Dentist
Form 4B

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Certification of Completion of Clinical Residency Program

Applicant Instructions

You may complete either a specialty dental residency program or a general dentistry residency program. The program must be accredited by an approved national accrediting body and of at least one year's duration. Please confirm with your residency program director that the residency program is participating in this route to licensure.

1. Complete Section I. In item 3, enter your name as it appears on your Application for Licensure (Form 1). Be sure to sign and date item 6.

2. Have your residency program director complete Section II certifying your successful completion of the residency program. The residency program director must return both pages of this form directly to the Office of the Professions at the address at the end of this form.

Section I: Applicant Information

1 **Social Security Number** ___ ___ ___ ___ ___ ___ ___ ___ ___

(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** Month ___ Day ___ Year ___

3 **Print Name As It Appears on Your Application for Licensure (Form 1)**

Last _____

First _____

Middle _____

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 _____

Line 2 _____

Line 3 _____

City _____

State ___ Zip Code _____

Country/ Province _____

5 Name of hospital or school where you completed the residency program (please type or print):

_____

Name of accredited residency program:

_____

Dates of residency program: _____ / _____ / _____ to: _____ / _____ / _____
mo. day yr. mo. day yr.

6 I request and give my permission to the hospital or school listed in item 5 above to complete this form and mail it to the New York State Education Department, and to release any other information requested by the State Education Department in connection with my application for licensure.

Applicant's Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Section II: Dental Residency Program Certification

INSTRUCTIONS: As a dental residency program director you must:

1. Review the New York State Law in Reference Guide on page 3.
2. Check the appropriate box in number 1 or enter the name of the specialty program in number 2 below based upon type of residency program.
3. Read, sign and date the certification in number 3 below, and have your signature notarized.
4. Send both pages of the completed form to the address at the end of this page.

Name of resident: _____

Date entered residency program: _____ / _____ / _____ Date completed residency program: _____ / _____ / _____
mo. day yr. mo. day yr.

1. Check appropriate box to indicate residency program completed.

☐ Endodontics ☐ Oral & Maxillofacial Pathology ☐ Oral & Maxillofacial Radiology ☐ Oral & Maxillofacial Surgery
☐ Orthodontics & Dentofacial Orthopedics ☐ Periodontics ☐ Pediatric Dentistry ☐ Prosthodontics ☐ General Practice (GPR)
☐ Advanced Education in General Dentistry (AEGD) ☐ Other

2. For <u>Other</u> Specialty Dental Residency Programs (not listed above)

Name of other specialty program: _____

Note: 50% of the residency program must consist of clinical training in one or more of the specialties listed above in number 1 or general dentistry.

3. I am the residency program director and I hereby certify that: **1)** The statements made on this form regarding this applicant's clinical residency experience are true, complete and correct; **2)** The applicant has successfully completed this dental residency program of at least one year's duration in the area indicated above; **3)** If this was a general practice or advanced education in general dentistry program, during the residency program the applicant successfully completed all nine required clinical procedures including: 4 restorations (2 anterior and 2 posterior), 2 crowns, 2 endodontically treated teeth, and one Type 1 periodontal case (see Reference Guide on page 3 for further information); and **4)** If this was a specialty dental residency program named in number 2 above, at least 50% of the accredited residency program completed by this individual consisted of clinical training in one or more of the areas listed in number 1 above and, **5)** The resident has competently completed the above mentioned residency program that includes an outcomes assessment that satisfactorily allows the resident to comply with section 6601 of the New York State Education Law.

Signature of Residency Program Director: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

License number: _____ State in which you are licensed: _____

Hospital or school name: _____

Address: _____

City: _____ State: _____ Zip code _____

Telephone: _____ Fax: _____ Email: _____

Notary

State of _____ County of _____ On

the _____ day of _____ in the year _____ before me, the undersigned, personally appeared

_____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose

name is subscribed to this application and acknowledged to me that he/she executed the certification.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Dentistry Unit, 89 Washington Avenue, Albany, NY 12234-1000.

Reference Guide

Applicable New York State Law

Definition of practice of dentistry (NYS Education Law S. 6601). The practice of the profession of dentistry is defined as diagnosing, treating, operating, or prescribing for any disease, pain, injury, deformity, or physical condition of the oral and maxillofacial area related to restoring and maintaining dental health. The practice of dentistry includes the prescribing and fabrication of dental prostheses and appliances. The practice of dentistry may include performing physical evaluations in conjunction with the provision of dental treatment.

General residency guidelines for certifying that the applicant completed procedures adhering to generally accepted professional standards for dentistry	
Topic	**Indicator of Care**
Procedure: Fixed Prosthodontics - Full Crown	
1. Caries	Caries has been completely removed.
2. Diagnosis and Treatment Planning	Root, bone and soft tissue are free of pathosis and/or adequate to support a fixed prosthesis. A comprehensive treatment plan has been developed.
3. Marginal Integrity	Margins are not open to the extent that dentin, cement or base is exposed. Margins do not overhang. Completed restoration exhibits retention.
4. Anatomic Form and Occlusion	Contour is continuous with existing tooth form. Appropriate proximal contact form exists. Appropriate occlusion exists (no occlusal prematurities). Occlusion is functional.
5. Esthetics	The prosthesis harmonizes with the patient's facial appearance. Pontics, facings and veneers match in appearance the natural teeth present.
6. Pulpal Integrity	Provided adequate linings or bases where indicated.
Procedure: Endodontics	
1. Subjective Symptoms	Ability to identify unprovoked, intermittent or continuous pain and/or pain in response to percussion and/or pain in response to palpation and/or pain during function.
2. Clinical Symptoms	Ability to identify clinical evidence of swelling and/or sinus tract and/or effect of cold or heat on a necrotic pulp and/or radiographic evidence of persistent pathosis.
3. Clinical Treatment	Proper instrumentation and debridement of canal(s). Proper obturation of canal(s), with all canals treated and is neither overextended nor underextended. The endodontic filling is uniformly dense. No evidence of perforation or untreated canal(s).
4. Recall Procedures	Has recommended a recall visit for endodontic follow-up.
Procedure: Operative Dentistry - Restorations	
1. Caries	Caries has been completely removed.
2. Choice of Restorative Material	Appropriate material used to withstand masticatory forces, considering the extent of tooth structure to be restored.
3. Preparation	Appropriate for extent of lesion and/or choice of restorative material.
4. Pulpal Integrity	Provided adequate linings or bases where indicated.
5. Marginal Integrity	Margins are not open to the extent that dentin or base is exposed. Margins do not overhang. Completed restoration exhibits retention.
6. Anatomic Form and Occlusion	Contour is continuous with existing tooth form. Appropriate proximal contact form exists. Appropriate occlusion exists (no occlusal prematurities).
7. Surface and Esthetics	Surface is smooth and finished. Restoration is esthetically acceptable.
Procedure: Periodontics (Note: A Type I periodontal case is indicated by inflammation of gingiva characterized by clinical changes in color, gingival form, position, surface appearance, and presence of bleeding and/or exudates.)	
1. Root Planing and Scaling	Adequate removal of deposits and/or smoothing of the roots.
2. Case Results and Management	Has established adequate follow-up observations. Has followed, completed, or appropriately modified treatment plan. Has counseled patient concerning home care requirements and prognosis.
3. Recall Procedures	Has recommended a recall program for follow-up supportive periodontal treatment.