

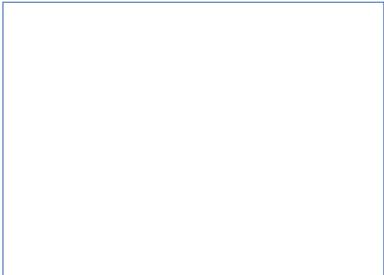


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OHIO STATE DENTAL BOARD

EVALUATION FORM FOR BIENNIAL SPONSOR CONTINUING EDUCATION COURSES



Do Not Write In This Space
For Office Use Only

DIRECTIONS: This form must be completed by organizations, agencies, or individuals who want to offer a course/program to dentists/dental hygienists/dental assistant radiographers that will satisfy part of the continuing education requirement for renewal of licenses. **A separate form must be submitted for each course/program.** You must complete all areas/questions and/or attach supplemental documentation (ie. instructor(s) resumes, course/program objectives or outlines, etc.) to this form. Refer to Ohio Revised Code Sections 4715.141(A) for guidance on approved course(s)/program(s) content. The Ohio State Dental Board (Board) does not approve individual course(s)/program(s). However, if you wish the Board to evaluate a particular course/program for classification purposes, you may submit this form and any supplemental documentation required by the Board to assist in a determination. **Recognition of a sponsor does not imply endorsement of course content presented.**

Name of Biennial Sponsor: _____

Course Title: _____

Instructor(s): _____

Qualifications of Instructor(s) *(You may attach copies of curriculum vitae to this worksheet):*

Course Objectives:

Course Curriculum or Outline *(You may attach additional pages to this worksheet):*

Course(s)/Program(s) offered to dental licensees should reflect appropriate didactic and clinical training for subject matter as defined by the American Dental Association's definition of dentistry, which states in pertinent part:

“Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body...”

A minimum of fifty percent (50%) of the course content must comply with Ohio Revised Code Section 4715.141(A). Please indicate which of the following apply:

- (1) Competency in treating patients who are medically compromised or who experience medical emergencies during the course of dental treatment;
- (2) Knowledge of pharmaceutical products and the protocol of the proper use of medications;
- (3) Competency to diagnose oral pathology;
- (4) Awareness of currently accepted methods of infection control;
- (5) Basic medical and scientific subjects including, but not limited to, biology, physiology, pathology, biochemistry, and pharmacology;
- (6) Clinical and technological subjects including, but not limited to, clinical techniques and procedures, materials, and equipment;
- (7) Subjects pertinent to health and safety.

Main Topic of Course/Program (Please indicate **one** of the following):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Air Abrasion | <input type="checkbox"/> Geriatrics | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Prosthodontics |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Implants | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Infection Control | <input type="checkbox"/> OSHA | <input type="checkbox"/> Restorative |
| <input type="checkbox"/> Dental Hygiene | <input type="checkbox"/> Lasers | <input type="checkbox"/> Compliance | <input type="checkbox"/> Sedation |
| <input type="checkbox"/> Endodontics | <input type="checkbox"/> Medical Emergencies | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Stomatology |
| <input type="checkbox"/> Esthetics | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Pedodontics | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Ethics or Jurisprudence | <input type="checkbox"/> Oral Medicine | <input type="checkbox"/> Periodontics | <input type="checkbox"/> TMD |
| <input type="checkbox"/> General Dentistry | <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Pharmacology | <input type="checkbox"/> Other _____ |

List the Category of Credit for this Course/Program (Please indicate **one** of the following):

- Category A: Education and scientific courses
- Category B: Substance abuse education
- Category C: Infection Control education
- Category D: Supervised self-instruction
- Category E: Nonsupervised self-instruction
- Category F: Papers, publications and scientific presentations
- Category G: Teaching and research appointments
- Category H: Table clinics

Type of Course/Program (Please indicate the following):

- | | | |
|-------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Supervised Self-instruction: | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Lecture | <input type="checkbox"/> Audio | _____ |
| <input type="checkbox"/> Convention | <input type="checkbox"/> Computer | _____ |
| <input type="checkbox"/> Forum | <input type="checkbox"/> Correspondence | |
| <input type="checkbox"/> Study Club | <input type="checkbox"/> Internet | |
| <input type="checkbox"/> Workshop | <input type="checkbox"/> Publication | |
| | <input type="checkbox"/> Textbook | |
| | <input type="checkbox"/> Video | |

Exact number of hours course/program is scheduled: _____

Number of **approved** continuing education credit hours requested: _____

CERTIFICATE OF AGREEMENT

As a provider of continuing education as required by the Ohio State Dental Board, I agree to the following (Please indicate by initializing):

_____ Course/Program content has a sound scientific basis, proven efficacy to ensure public safety and complies with Ohio Revised Code Sections 4715.141 and 4715.25.

_____ Participant objectives state the expected outcomes for the participant.

_____ Curriculum offerings reflect the appropriate didactic and clinical training for the subject matter.

_____ Ensure course(s)/program(s) have qualified clinically experienced instructor(s).

_____ Furnish to each participant at the course/program a certificate of completion which includes the sponsor’s name, title of course/program, instructor(s), date of course, location, number of hours of credit acceptable towards Ohio licensure renewal, and category of credit according to section 4715-8-01(A) through (H) of the Administrative Code.

_____ Maintain records of attendee participation for a period of no less than four (4) years.

I understand that Ohio State Dental Board (Board) approval does not imply endorsement of the course/program content presented, nor does it imply or assure approval by other regulatory boards. **The statement “Approved Sponsor of the Ohio State Dental Board”, or similar wording may appear on promotional materials, however, I may not advertise that a particular course/program has been approved by the Board.**

Signature _____ Date _____

FOR BOARD USE ONLY

Approved Reasons: _____

Denied _____

Number of CE hours approved for this course/program: _____

Signature _____ Date _____