

Dentist Form 4B

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 8.
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. This form will not be accepted if submitted by the applicant.

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 Last
 First
 Middle
5. Telephone/Email Address
Daytime Phone
 Home or Business

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address Home or Business
(You must notify the Department within 30 days of any address or name changes)
Line 1
Line 2
Line 3
City
State ZIP Code
Country/
Province
- Area Code Phone
Email Address (please print clearly)
 Home or Business
6. New York State DMV ID Number
(Driver or Non-Driver ID)

*(Leave this blank if you do not have a
New York State DMV ID Number)*

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

Name of accredited residency program

Dates of residency program From mo. day yr. To mo. day yr.

8. I request and give my permission to the hospital or school listed in item 7 above to complete Section II of this form and mail it to the Office of the Professions at the address at the end of this form, and to release any other information requested by the State Education Department in connection with my application.

Signature

Date

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 item 1 or enter the name of the specialty program in item 2 based upon type of residency program.
3. Read, sign and date the certification in item 3.
4. Send both pages of the completed form to the address at the end of this page.

Name of the applicant _____
(see Section I, item 3)

Date entered residency program mo. day yr. Date completed residency program 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)
- Dental Anesthesiology

2. For OTHER Special 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.

Residency Program Director's Signature _____ Date _____

Print Name _____

License Number _____ State in which you are licensed _____

Hospital or school name _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____ Email _____

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. **OR, Submit this form to the Department by E-mail at DPLSExperience@nysed.gov.**

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: 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.