signed electronically by the resident, the financial officer, and the faculty.

Consents

TP – CON Treatment Plan Consent

DO – CON Day of Consent

MA – CON Medical Assistance Consent

PR – CON Prosthodontic Delivery Consent

Patient consents are essential and required. **There are no exceptions**. Consents should be completed **PRIOR** to treatment. All consent forms are found in AXIUM. This is a must for medico-legal purposes. Not getting a consent puts everyone at risk, **including you.**

R. GUIDELINES FOR COMPLETING A MEDICAL CONSULTATION FORM

a. Reasons for Requesting a Medical Consultation
    - Clarification of a specific condition or a specific drug therapy
    - Clarification of a condition that may require pre-operative antibiotic coverage
    - Requesting specific
        - Laboratory test results, or
        - Complete findings from a recent complete physical examination

b. Providing Information to the Consulting Healthcare Practitioner
    - Oral diagnoses
    - Use language suitable to the knowledge of the other healthcare provider
    - Include all oral diagnoses
    - Include some indication of the severity of each diagnosis
        - i.e. “moderate to severe” periodontitis
        - “1.5 cm.” squamous cell carcinoma with “associated lymphadenopathy”

c. Advising HCWs about Recommended Dental Treatment

- Include all foreseeable forms of treatment that may be employed
    - All procedures that will cause significant bacteremia (e.g. deep scaling, C&B cord, etc.)
    - All procedures that involve mucogingival surgery
        - Biopsies, exodontia, implant placement
    - All modes of anesthesia
        - Local anesthetic; regional block anesthesia
        - N_2O, IVSD, general anesthesia
    - Drug therapies: antibiotic pre-meds, antibiotic management of perio dx, alteration of Coumadin, Amicar
- This is the most important part of any medical consultation request
- It establishes, for the physician or other HCW, that you have been careful
    - in:
    - Taking a thorough patient history
    - Assessing the patient’s simple or complex medical status, AND MOST IMPORTANTLY
- That you have appropriately analyzed the significant medical factors in the patient’s history and FORMULATED A SPECFIC SET OF RELEVANT QUESTIONS.
- All medical consultations should be narrowly tailored to ask specific medical management questions that call for specific objective answers.
- Only if the objective data is particularly open to a fairly wide range of clinical judgment, should an opinion on that objective data be expressly requested by the dentist and given by the consulting physician or other HCW.
- Better medical consultations identify the dental management problem for the physician to consider, in the first line of this section, and then suggest a specific management approach to be used to ameliorate the problem.

- Example: 72 y.o. AA female è h/o MI x 3, CABG, and A-fib, on Coumadin.
  - Must have patient's

    INR ⍰ 2.0-2.5 to proceed. If pt.'s INR is higher, we would normally D/C Coumadin 2 days prior to tx, do stat PT/INR the AM of tx, and resume Coumadin at the next scheduled dose. OK?

    Please report the pt.'s most recent INR and advise.

  - It is extremely important that a medical consultation reflects the patient's comprehensive needs so that repeated consults are not required because the dental practitioner failed to think through potential medical complications which may arise with different modalities of treatment.
  - Telephone consults are strongly discouraged!
    - They should be limited to clarification of the physician's recommendation, if it is illegible or contrary to regular regimens employed throughout Dentistry or Medicine.
    - For example, chronic renal failure patients on hemodialysis may require a different antibiotic for SBE prophylaxis, and/or a different dosing regimen than other patients.
    - A contemporaneous note in the chart should summarize this clarification of the initial consult.

d. The following patients may be unable to reliably relate their medical histories:

- Elderly
- Those suffering dementia or Parkinson's disease
- Developmentally Challenged; Special Needs Patients
- Mentally disable (psychosis patients)
- In these cases, the only reliable method for determining relative safety to treat is the Complete Physical Examination findings.
- The Complete Physical Examination
- Interpreting the Findings for Relative Safety to Treat the Dental Patient
- Who Cannot Reliably Relate a Medical History

S. **OUTLINE OF PHYSICAL EXAMINATION (H&PE)**

1. Vital signs: Temperature, pulse, blood pressure (both arms), respiratory rate. These observations need not be repeated under their respective subheadings.
2. General appearance: state of orientation; development, state of nutrition, degree of discomfort, cooperativeness, other conspicuous general characteristics of appearance (including dress, neatness, behavior, gait and posture).
3. Skin: color, temperature, texture, moisture, eruptions, ecchymoses or petechiae, hair distribution, nails. Significant scars.
4. Head and face: Conformation, symmetry, abnormal movements, signs of injury, tenderness.
5. Eyes: extraocular movements, sclerae, conjunctivae, pupils, (size, equality, regularity, reaction to light and accommodation), gross vision and visual fields.
6. Ears: pinna, external canal, tympanic membrane, gross hearing, mastoids.
7. Nose: obstruction, discharge, septal perforation or deviation. Sinus tenderness.
8. Mouth: breath, mucous membranes, teeth, tongue, tonsils, faucial pillars, postnasal drip.
9. Neck; stiffness, masses, venous distention, abnormal pulsations, thyroid, position of trachea; carotid bruits.
10. Lymph nodes: size, consistency, tenderness, and mobility of cervical, supraclavicular, axillary, inguinal. (All nodes may be described here, or the regional nodes may be described with appropriate areas as examined.)
11. Thorax: configuration, AP diameter, symmetry, and amplitude of motion.
    Breasts: masses, tenderness, discharge from nipples, areolae.
12. Lungs:
    Inspection: respiratory excursion, rhythm, symmetry.
    Palpation: fremitus (tactile).
    Percussion: resonance, lung borders and descent.
    Auscultation: breath sounds, spoken and whispered voice sounds (vocal fremitus), rales, friction rubs.
13. Heart:
    Inspection: Precordial movements, precordial bulging.
    Palpation: apex impulse and PMI, thrills, shocks.
    Percussion: Heart borders, sternum.
    Auscultation: rhythm, heart sounds, murmurs (include left lateral position and sitting in full expiration), friction rubs, extracardiac.
14. Abdomen:
    Inspection: contour, engorged veins, protrusions, umbilicus, visible peristalsis.
    Percussion: Hepatic, splenic, bladder dullness, gaseous distention, shifting dullness.
    Auscultation: peristaltic sounds, vascular bruits.
    Palpation: tenderness, rebound tenderness, rigidity, fluid wave, liver, spleen, kidney masses, hernias. If liver or spleen are palpable, note character or edge. Costovertebral tenderness.
15. Spine: Vertebral curvatures, mobility, tenderness.

16. Extremities:
Joints: swelling, effusion, deformities, tenderness, increased warmth, mobility. Clubbing, cyanosis, edema. Calf tenderness, Homan's sign. Character and equality of radial, femoral, posterior tibial and dorsalis pedis pulses; sclerosis of arterial walls; abnormal venous structures (varicosities, telangiectases).

17. Neurological: A limited or screening neurological examination is part of every routine physical examination. When positive findings make a more complete study necessary, the complete examination is done. Mental status; gait and station, abnormal movement; cerebellar signs; cranial nerves; muscle strength, atrophy, fasciculations; sensation: touch, pain, vibration, position sense; reflexes: (biceps, triceps, Hoffman, abdominals, cremasterics, knee jerks, ankle jerks, plantar); meningeal irritation (nuchal rigidity, Kernig's sign).

18. Genitalia:
    a. Male: penis, scrotum, testes, epididymis, spermatic cord. Discharge, inguinal canals.
    b. Female: speculum examination of vagina and cervix, palpation of uterus and adnexa. Pap smears, culture when indicated.

19. Rectal: External hemorrhoids, fissures.
Digital: Sphincter, hemorrhoids, prostate, seminal vesicles (or uterus and cervix), Feces (description of gross appearance) and test for occult blood.

* Summary

Concise summary of relevant points in history and physical examination.

* Formulation

This is intended to alert the reader to the basis on which the diagnoses were made and the direction in which the work-up will process.

It is a statement of what the leading diagnoses are, which diagnoses you favor and why, how you will differentiate between the likely diagnoses and a general approach to therapy, if there is a presumptive diagnosis.

Diagnosis: _____

Plans for further investigation and management: _____

_____

T. **INTRODUCTION TO TREATMENT PLANNING**

TECHNICAL CRITERIA:
FORMAT FOR COMPREHENSIVE TREATMENT PLAN WORK UP

I. History (S)
- A. Chief Complaint (CC)
  1. It should be a symptom - record the patient's impression of disease/problem in his/her own words.

- B. History of Present Illness (HPI)
  1. Record details of chief complaint and related complaints - history of chief complaint.

- C. Past Medical History (PMH)
  1. Record health history of systemic conditions, injuries, and hospitalizations in detail - medical consultation is present, if indicated.
     a. Childhood diseases
     b. Serious illnesses/transfusions
     c. Family health history which may bear on patient's present or future health status
  2. Allergies and sensitivities
  3. Current medications
  4. Review of systems (ROS)

- D. Environmental/social history
  1. Describe in detail any environmental factors that could impact on diagnosis and treatment planning, i.e., alcohol intake, tobacco usage, vocation, finances, etc.

- E. Dental History
  1. Describe in detail the patient's awareness of and involvement in previous dental treatment.
  2. Family dental health history (parents, siblings, spouse, children)
  3. Oral hygiene habits

II. Examination - Findings; list problems requiring attention, all of these must be addressed in TX sequence; charting must be complete - (O)

- A. List general observations and systemic findings - age, vital signs, skin, limbs, development nutrition.
- B. Record oral and extraoral findings: perform a thorough examination of the head, neck, face, and oral tissues.
  1. Head, neck, eyes, ears, nose, skin and secretions
  2. Lips, oral mucus, palate, pharynx, tongue and floor of mouth
  3. Gingival - color, texture, consistency, contour, amount of keratinized tissue, bleeding; details of periodontal condition on appropriate form
  4. Occlusion/musculature - a general statement of condition; details on appropriate form
  5. Dentition - a general statement of condition; details on appropriate form

6. Oral hygiene - a general statement of condition; details on appropriate form

C. Radiographic Findings
   1. Obtain indicated radiographs which may include the following:
      a. periapical films (full mouth survey)
      b. posterior bitewing films (**vertical bitewings are taken on patients exhibiting bone loss)**
      c. panoramic film
      d. any necessary supplemental films

D. Microscopic - if indicated, obtain a phase contrast evaluation of microflora
   NOTE: The case is mounted on an articulator, all required radiographs, laboratory and clinical tests are obtained.

III. Diagnosis - (A)
   A. List disease processes and abnormalities that address all pertinent findings.
      1. Systemic diagnosis
      2. Dental diagnosis

IV. Treatment Objectives - (A)
   A. Make a general statement of the desired goals of treatment taking into account the findings, the patient's situation and the resources of the practitioner. List considerations:
      1. Patient health
      2. Patient desires
      3. Patient age
      4. Patient financial restraints
      5. Prognosis (long and short term)
      6. Provider skills

   B. Devise ideal (long-term) treatment objectives and immediate objectives (if applicable) that will support the ideal; formulate a segmented (progressive) treatment plan. Discuss <u>all</u> treatment options with the patient.

   C. All fees for all treatment must be listed when the treatment plan is presented to the patient.

V. Planned Treatment Sequence - (P)
   (The Written Treatment Plan)

   A. A planned, well organized sequence of treatment is listed according to treatment phases that addresses all diagnosis and pertinent findings; materials to be used and alternate treatment plans are listed; best treatment plan for that individual patient is presented.

   B. Order of treatment (Enter Each Phase - e.g., If N/A Enter "Phase 1 - N/A")
      1. **Systemic phase**
         Systemic health considerations. Consult with physician when in doubt. Determine need for premedication, diet, precautions to protect patient and dental team, etc.

2. **Acute Urgent phase**
   Treat problems of acute pain, bleeding, lost restorations, etc.
3. **Disease Control Hygienic phase** (most import phase - steps necessary to control disease) for this specific patient generally in the order listed:
   a. Patient education and instruction in plaque control; fluoride program
   b. Biopsies if necessary
   c. Preliminary gross scaling - if necessary
   d. Caries control, and endodontic therapy
   e. Extraction of hopeless teeth. Temporary CPD's and RPD's if needed.
   f. Root planning
   g. Maintain plaque control
   h. Preliminary occlusal adjustment if indicated
   I. Minor tooth movement/orthodontic treatment
   j. Occlusal splints if indicated
   k. Definitive occlusal adjustment when necessary
   l. Continuous evaluation of oral hygiene and tissue response, and reassessment of the entire treatment plan
4. **Definitive/Corrective phase**: correct environment to allow patient to maintain good oral hygiene
   a. Hemisections with temporary splinting
   b. Periodontal surgery, bone and soft tissue grafting
   c. Treatment of hypersensitive teeth
   d. Implants
   e. Restorative dentistry (should wait at least two months following extensive surgery)
   f. Recheck and refine occlusion
5. **Maintenance phase**:
   a. Re-examine for effectiveness of plaque control, recurrence of periodontal disease, caries, and occlusal problems: reinforce oral hygiene instruction, perform prophylaxis including topical fluoride application. Recall based on the specific patient's needs.
   b. Complete periodic radiographic survey of the dentition if indicated. Compare with prior radiographs
   c. Recheck prosthetic treatment
   d. Treatment of any active periodontal disease
   e. Treatment of recurrent carious lesions
   f. Endodontic therapy if pulpal and/or periapical lesions have developed or not resolved
   g. Replacement of restorations which no longer satisfy health, function or esthetic requirements
   h. Make new occlusal splints when old ones are broken down, worn out or lost

VI. Prognosis
   1. State a prediction, based on an educated calculation, of the response of hard and soft tissue to the treatment planned, both long and short term.

VII. Signing the Treatment Plan Consent

1. The patient and attending faculty must electronically sign the treatment plan prior to any treatment being initiated. This is to establish that the patient accepts the treatment plan.
2. Patient consent is required for day of treatment

III. CLINICAL FORMS

A. CASE COMPLETE FORM INSTRUCTIONS

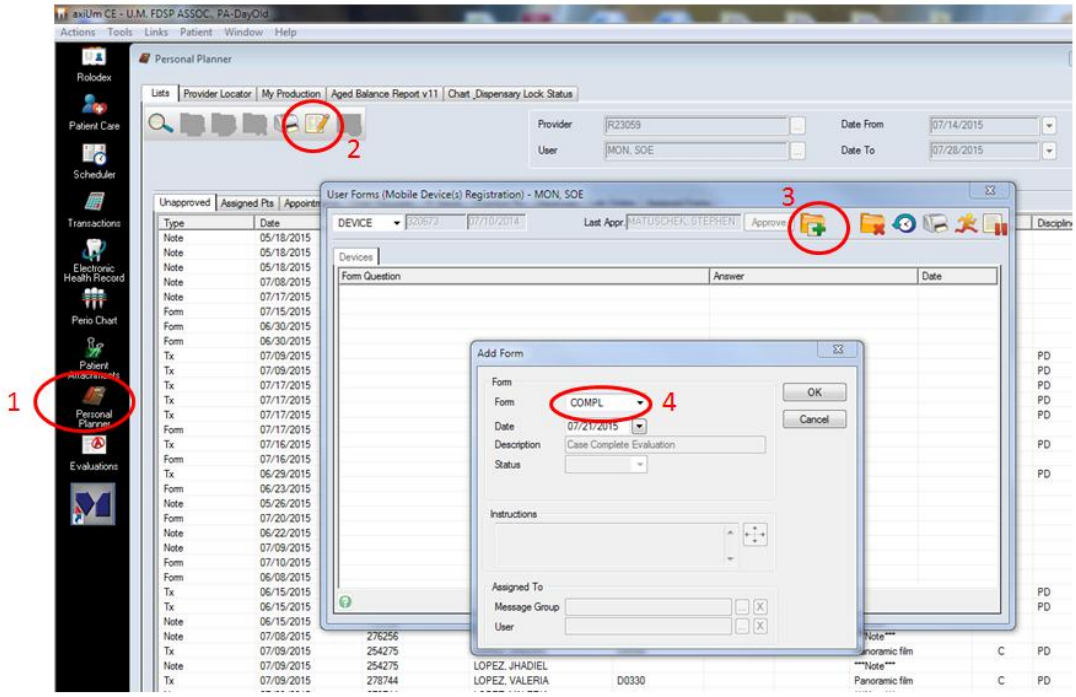
This scenario assumes that the AGD Resident is logged on to Axium at a clinic workstation.

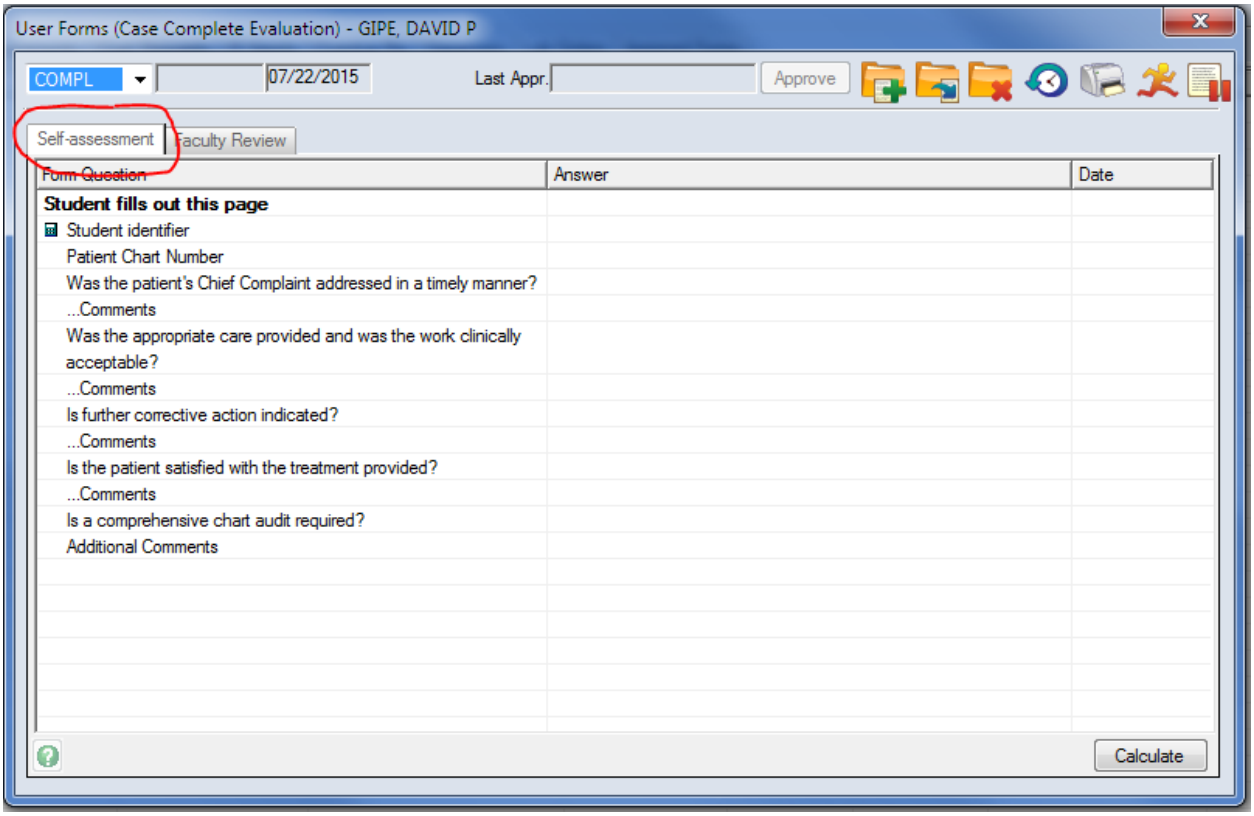
Refer to screenshot:

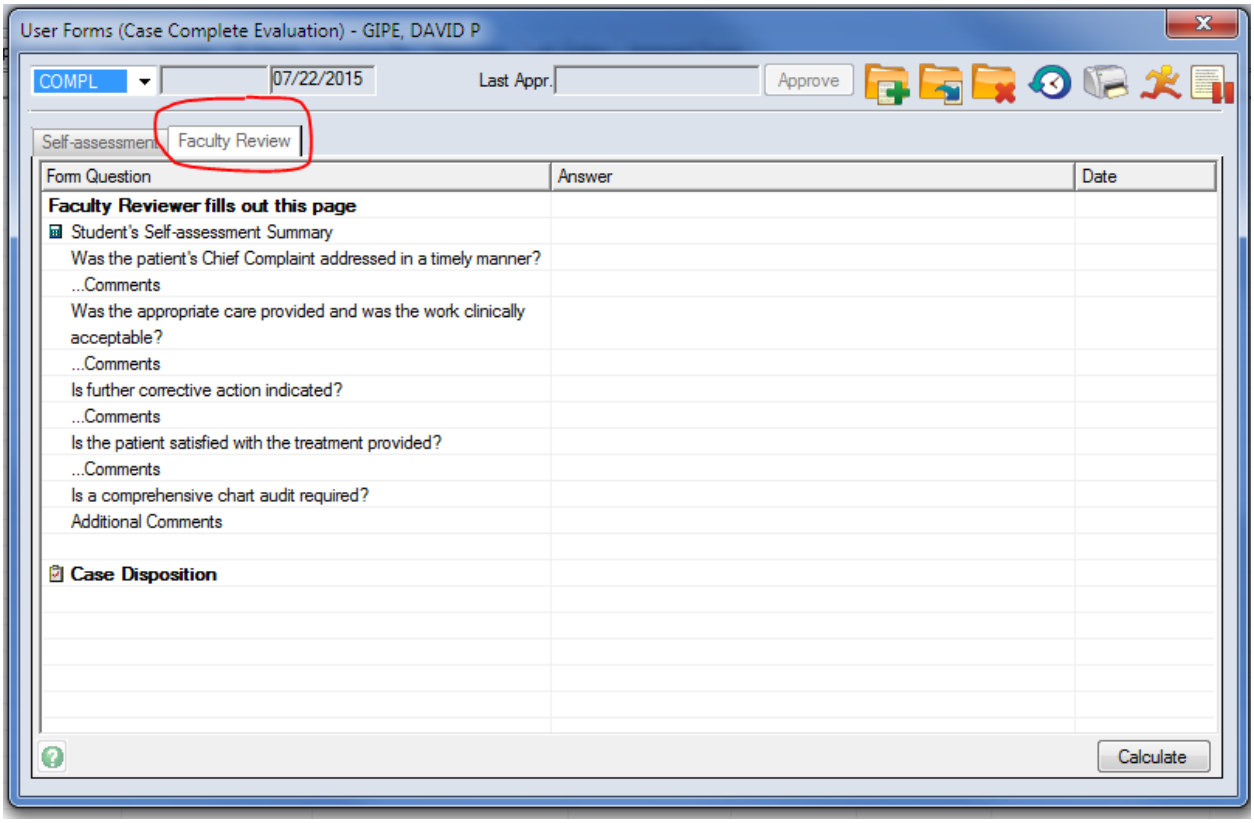
1. Open Personal Planner
2. Click the *User Forms* icon
3. Click the *Create New Form* icon (folder with green "+" sign)
4. Select the "COMPL" (Case Complete) form from the drop down list

Resident fills in page 1 of the form; click the Calculate button to automatically fill in the resident's provider number on the form; when finished, resident self-approves page 1 of the form by clicking the Approve button.

Faculty fills in page 2 of the form; click the Calculate button to automatically fill in the resident's responses from page 1 (no need to flip back and forth between pages); when finished, faculty approves page 2 of the
form by clicking the Approve button, then swiping their UMB One Card.




User Forms (Case Complete Evaluation) - GIPE, DAVID P
COMPL
07/22/2015
Last Appr.
Approve
Self-assessment
Faculty Review
Form Question
Answer
Date
Student fills out this page
Student identifier
Patient Chart Number
Was the patient's Chief Complaint addressed in a timely manner?
...Comments
Was the appropriate care provided and was the work clinically acceptable?
...Comments
Is further corrective action indicated?
...Comments
Is the patient satisfied with the treatment provided?
...Comments
Is a comprehensive chart audit required?
Additional Comments
Calculate


User Forms (Case Complete Evaluation) - GIPE, DAVID P
COMPL
07/22/2015
Last Appr.
Approve
Self-assessment
Faculty Review
Form Question
Answer
Date
Faculty Reviewer fills out this page
Student's Self-assessment Summary
Was the patient's Chief Complaint addressed in a timely manner?
...Comments
Was the appropriate care provided and was the work clinically acceptable?
...Comments
Is further corrective action indicated?
...Comments
Is the patient satisfied with the treatment provided?
...Comments
Is a comprehensive chart audit required?
Additional Comments
Case Disposition
Calculate

A. CASE COMPLETE FORM INSTRUCTIONS

Advanced Education in General Dentistry
Implant Progress Form

Patient:_____ **Densyst:**_____ **Date:**_____

	Date	Faculty Name And Signature	Resident Signature	Comments / Descriptions
T.P. Presentation # & Location of Proposed Implant				
T.P. Presentation Proposed Restoration Incl. Non-Implant Pros.				
Wax up and Stint				
Final Treatment Plan				
Financial Plan				
Placement Surgery				
Stage 2 Surgery				

Fixture/Component Order

Site	Quantity	Catalog Number	Description	Used/Returned

Complications

Date_____

Appliance:_____ **Completion Date:**_____

Quality Assessment Audit Date:_____

Signatures:_____ _____ _____

Faculty **Resident** **Date**

1-copy (Patient's Chart) 2-copy (Supply Order) 3-copy (PCC) 4-copy (Resident's Portfolio)

01.15064 (Rev. 10/03)

IV. CURRICULUM

A. AEGD COURSE ORGANIZATION

Full-Time, Two-Year Certificate

COURSE	TITLE	TOTAL CREDITS	FALL	SPRING
YEAR 1				
DAGD 567A	Literature Review	2	1	1
DAGD 568A	General Practice Seminar	4	2	2
DAGD 569A	Clinical Dental Practice	36	18	18
DAGD 577A	Case Conference Seminar	2	1	1
DBMS 626	Advanced Oral Radiology	1	1	
DBMS 633	Temporomandibular Disorders (TMD) and orofacial pains	1	1	
DBMS 668	Enteral & Inhalation Sedation	1.5	1.5	
DSUR 569B	Physical Diagnosis			
	TOTAL	**47.5**	**25.5**	**22**
YEAR 2				
DAGD 568B	General Practice Seminar	4	2	2
DAGD 569B	Clinical Dental Practice	36	18	18
DAGD 578B	Case Conference Seminar	2	1	1
DAGD 579B	Literature Review	2	1	1
	TOTAL	**44**	**22**	**22**

Full-Time, One-Year Certificate

COURSE	TITLE	TOTAL CREDITS	FALL	SPRING
YEAR 1				
DAGD 567A	Literature Review	2	1	1
DAGD 568A	General Practice Seminar	4	2	2
DAGD 569A	Clinical Dental Practice	36	18	18
DAGD 577A	Case Conference Seminar	2	1	1
DBMS 626	Advanced Oral Radiology	1	1	
DBMS 633	Temporomandibular Disorders (TMD) and orofacial pains	1	1	
DSUR 569B	Physical Diagnosis			
DBMS 668	Enteral & Inhalation Sedation	1.5	1.5	
	TOTAL	**47.5**	**25.5**	**22**

Part-Time, One-Year Certificate (over two years)

COURSE	TITLE	TOTAL CREDITS	FALL	SPRING
YEAR 1				

DAGD 567A	Literature Review	2	1	1
DAGD 568A	General Practice Seminar	4	2	2
DAGD 569A	Clinical Dental Practice	12.5	5.5	7
DAGD 577A	Case Conference Seminar	2	1	1
DBMS 626	Advanced Oral Radiology	1	1	
DBMS 633	Temporomandibular Disorders (TMD) and orofacial pains	1	1	
DBMS 668	Enteral & Inhalation Sedation	1.5	1.5	
	TOTAL	**24**	**13**	**11**
YEAR 2				
DAGD 568B	General Practice Seminar	2	1	1
DAGD 569B	Clinical Dental Practice	18	9	9
DAGD 578B	Case Conference Seminar	1	0.5	0.5
DAGD 579B	Literature Review	1	0.5	0.5
	TOTAL	**22**	**11**	**11**

NOTE: Courses are subject to change at the discretion of the postgraduate program.

B. RESPONSABILITIES

a. Students:

- Responsible for all phases of patient care:

- Necessary documentation for complete cases and case presentations
  - six basic photographs - intraoral anteriors, right and left posteriors (retracted and unretracted); mandibular and maxillary occlusals; and full face (lips in repose – profile); (photographs only for case presentations)
  - masticatory system assessment
  - periodontal chart, plaque index
  - full mouth radiographs and panoramic
  - complete verified dental record
  - medical history updated - blood pressure
  - consultations if applicable
  - written treatment plan
  - mounted study casts

- Accept patients from other departments or residents only after going through AEGD faculty first.
- Type of patients to be treated in AEGD clinic floor:
  - Carry over from previous year i.e.: continuation of treatment.
  - Emergency patients.
  - List of patients who are available on short notice
  - New patients to the AEGD clinic
  - Referrals from the Pre- and post-doctoral clinic

- Administrative Duties
  A. Become proficient with Axium (School of Dentistry's computer program).
  B. Complete accurately filling out all appropriate documentation
  C. Produce a Portfolio
  D. Treatment plans on all patients signed by faculty, resident and patient and entered into Axium.
  E. Financial/Insurance forms
  F. Assistant evaluations
  G. Complete Quality Assessment Audits and chart audits

b. Chief residents' duties

Include but not limited to the following

- Residents to submit **3 nominations** for the co-chiefs (2) to the program administration. Final selection will be determined by the program.
- Act as **liaison** between residents, staff and administration.
- Maintaining a digital lecture binder including recording objectives, attendance and monthly lecture hours.
- Review schedule
  - Coordinate lecture and Axium schedule
  - Notify program administrative assistant of any discrepancies
  - Post resident schedule (online and in the conference room)
- Post faculty coverage schedule.
- Record resident meeting minutes (per request).
- Responsible for organizing lectures.
  - Making sure computer and/or handouts are available when necessary.
- Organize staff gifts & events including Christmas, dental assistant week, dental hygienist week, business administrative day, end-of-year gifts, and birthday list.
- Develop and issue the academic year newsletter in coordination with the office of development and program administration.
- Enforce lab organization and conference room cleaning schedule.
- Act as a liaison between the AEGD and ASE residents in setting case conference, surgeries or any rotations.
- Arrange and develop the schedules for resident interviews during the enrollment period for the program.
- Compile all resident candidate interview evaluation forms and submit to program administrators.

C. QUALITY ASSESSMENT AUDIT

One mechanism of outcome measurement is to regularly evaluate the degree to which goals and objectives of the Advanced General Dentistry program are being met.

a. Purpose:

1. To assess the quality of work being performed
2. To verify the timely and sequential delivery of treatment as prescribed by a formal treatment plan developed by residents and faculty.

b. Mechanism:

- **Tracking remakes**

When a remake is necessary, the Resident should complete an ADJUSTMENT FORM. The proper procedure code for the restoration should be placed on the form with the reason for the remake. They should be signed by the AEGD Director.

- **Review of Personal Planner**

The program engages residents in clinical outcome assessment from the time they matriculate in the program. During orientation, residents are taught and expected to be versed in completing their own personal audit through utilizing the "personal planner" feature on axium. Residents are expected to review that on weekly basis to comply with policies set forth by Clinical Affairs.
Business office personnel review the reports to ensure compliance and to work with any struggling resident. The program director is notified of any delinquent resident who require counseling. During the tri-annual evaluation meeting, residents' clinical administrative compliance is reviewed to ensure that record keeping is optimal.

- **Case Completes**

Case completes are a form of quality assessment. When you finish a case, no matter how large or small, be sure to fill out a case complete form. Upon completion of clinical cases, residents utilize axium feature for case completion to log their evaluation for the treatment of the case, the patient's satisfaction, and submitting the report to the supervising faculty to audit the treatment. Residents are expected to complete a minimum of 10 case complete audits and uploading a copy of the reports on the digital portfolios.

- **Structured Audit Sessions**

The business office of the Advanced Education General Dentistry (AEGD) Program conducts a biannual chart audit which are completed in September and June of the academic year. Providers do not complete audits on their own patient charts. Instead, providers are given a different provider's ID number with access to specific patient charts. The process does not utilize provider or patient names, and only ID numbers are used. At each session, every provider is assigned 5 different patient charts, with 8 items to audit:

Note approval within one week
Date of last periodontal charting
Date of last panorex or full series of xrays
Dates when treatment was started/completed
Comprehensive exam completed after a limited exam (if patient returns)
Last recall appointment
Signed treatment plan
Medical consult reviewed

Once the audit process is completed, corrective action is shared with the treating providers so that revisions are made to the chart.

D. COMMUNITY SERVICE & ROTATIONS

a. Community service definition

Participate in community service activities to establish ties with the community and to improve the quality of life for the citizens of Maryland and surrounding communities. Community engagement within our program is via delivering treatment to patients who qualify for the family investment plan. Additionally, residents deliver care to underserved and uninsured patients in the Montgomery County area through rotating at The University of Maryland, School of Dentistry, Dental Clinic at Shady Grove (USG). The objectives of the rotation is to (1) increase residents' learning and exposure to a variety of clinical experiences delivered to patients in a community-based settings, (2) provide dental care to a diverse pool of un-insured and underserved patients in a community-based settings. Rotation is in 2-weeks blocks for up to 4-5 times per academic year.

E. AEGD COURSES

DAGD 567A Literature Review / DAGD 567B Literature Review

This course is divided into three main parts. Part 1 is a lecture delivered by faculty and a year-2 resident presentation to establish the basis of literature selection and level of evidence critique. In Part 2, Year 1 residents must select an experimental-designed research paper to present its critical analysis. It is an individual task, and each resident shall select the paper according to the topic rostered by his/her name. Part 3 consists of producing current literature mini review for the designated topics (3 or more papers related to the topic rostered by his/her name). Residents utilize the principles of literature review and evidence-based practice during their clinical sessions and patient encounters. Faculty encourage residents to search and review information on various emergent topics and challenging clinical situations during their patient care sessions. Additionally, principles learned in this course are linked and utilized for their patient case conferences (DAGD 577A Case Conference Seminar) during which residents are expected to support their treatment planning choices by as much scientific literature as possible.

The literature review sessions for YRII are designed as such to enhance the residents' ability to analyze and apply what they learned in their first year and provide in-depth learning into study design and its implications on the suitability of the clinically relevant questions and results. At each session, the course director will present an overview of the study design (principles for critical appraisal, descriptive study design, analytical study design, interventional study design) for the session, and the resident assigned to present the literature will select a study based on the design. The resident will be able to relate the pros and cons of the study design and its implications on the clinically relevant results.

DBMS 668 Enteral and inhalation sedation

Residents provide direct patient care 4.5 days a week, either at the Baltimore or Shady Grove site, as part of their required clinical practice (DAGD 569A General Dental Practice). During those interactions, residents provide comprehensive oral treatment to their patients. The knowledge they acquire in the Enteral and Inhalation Sedation course enables them to do inhalation sedation during dental interventions in patients with high levels of anxiety. The goal is to improve the operatory experience of those patients who would otherwise undertake a great deal of stress during the procedure. The AEGD program operatories are plumbed for NO_2 gas, regulating the oxygen level as well as the NO2 gas level, to establish a mild sedation. This keeps the patient safe and stable while allowing them to receive complex interventions. As a requirement to finish the residency program, all students must participate in hands-on clinical exercises. The clinical experience provided by this practice complements the theoretical and pre-clinical training they are exposed to during this course (DBMS 668 Enteral and inhalation sedation). This is a YRI course only, but YRII residents continue to apply skills learned in YRI throughout their second year.

DSUR 569B Physical Diagnosis

Residents provide direct patient care 4.5 days a week, either at the Baltimore or Shady Grove site, as part of their required clinical practice (DAGD 569A General Dental Practice). During those interactions, residents provide comprehensive oral treatment to their patients. The knowledge they acquire in the Physical Diagnosis course allows residents to treat patients with a broad variety of acute and chronic systemic disorders and social difficulties, including patients with special needs. It also helps to Develop and carry out dental treatment plans for patients with special needs in a manner that considers and integrates those patient's medical, psychological, and social needs. Our geographic location in the inner city with proximity to hospitals also allows our residents to see a multitude of patients with complex medical histories providing them a unique opportunity to develop a competency in managing populations with special medical, mental and behavioral needs.

DBMS 633 Temporomandibular Disorders (TMD) and orofacial pains

Principles of occlusion are applied daily during all restorative and prosthetic procedures, including centric relation, centric occlusion, utilization of the facebow, and occlusal adjustments. These concepts are highlighted during the General Practice Seminar course, occlusion section. (DAGD 568A General Practice Seminar – Occlusion). These basic concepts are discussed in depth during the Temporomandibular Disorders (TMD) and orofacial pain course, and the practice of intra-oral and extra-oral examinations becomes the cornerstone that allows the residents to recognize and manage facial pain of TMJ origin. This is a YRI course only, but YRII residents continue to apply skills learned in YRI throughout their second year.

DBMS 626 Advanced Oral Radiology

The residents apply the knowledge from this course daily, as part of the tools a general dentist use for diagnostic purposes, for the trans-operatory procedure, and for follow-ups. Every resident has access to produce periapical, bitewings, and panoramic radiographs by themselves. They will use digital software (INFINITT) to manipulate and interpret the images for whatever reason it is taken. The residents may refer patients to the Oral Radiology department to produce CBCT exams. These CBCT will be manipulated and interpreted using INFINITT Xelis 3D CBCT viewer, as well as using DTX implant planning software.

DAGD 569A General Dental Practice / DAGD 569B General Dental Practice

Prevention is a constant theme in all aspects of the clinical program. This subject is effectively taught. Residents use concepts of oral and systemic health and disease prevention in their everyday practice.

Application of oral diagnosis and treatment planning skills is done on a daily basis. In the AEGD Clinic, all patients are treated comprehensively unless they are seen for an emergency visit only. A formal sequenced treatment plan is developed jointly by AEGD resident and generalist faculty and signed by both. The treatment plan is then presented to the patient and subsequently signed. AEGD residents provide at least 90% of patients' treatment needs. When specialty referrals are made, the patient is followed by the generalist and returned to the generalist after the specialist has finished rendering treatment. Final treatment decisions and responsibility rest with the AEGD generalist faculty. This topic is very effectively covered.

The scope and effectiveness of didactic and clinical experience in periodontics is excellent, based upon the broad range of patients that need comprehensive care. Students routinely provide basic periodontal diagnostic and non-surgical care for all patients, and advanced care for selected patients. Periodontal surgery is routinely performed in the program including basic flap procedures, limited osseous surgery, crown lengthening surgery, gingival grafting, and pontic site procedures. Students perform these procedures with both general dentist faculty and specialist faculty, as appropriate.

Residents treat patients with uncomplicated implant needs in the AEGD clinic. Perio specialists provide oversight for implant placement following complete diagnosis and treatment planning utilizing mounted study models, using digital or conventional apporach and CBCT scans. Implants are performed by free-hand technique, or by fully guided technique, depending on the case-by-case evaluation. All AEGD students become proficient in uncomplicated implant procedures for a wide range of patients. AEGD students who have placed multiple single implants are exposed to placing multiple and immediate implants. Our Residents also have easy and complete access to the oral surgery department as needed for consultations and complex cases. The AEGD also restores the implants that they have placed, therefore receiving a complete implant experience. The second-year residents receive extensive clinical experience in periodontal surgery techniques with emphasis being placed on implantology. We have a designated periodontist, plus access to the rest of the department. This area is very effectively taught.

A great amount of clinical experience is provided in the area of oral surgery. The scope and effectiveness of clinical experience in oral and maxillofacial surgery is excellent. Students treat patients with uncomplicated and complicated exodontia in the AEGD clinic. Specialist faculty provide instruction for selected advanced procedures for comprehensive care of patients directly in the Oral Surgery Clinic. All AEGD students become proficient in uncomplicated procedures for a wide range of patients. All AEGD students have the opportunity to become competent in selected advanced surgical procedures such as surgical extraction, soft tissue impactions, preprosthetic surgery, implant placement, and alveoloplasty. AEGD students are exposed to other advanced surgical procedures such as impaction surgery, trauma, and removal of large soft or hard tissue lesions.

The scope and effectiveness of the clinical experience in fixed prosthodontics and removable prosthodontics is excellent. The patient pool presenting to the AEGD Program has a very wide range of restorative needs, resulting in a very broad and challenging clinical experience for the students. Students become proficient in basic fixed prosthodontic procedures, and competent in more advanced procedures such as all-ceramic crowns, attachments, and restoration of periodontally-treated teeth. Students treat more complex restorative cases with specialists, including periodontists, prosthodontics, and endodontists. Students become competent, or at least exposed to, placement and restoration of dental implants for partially edentulous patients. Several implant restoration systems are taught in the program. Students become proficient in uncomplicated removable prosthodontic procedures, and competent at treating more complex cases, all within the scope of comprehensive care of their assigned patients. Due to the wide variety of needs of the patients presenting to the AEGD Program for comprehensive care, and due to the selective assignment of patients to AEGD students, each student receives the full range of experience in restorative dentistry. This area is very effectively taught.

We have two designated board-certified endodontic faculty plus access to the rest of the department. The scope and effectiveness of clinical instruction in endodontics is excellent. Students provide endodontic treatment as part of comprehensive care to a wide variety of patients during the entire program. Students routinely treat uncomplicated endodontic cases with rotary instrumentation. They also complete cases complicated by anatomy or retreatment issues. Students are also responsible for managing referral of endodontic cases that are appropriate for specialist care. Progress of students toward proficiency in basic endodontics and competency in selected advanced endodontics is consistently demonstrated in the clinic and in seminars as the training year progresses. This area is very effectively taught.

DAGD 577A Case Conference Seminar / DAGD 577B Case Conference Seminar

This course encompasses a broad scope and is structured into three distinct academic components. Firstly, it includes a series of comprehensive dentistry treatment planning lectures, designed to guide students in managing their patients' oral care treatments. Secondly, there are interdisciplinary seminars where residents from all residency programs (AEGD, Periodontics, Prosthodontics, Orthodontics, and Endodontics) convene. Each group presents a clinical case study for

discussion. Finally, the course features a series of case conference presentations. Each AEGD resident selects a case of interest from their patient pool and presents it to their peers. These presentations must include comprehensive care management and relevant literature supporting aspects of the proposed treatment. Residents must formulate a PICO question, search the literature for a scientific paper, and present their findings in the form of a lecture. This final part of the course integrates with DAGD 567A Literature Review and DAGD 569A General Dental Practice. Year II residents combine their literature review course and case conference, present to the YRI peers and lead the AEGD interdisciplinary seminar.

DAGD 568A General Practice Seminar / DAGD 568B General Practice Seminar

Residents receive extensive clinical experience through a comprehensive curriculum that includes both theoretical and practical training. They attend lectures with members of the Maryland State Dental Association (MSDA) to understand the normative aspects of the profession. Additionally, they participate in lectures and hands-on training on partial denture design, occlusion, and presentations from dental laboratories. A series of lectures on restorative dentistry, delivered by various faculty members, further enhances their knowledge. Vendors provide presentations on specific equipment and materials, complemented by hands-on training in direct and indirect techniques, as well as digital dentistry. Residents also receive lectures on relevant topics, vendor presentations on laser equipment, and practical training on pig jaws for procedures such as flap elevation, crown lengthening, sutures, and bone and gingival grafts. Simulation exercises for root canal treatments using typodonts and extracted teeth are also part of the curriculum. Furthermore, a series of lectures by vendors, faculty, business administration personnel, dental hygienists, lawyers, and insurance companies provide a well-rounded educational experience regarding practice management. This diverse and immersive training ensures residents are proficient in a wide range of dental procedures and prepared for professional practice.

F. COMPETENCIES

COMPETENCIES OF GRADUATES
OF THE UNIVERSITY OF MARYLAND, SCHOOL OF DENTISTRY
ADVANCED EDUCATION IN GENERAL DENTISTRY PROGRAM
2025-2026

TABLE OF CONTENTS

a. Introduction

Postdoctoral General Dentistry (PGD) programs play an important and expanding role in the education of the nation's primary health care providers in dentistry. These programs build on and complement predoctoral dental education. In these postdoctoral programs, dental school graduates learn new techniques; become proficient in previously learned techniques; become capable of providing dental care for patients with complex medical, dental, and social conditions; and learn to integrate professional values with various aspects of dental treatment in order to provide long term comprehensive care to individuals and communities of patients.

There is a growing trend in dental education to describe curricula in terms of their impact on students (expressed as competencies) rather than on discipline-based content (expressed as behavioral objectives). Such a description focuses attention on the outcome, in terms of graduate's abilities, of educational experiences, rather than on the process of education. This focus is more likely to create a graduate with the desired skills and to encourage program directors to choose and provide educational experiences that will lead to the development of graduates with those skills.

The director and faculty of the Advanced Education Program in General Dentistry (AEGD) at the University of Maryland, School of Dentistry are committed to incorporating competency concepts and evaluation methodologies into the program. This document presents a method for describing graduates of University of Maryland School of Dentistry AEGD program in terms of their abilities and methodologies for assessing those abilities. It is anticipated that this document will be useful for applicants to the program desiring to know what skills they can expect to gain in the program; residents in the program who will be able to measure their progress and document their accomplishments in the areas of competency described; and for the program director and faculty who will be able to use these measures for outcomes assessment and continuous improvement of the program.

In order to facilitate reading this list of statements, certain terms have been predefined so they could be used in the manual without repetitive definition. These definitions are listed in the next section of this manual. In general, the definitions proposed by Chambers and Gerrow[5] have been followed, although some new definitions have been added and some definitions modified. In situations where it is expected that the AEGD program graduate will be able to, and likely to, actually perform the necessary procedures, the terms "perform", "provide", "restore", or "treat" have been used. In circumstances where the graduate may perform some treatment but is more likely to oversee treatment or refer, the term "manage" is used. The term "appropriate" is not used in these statements to eliminate repetitive

verbiage. It is assumed that all knowledge, skills, and procedures described will be performed for appropriate reasons, in appropriate circumstances, and in an appropriate manner. In this manual each statement is designated as an area of competency **(C)** in which graduates are expected to have some experience at the beginning of their program.

The following statements describe the graduates of University of Maryland School of Dentistry's AEGD program. They are intended to communicate the expectations of the faculty to the resident and serve as the basis for evaluation of resident's satisfactory completion of the program.

b. Definitions- adapted from Chambers and Gerrow [1]

Assess. Evaluation of physical, written, and psychological data in a systematic and comprehensive fashion to detect entities or patterns that would initiate or modify **treatment**, **referral**, or additional assessment. Assessment entails **understanding** of relevant theory, and may also entail **skill** in using specialized equipment or techniques. But assessment is always controlled by an **understanding** of the purpose for which it is made and its appropriateness under the present circumstances. **Recognition** is a more limited term that does not subsume the notion of evaluating findings. **Diagnosis** is a more inclusive term, which relates evaluated findings to treatment alternatives.

Competency. Behavior expected of the beginning practitioner. This behavior incorporates **understanding**, **skill**, and **values** in an integrated response to the full range of requirements presenting in practice. The level of performance requires some degree of speed and accuracy consistent with patient well being but not performance at the highest level possible. It also requires an awareness of what constitutes acceptable performance under the circumstances and desire for self-improvement.

Diagnose. Diagnosing means systematically comparing a comprehensive database on the patient with an **understanding** of dental and related medical theory to identify recognized disease entities or treatable conditions. The concept of diagnosis subsumes an **understanding** of disease etiology and natural history.

Discuss (**communicate**, **consult**, **explain**, **present**). A two-way exchange that serves both the practitioner's needs and those of patients, staff, colleagues, and others with whom the practitioner communicates. The conversation, writing, or other means of exchange must be free of emotional or other distorting factors and the practitioner must be capable of expressing and listening in terms the other party understands. [Caution should be exercised with using these verbs to ensure that the communication is between the practitioner and the patient. Communication between the student and faculty is language reminiscent of the old instructional objectives and is not evidence of competency.]

Document. Making, organizing, and preserving information in standardized, usable, and legally required format.

Manage. Management refers to the selection of treatment including: no intervention; choice of specific care providers-including hygienists, and medical and dental specialists; timing and evaluation of treatment success; proper handling of sequel; and insurance of patient comprehension of and appropriate participation in the process. In circumstances where the graduate may perform some treatment but is more likely to oversee treatment or refer, the term "manage" is used. In situations where it is expected that practitioners will be capable of and likely to provide treatment as well as oversee it, the terms "treat", "provide", or "perform", will be used.

Monitor. Systematic vigilance to potentially important conditions with an intention to intervene should critical changes occur. Normally monitoring is part of the process of **management**.

Obtain (**collect**, **acquire**). Making data available through inspection, questioning (patients, physicians, relatives), review of records etc., or capturing data by **using** diagnostic procedures. Health histories, radiographs, casts, and consults are **obtained**. It is always assumed that the procedures for obtaining data are performed accurately so that no bias is introduced, are appropriate to the circumstances, and no more invasive than necessary, and are legal.

Patients With Special Needs. Those patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations.

Perform (**conduct**, **restore**, **treat**). When a procedure is performed, it is assumed that it will be done with reasonable speed and without negative unforeseen consequences. Quality will be such that the function for which the procedure was undertaken is satisfied consistent with the prevailing standard of care and that the practitioner accurately **evaluates** the results and takes needed corrective action. All preparatory and collateral procedures are assumed to be a part of the performance.

Practice. Used to describe a general habit of practice, such as "practice consistent with applicable laws and regulations."

Prepare (see **perform**).

Present (see **discuss**).

Prevent [the effects of]. The negative effects of known or anticipated risks can be prevented through reasonable precautions. This includes **understanding** and being able to **discuss** the risk and necessary precautions and **skill** in carrying out the precaution. Because preventing future damage is of necessity a response to an internalized stimulus rather than a present one, additional emphasis is placed on supportive **values**.

Provide care (see **perform**).

Recognize (**differentiate**, **identify**). Identify the presence of an entity or pattern that appears to have significance for patient **management**. Recognition is not as broad as **assessment** -- assessment requires systematic collection and evaluation of data. Recognition does not involve the degree of judgment entailed by **diagnosis**. [Caution is necessary with these terms. They are often use in the old instructional objectives literature to refer to behavior students perform for instructors. They can only be used for competencies when practitioners recognize, differentiate, or identify for patients or staff.]

Refer. A referral includes determination that **assessment**, **diagnosis**, or **treatment** is required which is beyond the practitioner's **competency**. It also includes **discussion** of the necessity for the referral and of alternatives with the patient, **discussion** and cooperation with the professionals to whom the patient is referred, and follow-up **evaluation**.

Restore (see **perform**).

Skill. The residual performance patterns of **foundation skills** that is incorporated into **competency**. The importance of the skill is more than speed and accuracy: it is the coordination of performance patterns into an organized **competency** whole.

Treat (see **perform**).

Use. This term refers to a collateral **performance**. In the course of **providing care**, precautions and specialized routines may be required. For example, infection control and rapport building communication are used. **Understanding** the collateral procedure and its relation to overall care is assumed. It is often the case that supporting **values** are especially important for procedures that are needed -- they are usually mentioned specifically because their value requires reinforcement. ["Utilize" is a stylistic affectation that should be avoided.]

Understanding. The residual cognitive **foundation knowledge** that is incorporated into **competency**. Understanding is more than broad knowledge of details: it is organized knowledge that is useful in performing the **competency**. [Caution should be used with this term. Understanding alone is not a competency; it must be blended with skill and values.]

Values. Preferences for professional appropriate behavior in the absence of compelling or constraining forces. Values can only be inferred from practitioner's behavior when alternatives are available. "Talking about" values reflects a **foundation knowledge**; valuing can be inferred by observing the practitioner's attempts to persuade others. [Caution should be used with this term. Valuing alone is not a competency; it must be blended with skill and understanding.]

References

1. Chambers DW, Gerrow JD, Manual for developing and formatting competency statements. J Dent Educ 1994;58:361-6.

c. First year resident AEGD competencies:

I. *Planning and providing comprehensive multidisciplinary oral health care*

1. Function as a patient's primary, and comprehensive, oral health care provider. **(C)**
2. Explain and discuss with patients, or parents or guardians of patients, findings, diagnoses, treatment options, realistic treatment expectations, patient responsibilities, time requirements, sequence of treatment, estimated fees and payment responsibilities in order to establish a therapeutic alliance between the patient and care provider. **(C)**
3. Integrate multiple disciplines into an individualized, comprehensive, sequenced treatment plan using diagnostic and prognostic information for patients with complex needs. **(C)**
4. Modify the treatment plan, if indicated, based on unexpected circumstances or patient's individual needs. **(C)**
5. Functioning effectively within multidisciplinary health care teams, including consultation and referral. **(C)**

II. *Oral disease detection and diagnosis:*

1. Select and use assessment techniques to arrive at a differential, provisional and definitive diagnosis for patients with complex needs. **(C)**
2. Obtain and interpret the patient's chief complaint, medical, dental, and social history, and review of systems. **(C)**
3. Obtain and interpret clinical and radiographic data and additional diagnostic information from other health care providers or other diagnostic resources. **(C)**
4. Use the services of clinical, medical, and pathology laboratories and refer to other health professionals for the utilization of these services. **(C)**
5. Perform a limited history and physical evaluation and collect other data in order to establish a risk assessment for dental treatment and use that risk assessment in the development of a dental treatment plan. **(C)**
6. Diagnose and manage common oral pathological abnormalities including soft tissue lesions. **(C)**

III. *Assessment of medical risk:*

1. Develop treatment plans for and treat patients with a broad variety of acute and chronic systemic disorders and social difficulties including patients with special needs. Treat in a manner that considers and integrates those patient's medical, psychological, and social needs. (C)
2. Perform dental and medical consultations for patients in a health care setting. (C)

IV. *Health care delivery:*

1. Treat patients efficiently in a dental practice setting. **(C)**
2. Support the hygiene team by performing recall examinations. **(C)**
3. Support the program's mission statement by acting in a manner to maximize patient satisfaction in a dental practice. **(C)**
4. Use and implement accepted sterilization, disinfection, standard precautions and occupational hazard prevention procedures in the practice of dentistry. **(C)**
5. Provide patient care by working effectively with allied dental personnel, including performing sit down, four-handed dentistry. **(C)**
6. Provide dental care as a part of an interprofessional health care team such as that found in a hospital, institution, or community health care environment. **(C)**

7. Demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management. **(C)**
8. Familiarize residents with organized dentistry. **(C)**

V. *Information management and analysis:*

1. Evaluate scientific literature and other sources of information to determine the safety and effectiveness of medications and diagnostic, preventive, and treatment modalities, and make decisions regarding the use of new and existing medications, procedures, materials, and concepts. **(C)**
2. Maintain a patient record system that facilitates the retrieval and analysis of the process and outcomes of patient treatment. **(C)**
3. Analyze the outcomes of patient treatment to improve that treatment. **(C)**
4. Understand and use a system for continuous quality improvement in a dental practice. (C)
5. Utilize a system for continuous quality improvement in a dental practice, and analyze the outcomes of patient treatment to improve that treatment via Personal planner. **(C)**
6. Use current dental practice system including scheduling patient flow, EHR record keeping, insurance financial arrangement, and continuing care systems.(C)

VI. *Promoting oral and systemic health and disease prevention*:

1. Participate in community programs to prevent and reduce the incidence of oral disease. **(C)**
2. Use accepted prevention strategies such as oral hygiene instruction, nutritional education, and pharmacologic intervention to help patients maintain and improve their oral and systemic health. **(C)**

VII. *Sedation, pain, and anxiety control:*

1. Use pharmacologic agents in the treatment of dental patients. **(C)**
2. Provide control of pain and anxiety in the conscious patient through the use of psychological interventions, behavior management techniques, local anesthesia, and oral and nitrous oxide conscious sedation techniques. **(C)**
3. Prevent, recognize, and manage complications related to use and interactions of drugs, local anesthesia, and conscious sedation. **(C)**

VIII. *Restoration of teeth:*

1. Restore single teeth with a wide range of materials and methods. **(C)**
2. Place restorations and perform techniques to enhance patient's facial esthetics. **(C)**
3. Restore endodontically treated teeth. **(C)**

IX. *Replacement of teeth using fixed and removable appliances:*

1. Treat patients with missing teeth requiring removable restorations. **(C)**
2. Treat patients with missing teeth requiring uncomplicated fixed restorations. **(C)**
3. Diagnose and manage a patient's occlusion. **(C)**
4. Communicate case design with laboratory technicians and evaluate the resultant prostheses. **(C)**
5. Utilize Digital Dentistry modalities to treat patients requiring fixed or removable prostheses. **(C)**
6. Manage uncomplicated endosseous implant restorations. **(C)**

X. *Periodontal therapy*

1. Diagnose and treat early and moderate periodontal disease using non-surgical and surgical procedures. **(C)**
2. Manage advanced periodontal disease. **(C)**
3. Evaluate the results of periodontal treatment and establish and monitor a periodontal maintenance program. **(C)**

XI. *Pulpal therapy:*

1. Diagnose and treat pain of pulpal origin. **(C)**
2. Perform uncomplicated non-surgical anterior endodontic therapy. **(C)**
3. Perform uncomplicated non-surgical posterior endodontic therapy. **(C)**
4. Treat uncomplicated endodontic complications. **(C)**
5. Manage complex endodontic complications. **(C)**

XII. *Hard and soft tissue surgery:*

1. Perform surgical and nonsurgical extraction of teeth. **(C)**
2. Perform uncomplicated pre-prosthetic surgery. **(C)**
3. Treat patients with complications related to intra-oral surgical procedures. **(C)**

XIII. *Treatment of dental and medical emergencies:*

1. Treat patients with intra-oral dental emergencies and infections. **(C)**
2. Anticipate, diagnose and provide initial treatment and follow-up management for medical emergencies that may occur during dental treatment. **(C)**
3. Treat intraoral hard and soft tissue lesions of traumatic origin. **(C)**
4. Recognized and manage facial pain of TMJ origin. **(C)**

d. Second year competency statements

The following are competency statements that describe the additional areas beyond those of the first year program that apply to residents completing the second year program.

1. Integrate all aspects of dentistry in the treatment of patients with complex dental, medical and social situations. **(C)**
2. Perform advanced procedures in the selected clinical Area of Concentration. **(C)**
3. Use proper dental school protocol when treating and managing patients in a health center environment. **(C)**
4. Participate in the management of a system of continuous quality improvement in a dental practice. **(C)**
5. Apply the treatment planning presentation skills gained in YRI to chair the interdisciplinary Case Conference for AEGD program. **(C)**
6. Develop and participate in the second year curriculum that is customized for their particular interests. **(C)**
7. Perform and maintain uncomplicated endosseous implant restorations. **(C)**

V. PROGRAM EVALUATIONS

a. General considerations

Complaints with the Commission can be made by writing or calling the ADA Commission on Dental Accreditation: A copy of the appropriate accreditation standards and/or the Commission's policy and procedure for submission of complaints may be obtained by contacting the Commission at 211 East Chicago Avenue, Chicago, IL 60611-2678 or by calling 312-440.4653. The Commission's web address is: https://coda.ada.org

The Commission on Dental Accreditation will review complaints that relate to a program's compliance with the accreditation standards. The Commission is interested in the sustained quality and continued improvement of dental-related education programs but does not intervene on behalf of individuals or act as a court of appeal for individuals in matters of admission, appointment, promotion or dismissal of faculty, staff or students.

The above Complaints Notice is also posted in select locations of the University of Maryland School of Dentistry and on the school's website.

- Critiques by Residents
    1. Curriculum Review/Instructor Feedback forms on short courses, lectures and seminars
    2. Complete an on-line program critique at the end of the year.
    3. Faculty Evaluation by students.
    4. Tri-annual critique of program by residents found in the tri-annual Evaluation of Resident.
    5. Three year post graduation follow-up critique/outcomes assessment (recent resident survey).
    6. Exit interview with Dental School administration
    7. Quality and relevance of classroom instruction
        a. quality and relevance of seminars
        b. quality and amount of clinical instruction
        c. clinical and laboratory support
        d. staff's approach
        e. faculty's approach

- Critiques by Faculty
    1. Tri-annual evaluation of resident
    2. Quality Assessment Audit (Case Completes)

b. AEGD Seminar Evaluation Form

Curriculum Review / Instructor Feedback

Date:	Time:	Hours:

Session Title: _____
Presenter: _____
Format: ☐ Seminar ☐ Hands-on
Number in Attendance: _____
AV Aids Used: ☐ Yes ☐ No
Learning Objectives:

_____
_____

Session Evaluation
Rate each item from 0 (Poor) to 3 (Excellent) or mark N/A if not applicable.

#	Item	Rating (0–3 / N/A)
1	Instructor started and ended on time	_____
2	Instructor communicated clearly	_____
3	Instructor was prepared and organized	_____
4	Content was appropriate and accurate	_____
5	Learning objectives were met	_____
6	Students were engaged	_____

Suggestions for Improvement:

_____
_____
_____
_____

Resident Signature: _____

c. TRI-ANNUAL RESIDENT EVALUATION <u>BY FACULTY MENTOR</u>

Resident's Name: _____

Period: 1st_____ 2nd_____ 3rd_____

I. Professionalism	**0**	**1**	**2**	**3**
a. Professional appearance and demeanor				
b. Time management skills				
c. Overall work ethic				
d. Compliance with clinic protocols/infection control				
e. Accepts responsibility for patients' welfare				

II. Assessment	**0**	**1**	**2**	**3**
a. Sound Clinical judgment				
b. Diagnostic capability				
c. Ability to formulate comprehensive treatment plan				
d. Self-assessment ability				

III. Technical Performance	**0**	**1**	**2**	**3**
a. Knowledge of procedures and materials				
b. Ability to work independently				
c. Clinical skills/procedural know-how				
d. Quality of treatment provided				
e. Productivity and efficiency				
f. Pain control/patient management				
g. Ergonomics				

IV. Interpersonal Qualities	**0**	**1**	**2**	**3**
a. Communication and patient rapport				
b. Collaboration/teamwork				
c. Leadership skills				
d. Ability to follow directions				
e. Dependability				

Key:

0 Not observed
1 Honors (Superior)
2 Pass (Satisfactory)
3 Fail (Unsatisfactory)

d. **OVERALL CLINICAL COMPETENCE**

Circle the number which best describes overall clinical competence.

Total weight divided by 7

HONORS	**PASS**	**FAIL**
(Superior)	(Satisfactory)	(Unsatisfactory)
9 8 7	6 5 4	3 2 1

I have reviewed this evaluation. Comments are as above.

Date: _____ Resident's Signature: _____

Program Director's Signature: _____
Comments:

- **The tri-annual evaluation is uploaded on an online survey link which is sent to all faculty members in the program**
- **All responses are anonymous**
- **The results are compiled and provided to the residents during the evaluation**
- **Any grades awarded in clinical courses are reflective of the overall grade of the tri-annual evaluation**

II. AEGD CHECK-OFF LIST FOR TRI-ANNUAL RESIDENT's EVALUATION

1. Review of Portfolio
    a. Copy of CPR Card
    b. Copies of Electronic signed Treatment Plans
    c. Case Completes (at least 10)
    d. Roster and Schedule
    e. Presentations
    f. Productivity report
    g. Evaluation and Goals
    h. Competency Statements
    i. Competency Certifications Forms
    j. Resume
    k. Other documentation
    l. AEGD programmatic documents

2. Review of Status of Patient Treatment
3. Review of Needs (treatment areas where resident needs more experience)
4. Review of Clinical Performance
    1. Quality of Work
    2. New Techniques Learned
    3. Complexity of Cases
    4. Quantity of Work (Productivity sheets)
    5. Q.A. Review (Case Complete and Chart Audits)
5. Review of Didactic Performance
    1. Quality of Portfolio
    2. Seminar Planning and Leading
    3. Seminar Participation
    4. Examination scores and grade transcripts

F. Resident Evaluation of Program

1. Quality and relevance of seminars
2. Quality and amount of clinical instruction
3. Clinical and laboratory support
4. Staff's approach
5. Faculty's approach
6. Q.A. review (End of year evaluations)
7. Residents' complaints

STUDENT SURVEY OF PROGRAM

INSTITUTIONAL AND PROGRAM EFFECTIVENESS

FIRST-YEAR AEGD RESIDENTS

1. Do you have the same privileges and responsibilities afforded residents in other professional programs at this institution?
2. Based on your knowledge of the AEGD Program, have overall program goals and objectives been developed?
3. Do the overall AEGD Program's goals and objectives emphasize general dentistry, resident education, and patient care?
4. Have you been afforded the opportunity to evaluate whether the AEGD Program has met its stated goals and objectives?
5. Have goals and objectives OR competency statements been developed for each area of resident training?
6. Do the goals and objectives OR competency statements reflect the intended outcomes of your education?
7. Has your training included comprehensive, multidisciplinary oral health care?
8. Has your training been at a level beyond that of dental school?
9. Have you received didactic and/or clinical training and experience in patient assessment and diagnosis?
10. Have you received didactic and/or clinical training and experience in planning/providing comprehensive, multidisciplinary oral health care?
11. Have you received didactic and/or clinical training and experience in obtaining informed consent?
12. Have you received didactic and/or clinical training and experience in promoting oral and systemic health and preventing disease?
13. Have you received didactic and/or clinical training and experience in sedation, as well as pain and anxiety control?
14. Have you received didactic and/or clinical training and experience in restoration of teeth?
15. Have you received didactic and/or clinical training and experience in replacement of missing teeth with fixed and/or removable prostheses?
16. Have you received didactic and/or clinical training and experience in periodontal therapy?
17. Have you received didactic and/or clinical training and experience in pulpal therapy?
18. Have you received didactic and/or clinical training and experience in hard and soft tissue surgery?
19. Have you received didactic and/or clinical training and experience in the treatment of dental and medical emergencies?
20. Have you received didactic and/or clinical training and experience in medical risk assessment?
21. When delivering outpatient care, do you believe you have received sufficient instruction and experience in the management of pain and anxiety,
    using behavioral and pharmacological modalities beyond local anesthesia?
22. Are patient care conferences scheduled monthly to discuss diagnosis, treatment planning, and progress toward treatment outcomes?
23. Were you given assignments that required critical analysis of the scientific literature?
24. Have you received adequate instruction regarding the principles of practice management?
25. Describe the frequency by which your progress toward achieving the AEGD Program's written goals and objectives is evaluated.

26. Following the evaluations, are you given the opportunity to discuss your individual progress toward achieving program goals and objectives with the program director and/or relevant faculty members?
27. How frequently are you evaluated on your progress toward achieving the program's written goals and objectives?
28. Following each evaluation, are you given an opportunity to discuss the evaluation with the program director and/or faculty?
29. In general, does the faculty have collective competence in the areas of dentistry that are included in the program?
30. In your opinion, do the general dentists have a significant role in program development and instruction?
31. Are you provided the opportunity to evaluate the performance of faculty members annually?
32. Approximately what percentage of time is a faculty member present in clinic for consultation, supervision, and/or active teaching when residents are treating patients in scheduled clinic sessions?
33. Are allied dental personnel and clerical staff available to ensure residents receive training and experience in the use of modern concepts of oral health care delivery, and to ensure efficient administration of the program?
34. Do residents and teaching staff regularly need to perform the tasks of dental assistants, laboratory technicians, or clerical personnel?
35. Are the facilities and resources adequate and appropriately maintained to support the goals and objectives of the program?
36. Are you aware of specific written "due process" policies and procedures for adjudication of academic and disciplinary complaints?
37. Prior to contact with patients and/or infectious objects or materials, were you encouraged or required to be immunized against and/or tested for infectious diseases such as mumps, measles, rubella, and hepatitis B?
38. Have you had adequate patient experiences to achieve the program's state goals and objectives OR competencies and proficiencies of resident training?
39. Have you been involved in a structured system of continuous quality improvement for patient care?
40. Prior to providing direct patient care, were you required to be certified in basic life support procedures, including cardiopulmonary resuscitation?
41. Have you been provided with the institution's policies on radiation hygiene and protection, ionizing radiation, hazardous materials, and blood-borne and infectious diseases?
42. Does the program have policies that ensure that the confidentiality of information pertaining to the health status of each individual is strictly maintained?
43. In your opinion, what are the strengths of the AEGD program?
44. In your opinion, what are the weaknesses of the AEGD program?

ADDITIONAL QUESTIONS FOR SECOND-YEAR AEGD RESIDENTS

1. In general, do you believe that the goals and objectives OR competency statements of the second year of training were at a higher level than were those of the first year of training?
2. Regarding both years of training, the program provided experiences in managing highly complex, comprehensive dental care.

3. Regarding both years of training, the program improved my clinical management skills.
4. Regarding both years of training, the program allowed me to pursue areas of individual concentration (e.g., temporomandibular disorders & facial pain, anesthetics & sedation, oral pathology, CAD-CAM, etc)
5. Regarding both years of training, the program provided an interdisciplinary graduate foundation in the biological and clinical sciences for careers in dental research and/or education and the practice of dentistry. (For candidates pursuing a Master of Science degree (Oral biology)
6. Regarding both years of training, the program provided teaching experiences, opportunities to conduct original research, and an opportunity to earn a Master of Science degree (Oral Biology).
7. If you would like, you may provide any <u>other</u> comments about the second year of the AEGD program here.

AEGD Case Presentation Evaluation			
Resident's Name:	**Faculty's Name and Date:**		
Scoring Criteria	**Poor**	**Average**	**Excellent**
Presenter is well prepared	1 2	3 4	5
Case selection was appropriate	1 2	3 4	5
Proper background information on the topic given	1 2	3 4	5
Readability of the slides	1 2	3 4	5
Audio-visual aids used effectively	1 2	3 4	5
Quality of intra-oral pictures	1 2	3 4	5
Clinical information was presented in a logical sequence	1 2	3 4	5
The case was well documented	1 2	3 4	5
Presenter expressed clearly and concisely	1 2	3 4	5
Content was scientifically accurate (findings, diagnoses & prognoses)	1 2	3 4	5
Substantial discussion was presented	1 2	3 4	5
Treatment options presented	1 2	3 4	5
Rational for selected treatment presented	1 2	3 4	5
Prognosis of case was discussed	1 2	3 4	5
Presenter established good rapport with the audience	1 2	3 4	5
Presenter showed interest and enthusiasm for the material presented	1 2	3 4	5
Presenter demonstrated depth of knowledge during question time	1 2	3 4	5
The number and quality of scientific literature were appropriate	1 2	3 4	5
Length of presentation was within the assigned time limits	1 2	3 4	5
Professionalism and response to questions	1 2	3 4	5
Total Points			

GRADE: H P F

H: Honors >90
P: Pass 79-89
F: Fail <70

Revised: 06/06/2023

H. AEGD FACULTY EVALUATION OF THE PROGRAM

FACULTY: **DATE:**

Please complete the following confidential evaluation for the above faculty member. Please do not write your name on the form. The following 5 to 1 rating scale will be used, where 5 will always represent an excellent or the most favorable rating and 1 will always represent a poor or unfavorable evaluation.

1. How knowledgeable is the faculty member?
2. How effectively does the faculty member convey meaningful information via
    a. discussion
    b. demonstration
    c. clinical supervision
3. How consistent is the information you receive from the individual faculty member?
4. How helpful is the faculty member?
5. How is the faculty member's availability and accessibility?
6. To what extent is the faculty member punctual?
7. To what extent does the faculty member demonstrate
    a. a positive attitude towards you
    b. a positive attitude towards your patients
    c. a positive attitude towards his/her responsibilities
8. To what extent does the faculty member demonstrate professionalism?
9. To what extent is the faculty member a role model for you?
10. To what extent is the faculty member an asset to the AEGD Program?

ADDITIONAL COMMENTS:

I. AEGD Alumni outcomes assessment survey

The information from this survey will be combined with information from other graduate's surveys to provide a basis for evaluating the effectiveness of the AEGD Program in achieving its program goals and objectives. Information gained from these surveys can serve as a basis for change and improvement of the program. Your cooperation in providing this information is appreciated and is important in the continuing development of the AEGD Program. Thank you.

1. Please describe your **clinical practice involvement** at this time.

   General Practice _____(Full time/part time)

   Academia?
   Government agency?
   Specialty _____ which specialty? _____
   Other (please specify:

2. Considering that a full 5-day work week is 40 hours or 100%, please describe your **professional efforts by category:**

   Practice % _____ Hours _____

   Teaching % _____ Hours _____

   Research % _____ Hours _____

3. How many continuing education hours have you completed over the past year?

4. List the **professional journals** that you read regularly:

5. List the **professional organizations** to which you belong:

PLEASE USE THE FOLLOWING SCALE TO ANSWER THE QUESTIONS BELOW:

1= minimally
2= somewhat
3= moderately
4= fairly well
5= greatly

6. To what extent did the AEGD program enhance your **clinical** skills in the following disciplines:

_____ Diagnosis	____ Treatment Planning
_____ Operative Dentistry	_____ Periodontics
_____ Fixed Prosthodontics	_____ Removable Prosthodontics
_____ Oral Surgery	_____ Endodontics
_____ Implants	_____ Oral Medicine/Pathology
_____ management of medically-compromised patients	

7. To what extent did the AEGD program provide experience and enhance your abilities in**:**

_____ Dental Practice Administration
_____ Patient management
_____ Dental Staff management
_____ Ethics and professionalism

8. Now that you have been practicing for a few years, can you describe the most impactful AEGD residency learning experience that prepared you for a career in general dentistry?

8.a Describe the ways the AEGD can **be improved upon** in preparing residents for a career in general dentistry?

8.b Would you be willing to participate in a more detailed interview about improving the program?

If so, please send your name and email contact information to [enter contact details]

J. THE PORTFOLIO EVALUATION SYSTEM

THE PORTFOLIO EVALUATION SYSTEM FOR COMPLETION OF UNIVERSITY OF MARYLAND SCHOOL OF DENTISTRY'S ADVANCED EDUCATION IN GENERAL DENTISTRY PROGRAM

The Portfolio

A portfolio is a collection of authentic evaluation of a resident's ability to perform tasks in realistic, unaided situations representative of what will be performed after graduation. The portfolio refers literally to a loosely bound document in which residents assemble and organize for presentation, various pieces of evidence that they have satisfied program competencies and proficiencies. The evidence may consist of checklists, case documentations, write-up of interviews, papers, letters and other documentation. It is the resident's responsibility to assemble two copies of the portfolio. An important tenet in competency-based education and portfolio evaluation is the shift of responsibility from teachers to students. One copy of the portfolio will be kept by the program as a part of the program's outcomes assessment documentation. The other copy is kept by the resident and may be used in applications for employment, other programs or for documentation for hospital privileges.

Portfolio Description

The completed portfolio shall be submitted in duplicate and consist of the following parts:

1. A section for at least 10 completed Quality Assessments.

2. A section for case documentation materials - Treatment plan presentation cases.

3. A section for evidence
   a. Productivity sheets/Procedure Utilization Report
   b. Certification (i.e., CPR, Boards, etc.)
   c. Publications/research projects (thesis)/presentations
   d. Quarterly evaluations
   e. Certificate of completion of CE courses.
   f. Seminars/lecture schedule
   g. Course schedule/transcript (MS and PhD residents)
   h. Resume
   i. Copy of signed treatment plan.

Note: The resident may propose alternative forms of evidence to the program director and use them with the program director's approval.

Logistics

1. Residents will get approval for methodology and projects and gather evidence throughout the program as described above.

2. At the resident's **second** review, the residents will submit the data that they have collected for review.

3. One month before the end of the program residents will turn in the completed portfolio for evaluation. The program director may accept it as complete, or request additional evidence, or other changes.

4. Two weeks prior to the end of the program the program director will make the final decision as to granting a program completion certificate.

5. In case of dispute the resident may ask for an appointment with the Department Chair to review the program director's decision.

6. In addition, the program director must follow the School of Dentistry's Due Process Policy for Advanced Dental Education for an academic dismissal from the program.

Competencies

The Program Director will provide the program's competency list for the residents and faculty and train them in the evaluation methodology and technique of developing a portfolio.

Evidence

The statements in the competency list can be divided into several categories for the purpose of determining appropriate evaluation methodologies.

1. Statements related to technical procedures: Statements 5-9, 26-28, 33-57.
    a. These all represent procedures that are performed on or with patients and can be directly observed by faculty members.
    b. At the beginning of the program, faculty members are designated as responsible for evaluation of each technical competency and must certify the resident as competent in that area based on observation of the resident's work in that area.
    c. The resident will work with the designated faculty member from start to completion on a particular patient or procedure, but the performance must be independent. If faculty intervention is necessary, that procedure cannot be counted as evidence toward competency.

2. Observation can be documented by:
    a. a signed case write-up including case history, procedures performed, and outcomes, supplemented with appropriate photographs or x-rays.
    b. faculty signature on the "certification" sheet, with evidence listed as "direct observation".
3. Where observation forms or case write-ups are used, more than one competency may be observed at a time. The observations can, and will in many instances, span several appointments or the entire treatment of a patient. A single evaluation form or case write-up may contain evidence related to several competency statements.
4. Where observation forms or case treatment plan write-ups are used, residents will accumulate at least one signed observation form or prepare one case write-ups that contain evidence related to each technical competency. Since each form or case write-up may contain evidence related to several statements, there should be less total forms or case write-ups than technical competency statements.
5. Faculty will certify the resident in that competency prior to the end of the program by considering the procedures formally documented and also other examples of procedures observed that are related to that competency statement.

2. Statements related to oral disease detection, diagnosis, prevention: Statements 23-25, 29, 30.
    1. These statements, as with technical competencies are performed with individual patients, and can be directly observed by faculty members.
    2. The process of evaluating and documenting these procedures is the same as that listed above for technical competencies and can use the same evaluation form, case write-up technique, or direct observation.
    3. Different faculty members may be designated to be responsible for certifying the resident in these competencies than were assigned to certify the resident on various technical competencies.

3. Statement related to developing treatment plans: Statement 3.
    1. This statement requires evidence of the formation of a treatment plan for a patient with complex needs.
    2. The resident shall prepare one formal treatment plan for presentation at a group treatment planning seminar.
    3. The treatment plan presentation shall include formal documentation of:
        i. a complete patient history
        ii. dental examination
        iii. mounted study models and photographs of the patient's pre-treatment condition
        iv. diagnosis of the patient's conditions
        v. alternate treatment plans that could be accomplished for this patient
    4. The portfolio evidence for the formal treatment plan shall include the write-up of the above treatment plan presentation, and mounted print photographs of the x-rays and clinical slides.
        a. Treatment plan forms.

5. Statements related to comprehensive care: Statements 1, 2, 4, 31, 32.
    a. These statements require evidence of complete care of patients. (IO case complete reviews signs by AEGD faculty)
    b. The resident shall document and have signed by the program faculty one multi-disciplinary, comprehensive care. The documentation shall be assembled in a form suitable for inclusion in a portfolio binder. The documentation shall include:
        i. A complete write-up of the patient's history, examination, and treatment plan and effect of patient's psychological, medical, or oral conditions on the treatment plan.
        ii. Mounted prints of photographs of the patient's pre-operative condition and post-operative condition.
        iii. A write-up summarizing the treatment performed, special considerations, problems, or modifications encountered and prognosis and plans for further care.
    c. The resident shall make one formal case presentation in front of the faculty and other residents documenting complex, multi-disciplinary, comprehensive care. The case presentation shall include the items listed above with slides substituted for mounted prints.

6. Statements related to providing dental care in a dental practice setting and community and interprofessional teams: Statements 10-15.
    a. These statements refer to activities that take place in conjunction with practice in the program clinic with program staff over a period of time. They can be evaluated by interviews, written evaluations, or questionnaires solicited from staff, faculty, and patients.
    b. The resident is expected to design and carry-out a measure of each of these statements. A single measure can be used for more than one statement. Possible measures are:
        i. a patient questionnaire to be given to the resident's own patients participation in a community program (Health Care for Homeless and the Family Investment Program).
    c. other measure approved by the program director or assistant program director. The results of these evaluation efforts will be summarized in writing and presented to the program director or assistant program director for approval.

7. Statements related to organized dentistry and professional ethics: Statements 16, 17.
    a. Statements related to participation in organized dentistry can be evaluated by evidence of participation in professional dental meetings.
    b. The ability to engage in an ethical analysis of dental practice situations or case studies and interact with colleagues in an ethical and professional manner can be documented by participation in an ethics discussion seminar series, which can be certified by the program ethicist or faculty.

8. Statements related to gathering and using information about dental practice: Statements 18-22.
    a. These statements refer to the ability to maintain continuous professional growth by gathering and using information relevant to various aspects of the practice of dentistry.
    b. Evidence of this ability must be by activities where residents gather and evaluate information.
    c. The residents will design and carry out three information projects in which they will gather and use data in each of the following areas:
        i. Documentation of dental materials or procedure evaluation. This project will involve gathering and evaluating information about a new dental material or procedure. It will take the form of a short oral presentation. This write-up will be a maximum of one page plus literature search and references, use at least 3 referenced sources, and include a summary of the referenced literature and conclusions about the use of the material or procedure in dental practice.
        ii. Dental records evaluation. This project will involve analyzing outcomes from the resident's own records. It will take the form of a structured record review with written documentation, analysis, and conclusions.
    d. The resident will propose a specific topic and format for each of the projects described above and present them to the program director or assistant program director for approval. The program director or assistant program director will also sign off on the completed projects.

9. Other evidence:
    a. Some of the evaluation methods described may be applicable to statements not listed with that method. In addition, there may be other forms of evidence not listed that may be acceptable.
    b. Examples of other forms of evidence that may be used include:
        i. A certificate of completion of an CPR course for the competency related to medical emergencies.

6. In addition, the program director must follow the School of Dentistry's Due Process Policy for Advanced Dental Education for an academic dismissal from the program.

AEGD competency statements
First year
Statement certification sheets

Statement	Type of evidence or documentation	Certification by: name/signature
I. Planning and providing comprehensive multidisciplinary health care		
1. Function as a patient's primary, and comprehensive, oral health care provider (C)		
2. Explain and discuss with patients, or parents or guardians of patients, findings, diagnoses, treatment options, realistic treatment expectations, patient responsibilities, time requirements, sequence of treatment, estimated fees and payment responsibilities in order to establish a therapeutic alliance between the patient and care provider. **(C)**		
3. Integrate multiple disciplines into an individualized, comprehensive, sequenced treatment plan using diagnostic and prognostic information for patients with complex needs. **(C)**		
4. Modify the treatment plan, if indicated, based on unexpected circumstances or patient's individual needs. **(C)**		
5. Functioning effectively within multidisciplinary health care teams, including consultation and referral. **(C)**		
II. Oral disease detection and diagnosis		
1. Select and use assessment techniques to arrive at a differential, provisional and definitive diagnosis for patients with complex needs. **(C)**		
2. Obtain and interpret the patient's chief complaint, medical, dental, and social history, and review of systems. **(C)**		
3. Obtain and interpret appropriate clinical and radiographic data and additional diagnostic information from other health care providers or other diagnostic resources. **(C)**		
4. Use the services of clinical, medical, or pathology laboratories and refer to other health professionals for the utilization of these services. **(C)**		

Statement	Type of evidence or documentation	Certification by: name/signature
5. Perform a limited history and physical evaluation and collect other data in order to establish a risk assessment for dental treatment and use that risk assessment in the development of a dental treatment plan. **(C)**		
6. Diagnose and manage common oral pathological abnormalities including soft tissue lesions. **(C)**		
III. Assessment of medical risk		
1. Develop treatment plans for and treat patients with a broad variety of acute and chronic systemic disorders and social difficulties including patients with special needs. Treat in a manner that considers and integrates those patient's medical, psychological, and social needs. **(C)**		
2. Perform dental and medical consultations for patients in a health care setting. **(C)**		
IV. Health care delivery		
1. Treat patients efficiently in a dental practice setting. **(C)**		
2. Support the hygiene team by performing recall examinations. **(C)**		**HYG**
3. Support the program's mission statement by acting in a manner to maximize patient care in the dental practice. **(C)**		
4. Use and implement accepted sterilization, disinfection, standard precautions and occupational hazard prevention procedures in the practice of dentistry. **(C)**		
5. Provide patient care by working effectively with allied dental personnel, including performing sit down, four-handed dentistry. **(C)**		**Dental Assistant**
6. Provide dental care as a part of an interprofessional health care team such as that found in a hospital, institution, or community health care environment. **(C)**		
7. Demonstrate the application of the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care and practice management.**(C)**		

Statement	Type of evidence or documentation	Certification by: name/signature
8. Familiarize residents with organized dentistry. **(C)**		
V. Information management and analysis		
1. Evaluate scientific literature and other sources of information to determine the safety and effectiveness of medications and diagnostic, preventive, and treatment modalities, and make appropriate decisions regarding the use of new and existing medications, procedures, materials, and concepts. **(C)**		
2. Maintain a patient record system that facilitates the retrieval and analysis of the process and outcomes of patient treatment. **(C)**		
3. Analyze the outcomes of patient treatment to improve that treatment. **(C)**		
4. Understand and use a system for continuous quality improvement in a dental practice. (**C)**		
5. Utilize a system for continuous quality improvement in a dental practice, and analyze the outcomes of patient treatment to improve that treatment via Personal planner. **(C)**		
6. Use current dental practice system including scheduling patient flow, EHR record keeping, insurance financial arrangement, and continuing care systems.**(C)**		**Office Manager**
VI. Promoting oral and systemic health and disease prevention		
1. Participate in community programs to prevent and reduce the incidence of oral disease. **(C)**		
2. Use accepted prevention strategies such as oral hygiene instruction, nutritional education, and pharmacologic intervention to help patients maintain and improve their oral and systemic health. **(C)**		
VII. Sedation, pain, and anxiety control		
1. Use pharmacologic agents in the treatment of dental patients. **(C)**		

Statement	Type of evidence or documentation	Certification by: name/signature
2. Provide control of pain and anxiety in the conscious patient through the use of psychological interventions, behavior management techniques, local anesthesia, and oral and nitrous oxide conscious sedation techniques.(**C)**		
3. Prevent, recognize, and manage complications related to use and interactions of drugs, local anesthesia, and conscious sedation. **(C)**		
VIII. Restoration of teeth		
1. Restore single teeth with a wide range of materials and methods. **(C)**		
2. Place restorations and perform techniques to enhance patient's facial esthetics. **(C)**		
3. Restore endodontically treated teeth. **(C)**		
IX. Replacement of teeth using fixed and removable appliances		
1. Treat patients with missing teeth requiring removable restorations. **(C)**		
2. Treat patient with missing teeth requiring uncomplicated fixed restorations. **(C)**		
3. Communicate case design with laboratory technicians and evaluate the resultant prostheses. **(C)**		
4. Diagnosis and management of occlusion. **(C)**		
5. Manage uncomplicated endosseous implant restorations and refer advanced cases. **(C)**		
6. Utilize digital Dentistry modalities to treat patients requiring fixed or removable prostheses. **(C)**		
X. Periodontal therapy		
1. Diagnose and treat early and moderate periodontal disease using nonsurgical and evaluate the need for surgical procedures. **(C)**		
2. Manage advanced periodontal disease. **(C)**		
3. Evaluate the results of periodontal treatment and establish and monitor a periodontal maintenance program. **(C)**		

Statement	Type of evidence or documentation	Certification by: name/signature
XI. Pupal therapy		
1. Diagnose and treat pain of pulpal origin. **(C)**		
2. Perform uncomplicated non-surgical anterior endodontic therapy. **(C)**		
3. Perform uncomplicated non-surgical posterior or bicuspid endodontic therapy. **(C)**		
4. Be able to anticipate, identify, evaluate & properly refer (when appropriate) an endodontic complication **(C)**		
5. Evaluate and properly refer complex endodontic complications. **(C)**		
XII. Hard and soft tissue surgery		
1. Perform surgical and nonsurgical extraction of teeth. **(C)**		
2. Perform uncomplicated pre-prosthetic surgery.**(C)**		
3. Treat patients with complications related to intra-oral surgical procedures. **(C)**		
XIII. Treatment of dental and medical emergencies		
1. Treat patients with intra-oral dental emergencies and infections. **(C)**		
2. Anticipate, diagnose and provide initial treatment and follow-up management for medical emergencies that may occur during dental treatment. **(C)**		
3. Treat intraoral hard and soft tissue lesions of traumatic origin. **(C)**		
4. Recognize and manage facial pain of TMJ origin. (**C**)		

AEGD competency statements
Second year
Statement certification sheets

Statement	Type of evidence or documentation	Certification by: name/signature
1. Integrate all aspects of dentistry in the treatment of patients with complex dental, medical and social situations. **(C)**		
2. Perform advanced procedures in the selected clinical Area of Concentration. **(C)**		
3. Use proper dental school protocol when treating and managing patients in a health center environment. **(C)**		
4. Participate in the management of a system of continuous quality improvement in a dental practice. **(C)**		
5. Apply the treatment planning presentation skills gained in YRI to chair the interdisciplinary Case Conference for AEGD program. **(C)**		
6. Develop and participate in the second year curriculum that is customized for their particular interests. **(C)**		
7. Perform and maintain uncomplicated endosseous implant restorations. **(C)**		

University of Maryland School of Dentistry
Advanced Education in General Dentistry Program

CERTIFICATE OF COMPLETION OF
COMPETENCY DOCUMENTATION

Program: _____

Student Name: _____

The above named resident has presented in this portfolio evidence of competency in all the areas listed in the program competency statements and is therefore certified as having completed the program competency requirements.

Date: _____

Program Director's Name: _____

Program Director's Signature: _____

ACKNOWLEDGMENT STATEMENT

I, _____, have reviewed and understood the 2025-2026

AEGD Resident's Orientation Manual and Clinic Manual and will adhere to the guidelines set forth.

Signature: _____

Print: _____

Date: _____