



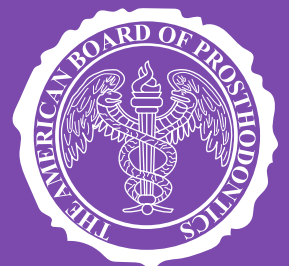
# Guidelines for the Certification Process

## American Board of Prosthodontics

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This document represents the Guidelines as of the above listed dates, but is subject to change at the discretion of the American Board of Prosthodontics. The most current Guidelines are available on the American Board of Prosthodontics website ([www.abpros.org](http://www.abpros.org)). Interested parties are strongly encouraged to visit this online resource.

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# 1. The American Board of Prosthodontics

## 1.1 MISSION STATEMENT

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

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

## 1.2 GENERAL STATEMENT OF PURPOSE

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

- to advance the science and art of prosthodontics by encouraging its study and improving its practice;
- to determine the eligibility of candidates within the regulations for qualification for examination;
- to conduct examinations to determine the proficiency of applicants for certification as Diplomates;
- to grant and issue Diplomate certificates to successful candidates; and
- to maintain a roster of Diplomates for the general information of the public, the dental and medical professions, dental schools, and health agencies.

## 1.3 SPECIFIC GOALS OF THE ABP

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

## 1.4 HISTORY OF THE ABP

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

The first Board examination was given in 1949 and included written essays and oral and clinical components administered during a one-week examination session. To be eligible for the certifying examination prior to January 1, 1954, the applicant had to present evidence of formal prosthodontic training or evidence of having spent 10 years in the practice of den-

tistry with special interest in prosthodontics. Thereafter, formal educational requirements included a Master of Science degree in prosthetic dentistry, or the equivalent, from a dental school approved or provisionally approved by the American Dental Association.

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

In 1960, the written examination was changed from essay to objective format, and consideration was given to dividing the weeklong examination into two separate phases. Additional study of a phased

examination culminated in application of this concept in 1962. Also during 1962, the American Dental Association House of Delegates changed eligibility requirements for ABP certification mandating two years of formal advanced education in prosthodontics for candidates applying after January 1, 1965.

From 1962 to 1987, a Phase I examination, consisting of written, oral and patient presentation parts, was given each February and followed in June by Phase II, which consisted of clinical and oral parts. In 1987 the Phase I oral examination was lengthened to one hour to include the patient presentation, the broad areas of prosthodontics, and the related basic and applied sciences. The Phase II oral examination was eliminated.

In 1967, at the request of the Federation of Prosthodontic Organizations and the American Academy of Maxillofacial Prosthetics, and as sanctioned by American Dental Association, the ABP accepted the responsibility for including maxillofacial prosthetics as a component area of prosthodontics to be included for competency certification. In 1974, provision was made for candidates to electively undergo clinical examination in maxillofacial prosthetics.

In 1972, upon recognition of the growing complexity of the prosthodontic specialty and the need for a broader Board membership base, the Academy of Denture Prosthodontics (now the Academy of Prosthodontics) relinquished sponsorship of the ABP to the Federation of Prosthodontic Organizations.

In 1987, the American Dental Association mandated the recognition of prosthodontics as a single specialty consisting of fixed prosthodontics, removable prosthodontics, and maxillofacial prosthetics. Also mandated was the requirement that all advanced educational programs in prosthodontics provide education and training in fixed, removable, and maxillofacial components. In 1990, recognizing a need for a more comprehensive examination process that considers mandated standards changes, the ABP announced significant modification of the examination format to more appropriately assess candidates' knowledge and clinical proficiency in all aspects of prosthodontics (i.e., fixed prosthodontics, removable partial prosthodontics, complete denture prosthodontics, maxillofacial prosthetics, implant prosthodontics, and occlusion). Following the 1991 transition year, the Phase I examination was expanded from one half day to one full day. Oral examination

and patient presentation parts were expanded and moved to the Phase II examination, and the on-site clinical examination was discontinued. Additionally, a written examination covering general clinical prosthodontics was incorporated into the Phase II examination.

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

In an effort to simplify examination description in 1993, the various parts were numbered from 1 to 5. The Part 1 examination was a half-day comprehensive written examination. Parts 2, 3 and 4 consisted of evaluating three specific patient treatments; each included oral examination of the candidate. The candidate made a slide presentation of patient treatment for Parts 3 and 4. The Part 5 examination was a three-hour written examination. In 1996, Part 5 was eventually incorporated into the Part 1 by increasing the number of questions and scope of

the written examination.

To provide more flexibility for candidates in the certification process, additional modifications were made in 1996. Candidates were given the option of taking the Part 1 written examination during the third year of formal prosthodontic training, prior to establishing board eligibility. In 2003 candidates were permitted to complete all patient treatments (Parts 2, 3 and 4) during formal prosthodontic training and challenge one patient presentation examination (Part 2, 3 or 4) during the last six months of residency.

In 2006 computer-based testing was initiated to allow candidates to challenge the Part 1 written examination closer to home using one of various testing centers throughout the country.

In 2008 substantive changes were made to the oral examination process. To minimize confusion during the transition period, the various parts of the examination were renamed. Effective 2008, the Part 1 written examination was renamed Section A and offered annually in April at remote testing centers throughout the country. Parts 2, 3 and 4 were renamed Section B Part 2, Section B Part 3, and Section B Part 4, respectively. A Section C examina-

tion was developed to involve scenario-based oral examination, and candidates were given the option to substitute the Section C examination for one of the patient presentation oral examinations in Section B. Therefore, candidates could elect to challenge all three parts of Section B examination (Parts 2, 3 and 4), or challenge any two parts of the Section B examination plus the Section C examination.

In 2011 modifications were made to the Section B oral examination with respect to patient treatment criteria in order to make this examination more relevant to contemporary prosthodontic treatment principles.

To give due consideration to the significant 2016 changes in prosthodontic education and training standards, a Section D oral examination was developed focusing on implant prosthodontics. This one-hour examination consists of candidate-generated patient treatment presentations and oral examination. The broad scope of implant dentistry serves as the basis of Section D. At this time, candidates may challenge all three parts of Section B, or any two parts of Section B plus Section C, or any two parts of Section B plus Section D.

As has been the objection from its inception, ABP strives to determine the proficiency of

eligible candidates who desire certification in prosthodontics.

## 1.5 DEFINITIONS

### **Prosthodontics**

Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or maxillofacial tissues using biocompatible substitutes.

### **Maxillofacial Prosthetics**

Maxillofacial Prosthetics is the branch of prosthodontics concerned with the restoration and/or replacement of the stomatognathic and craniofacial structures with prostheses that may or may not be removed on a regular or elective basis.

### **ABP Section A Examination**

ABP Section A Examination is a criterion-referenced examination constructed through the coordinated efforts of ABP members and psychometric experts. This computer-based examination is given at regional testing centers and aims to measure the knowledge and skills of qualified candidates. A resultant test score is a measure of how well a candidate performs in relation to the test items rather than the performance of other candidates. The content of the examination

gives due consideration to the Commission of Dental Accreditation (CODA) Standards for Advanced Specialty Education Programs in Prosthodontics. A detailed discussion of the Section A Examination is provided later in this document.

### **ABP Section B, Part 2 Examination**

ABP Section B, Part 2 Examination is a criterion-referenced examination consisting of a 20-minute candidate-generated patient treatment presentation immediately followed by a 40-minute oral examination. Total time for the examination is approximately one hour. Patient treatment must include a removable partial denture (or partial denture obturator) in either arch and fabrication of at least four (4) crowns restoring natural teeth in either arch. Treatment cannot involve a complete denture or complete overdenture. A detailed discussion of the Section B, Part 2 Examination is provided later in this document.

### **ABP Section B, Part 3 Examination**

ABP Section B, Part 3 Examination is a criterion-referenced examination consisting of a 20-minute candidate-generated patient treatment presentation immediately followed by a 40-minute oral examination. Total time for the examination is approximately one hour. Patient treatment must include a fixed



prosthodontic reconstruction consisting of at least fourteen (14) fixed prosthodontic units restoring occlusal surfaces. At least six (6) fixed units must restore natural teeth. A detailed discussion of the Section B, Part 3 Examination is provided later in this document.

#### **ABP Section B, Part 4 Examination**

ABP Section B, Part 4 Examination is a criterion-referenced examination consisting of a 20-minute candidate-generated patient treatment presentation immediately followed by a 40-minute oral examination. Total time for the examination is approximately one hour. Patient treatment must include a complete denture, complete overdenture, or complete denture obturator prosthesis in one arch and any method of restoring the opposing arch. All complete arch removable prostheses fabricated for the Part 4 examination MUST demonstrate bilateral (cross-arch) balanced articulation. A detailed discussion of the Section B, Part 4 Examination is provided later in this document.

#### **ABP Section C Examination**

ABP Section C Examination consists of three, highly objective, 20-minute oral examinations that are complete during a 1-hour period. Two examiners present clinically related scenarios to the candidate and pose predetermined questions

structured to evaluation of the candidate's depth and breadth of knowledge in prosthodontics and related disciplines. The scenarios are based on patient treatment and clinical presentations supplied by the ABP. Each scenario includes four themes: Diagnosis, Treatment Planning, Treatment, and Prognosis, Outcomes and Maintenance Plan. Candidates are scored based on the combined performance in all three examinations. A detailed discussion of the Section C Examination is provided later in this document.

#### **ABP Section D Examination**

ABP Section D Examination is a criterion-referenced examination, one hour in length, consisting of three distinct elements: (1) a 20-minute candidate-generated patient treatment presentation involving a minimum of two dental implant treatments, (2) a 20-minute oral examination based on standardized questions, and (3) a 20-minute oral examination based on open questioning. The broad scope of implant dentistry serves as the focus of oral examination during both standardized- and open-question examinations. A detailed discussion of the Section D Examination is provided later in this document.

## **1.6 THE VALUE OF ABP CERTIFICATION CREDENTIALS**

Board certification in the various specialties of dentistry and medicine is a method of credentialing specialists by examination and peer evaluation. It signifies qualification and achievement beyond formal training in an academic institution or clinical teaching program. Specialty certification defines the specialty. Without it, the specialty does not exist.

The certification process is the last step in defining the specialty, as the Board recognizes a group of individuals who meet or exceed the examination expectations. This process, in concert with the specialty's parameters of care document, ADA Council on Dental Education and Licensure definition, and recognized education standards, clearly outlines that definition. The certification process validates the specialty as a whole as providing high-level, specialized patient care. As the number of certified prosthodontists grows, public recognition of the specialty as setting the standard for care grows. For a clinician, certification is earned recognition by peers who affirm the individual meets the knowledge, skill, and professionalism of a specialist.

Traditionally, specialty board certification has been a prerequisite for obtaining staff privileges in hospitals and clinics. While this may not impact the private practitioner, anyone considering an institutional appointment should be aware that this prerequisite exists in most institutions. Additionally, some states require board certification or a state dental board specialty license in order for the practitioner to be listed as a specialist. In the military services, a specialist receives increased salary (called “board-certified pay”) when board certification has been achieved. This financial incentive correlates with the high rate of board certification seen in the armed services. Similarly, board certification is used as a factor in promotion and tenure reviews by many professional schools.

For the private practitioner of prosthodontics, the incentive to become board-certified is a more personal decision. For many, the value is very real. Currently, 50% of all board-certified prosthodontists are in private practice. The pride of accomplishment and the ability to call oneself a Diplomate of the American Board of Prosthodontics (ABP) and a Fellow of the American College of Prosthodontists (ACP) is incentive enough for many. However, the benefits go beyond personal accomplishment.

Distinguishing oneself within the private practice community may carry considerable tangible benefits as well. The consumer public is becoming more aware of the importance of board certification, and the frequency of inquiries regarding certification in prosthodontics has increased dramatically over the past decade. Potential patients contact the ABP regularly to determine whether the prosthodontist they are considering as their care provider is board-certified. Patients also seek board-certified prosthodontists in their geographic region and are often willing to travel substantial distances to be seen by a Diplomate. This trend of increased awareness on the part of the public will likely grow in the future.

The Board of Directors of the ACP is very aware that a strong specialty board and a high rate of certification among its members are critical to maintaining specialty status. The need for a high rate of certification will become more critical in the future to support the specialty and ensure a high level of patient care for the public. For these reasons, the ACP Board of Directors strongly supports the position that board certification in prosthodontics is critical to the future growth and well-being of the specialty and encourages its members to actively pursue board certification.

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- Al-Sowygh ZH, Sukotjo C: Advanced education in prosthodontics: Residents’ perspectives on their current training and future goals. *Journal of Prosthodontics* 2010;19:150-156.

## 1.7 CERTIFICATION FOR THE SPECIALTY OF PROSTHODONTICS

By the authority of the American Dental Association and the Council on Dental Education, the ABP is empowered to issue certification in the specialty of prosthodontics. Successful certification attests to a dentist’s knowledge, ability and proficiency in the specialty of prosthodontics.

Individuals who meet qualifications set forth in this document may become a candidate for certification by making formal application to the ABP. The ABP does not and shall not discriminate on the basis of race, color, religion (creed), sex, gender identity (including gender expression), sexual orientation, age, national origin (ancestry), disability, marital status, family/parental status, income status, military/veteran status, political beliefs, or any other characteristic prohibited by law in any of its activities or operations.

For the purposes of the ABP, the following terms and definitions are used:

**Prosthodontist** — A dentist who has successfully completed an advanced education program in prosthodontics that is accredited by the appropriate accrediting body; in the United States, that authoritative body is the Commission on Dental Accreditation (CODA) of the American Dental Association; in Canada, that authoritative body is the Commission of Dental Accreditation of the Canadian Dental Association.

**Educationally Qualified Prosthodontist** — A prosthodontist who, by virtue of advanced training (see above), is eligible to apply for certification examination by the ABP.

**Board Eligible Prosthodontist** — A prosthodontist whose application for certification examination has been accepted by the ABP and is current.

**Duration of Eligibility** — The period of Board eligibility begins on the date the application is accepted and approved by the ABP and extends for six (6) consecutive years. It is anticipated that all required elements of the examination will be successfully completed within six years of initial eligibility.

Extension of eligibility beyond the initial six-year period may be possible. In order to be considered for an extension, the individual must petition the ABP, in writing, and describe the extenuating circumstances that warrant an extension of eligibility. Candidates for whom eligibility has expired must reapply.

A resident/graduate student approved to challenge the Section A written examination during the third year of formal prosthodontic training is not considered Board eligible. Successful completion of the Section A written examination is not time dependent and does not expire. A resident/graduate student who successfully completes the Section A examination is not considered Board eligible. Formal application to the ABP is still required in order to attain Board eligible status. The six-year duration of

official Board eligibility begins only after formal application has been submitted to and approved by the ABP.

A resident/graduate student interested in challenging one of the Section B patient presentation oral examinations (Part 2, 3, or 4) during the last six months (typically February) of formal prosthodontic training must have applied for and been granted Board eligibility by the ABP prior to the examination. Board eligibility will continue for a period of six years from the date of initial approval.

**Diplomate in Prosthodontics** — A prosthodontist who has successfully completed all required elements of the ABP certification process and remains in good standing with ABP policies and procedures.

## 1.8 ROLE OF THE ABP AND ITS EXAMINERS IN THE EVALUATION PROCESS

An examiner may be described as one who works to evaluate records or people and who tests by careful questioning in order to ascertain the knowledge, skill, competency, proficiency, or qualifications of candidates under scrutiny. Since its inception, the primary objective of the ABP has been, and will continue to be, the protection of the public through determination of the competency of eligible candi-

dates who desire certification as a specialist in prosthodontics. The ABP is an examining and certifying body. It remains independent from political issues and is not directly responsible for the education of candidates.

Certification by the American Board of Prosthodontics reflects the broad scope and scientific basis for prosthodontics. Prosthodontics is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using bio-compatible substitutes (ADA, adopted April 2003). Determination of and examination to the broad scope and scientific basis of prosthodontics is the responsibility of the ABP Board of Directors. The certification examination reflects, but is not limited to, the Commission of Dental Accreditation (CODA) Standards for Advanced Specialty Education Programs in Prosthodontics.

The ABP is not static or unchanging; changes occur regularly and when indicated. However, change is implemented only after substantial consideration. The ABP strives to be fair, objective and consistent with all candidates. The

existing Guidelines and examination procedures may be modified when such change is determined to benefit those it serves: the public, the profession, the specialty, the Diplomates, and the candidates seeking diplomate status.

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

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Individuals knowledgeable in testing have emphasized that any system of evaluation must be objective if it is to be considered valid and reliable. The ABP's dedication to improving the examinations is ongoing.

Criterion-based evaluation is a method of increasing the validity and reliability of an examination. The ABP has developed criterion statements for the different oral examination phases of the certification process. The criterion statements developed for patient presentation examinations critically assess areas of clinical practice and didactic knowledge.

ABP examiners evaluate candidate performance in each applicable category using criterion statements developed as objective descriptions of varying performance levels. To qualify performance, examiners consider performance levels (i.e., acceptable, marginal, or unacceptable) that best reflect

candidate skill and knowledge as demonstrated during the examination. Each examiner then calculates and submits a numerical value that corresponds to candidate performance (i.e., 1 or 2 for acceptable, 3 for marginal, and 4 or 5 for unacceptable).



## 2. Certification & Recertification Processes

### 2.1 INQUIRIES AND GENERAL INFORMATION

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For questions about the *examination process and logistics* that are not covered in these Guidelines, email [exams@abpros.org](mailto:exams@abpros.org). These questions are directed to the immediate past-president of the ABP, formally serving as the Board's Chief Professional Officer. Please note that The American Board of Prosthodontics will not provide guidance regarding specific therapies. These matters must be determined and justified by the candidate during the examination.

For other questions contact Bryan Mowry, Chief Operations Officer, at [info@abpros.org](mailto:info@abpros.org), direct phone (651-366-6099), secure fax (651-290-2266), or traditional letter (American Board of Prosthodontics, 1000 Westgate Drive, Suite 252, St. Paul, MN 55114). These questions may relate to:

- Required qualifications for candidates

- Application to become Board eligible
- Confirmation that the submitted qualifying credentials are complete
- Online payments - candidate application for Board-eligibility, examination application fees, dues, recertification, credential verification, etc.
- Continuing education course entry (for Diplomates)
- Recertification timing (for Diplomates)
- Questions about dues (for Diplomates)
- Request for documents (for Diplomates)
- Other

### 2.2 EXAMINATION SEQUENCING AND EXECUTION

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In order to strategically navigate the various ABP required examinations, candidates may consider one of three possible pathways to successful Board certification:

- Pathway #1: Section A + Section B (all 3 parts)

- Pathway #2: Section A + Section B (any 2 parts) + Section C
- Pathway #3: Section A + Section B (any 2 parts) + Section D

Requirements and stipulations related to successful execution of the ABP certification examination process include:

- English is the official language of the ABP.
- The Section A written examination may be challenged in April of the third year of formal prosthodontic training, prior to establishing Board eligibility.
- A resident/graduate student whose prosthodontic education extends beyond three years may take the Section A examination in the third year of training.
- All patients presented during Section B or Section D examinations may have been treated and documented during formal prosthodontic training.

- Residents/graduate students may challenge any one of the three parts (Part 2, 3 or 4) of Section B during the last six months (typically February) of formal prosthodontic training.
- Candidates may not challenge the Section C examination or the Section D examination until after completion of formal prosthodontics training.
- The Section C and Section D examinations **cannot** both be challenged during the same examination cycle. Once the Section C or the Section D examination has been successfully completed, that candidate may not challenge the other examination (see potential examination pathways above).
- If a candidate fails any aspect of the examination process, but remains within the six (6) consecutive years of Board eligibility, reapplication for reexamination on failed examination elements is possible.
- If a candidate has appropriately documented a patient therapy that fulfills both Section B and Section D requirements, the candidate may present this patient therapy for both Section B and Section D examinations during the same examination cycle or at different examination cycles.
- Candidates are not required to challenge any part of the

Section B examination prior to challenging Section D.

- The candidates' use of recording devices of any kind during any of the examinations is strictly prohibited. Cellular telephones, miniature recording devices, or any instrument capable of recording or transmitting information from the examination room are not permitted. Likewise, any handwritten notes made during the examination period must be provided to examiners upon completion of each examination period. Should a candidate use a recording or transmitting device during an examination period, or fail to relinquish handwritten notes made during an examination period, that individual will be disqualified from the examination in question and will forfeit all future opportunities to challenge the ABP examinations. Examination security measures consistent with industry standards and candidate compliance is monitored before, during and after all examinations.

### 2.3 CANDIDATE QUALIFICATIONS FOR EXAMINATION

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A candidate for certification examination by the ABP must:

1. Be a trained prosthodontist or be a prosthodontic resident/graduate student in the third year of formal training. Candidates must provide evidence of satisfactory completion, or anticipated completion, of advanced education in prosthodontics as defined by the Commission of Dental Accreditation of the American Dental Association or by the Commission on Dental Accreditation of the Canadian Dental Association. Advanced education in prosthodontics may be attained at a graduate level, postgraduate level, or both.
  - Participants in a graduate prosthodontics program (i.e., graduate students) undertake a planned sequence of advanced courses and clinical training leading to a master's or doctoral degree.
  - Participants in a postgraduate prosthodontics program (i.e., residents) undertake a planned sequence of advanced courses and clinical training leading to a certificate of completion in prosthodontics.
  - Prosthodontic instruction offered by graduate and postgraduate programs at recognized and accredited institutions must be consistent with CODA standards.

2. Complete the required application procedures. Formal application procedures involve submitting a completed application, including all required supplemental documentation, as described below (see 2.4 Application Procedures).

- *Prosthodontists* — Upon review of all application materials submitted by a prosthodontist and approval by the ABP, the candidate becomes Board eligible and may then enter the certification examination process.
- *Residents/Graduate Students* — A resident/graduate student in the third year of formal training may apply to challenge: (1) the Section A written examination in April of the third year of training, and/or (2) one part of the Section B patient presentation oral examination in the last six months, typically February, of formal prosthodontic training. Upon review of all application materials submitted by a resident/graduate student and approval by the ABP, the candidate is permitted to pursue the examinations requested, but will not yet possess Board eligible status. Additionally, successful completion of the Section A examination

does not automatically confer Board eligibility. Residents/graduate students may achieve Board eligible status in two ways:

*Following Formal Training* — Upon completion of formal training in a recognized and accredited prosthodontic program, an appropriately executed application for eligibility may be submitted. Board eligibility is granted upon application approval by the ABP.

*During Formal Training* — A resident/graduate student interested in challenging one part of the Section B patient presentation oral examinations (Part 2, 3, or 4) during the last six months (typically February) of formal prosthodontic training must have applied for and been granted Board eligibility by the ABP 90 days prior to the examination. Challenging one part of the Section B examination automatically extends Board eligible status for the remainder of the total six (6) year period.

## 2.4 APPLICATION PROCEDURES

Requests for application forms should be submitted to the ABP Chief Operations Officer, Bryan Mowry at the ABP office, via email (info@abpros.org), traditional letter (1000 Westgate Drive, Suite 252, Saint Paul, MN 55114), or fax (651-290-2266).

**As a prosthodontist (having completed formal training)**, applying for the Section A examination, and/or any part of the Section B (Part 2, 3, or 4), and/or Section C or Section D examination requires the following:

- Acquire the appropriate application form (Section A, Section B, Section C, and/or Section D) from the ABP Chief Operations Officer (as indicated above) and carefully complete the form(s).
- Provide proof of professional status in the form of a notarized copy of the diploma and/or certificate received at the conclusion of formal prosthodontic training.
- Provide payment for all application and examination fees (see below) in the form of a personal check (made out to “American Board of Prosthodontics”) or credit card (provide all requested credit card information on the application form).

- Forward all completed application and supplemental materials to the Chief Operations Officer at the ABP office (as indicated below).

**As a resident/graduate student in the third year of formal training**, applying for the Section A examination and/or one part of the Section B examination (Part 2, 3, or 4) requires the following:

- Acquire the appropriate application form (Section A, Section B, or both) from the Bryan Mowry at the ABP office (as indicated above) and carefully complete the form(s).
- Provide proof of training status by acquiring a letter from the Director of your formal training program indicating: (1) that you are in good standing in the program, (2) that you are currently in the third year of training, and (3) on what date your training program is expected to be completed.
- Provide payment for all application and examination fees (see below) in the form of a personal check (made out to “American Board of Prosthodontics”) or credit card (provide all requested credit card information on the application form).

- Forward all completed application and supplemental materials to the Chief Operations Officer at the ABP office (as indicated below).

The completed application form and all supplemental application materials must be forwarded to Bryan Mowry at the ABP office, via email (info@abpros.org), traditional letter (1000 Westgate Drive, Suite 252, Saint Paul, MN 55114), or fax (651-290-2266).

For questions about the examination process or logistics, not covered in these Guidelines, contact the ABP Chief Professional Officer at exams@abpros.org. **PLEASE NOTE** that ABP Directors and the ABP Chief Operations Officer will not address questions related to Section B or Section D patient selection, patient treatment, or patient examination presentation. Candidates must refer to the most current published Guidelines for the Certification Process for appropriate answers to all questions.

**PLEASE ALSO NOTE** that incomplete forms or improperly notarized documents will not be considered by the ABP. If the candidate feels that any item on the application form must be left blank or incompletely answered, a clearly detailed explanation for this lack of information must accompany the application. All copied

diplomas and certificates submitted as proof of professional status must be notarized.

**ADDITIONALLY PLEASE NOTE** that the application deadline for the Section A examination is 90 days prior to the April examination date. The application deadline for the Section B and Section C examinations is 30 days prior to the scheduled examination date.

Upon review and approval of the completed application form and all supplemental application materials by the ABP Chief Operations Officer, the candidate will receive a Letter of Eligibility as notification of certification examination status and indication of the date and location of the next examination.

## 2.5 APPLICATION, REAPPLICATION AND EXAMINATION FEES

There is an *Application for Certification* fee plus a separate *Section/Part* fee for each individual section and part of the examination. Appropriate total fees must accompany each application. The examination fee schedule is as follows:

- Application for Board Eligibility fee is \$250.
- Reapplication for Board Eligibility fee is \$250.
- Section A (computer-based written) examination or reexamination fee is \$500.



- Section B (patient presentation oral) examination or reexamination fee is \$500 **for each part** (Part 2, 3, and/or 4) challenged.
- Section C (scenario) examination or reexamination fee is \$500; this is a single fee for the entire Section C examination.
- Section D (implant) examination or reexamination fee is \$500; this is a single fee for the entire Section D examination.

The appropriate total fee must accompany applications for examination, or reexamination, at the time applications are forwarded to the ABP Chief Operations Officer. All fees must be paid in United States currency in the form of a personal check (made out to “American Board of Prosthodontics”) or credit card (provide all requested credit card information on the application form).

Candidates who withdraw from scheduled examinations less than 90 days prior to the examination date will forfeit all fees paid.

If time has expired on Board eligibility, the candidate must submit a new Application for Board Eligibility and pay a Re-application for Board Eligibility fee of \$250.

If a candidate is unsuccessful on any element of the examination process, but remains within the six (6) consecutive years of Board eligibility, re-application for reexamination on the unsuccessful element is possible and must be accompanied by the appropriate fee as listed in the fee schedule.

## 2.6 REEXAMINATION

If a candidate is unsuccessful on any element of the examination, reexamination is possible. Policies governing reexamination include the following:

- All reexaminations require the submission of new completed application, with repayment of the appropriate fees, to the ABP Chief Operations Officer.
- If a candidate provides an acceptable Section B patient presentation, but is unsuccessful in the oral phase of the examination, the candidate may be required to complete a 40-minute oral-only reexamination at a subsequent examination session. This reexamination will focus primarily on the scope of the Section B examination that was unsuccessful, but is open to questioning on all prosthodontics concepts and related sciences.
- If a candidate is unsuccessful on the patient presentation aspect of any Section

B examination, the candidate cannot pass that part of the Section B examination. In order to be reexamined on that part of Section B, the candidate is required to: (1) document, present and defend retreatment of the patient originally presented, or (2) document, present and defend a new patient treatment.

## 2.7 APPEALS PROCESS

The ABP has a formal appeals process for concerns related to administration or examination scoring only. There is no appeals process for concerns related to examination execution or candidate performance. Details related to appeals are available from the ABP Chief Operations Officer upon request.

## 2.8 REVOCATION OF CERTIFICATE

The ABP maintains the power, jurisdiction, and right to determine whether evidence placed before it is sufficient to constitute grounds for suspension or revocation of certification issued by the ABP.

## 2.9 ANNUAL FEE

The ABP issues time-limited certificates of eight (8) years duration, after which recertification is required. Holders of these certificates (i.e., Diplomates) are required to pay

an annual fee as determined by the ABP. Annual fees are payable to the ABP online at [www.abpros.org](http://www.abpros.org) or by mail to the executive director before February 1.

Certification will be revoked if the annual fee is six (6) months delinquent. Payment is the responsibility of the Diplomate. Diplomates delinquent in annual fee payment will receive final notification from the ABP Chief Operations Officer approximately one month prior to the end of the six-month delinquency period. Delinquent Diplomates will not be listed on the ABP roster, nor will they be listed on the ABP website.

## 2.10 CONTINUED PROFICIENCY OR RECERTIFICATION

Maintenance of Diplomate status requires periodic recertification. Certificates of Diplomate status are issued for eight (8) year periods. All active Diplomates are required to undergo a process of continued proficiency (i.e., recertification) involving **continuing education** and **recertification**. The following details the continued proficiency process that all Diplomates must undertake.

**Continuing Education** – All Diplomates, except for those with Life Diplomate status, must obtain at least two hun-

dred forty (240) continuing education hours over an eight (8) year period. A maximum of sixty (60) hours per year may be accumulated in fulfillment of the two hundred forty (240) point total. Points may be accrued in the following ways:

- Attendance by the Diplomate at a scientific session sponsored by a major prosthodontic organization (6 hours per day of session attendance).\*
- Attendance by the Diplomate at other courses, conferences, or meetings applicable to prosthodontics, preferably courses with “CERP” approval (hours of meeting attendance).\*
- Presentation by the Diplomate of invited professional prosthodontics lectures or study club activities related to prosthodontics (hours).\*
- Article publication by the Diplomate in peer-reviewed professional journals. Abstract publications will not be accepted for continuing education points (12 hours per article).\*
- Prosthodontic book chapter publication by the Diplomate (6 hours per chapter).\*

*\* A maximum of ninety-six (96) hours in an eight (8) year period may be accrued from article and chapter publications, professional presentations, and study club activities.*

Continuing education activity is reported on the Diplomate registration website, [www.abpros.org](http://www.abpros.org). All Diplomates are responsible for maintaining updated documentation of their continuing education activity. To periodically audit reporting accuracy, randomly chosen Diplomates are required to furnish documentation to the ABP supporting the continuing education activities reported.

**Recertification** – Since 1998, a recertification examination related to recent prosthodontic advances has been made available by the ABP for Diplomates. To satisfactorily demonstrate continued proficiency in prosthodontics, at least one (1) documented recertification examination must be successfully completed in every eight (8) year recertification period following acquisition of Diplomate status. Successful completion of the recertification examination requires that 70% or more of the test items are completed correctly.

The recertification examination can be requested online or from the ABP Chief Operations Officer, Bryan Mowry, via email ([info@abpros.org](mailto:info@abpros.org)), traditional letter (American Board of Prosthodontics, 1000 Westgate Drive, Suite 252, St. Paul, MN 55114), direct phone (651-366-6099), or secure fax (651-290-2266), by indicating the desire to challenge the reexamination.

Upon request, a package of multiple-choice questions with associated literature citations and a scorecard is forwarded to the Diplomate. The Diplomate is not expected to guess, but rather read each question, review the appropriate literature citations provided, and then enter responses on the scorecard. It is expected that the Diplomate will consult the literature citations provided in order to render informed answers. Once completed, the finalized scorecard is returned to the ABP Chief Operations Officer for evaluation. Performance results with correct answers are then returned to the Diplomate.

**PLEASE NOTE** that the ABP assumes Diplomates challenging the self-assessment examination will respect the confidentiality of the reexamination process by not reproducing or sharing the contents. Although the reexamination is presented in “open book” format, it is expected that each Diplomate completing the reexamination will do so independently and without external assistance beyond the literature citations provided. Recertification is a responsibility of the specialty of prosthodontics and each Diplomate is a representative of the specialty. Diplomates are expected to uphold the highest ethical standards of prosthodontics by not compromising the reexamination.

In summary, to satisfy continued proficiency requirements (i.e., recertification) once in every eight (8) year certification period, all Diplomates must:

1. Accumulate at least two hundred forty (240) hours of continuing education;
2. Successfully complete (score 70% or greater) at least one (1) recertification examination; and
3. Monitor (by report to the ABP) progress toward continued proficiency on a yearly basis.



# 3

## 3. Section A: Computerized Written Examination

### **3.1 SECTION A APPLICATION**

The application deadline for the Section A examination is 90 days in advance of the April examination date. A resident/graduate student may take this examination in the third year of formal prosthodontic training, prior to establishing Board eligibility. An individual whose prosthodontic education extends beyond three years may take the Section A examination in the third year of training. The resident/graduate student must provide proof of training status by acquiring a letter from the director of his/her formal training program indicating: (1) that the candidate is in good standing in the program, (2) that the candidate is currently in the third year of training, and (3) on what date the candidate is expected to be complete the training program.

### **3.2 SECTION A GENERAL INFORMATION**

The ABP Section A examination is a criterion-referenced examination constructed through the coordinated efforts of the ABP and psychometric experts. This computer-based examination is offered once a year, usually early in April, at PearsonVUE professional testing facilities located throughout the United States and internationally. Information on the computer-based testing process can be found at [www.measurementresearch.com](http://www.measurementresearch.com):

- Frequently asked questions about computer-based testing are available at <http://www.measurementresearch.com/testing/faq.shtml>.
- A sample examination demonstrating computer examination processes and test item formatting is available at <http://www.measurementresearch.com/testing/tutorial.shtml>.

The questions (i.e., test items) that constitute the Section A examination are selected and/or modified from the ABP test item database. Questions in this database are statistically qualified based on performance during past examinations. New test items are continuously developed by ABP directors and added to this database for inclusion in future Section A examinations.

The content of the examination reflects the broad scope and scientific basis for prosthodontics. Determination of and examination to the broad scope and scientific basis of prosthodontics is the responsibility of the ABP Board of Directors. The certification examination reflects, but is not limited to, the Commission of Dental Accreditation (CODA) Standards for Advanced Specialty Education Programs in Prosthodontics. Current standards may be found at [http://www.ada.org/~media/CODA/Files/2016\\_prostho.pdf?la=en](http://www.ada.org/~media/CODA/Files/2016_prostho.pdf?la=en). In addition to these areas, questions from

current professional literature in prosthodontics and related clinical, laboratory and basic sciences contribute to the ABP test item database.

This criterion-referenced examination is developed to measure the knowledge and skills of qualified candidates. Test items are carefully evaluated to verify that they: (1) measure what they purport to measure, (2) are appropriate for prosthodontic candidates, (3) minimize the amount of test error, and (4) are coherent in style and format. Those questions not meeting accepted criteria are either discarded or modified to conform to criteria. A test score from a criterion-referenced test is a measure of how well a candidate performs in relation to the test items, rather than how well a candidate performs relative to other candidates challenging the same examination.

Candidates are provided 4 hours to complete the Section A examination, which typically consists of 200 multiple-choice questions that may require review of images, diagrams, or short videos appearing with the questions.

### 3.3 SECTION A SCORING

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The examination is constructed using accepted psychometric methods and designed to identify candidates capable of achieving cognitive levels commensurate with the broad scope and scientific basis for prosthodontics. The ABP has established the criterion-referenced standard based upon acceptable knowledge and understanding. Measurement Research Associates (MRA), a division of Measurement, Inc., conducts statistical analysis of examination results based upon established examination parameters. A candidate's test score is a measure of how well that candidate performed in relation to the test items, rather than a performance comparison of candidates challenging the same examination. The ABP Chief Operations Officer communicates examination results to candidates after ABP approval of the statistical report developed by MRA.

## 4. Section B: Treatment-Based Presentations and Oral Examinations

# 4

For questions about the examination process or logistics that are not covered in these Guidelines, contact the ABP Chief Professional Officer at [exams@abpros.org](mailto:exams@abpros.org). **PLEASE NOTE**, ABP and its Directors will not address questions related to Section-B patient selection, patient treatment decisions, or patient examination presentation. Candidates must refer to the most current published “Guidelines for the Certification Process” for appropriate answers to all questions. The American Board of Prosthodontics will not provide guidance regarding specific therapies. Determination, justification, and defense of specific therapies and all related matters are the responsibility of the candidate during the examination.

### 4.1 SECTION B GENERAL INFORMATION

The **ABP Section B** examination consists of a series of three (3) distinct, candidate-generated patient

treatment presentations with oral examinations. The three distinct parts of the Section B examination are designated Part 2, Part 3, and Part 4. Board eligible candidates may take any or all parts of this examination in any order, at any of the examination sessions. In addition to successful completion of the Section A examination, a candidate may elect to challenge all three parts of the Section B examination, or the candidate may elect to challenge any two parts of the Section B examination plus either the Section C (scenario-based oral) examination or the Section D (implant-based patient presentation oral) examination to complete the certification process.

Each part of the Section B examination is conducted over a 1-hour time period. The examination begins with an uninterrupted, 20-minute, patient-treatment presentation given by the candidate, immediately followed by a 40-min-

ute (approximate) oral examination conducted by a team of two ABP examiners.

Section B patient presentations must be developed by candidates as PowerPoint or Keynote presentations (PDF files are not acceptable). Prior to the examination, candidates will submit presentation and narrative files to the ABP on a virus-free USB drive. The candidate is responsible for confirming USB drive compatibility with an Apple computer. Failure to submit the presentation and narrative in proper format will result in candidate disqualification and forfeiture of the examination fee. Specific instructions for USB drive submission will be provided to candidates prior to the examination date. Radiographs, as required by ABP Guidelines, may be either film or digital, but must be of exceptional resolution and quality. Once submitted, the USB drive, its contents, and radiographs become the property of the Board and may be used as material for future ABP examinations.

During examinations, presentations are made using an ABP laptop (Apple) computer connected to an ABP monitor provided in the examination room. All digital images presented by candidates must be original images with **no alterations except peripheral cropping**. Presentation of images with unauthorized alterations (including but not limited to “instant alpha” or similar, background elimination, or like manipulations) will result in automatic disqualification of the candidate and result in forfeiture of the examination fee.

Each candidate must complete at least four (4) dental implants supporting fixed restorations in one or any combination of the patient treatments within the Section B examination. Either photographic images or dental casts (gypsum, printed, or milled) replicating all abutments for cement-retained implant restorations must be included in presentations that involve implant treatment.

All laboratory work for one of the patient treatments in the Section B examination must be performed by the candidate, with the exclusion of removable partial denture framework fabrication that may be performed by a dental laboratory technician. At the examination, the candidate will indicate, in writing on an ABP form, the

part of the Section B examination in which all laboratory work was personally accomplished. Laboratory technicians may be used to aid in fabrication of prostheses in other patient presentations. Candidates must have a thorough understanding of laboratory procedures and are responsible for the outcome of laboratory procedures in the completed treatment. Laboratory work authorization forms must be presented for both the fixed and removable prosthodontic laboratory work completed by a dental laboratory technician.

For all indirect coronal restorations, retention and resistance form of tooth preparations must be appropriately provided by sound tooth structure and minimally dependent on mechanically anchored core material. The strategic presence of sound tooth structure is necessary to establish adequate preparation resistance and retention form. Therefore:

- Reliance on dentin bonding as the sole means of **core retention** is unacceptable.
- Reliance on dentin bonding as the sole means of **coronal restoration retention**, in the absence of sound preparation retention and resistance form, is unacceptable.
- Adequate ferrule must be demonstrated photographically.

The candidate must remove all carious lesions and replace all existing restorations associated with fixed prosthodontic foundations. Candidates must be prepared to justify foundation restoration selection and design, as well as the physical and chemical properties of the restorative materials used.

Candidates must perform all clinical prosthodontic and restorative procedures for all Section B patient treatments. **Candidates are responsible for comprehensive patient care, and will be evaluated on the quality of diagnosis, treatment planning, alternative treatment considerations, and treatment provided to the patient, including justification of all care provided and/or not provided by other dentists.**

Candidates must be prepared to justify treatment rendered and techniques/materials used, as well as rationale for not managing pre-existing conditions and restorations if such is the case. Patient treatments will serve as the primary focus of the oral examination. However, questioning may include principles and concepts related to the broad scope of prosthodontics.

With regard to dental casts and articulation:

- Magnetic mounting plates are the required method for securing casts to articula-



tors for all patient presentations.

- All articulated diagnostic, working, and definitive casts must be accompanied by the articulator used during patient treatment.
- All physical dies and working casts (printed, milled, or cast) associated with the fabrication of fixed prosthodontics restorations must be available during the examination and properly mounted in a physical (not virtual) articulator.

### Digital Prosthodontics

Digital technologies may be used during the treatment of patients presented for Section B examinations. When implemented, the selection of any digital technology and its application must be consistent with specialty level prosthodontic patient management. All Section B examinations are assessed using ABP evaluation categories and criteria. Candidates must be prepared to provide evidence-based support for any patient treatment methods used, digital or otherwise.

The following guidelines must be considered when digital technologies are used during the treatment of patients presented for Sections B examination. All required documentation for the Section B examinations remains the same,

regardless of the incorporation of digital processes.

- It is appropriate that the candidate consider application of digital technology during patient management when such technology: (1) augments otherwise available diagnostic information and diagnostic assessment, and/or (2) when it improves therapeutic logistics and/or quality of care. Depending on patient needs, this may include, but not be limited to, procedures associated with diagnosis, virtual planning, implant placement, interim restoration, definitive prosthodontic care, and maintenance.
- Intraoral or laboratory digital surface scan technology must be selected and applied in a manner consistent with optimal fabrication of clinically acceptable interim and definitive prostheses.
- When digital surface scans are used to render definitive information for examination, diagnosis, treatment planning, and/or direct patient care, Section B documentation requirements must be satisfied with diagnostic quality physical casts (printed, milled, or cast) appropriately mounted in a physical (not virtual) articulator.
- Physical (not virtual) articulation using a programmed physical (not virtual) articulator is the standard for

assessing definitive occlusal relationships for all ABP examinations. Articulation presented on the physical casts must visually correspond to all required clinical images presented during the examination.

- Digital complete denture protocols may be used for the Section B, Part 4 examination. However, physical (not virtual) casts must be presented to satisfy all applicable requirements of the Section B, Part 4 examination. Physical (not virtual) trial dentures must be present in all required clinical and laboratory images and articulations.

### Section B, Part 2

The Section B, Part 2 examination focuses on therapy involving a removable partial denture in either arch and at least four (4) crowns that restore natural teeth in either arch. A removable partial obturator prosthesis may fulfill the removable partial denture requirement. **NOTE:** Presentation of maxillofacial prosthetics patients in both Part 2 and Part 4 is not permitted. Unless clinically indicated, it is not required that the fixed prosthodontic crown restorations serve as abutments for the removable partial denture. Implants supporting removable partial overdentures do not fulfill the global ABP requirement for “4 implants

supporting fixed restorations.” Patient treatment for the Part 2 examination cannot include a complete denture or complete overdenture. Removable partial overdentures supported by natural teeth or dental implants may be included.

### Section B, Part 3

The Section B, Part 3 examination focuses on therapy incorporating fixed prosthodontic treatment comprising at least fourteen (14) fixed prosthodontics units restoring articulating occlusal surfaces. At least six (6) of the fixed prosthodontics units must restore natural teeth.

### Section B, Part 4

The Section B, Part 4 examination focuses on therapy using a complete denture, complete overdenture, or complete denture obturator prosthesis to restore one arch. Specifically, removable prosthodontic options for this examination include any of the following:

- Complete denture opposing a complete denture
- Complete denture or complete overdenture opposing an overdenture (overdentures may be supported and/or retained by natural teeth or dental implants)
- Complete denture, complete overdenture, or complete obturator prosthesis

opposing natural teeth or any method of restoring the opposing arch

The patient’s opposing arch may consist of any combination of natural unrestored or restored teeth, implant restorations, or removable prostheses. The candidate is responsible for, and will be evaluated on, comprehensive care of the patient. As such, dental restoration of the opposing arch, and dental therapy provided or required in the opposing arch, are the responsibility of the candidate.

All complete arch removable prostheses fabricated for the Part 4 examination **MUST demonstrate bilateral (cross-arch) balanced articulation.**

Presentation of maxillofacial prosthetic patients in **both** Part 2 and Part 4 is not permitted.

Implants supporting overdentures will not fulfill the global ABP requirements for “4 implants supporting fixed restorations.”

## 4.2 SECTION B PRESENTATION FORMATS

Each Part of the Section B examination is conducted over a 1-hour time period. The examination begins with an uninterrupted, 20-minute, patient-treatment presentation developed and presented

by the candidate, immediately followed by a 40-minute (approximate) oral examination conducted by a team of two ABP examiners.

Section B patient presentations are developed by candidates as PowerPoint or Keynote presentations. Prior to the examination, candidates will submit to the ABP their presentation and narrative files on a portable USB flash drive. The candidate is responsible for confirming USB drive compatibility with an Apple computer. Failure to submit the presentation and narrative files in proper format will result in candidate disqualification and forfeiture of the examination fee. Specific instructions for USB drive submission will be provided to candidates prior to the examination date. Radiographs, as required by these Guidelines, may be either film or digital, but must be of exceptional resolution and quality. Once submitted, the USB drive, its contents, and radiographs become the property of the Board and may be used as material for future ABP examinations.

During examinations, presentations are made using an ABP laptop (Apple) computer connected to an ABP monitor provided in the examination room. All digital images presented by candidates must be original images with **no alterations except peripheral cropping.** Presen-

tation of images with unauthorized alterations (including but not limited to “instant alpha” or similar, background elimination, or like manipulations) will result in automatic disqualification of the candidate and forfeiture of the examination fee.

Oral Section B patient presentations must be presented in the following order:

1. Health History and Chief Complaint
2. Clinical Findings
3. Diagnosis
4. Treatment Plan
5. Treatment
6. Completed Treatment
7. Prognosis, Outcomes and Maintenance Plan

Digital presentations should be populated by well composed, properly focused, color images. There is no limit to the number of images that can be included in the presentation, but candidates must complete their verbal/visual presentation within the allotted 20-minute time period. **Only one image may be included per screen** with exceptions noted below. All digital images presented by candidates must be original images with **no alterations except peripheral cropping**. Presentation of images with unauthorized alterations (including but not limited to “instant alpha” or similar, background elimination, or like manipulations) will result in automatic disqualification of

the candidate and forfeiture of the examination fee.

### For Section B, Part 2 and Part 3 examinations

Candidates must provide the following to the ABP:

- The original PowerPoint or Keynote patient treatment presentation (PDF files will not be accepted)
- The narrative (Microsoft Word or Pages for Mac format)
- A complete series of periapical and bitewing radiographs depicting post-treatment conditions of teeth and implants
- A copy of all dental laboratory authorization forms

### Required Images for Part 2 and Part 3

At minimum, images for the Part 2 and Part 3 treatments must clearly show:

1. Pre-treatment
  - Full-head (patient’s eyes blocked out), upright posture, repose (front and profile views)
  - Full-head (patient’s eyes blocked out), upright posture, smile (front and profile views)
  - Teeth in maximal intercuspal position (front, left side, and right side views)
  - Teeth in laterotrusion and mediotrusion (left side and right side views)
  - Teeth in protrusion (front, left side, and right side views)

- Maxillary and mandibular arches (occlusal views)
- Complete mouth periapical and bitewing radiographs
- Panoramic radiograph
- For Part 2 presentations, if the patient is edentulous in one arch, the maximal intercuspal position, laterotrusion, mediotrusion and protrusion images should be made with the pre-existing complete denture prosthesis in place. If the patient presented with no complete denture prosthesis, these images are not required.

2. Treatment
  - Tooth preparations (occlusal view)
  - Tooth preparations (front, left side, and right side views)
  - Interim restorations (front, left side, and right side views)
  - Final impressions
3. Post-Treatment
  - Same series of images as defined for pre-treatment above
  - At the end of the presentation, include 4 slides depicting a series of full-head images (patient’s eyes blocked out) arranged as follows:
    - a) Slide 1: side-by-side (pre-treatment and post-treatment), repose, front views
    - b) Slide 2: side-by-side (pre-treatment and post-treatment), repose, profile views

- c) Slide 3: side-by-side (pre-treatment and post-treatment), smile, front views
- d) Slide 4: side-by-side (pre-treatment and post-treatment), smile, profile views

#### Required Images for Part 4

Images for removable prosthodontic treatment must clearly show at minimum:

1. Pre-Treatment
  - Full-head (patient's eyes blocked out), upright posture, repose, no dental prosthesis (front and profile views); if the patient was wearing removable dental prostheses when they presented for treatment, provide the same images with those prostheses in place.
  - Full-head (patient's eyes blocked out), upright posture, smile, no dental prosthesis (front and profile views); if the patient was wearing removable dental prostheses when they presented for treatment, provide the same images with those prostheses in place.
  - Maxillary and mandibular edentulous or partially edentulous ridges (occlusal views)
  - Maxillary and mandibular ridges at approximate occlusal vertical dimension (front view)
2. Treatment
  - Complete mouth periapical radiographic series or panoramic radiographic
  - Border molded impression trays (intaglio surface view)
  - Final impressions (intaglio surface view)
  - The intraoral technique and materials used to record maxillomandibular relationships (front, left side, and right side views)
  - Trial denture on articulator (front, left side, right side, maxillary occlusal, and mandibular occlusal views)
3. Post-Treatment
  - Maxillary and mandibular arches without the prosthesis (occlusal views), if implants or natural teeth are present
  - Completed prostheses (intaglio surface views)
  - Prostheses in place, teeth in maximal intercuspal position (front, left side, and right side views)
  - Laterotrusion and mediotrusion (left side and right side views)
  - Teeth in protrusion (front, left side, and right side views)
  - At the end of the presentation, include 4 slides depicting a series of full-head images (patient's eyes blocked out) arranged as follows:
    - a) Slide 1: side-by-side (old prostheses, no prostheses, new prostheses), repose, front views
    - b) Slide 2: side-by-side (old prostheses, no prostheses, new prostheses), repose, profile views
    - c) Slide 3: side-by-side (old prostheses, no prostheses, new prostheses), smile, front views
    - d) Slide 4: side-by-side (old prostheses, no prostheses, new prostheses), smile, profile views

**IMPORTANT NOTE:** If the patient presents for treatment and does not possess, or is not wearing removable prostheses, all images requiring existing (or "old") removable prostheses to be in place, are not required.

#### Required Casts and Dies

The following casts and dies must be presented:

1. Removable Partial Prosthodontic and Fixed Prosthodontic Treatments
  - Pre-treatment and post-treatment articulated casts
  - Articulated casts with diagnostic patterns
  - Articulated working casts/dies
  - Duplicate master cast for RPD framework fabrication with RPD design

- drawn on cast (must be surveyed and tripoded)
2. Removable Complete Prosthodontic Treatment
    - Pre-treatment articulated casts of edentulous or partially edentulous ridges at the occlusal vertical dimension
    - Post-treatment articulated casts of completed prostheses
    - Duplicate master casts
    - Working casts/dies for any fixed prosthodontic restorations used in conjunction with the removable prosthodontic treatment

All articulated diagnostic, working, and definitive casts must be accompanied by the articulator used during patient treatment. All dies and working casts (gypsum, printed, or milled) used to fabricate fixed prosthodontic restorations must be available during the examination and properly mounted in the articulator used for restoration fabrication. If digital workflow is used, articulated gypsum, milled, or printed casts and dies must be presented.

### Required Radiographic Images

Radiographs may be film-based or digital images, must be of high resolution, exceptional diagnostic quality, and must include:

- Mounted periapical and bitewing pre-treatment and post-treatment complete mouth radiographs/images of all teeth and implants
- Panoramic radiograph (pre-treatment and post-treatment)

All images become the property of, and will be retained by, the ABP.

Missing documents, images, radiographs, records, articulators, casts, dies, or any other materials required by the ABP will result in immediate disqualification from the examination and forfeiture of the examination fee.

### 4.3 SECTION B GRADING

Successful completion of Part 2, 3, or 4 of Section B requires acceptable performance in all three categories: (1) patient presentation, (2) general prosthodontics, and (3) related dental sciences. All candidates are scored according to published criteria that include both major and minor categories. Major categories are scored on a numerical scale of 1 to 5 (1 being superior performance). Minor categories are scored from 2 to 4 (2 being superior performance). Examination failure occurs when the candidate receives any of the following:

- a single (1) score of 5 in a major category;

- two (2) scores of 4 in major categories; or
- four (4) scores of 4 in any categories.

After all candidates have been examined, the Board meets in executive session to consider each candidate. Candidate anonymity is maintained throughout the process. Each examination team provides a “pass” or “defer” performance evaluation for each of the candidates examined based on published criteria. For deferred candidates, a review of patient documentation, presentation and oral examination is provided to the entire Board by the examiner team that conducted the oral examination in question.

Following thorough discussion of a deferred candidate, each member of the Board registers an anonymous vote of “pass” or “fail.” No candidate can fail the examination based exclusively on the opinion of one examiner or one examination team. A simple majority of examiners must reach consensus before a candidate is determined to have failed the Section B examination. In the event of a tie vote, the candidate passes the examination.

A candidate who provides a satisfactory patient presentation during a Part 2, 3, or 4 examination, but performs

unsatisfactorily on the oral examination, will be required to return to a future examination session to complete a 40-minute **comprehensive oral-only examination on general prosthodontics and related sciences.**

#### 4.4 SECTION B EVALUATION CATEGORIES

As part of the examination process, candidates are expected to provide comprehensive assessment of existing oral conditions and appropriate referrals for necessary therapy when indicated. Additionally, candidates must assess outcomes of all referred therapy and ensure that it was accomplished at a satisfactory level. Candidates are responsible for, and will be evaluated on, comprehensive patient management including justification of all care provided and/or not provided by other clinicians. Failure to comprehensively manage patients in this manner will result in failure of the examination.

##### 4.4.1 EVALUATION CATEGORIES: SECTION B, PART 2 TREATMENT

- Records
- Patient Presentation
- Fixed Prosthodontics/Natural Teeth
- Fixed Prosthodontics/Implants
- Removable Partial Denture/Overdenture Prosthodontics

- Maxillofacial Prosthodontics
- Occlusion
- Prognosis, Outcomes and Maintenance Plan
- Work Authorization Form(s)
- Oral Examination

##### 4.4.2 EVALUATION CATEGORIES: SECTION B, PART 3 TREATMENT

- Record
- Patient Presentation
- Fixed Prosthodontics/Natural Teeth
- Fixed Prosthodontics/Implants
- Removable Prosthodontics/Implants
- Occlusion
- Prognosis, Outcomes and Maintenance Plan
- Work Authorization Form(s)
- Oral Examination

##### 4.4.3 EVALUATION CATEGORIES: SECTION B, PART 4 TREATMENT

- Record
- Patient Presentation
- Fixed Prosthodontics/Natural Teeth
- Fixed Prosthodontics/Implants
- Removable Prosthodontics/Implants
- Removable Partial Denture/Overdenture Prosthodontics
- Complete Denture/Overdenture Prosthodontics

- Maxillofacial Prosthodontics
- Occlusion
- Prognosis, Outcomes and Maintenance Plan
- Work Authorization Form(s)
- Oral Examination

#### 4.5 SECTION B EVALUATION CATEGORIES WITH CRITERIA

##### 4.5.1 RECORDS

###### MINOR CATEGORY:

###### Pre-operative Radiographs, Casts, Dies and Photographs

###### Level 2

Pre-operative radiographs are originals, properly processed and mounted with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely articulated and accurately reproduce oral structures. Casts are free of any elements that would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.

###### Level 3

Radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements though with less than ideal contrast and sharpness.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

Radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely articulated. Casts are porous, dirty. The articulated casts are not smooth and neat. Articulation instrument is inadequately programmed or inappropriately used. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

#### MINOR CATEGORY:

#### Post-operative Radiographs, Casts, Dies and Photographs

##### Level 2

Post-operative radiographs are originals properly processed and mounted with no evidence of cone articulated and accurately reproduce oral structures. Casts are free of any elements which would introduce error. Photographs conform to size requirements and have been properly exposed and printed. All required views are present.

##### Level 3

Post-operative radiographs are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements with less than ide-

al contrast and sharpness.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

Post-operative radiographs are improperly processed and mounted. Cone cuts, distortions, improper film placement or apical “cut off” seriously compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely articulated. Casts are porous, dirty. The articulated casts are not smooth and neat. Photographs exhibit poor contrast and sharpness. One or more required views are missing.

#### 4.5.2 PATIENT PRESENTATION

#### MINOR CATEGORY:

#### History and Clinical Examination

##### Level 2

History records chief complaint, an account of current problems, past history of dental and general health, family history, personal history and a review of systems. Clinical examination includes a general survey of patient condition, examination of the head and neck, examination of soft tissues of the mouth, and detailed information gained from a comprehensive dental examination.

##### Level 3

History is adequate though in-depth coverage of some elements is marginal. Clinical examination is adequate though some aspects of the examination are marginally covered.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

Dental history is not organized and fails to elicit pertinent information. Omissions compromise the formulation of an accurate diagnosis. Clinical examination is deficient resulting in a lack of needed diagnostic information.

#### MAJOR CATEGORY:

#### Diagnosis and Treatment Plan

##### Level 1

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

##### Level 2

Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment plan is organized and chronologically sequenced to prevent and correct oral disease.

##### Level 3

Diagnosis is adequate though method used to formulate it is questionable. Treatment plan is marginally adequate but not well organized.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Diagnosis is incomplete, inappropriate, or not supported by clinical findings. Treatment plan is inappropriate. Treatment plan is incomplete, inappropriate, not supported by clinical findings, not organized or improperly sequenced.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

Diagnosis is incomplete, inappropriate, or not supported by clinical findings. Treatment plan is inappropriate. Treatment plan is incomplete, inappropriate, not supported by clinical findings, not organized or improperly sequenced.

### 4.5.3 FIXED PROSTHODONTICS/NATURAL TEETH

#### MAJOR CATEGORY: Overall Design Concept

**Level 1**

All basic components of accepted design concepts have been addressed and optimally applied.

**Level 2**

All basic components of accepted design concepts have been considered, but some aspect of the design may be considered controversial.

**Level 3**

Most basic components of accepted design concepts have been considered and those not addressed have been justified upon oral examination.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Some of the basic components of accepted design concepts have not been considered or addressed.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

Most basic components of accepted design concepts have not been considered or addressed. Components not addressed cannot be justified in the light of current knowledge.

#### MAJOR CATEGORY: Abutment Preparation

**Level 1**

Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Finish line design and location are optimal for the preparation. Finish of the preparation displays finesse.

**Level 2**

Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. Finish line design and location are generally adequate but not

optimal. Finish of the preparations generally is adequate but not optimal.

**Level 3**

Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Finish line design or location is questionable. Finish of the preparations is marginally adequate.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Preparation is over or under reduced. Retention or resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate. Adjacent teeth were damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

Preparation is over or under reduced. Retention or resistance form is lacking or ill-defined. Finish line design or location is inappropriate. Undercut(s) present, not recognized. Preparation finish is inadequate. Adjacent teeth were damaged. Existing restorations that have deficiencies were not removed/replaced prior to or in conjunction with tooth preparation.



### **MINOR CATEGORY: Interim Restorations**

#### **Level 2**

The interim restorations are esthetic, well contoured, with proper fit, proper occlusion, and are not irritating to the tissues.

#### **Level 3**

The interim restorations are generally acceptable but differences exist in esthetics, occlusion, contour, or tissue reaction.

#### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

The interim restorations are poorly contoured, unesthetic, lack proper fit, are irritating to the tissues, or lack adequate occlusion. Interim restoration was not integrated into comprehensive care.

### **MINOR CATEGORY: Pontic(s)**

#### **Level 2**

Pontic type, contour, and/or tissue relationship are well designed. Patient presentation clearly demonstrates appropriateness of pontic design.

#### **Level 3**

Pontic type, design, contour, and/or tissue relationship are marginally acceptable.

#### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

There are inadequacies in pontic design, contour, and/or tissue relationships. Demonstration of the appropriateness of pontic design is not available in the patient presentation.

### **MINOR CATEGORY: Other Restorative Procedures**

#### **Level 2**

Restorative materials are appropriately selected and applied. Restorative margins are properly designed and well adapted. Restoration contours are physiologic and appropriate. Post and cores are adequately dimensioned, designed, and applied (if employed).

#### **Level 3**

Restorative materials, margin design/adaptation/contours, and post and core dimensions and applications are marginally acceptable.

#### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

Other restorative procedures are poorly integrated into comprehensive patient care. Restorative material selection and application are inappropriate for existing conditions. Restorative margins are improperly designed or poorly adapted. Restorative contours are inappropriate and non-physiolog-

ic. Post and core dimensions, designs and applications are inappropriate.

### **MAJOR CATEGORY: Completed Restorations**

#### **Level 1**

Restoration is physiologically compatible and well integrated with other elements of care. Completed restorations appear esthetic.

#### **Level 2**

Restoration is generally physiologically compatible and integrates with other elements of care, but exhibits some compromise. Completed restorations appear esthetic.

#### **Level 3**

Restoration is physiologically marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care are considered, but desired integration is lacking. Completed restorations are not consistent with accepted esthetic standards.

#### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

Adverse outcomes may potentially occur. Physiologic or esthetic integration with other elements of care is lacking.

Level 5 (more than one aspect from the following constitute Level 5 performance)

Adverse outcomes have occurred. Physiologic integration with other elements of care is lacking. Esthetic appearance of completed restorations is unacceptable.

#### 4.5.4 FIXED PROSTHODONTICS/IMPLANTS

##### MAJOR CATEGORY: Overall Design Concept

###### Level 1

All basic components of accepted design concepts have been addressed and optimally applied.

###### Level 2

All basic components of accepted design concepts have been considered, but some aspect of the design may be considered controversial.

###### Level 3

Most basic components of accepted design concepts have been considered and those not addressed have been justified upon oral examination.

Level 4 (any one aspect from the following constitutes Level 4 performance)

Some of the basic components of accepted design concepts have not been considered or addressed.

Level 5 (more than one aspect from the following constitute Level 5 performance)

Most basic components of accepted design concepts have not been considered or addressed. Components not addressed cannot be justified in the light of current knowledge.

##### MAJOR CATEGORY: Implants and Implant Abutments

###### Level 1

An appropriate number of implants (and associated abutments) of proper length and diameter have been well placed in the edentulous area, demonstrating excellent adaptation (implant to abutment and/or restoration) and appear to be physiologically compatible.

###### Level 2

An appropriate number of implants (and associated abutments) with generally adequate length and diameter have been placed in the edentulous area, demonstrating adequate adaptation (implant to abutment and/or restoration) and appear to be physiologically compatible.

###### Level 3

The number, length, diameter, placement of the implants (and associated abutments) is marginal but they appear to be physiologically compatible.

Level 4 (any one aspect from the following constitutes Level 4 performance)

The number, length, diameter, placement of the implants (and associated abutments) is unacceptable and that may affect their physiologic compatibility. There is soft tissue inflammation (peri-implant mucositis) that may be the result of retained cement, inadequate abutment contour, or other factors.

Level 5 (more than one aspect from the following constitute Level 5 performance)

The number, length, diameter, distribution of the implants (and associated abutments) is unacceptable and/or the implants appear to not be physiologically compatible. There is soft tissue inflammation and bone loss (peri-implantitis) that may be the result of retained cement, inadequate abutment contour, or other factors.

##### MINOR CATEGORY: Pontic(s)

###### Level 2

Pontic type, contour, and/or tissue relationship are well designed. Patient presentation clearly demonstrates appropriateness of pontic design.

###### Level 3

Pontic type, design, contour, and/or tissue relationship are marginally acceptable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

There are inadequacies in pontic design, contour, and/or tissue relationships. Demonstration of the appropriateness of pontic design is not available in the patient presentation.

#### **MAJOR CATEGORY: Completed Restorations**

##### **Level 1**

Restoration is physiologically compatible and well integrated with other elements of care. Completed restorations appear esthetic.

##### **Level 2**

Restoration is generally physiologically compatible and integrates with other elements of care, but exhibits some compromise. Completed restorations appear esthetic.

##### **Level 3**

Restoration is physiologically marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care are considered, but desired integration is lacking. Completed restorations are not consistent with accepted esthetic standards.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Adverse outcomes may potentially occur. Physiologic or esthetic integration with other elements of care is lacking.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

Adverse outcomes have occurred. Physiologic integration with other elements of care is lacking. Esthetic appearance of completed restorations is unacceptable.

#### **4.5.5 REMOVABLE PARTIAL DENTURE/OVERDENTURE PROSTHODONTICS**

#### **MINOR CATEGORY: Overall Design Concept as Defined on Surveyed Cast**

##### **Level 2**

All basic components of accepted design have been addressed on a surveyed cast for edentulous and the dentate areas.

##### **Level 3**

Most basic components of accepted design have been addressed on a surveyed cast for both the edentulous and dentate areas. Those components not addressed might be justified upon oral examination. Specific aspects of the design implemented may be controversial.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Basic components of accepted design have not been addressed on a surveyed cast for edentulous and the dentate areas. The design implemented is clearly controversial.

#### **MINOR CATEGORY: Clasp Assemblies**

##### **Level 2**

An acceptable number of clasp assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation, and support.

##### **Level 3**

The type, number, and placement of most clasp assemblies are adequate, but at least one clasp assembly is inappropriate in type and/or placement.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The type, number, and placement of most clasp assemblies are unacceptable.

#### **MAJOR CATEGORY: Rest Seats and Rests**

##### **Level 1 and 2**

Occlusal, cingulum, or incisal rests and rest seats have been properly prepared, located and fabricated to facilitate optimal prosthesis support.

##### **Level 3**

Most of the occlusal, cingulum, or incisal rests and rest seats have been properly prepared, located and fabricated to facilitate optimal prosthesis support.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Most of the occlusal, cingulum, or incisal rests or rest seats have been improperly prepared, located or fabricated providing suboptimal prosthesis support.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Most of the occlusal, cingulum, or incisal rests or rest seats have been improperly prepared, located or fabricated providing suboptimal prosthesis support.

**MINOR CATEGORY:  
Retention/Reciprocation**

**Level 2**

Reciprocating and retentive components of all clasp assemblies have been acceptably placed to facilitate tooth stability while the prosthesis is placed and removed. The material used and the contours of the reciprocating and retentive components are proper for the type of prosthesis.

**Level 3**

Reciprocating and retentive components of some clasp assemblies have been acceptably placed to facilitate tooth stability while the prosthesis is placed and removed. The material used and the contours of the reciprocating and retentive components are marginal for the type of prosthesis.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

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

**MINOR CATEGORY:  
Indirect Retainer(s)**

**Level 2**

An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.

**Level 3**

An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line or is less than optimal from a rest seat position/preparation standpoint.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

An indirect retainer(s) has not been placed to resist rotation around the fulcrum line, or the prosthesis lacks elements to resist rotation occlusally around the fulcrum line. The size of the indirect retainer is inadequate or is less than optimal from a rest seat position/preparation standpoint.

**MAJOR CATEGORY:  
Major Connector Selection/  
Placement/Size**

**Level 1 and 2**

The major connector selection is appropriate, it is placed within the scope of acceptable principles, appears to be rigid, and will provide adequate stabilization and support to the prosthesis and remaining oral structures.

**Level 3**

The major connector is acceptable, it appears to be rigid, but the placement and selection are questionable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Aspects of major connector selection, placement and/or rigidity are inadequate.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Aspects of major connector selection, placement and/or rigidity are inadequate.

**MINOR CATEGORY:  
Base(s) Coverage/Contour**

**Level 2**

The denture bases are extended and contoured properly within physiologic limits facilitating maximum stability and support for the prosthesis. Denture base contour is appropriate.

**Level 3**

Denture base extension and contour are marginally acceptable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Denture bases are over-extended or under-extended and denture base contour is inappropriate.

**MINOR CATEGORY:****Denture Finish, Contour and Esthetics****Level 2**

Denture base resin exhibits no porosity. Cameo denture surface is highly polished, properly contoured, free of scratches, and free of plaster inclusions. Stippling, if present, is appropriately textured and positioned. Denture base color is appropriate for the patient. Adjusted occlusal surfaces have been restored to a high polish. Completed restorations appear esthetic.

**Level 3**

Denture base resin exhibits minor areas of porosity. Cameo surfaces of dentures contain minor scratches and blemishes. Limited gypsum inclusions are apparent. The cameo denture surface is over or under contoured. Denture base color is acceptable for the patient. Occlusal surfaces of modified denture teeth may not be polished. Completed restorations

are not consistent with accepted esthetic standards.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Denture base resin is porous throughout. Cameo surfaces of denture have numerous scratches and blemishes. Significant gypsum inclusions are apparent. The cameo denture surface is significantly over or under contoured. Denture base color is inappropriate for the patient. Occlusal surfaces of modified denture teeth are irregular and not polished. The denture base or denture teeth have been fractured and not repaired or inadequately repaired. Esthetic appearance of completed restorations is unacceptable.

**MAJOR CATEGORY:****Abutment Restoration(s)****Level 1**

Abutment restorations have good margin integrity, incorporate appropriate material, and demonstrate survey contours that permit placement of retainer assemblies.

**Level 2**

Abutment restorations have good margin integrity, incorporate appropriate material, but demonstrate less than ideal survey contours for the chosen retainer assemblies.

**Level 3**

Abutment restorations lack ideal margin integrity. Material used or survey contours present are less than ideal for properly designed retainer assemblies.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Abutment restorations lack margin integrity. Materials used or contours present are inadequate for properly designed retainer assemblies.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

Abutment restorations lack margin integrity. Materials used or contours present are inadequate for properly designed retainer assemblies.

**4.5.6 COMPLETE DENTURE/NATURAL TOOTH OVERDENTURE PROSTHODONTICS****MAJOR CATEGORY:****Overdenture/Natural Tooth Abutment Preparations (without copings)****Level 1**

Reduction is optimal. Contours are smooth with no undercuts. Occlusal or incisal restorations sealing the root canal and tooth surfaces are smooth and polished. Margins are supragingival with no ledging. Casts clearly document all of these requirements.

**Level 2**

Reduction is generally adequate though not optimal. Occlusal or incisal restorations sealing the root canal are generally smooth and polished. Margins are supragingival with areas slightly roughened. Casts clearly document these requirements.

**Level 3**

Reduction is marginally acceptable with abutment(s) being over or under reduced. Occlusal or incisal restorations sealing the root canal and abutment surface are not smooth. Margins are mostly supragingival though some are subgingival. Casts marginally document requirements.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Abutments have been over or under prepared to an extent that will compromise treatment outcome. Occlusal or incisal restorations and abutment surfaces are rough and poorly contoured. Significant portions of the margins are subgingival leaving marginal gingiva unsupported. Casts do not document requirements.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Abutments are over or under reduced decidedly compromising treatment outcome. Abutment restorations and surfaces

are very rough and poorly contoured. Most margins are subgingival resulting in unsupported marginal gingiva.

**MAJOR CATEGORY:  
Overdenture/Natural Tooth  
Abutment Preparations (for  
copings)****Level 1**

Reduction is optimal for restorative material. The retention form is optimal. The resistance form has been incorporated. Margin design is optimal for the preparation. Finish of the preparation displays finesse.

**Level 2**

Reduction is generally adequate but not optimal. The retention form is generally adequate but not optimal. The resistance form is generally adequate but not optimal. Margin design is generally adequate but not optimal. Finish of the preparations generally is adequate but not optimal.

**Level 3**

Reduction is marginally acceptable. The retention and resistance forms are marginally acceptable. Margin design is questionable. Finish of the preparations is marginally adequate.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Preparation is over or under reduced. Retention and resis-

tance form is lacking or ill-defined. Margin design is inappropriate. Preparation finish is inadequate.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Reduction, retention, resistance form, margin design, and/or finish of the preparations are inadequate.

**MAJOR CATEGORY:  
Completed Overdenture  
Abutment Restorations****Level 1**

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

**Level 2**

Restoration is generally physiologically compatible and integrates with other elements of care but exhibits some compromising aspects.

**Level 3**

Restoration is marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

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

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Neglect of integration with other elements of care is evident. Future damage to surrounding tissues is very likely to occur or damage has occurred.

**MAJOR CATEGORY:  
Maxillary Impression**

**Level 1**

The impression borders extend into the vestibule without impinging on movable tissue. The surface of the impression accurately reproduces the anatomy of the supporting tissues. The posterior extension of the impression includes the soft tissue overlying the pterygomaxillary fissure and the posterior junction of the hard and soft palate.

**Level 2**

The border extensions are generally acceptable. There are some localized areas of over extension that can be corrected. The impression records the anatomy of the supporting tissues. The posterior extension includes the anatomic guides.

**Level 3**

Some of the border extensions are generally acceptable with local areas of over or under extension. The impression records the anatomy of the tissues. The posterior extension of the impression includes the

anatomic guides. Some voids present in impression. The border extensions are generally acceptable, with localized areas of over or under extension. The impression records the anatomy of the tissues. There are some voids.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The border extensions are generally over or under extended with the potential for loss of stability and/or retention. The impression lacks detail, and there are several voids.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

The border extensions are under or over extended. The tissue registered by the impression lacks detail. There are voids and/or distortions evident.

**MAJOR CATEGORY:  
Mandibular Impression**

**Level 1**

The impression borders extend into the vestibule without impinging on movable tissue. The tray covers, but does not extend beyond the retromolar pads. The surface of the impression contacting the supporting oral mucosa accurately reproduces the anatomy of these tissues. The impression material is uniformly distributed in the impression tray.

**Level 2**

The border extensions are generally acceptable. There are also some localized areas that are over extended, but the conditions are correctable with minor alterations. The impression records the anatomy of the tissues. The impression material is uniformly in the impression tray.

**Level 3**

The border extensions are generally acceptable, with local areas of over or under extension. The retromolar pads are only partially covered. The impression records the anatomy of the tissues. The impression material is uniformly in the impression tray; however, there are a few small voids.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The border extensions are generally over or under extended, with the potential for loss of stability and/or retention. The tray does not contact the retromolar pads. The impression lacks tissue detail, and there are several voids. The impression material is unevenly distributed in the impression tray.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

The border extensions are under or over extended. The tissues registered lack detail. The impression material is unevenly

distributed in the impression tray, and there are several areas where the tray has distorted tissue.

#### **MINOR CATEGORY:**

#### **Maxillomandibular Relationship Records**

##### **Level 2**

The methods used to make centric relation records follow acceptable techniques. Casts are properly poured, trimmed, and articulated. Record bases properly contoured. Articulated casts clearly show that these requirements have been met.

##### **Level 3**

The methods used to make centric relation records follow acceptable techniques. Casts show minor discrepancies that will produce errors correctable with minor adjustments on the finished denture.

##### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

The methods used to make centric relation records do not follow acceptable techniques. Casts show major discrepancies. Record bases are unacceptable.

#### **MAJOR CATEGORY:**

#### **Trial Dentures**

##### **Level 1**

The prosthetic teeth have been optimally arranged for function and esthetics with appropriate and smooth contours.

##### **Level 2**

The prosthetic teeth are arranged for good function and esthetics with appropriate and smooth contours.

##### **Level 3**

The tooth arrangement is marginal and/or the contours and smoothness lack finesse.

##### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

The teeth are not acceptably arranged for function or esthetics. General contours or surface smoothness are unacceptable.

##### **Level 5**

There are discrepancies in tooth arrangement or contours.

#### **MAJOR CATEGORY:**

#### **Bilateral (Cross-Arch) Balanced Articulation**

##### **Level 1 and 2**

Centric occlusion and maximal intercuspals contacts are coincident. Most teeth participate in bilateral, simultaneous, anterior and posterior occlusal contact through all excursive movements. Occlusal contact of posterior teeth is bilateral and simultaneous when the articulator is closed in centric occlusion. An identical occlusal contact relationship is demonstrated in the photographs presented.

##### **Level 3**

Centric occlusion and maximal intercuspals contacts are coincident. Some, but not all, teeth participate in bilateral, simultaneous, anterior and posterior occlusal contact through all excursive movements. Occlusal contact of posterior teeth demonstrates minor deflections that are within a correctable range. An identical occlusal contact relationship is demonstrated in the photographs presented.

##### **Level 4 (any one aspect from the following constitutes Level 4 performance)**

Centric occlusion and maximal intercuspals contacts are not coincident. Bilateral, simultaneous, anterior and posterior occlusal contact through all excursive movements is minimally present and inadequate to establish balanced articulation.

##### **Level 5**

Bilateral, simultaneous, anterior and posterior occlusal contact through all excursive movements is absent.

#### **MAJOR CATEGORY:**

#### **Occlusal Vertical Dimension**

##### **Level 1 and 2**

The restored patient demonstrates acceptable occlusal vertical dimension and acceptable interocclusal rest distance.



**Level 3**

The restored patient demonstrates an occlusal vertical dimension that is acceptable but less than ideal (slightly open or slightly closed).

**Level 4**

The restored patient demonstrates an occlusal vertical dimension that is unacceptable (open or closed), but correctable by conservative means.

**Level 5**

The restored patient demonstrates an occlusal vertical dimension that is unacceptable (open or closed) and correctable only by prosthesis remake.

**MAJOR CATEGORY:****Centric Occlusion/Maximal Intercuspal Contacts****Level 1 and 2**

Centric occlusion and maximal intercuspal contacts are coincident. Posterior occlusal contacts are bilateral and simultaneous in centric occlusion.

**Level 3**

Contacts in centric occlusion show minor but correctable errors. Clinical remount and minor occlusal adjustment is necessary.

**Level 4**

Centric occlusion and maximal intercuspal contacts are not coincident. Clinical remount and considerable occlusal adjustment is necessary.

**Level 5**

Centric occlusion and maximal intercuspal contacts are not coincident. Occlusal discrepancies are not correctable by clinical remount or other conventional means. Prosthesis remake appears to be necessary.

**MINOR CATEGORY:****Denture Finish, Contour and Esthetics****Level 2**

Denture base resin exhibits no porosity. Cameo denture surface is highly polished, properly contoured, free of scratches, and free of plaster inclusions. Stippling, if present, is appropriately textured and positioned. Denture base color is appropriate for the patient. Adjusted occlusal surfaces have been restored to a high polish. Completed restorations appear esthetic.

**Level 3**

Denture base resin exhibits minor areas of porosity. Cameo surfaces of dentures contain minor scratches and blemishes. Limited gypsum inclusions are apparent. The cameo denture surface is over or under contoured. Denture base color is acceptable for the patient. Occlusal surfaces of modified denture teeth may not be polished. Completed restorations are not consistent with accepted esthetic standards.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Denture base resin is porous throughout. Cameo surfaces of denture have numerous scratches and blemishes. Significant gypsum inclusions are apparent. Denture base color is inappropriate for the patient. The cameo denture surface is over or under contoured. Occlusal surfaces of modified denture teeth are irregular and not polished. The denture base or denture teeth have been fractured and not repaired or inadequately repaired. Esthetic appearance of completed restorations is unacceptable.

**MAJOR CATEGORY:****Denture Extension****Level 1 and 2**

Prosthesis extension into vestibules does not impinge on movable tissue. Border approximation to critical anatomy (e.g., pterygomaxillary fissure, junction of the hard and soft palate, retromolar pads, frenal attachments) is appropriate.

**Level 3**

Prosthesis extension into vestibules is generally acceptable with local areas of limited over or under extension that will not adversely affect prosthesis stability, support, and/or retention. Border approximation to critical anatomy is appropriate.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Prosthesis extension into vestibules is over or under extended with expected compromise in prosthesis stability, support and/or retention.

**Level 5**

Prosthesis extension is unacceptable.

#### 4.5.7 REMOVABLE PROSTHODONTICS/IMPLANTS

##### MAJOR CATEGORY: Overall Design Concept

**Level 1**

All basic components of accepted design have been addressed and optimally applied.

**Level 2**

All basic components of accepted design have been considered, but some aspect of the design may be controversial.

**Level 3**

Most basic components of accepted design have been considered and those not addressed have been justified upon oral examination.

**Level 4**

Some of the basic components of accepted design have not been considered or addressed.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Most basic components of accepted design have not been considered or addressed. Those components not addressed cannot be justified in the light of current knowledge.

##### MAJOR CATEGORY: Implants and Implant Abutments

**Level 1**

An adequate number of implants of proper length have been well distributed in the edentulous area and they appear to be physiologically compatible.

**Level 2**

An adequate number of implants with generally adequate length have been distributed in the edentulous area and they appear to be physiologically compatible.

**Level 3**

The number, length, distribution of the implants is marginal, but they appear to be physiologically compatible.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The number, length, distribution of the implants is unacceptable and that may affect their physiologic compatibility.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

The number, length, distribution of the implants is unacceptable and the implants appear not to be physiologically compatible.

##### MAJOR CATEGORY: Completed Restorations

**Level 1**

Prostheses are properly contoured and finished and well integrated with other elements of care. Completed restorations appear esthetic.

**Level 2**

Prostheses are generally properly contoured, finished and integrated with other elements of care. Completed restorations appear esthetic.

**Level 3**

Prosthesis contours, finish or integration with other elements of care is marginal. Completed restorations are not consistent with accepted esthetic standards.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Prosthesis contours, finish, integration with other elements of care is unacceptable. Esthetic appearance of completed restorations is unacceptable.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Prosthesis contours, finish, integration with other elements of care is unacceptable. Esthetic appearance of completed restorations is unacceptable.

## 4.5.8 MAXILLOFACIAL PROSTHETICS

### MAJOR CATEGORY: Overall Design Concept

#### Level 1

All basic components of accepted design have been addressed for defect and the non-defect areas.

#### Level 2

All basic components of accepted design have been considered for defect and non-defect areas. Components not addressed were justified during oral examination.

#### Level 3

Most basic components of accepted design have been considered for defect and non-defect area. Methods used for component design may be controversial.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

Basic components of accepted design have been considered for defect and non-defect areas. Failure to address specific design elements cannot be

justified in the light of current knowledge.

#### Level 5 (more than one aspect from the following constitutes Level 5 performance)

Basic components of accepted design have not been addressed for defect and non-defect areas. Design elements not addressed cannot be justified in the light of current knowledge.

### MINOR CATEGORY: Clasp Assemblies

#### Level 2

An acceptable number of clasp assemblies have been selected and placed according to accepted philosophies of prosthesis retention, reciprocation and support.

#### Level 3

The type, number, and placement of most clasp assemblies are acceptable, but at least one clasp assembly is unacceptable in type and/or placement.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

The type, number, and placement of most clasp assemblies are unacceptable.

### MAJOR CATEGORY: Rest Seats and Rests

#### Level 1 and 2

Occlusal, cingulum, or incisal rests and rest seats have been

properly prepared, located and fabricated to facilitate optimal prosthesis support.

#### Level 3

Most of the occlusal, cingulum, or incisal rests and rest seats have been properly prepared, located and fabricated to facilitate optimal prosthesis support.

#### Level 4 (any one aspect from the following constitutes Level 4 performance)

Most of the occlusal, cingulum, or incisal rests or rest seats have been improperly prepared, located or fabricated providing suboptimal prosthesis support.

#### Level 5 (more than one aspect from the following constitutes Level 5 performance)

Most of the occlusal, cingulum, or incisal rests or rest seats have been improperly prepared, located or fabricated providing suboptimal prosthesis support.

### MINOR CATEGORY: Retention/Reciprocation

#### Level 2

Reciprocating and retentive components of all direct retainers have been appropriately placed to facilitate tooth stability while the prosthesis is placed and removed. The material used and the contours of the reciprocating and retentive components are proper for the type of prosthesis.

**Level 3**

Reciprocating and retentive components of some direct retainers have been acceptably placed to facilitate tooth stability while the prosthesis is placed and removed. The material used and the contours of the reciprocating and retentive components are marginal for the type of prosthesis.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

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

**MINOR CATEGORY:  
Indirect Retainer(s)****Level 2**

An indirect retainer(s) has been optimally placed to resist rotation of the prosthesis around the fulcrum line.

**Level 3**

An indirect retainer(s) has been placed but its location does not provide the optimal resistance to rotation around the fulcrum line or is less than optimal from a rest seat position/preparation standpoint.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

An indirect retainer(s) has not been placed to resist rotation around the fulcrum line, or the prosthesis lacks elements to resist rotation occlusally around the fulcrum line. The size of the indirect retainer is inadequate or is less than optimal from a rest seat position/preparation standpoint.

**MAJOR CATEGORY:  
Major Connector Selection/  
Placement/Size****Level 1 and 2**

The major connector selection is appropriate, it is placed within the scope of acceptable principles, appears to be rigid, and will provide adequate stabilization and support to the prosthesis and remaining oral structures.

**Level 3**

The major connector is acceptable, it appears to be rigid, but the placement and selection are questionable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Aspects of major connector selection, placement and/or rigidity are inadequate.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Aspects of major connector selection, placement and/or rigidity are inadequate.

**MINOR CATEGORY:  
Base Coverage/Contour (non-defect area, if present)****Level 2**

Denture bases extension in the non-defect area(s) is appropriate and results in maximum stability and support for the prosthesis. Denture base contour is appropriate.

**Level 3**

Denture base extension in the non-defect area(s) is marginally acceptable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Denture bases are over extended or under extended and denture base contour is inappropriate.

**MINOR CATEGORY:  
Obturator Extension/Contour****Level 2**

The extent and contour of the bases in the defect areas are appropriate.

**Level 3**

The extent of the bases in the non-defect area or areas is marginally acceptable and the contour is questionable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The extent and contour of the bases are inadequate to provide support, stability, retention, and oral-nasal seal.

**MAJOR CATEGORY:  
Design**

**Level 1 and 2**

The design and materials used are appropriate for the type of defect to be obturated.

**Level 3**

The design and materials used are generally appropriate, but not optimal for the defect to be obturated.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

The design or materials used are inappropriate for the type of defect to be obturated.

**Level 5 (more than one aspect from the following constitute Level 5 performance)**

The design and materials used are inappropriate for the type of defect to be obturated.

**MAJOR CATEGORY:  
Abutment Restoration(s)**

**Level 1**

Abutment restorations have good margin integrity, incorporate appropriate material, and demonstrate survey contours that permit placement of retainer assemblies.

**Level 2**

Abutment restorations have good margin integrity, incorporate appropriate material, but demonstrate less than ideal survey contours for the chosen retainer assemblies.

**Level 3**

Abutment restorations lack ideal margin integrity. Material used or survey contours present are less than ideal for properly designed retainer assemblies.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Abutment restorations lack margin integrity. Materials used or contours present are inadequate for properly designed retainer assemblies.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Abutment restorations lack margin integrity. Materials used or contours present are inadequate for properly designed retainer assemblies.

**4.5.9 MAJOR CATEGORY:  
OCCLUSION**

**Level 1**

Centric occlusion and maximal intercuspal contacts are coincident. Occlusal contacts are harmonious in maximal intercuspal position and eccentric positions. The occlusal plane and type of teeth selected (material and cusp form)

enhance the stability of the prosthesis.

**Level 2**

Occlusal contacts are generally harmonious in maximal intercuspal position and eccentric positions, but minor discrepancies exist.

**Level 3**

Occlusal discrepancies exist in either maximal intercuspal position or eccentric positions. The choice of teeth and position of the occlusal plane is suspect.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

Occlusal discrepancies exist. Occlusal contacts may be lacking in maximal intercuspal position. Undesirable occlusal contacts are present and may result in potentially adverse outcomes. Occlusal plane irregularities, lack of uniform maximal intercuspal contacts, or inappropriate eccentric tooth contacts exist.

**Level 5 (more than one aspect from the following constitutes Level 5 performance)**

Occlusal discrepancies exist. Occlusal contacts are lacking in maximal intercuspal position. Undesirable occlusal contacts are present resulting in potentially adverse outcomes. Occlusal plane irregularities, lack of uniform maximal intercuspal contacts, or inappropriate eccentric tooth contacts exist.

#### 4.5.10 MINOR CATEGORY: PROGNOSIS, OUTCOMES AND MAINTENANCE PLAN

##### Level 2

Prognosis is realistic, based on an appropriate diagnosis, a well-organized treatment plan, and appropriate treatment. The maintenance plan includes an appropriate patient recall regimen, professional maintenance regimen, and at-home maintenance regimen. Maintenance plan fully addresses specific patient treatment and prognosis.

##### Level 3

Prognosis is reasonable though slightly optimistic. The maintenance plan is not ideally suited to the patient's needs for a patient recall regimen, professional maintenance regimen, and/or at-home maintenance regimen. Maintenance plan partially addresses specific patient treatment and prognosis.

##### Level 4 (any one aspect from the following constitutes Level 4 performance)

Prognosis is not realistic. The maintenance plan is deficient and will likely lead to biological and mechanical complications because of an inappropriate patient recall regimen, professional maintenance regimen, and/or at-home maintenance regimen. Maintenance plan is absent or does not support specific patient treatment and prognosis.

#### 4.5.11 MINOR CATEGORY: WORK AUTHORIZATION FORM(S)

##### Level 2

All pertinent information is present and clearly described.

##### Level 3

Information is generally adequate but some aspects are marginally covered.

##### Level 4 (any one aspect from the following constitutes Level 4 performance)

Pertinent information has not been written, information is confusing, incomplete or no form was used.

#### 4.5.12 MAJOR CATEGORY: ORAL EXAMINATION PERFORMANCE

##### Level 1

The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates a superior understanding of the broad scope of Prosthodontics.

##### Level 2

The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of

care associated with the patient treatment. The candidate demonstrates an adequate understanding of the broad scope of Prosthodontics.

##### Level 3

The candidate responds adequately to questioning associated with the patient presentation. The candidate understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate's understanding of the broad scope of Prosthodontics is marginal.

##### Level 4 (any one aspect from the following constitutes Level 4 performance)

Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of implant placement and prosthodontics is not adequate.

##### Level 5 (more than one aspect from the following constitutes Level 5 performance)

Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of implant placement and prosthodontics is not adequate.

# 5

## 5. Section C: Scenario-Based Oral Examination

### 5.1 SECTION C GENERAL INFORMATION

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The scenario examination consists of three separate 20-minute oral examinations in which two examiners present scripted questions based on a clinical scenario created by the ABP. Each clinical scenario incorporates four five-minute themes: Diagnosis, Treatment Planning, Treatment, and Prognosis, Outcomes and Maintenance Plan. Within each theme, multiple questions are asked. The content of the examination is consistent with current Commission of Dental Accreditation (CODA) Standards for Advanced Specialty Education Programs in Prosthodontics. Scenarios serve to evaluate depth and breadth of candidate knowledge in prosthodontics and related disciplines and sciences.

### 5.2 SECTION C GRADING

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Each candidate challenges three 20-minute scenario ex-

aminations completing Section C in one hour. Different two-examiner teams conduct each of the three scenario examinations for each candidate. Therefore, a total of six examiners enter scores for each candidate. The four themes within each scenario are scored separately, resulting in 24 data points per candidate for the Section C examination (2 examiners x 3 scenarios x 4 themes/scenario). An aggregate score derived from the 24 data points determines candidate performance.

Scenario questions and anticipated responses are specifically developed by the ABP to standardize Section C content and grading. The ABP reaches agreement as to questions and anticipated responses before a scenario is offered in an examination. Questions and anticipated responses are scripted, such that every candidate challenging a particular scenario during any examination cycle faces the same questions, anticipated responses, and allotted time.

It is expected that candidates will not provide brief one-word or one-sentence responses. Rather, responses should be expansive in nature to demonstrate the candidate's breadth of understanding, interpretation, and integration of prosthodontic knowledge.

### 5.3 SECTION C EVALUATION CATEGORIES

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Candidate will be scored relative to the anticipated responses determined by the ABP. Scoring is recorded as:

1. Fail
2. Marginal Fail
3. Marginal Pass
4. Pass

### 5.4 EVALUATION OF EXAMINERS AND EXAMINATION: CONSISTENCY AND RELIABILITY

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Intra-examiner scoring severity and consistency are compared within the examination cycle and between previous

examination cycles. Inter-examiner scoring is compared in the same manner. Inter-scenario difficulty is also calculated comparing present and past candidate pools. In doing so, individual scores and the pass-fail point for Section C examinations are

statistically validated at several levels. Following extensive psychometric assessment, the ABP defines a pass-point reflecting a high confidence interval to assure that all candidates who should will indeed pass the examination.



## 6. Section D: Implant-Based Patient Presentation and Oral Examination

# 6

For questions about the examination process or logistics not covered in these Guidelines, contact The ABP Chief Professional Officer at [exams@abpros.org](mailto:exams@abpros.org). **PLEASE NOTE,** ABP and its Directors will not address questions related to Section-D patient selection, patient treatment decisions, or patient examination presentation. Candidates must refer to the most current published “Guidelines for the Certification Process” for appropriate answers to all questions. The American Board of Prosthodontics will not provide guidance regarding specific therapies. Determination, justification, and defense of specific therapies and all related matters are the responsibility of the candidate during the examination.

### 6.1 SECTION D GENERAL INFORMATION

With the evolution in scope of prosthodontic care, to include dental implant placement, examination of candidate knowl-

edge, skill, and experience in providing such care is the focus of Section D. Candidates should be prepared to present and defend implant therapy with an emphasis on biologic interfaces associated with implantation of biomaterials into osseous structures and surrounding soft tissues. Design of the Section D examination permits ABP Examiners the latitude to explore a candidate’s understanding of implant diagnosis and treatment planning, the biology of implant placement, adjunctive/incidental hard and soft tissue procedures, definitive prosthodontic restoration, and prognosis, outcomes, and maintenance planning for implant therapy.

This 60-minute examination involves three (3) 20-minute segments that include:

1. Candidate-generated patient treatment presentation consisting of surgical and fixed prosthodontic management of a natural tooth-bounded (receiv-

ing one or more implants) space and an unbounded (receiving one or more implants) edentulous space. The unbounded edentulous space may be an edentulous arch restored with a fixed prosthesis(es).

2. Oral examination based on standardized questioning.
3. Oral examination based on unrestricted questioning that may relate to the patient treatment presentation.

The broad scope of implant dentistry will serve as the focus of the oral examination during both standardized and unrestricted questioning.

Candidates must be prepared to defend diagnosis, prognosis, treatment planning, treatment, and maintenance planning using available evidence. Any laboratory work not completed by the candidate must be accompanied by dental laboratory work authorizations.

The candidate must perform all surgical and prosthodontic

procedures of the treatment being examined. Additionally, the candidate will be evaluated on the quality of, and justification for, **all** care provided or not provided by other clinicians. The candidate is also responsible to defend the quality of pre-existing restorations and conditions.

Failure to abide by the instructions and examination policies provided here may lead to **disqualification** from the current exam. Disqualification means that the examination session is terminated and the examination fee is forfeited. A disqualification is **not** recorded as a failed examination. The same patient treatment presentation, with full and proper documentation, can be presented at a future examination date with payment of a new examination fee.

## 6.2 SECTION D REQUIREMENTS AND FORMAT OF PRESENTATION

The candidate will provide a PowerPoint or Keynote presentation depicting two implant-supported fixed prosthodontic treatments (may or may not be on the same patient) that must involve:

1. A tooth-bounded edentulous space receiving one or more implants; and

2. An unbounded edentulous space, which may include an edentulous arch, receiving one or more implants.

The candidate must surgically place all implants for the treatment being examined. A signed document attesting to this will be supplied by the ABP, and must be signed by the candidate, at the time of the examination.

For the implant treatments being examined, the following well-composed, high quality, color images are required:

Pretreatment photographic documentation of maxilla, mandible, and of anticipated surgical site:

- Teeth in maximal intercuspal position (front, left lateral and right lateral views)
- Occlusal view of surgical site.

Pre-treatment radiographic imaging, to include anticipated implant site(s):

- Dental radiographic images appropriate for comprehensive analysis
- Forms of documentation of the anticipated surgical site:
  - 2-dimensional imaging with documentation of volume underlying bone; and/or
  - 3-dimensional imaging of anticipated implant site(s) (cross sectional images extending to ad-

acent structures — within approximately 6 mm mesial and distal of the site)

Treatment Documentation:

- Demonstration of surgical site(s) with osteotomy(s) after implant placement showing implant position and trajectory consistent with prosthetic treatment plan. At least one of the following methods of documentation must be provided:
  - Surgical guide(s) used and cast(s) created after implant treatment that include implant analog(s) with removable guide pin(s)
  - Post-treatment sagittal and coronal views developed from 3-dimensional imaging
  - Photographic images immediately following implant placement with guide pin or transfer component in place (facial and occlusal views)
- If soft tissue flap is elevated, photographic images of occlusal and lateral view of implant position and surgical closure are required.
- For all treatments presented, lateral and occlusal photographs demonstrating developed soft tissue contours with and without fixed interim prostheses.

Post-treatment Intraoral Photographic Images:

- Front, left lateral and right lateral views of teeth in maximal intercuspal position
- Occlusal view of definitive prostheses

Post-treatment demonstration of care consistent with comprehensive planning and treatment:

- Must have photographic images (front, left lateral and right lateral views)
- Must have mounted dental casts that include all dental prostheses
- Must have 2- and/or 3-dimensional dental radiographic images appropriate for demonstration of comprehensive care

When cement-retained prostheses are part of the treatment being examined, clear photographic documentation of all involved abutments, prior to cementation, must be included in the presentation.

Additional photographic/radiographic documentation may be provided at the candidate's discretion. Only high quality digital images are acceptable. All images presented by candidates must be original with no alterations except peripheral cropping. Presentation of images with unauthorized alterations (including but not limited

to "instant alpha" or similar, background elimination, or like manipulations) will result in automatic disqualification of the candidate and forfeiture of the examination fee. The presentation should include one photographic image per screen. Periapical and bite-wing radiographic images may be grouped to include more than one image per screen. However, each panoramic or CBCT image incorporated in the presentation must be displayed on separate screens and not grouped.

For both implant treatments, additional documentation may be presented. Although there is no limit to the number of images included, the presentation segment of the examination must be completed in 20 minutes or less.

Articulated diagnostic and post-treatment casts for both patient treatments are required and must be available for review during the examination. Magnetic mounting plates are the preferred method for cast mountings.

A checklist of required items is available at the end of this document.

## 6.3 PRESENTATION LOGISTICS

Section D patient presentations are developed by candidates as PowerPoint or Keynote presentations. Prior to the examination, candidates will submit to the ABP their presentation and narrative files on a portable USB flash drive. The candidate is responsible for confirming USB drive compatibility with an Apple computer. Failure to submit the presentation and narrative files in proper format will result in candidate disqualification and forfeiture of the examination fee. Specific instructions for USB drive submission will be provided to candidates prior to the examination date. Radiographs, as required by these Guidelines, may be either film or digital, but must be of exceptional resolution and quality. Once submitted, the USB drive, its contents, and radiographs become the property of the Board and may be used as material for future ABP examinations.

During examinations, presentations are made using an ABP laptop (Apple) computer connected to an ABP monitor provided in the examination room. All digital images presented by candidates must be original images with **no alterations except peripheral cropping**. Presentation of images with unauthorized alterations (including but not limited to "instant alpha" or similar, back-

ground elimination, or like manipulations) will result in automatic disqualification of the candidate and forfeiture of the examination fee.

#### 6.4 DENTAL LABORATORY WORK

Dental laboratory technicians may be used to aid in the fabrication of prostheses for patient treatments presented. Laboratory work completed by the candidate in Section D may not be used to fulfill the laboratory work requirements specified in Section B. Candidates must be able to demonstrate a thorough understanding of dental laboratory procedures. Candidates are responsible for the outcome of all dental laboratory procedures associated with the patients and patient treatments presented. Any dental laboratory work not completed by the candidate must be accompanied by properly executed dental laboratory work authorizations.

#### 6.5 THE 60-MINUTE SECTION D EXAMINATION TIMELINE

20 Mins. The candidate will provide a PowerPoint or Keynote presentation of treatment rendered (20 minutes maximum time allotted).

20 Mins. Examiners will pose predetermined standardized questions related to the broad scope of implant dentistry.

20 Mins. Examiners will pose general unrestricted questions related to the candidate's treatment presentation and the broad scope of implant dentistry.

60 Mins. TOTAL

#### 6.6 SECTION D GRADING

After all candidates have been examined, the Board meets in executive session to consider each candidate. Candidate anonymity is maintained throughout the process. Each examination team provides a "pass" or "defer" performance evaluation for each candidate examined based on published criteria. For deferred candidates, a review of patient documentation, presentation and oral examination is provided to the entire ABP by the examiner team that conducted the oral examination in question.

Successful completion of Section D requires acceptable performance in three categories: (1) patient presentation, (2) implant surgery and prosthodontics, and (3) related dental sciences. All candidates are scored according to the published criteria that include both major and minor categories.

Major categories are scored on a numerical scale of 1 to 5. Minor categories are scored from 2 to 4. Examination failure occurs when the candidate receives any of the following:

- A single (1) score of 5 in a major category;
- Two (2) scores of 4 in major categories; or
- Four (4) scores of 4 in any categories.

Following thorough discussion of a deferred candidate, each member of the Board registers an anonymous vote of "pass" or "fail." No candidate can fail the examination based exclusively on the opinion of one examination team or one ABP Examiner. A simple majority of ABP Examiners must reach consensus before a candidate is determined to have failed the Section D examination. In the event of a tie vote, the candidate passes the examination.

#### 6.7 SECTION D EVALUATION CATEGORIES AND CRITERIA

**MINOR CATEGORY:  
Unaltered Preoperative Radiographs/Images, Casts, and Photographs (missing elements will result in candidate disqualification)**

##### Level 2

Preoperative radiographs/images are originals of acceptable diagnostic quality with no evi-

dence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements that would introduce error. Photographs conform to size requirements and have been properly exposed. All required views and components as identified in checklist are present.

### Level 3

Radiographs/images are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements though with less than ideal contrast and sharpness. All required views and components as identified in checklist are present.

### Level 4 (any one of the following items constitutes Level 4 performance)

Radiographs/images are inadequate. Cone cuts, distortions, improper film placement or apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Articulation instrument is inadequately programmed or inappropriately used. Photographs exhibit poor contrast and sharpness. One or more required views and components are missing.

### MINOR CATEGORY: Unaltered Post-operative Radiographs/Images, Casts, and Photographs (missing elements will result in candidate disqualification)

#### Level 2

Post-operative radiographs/images are originals of acceptable diagnostic quality with no evidence of cone cuts, distortions, improper film placement and apical areas “cut off.” Casts are clean, securely mounted and accurately reproduce oral structures. Casts are free of any elements that would introduce error. Photographs conform to size requirements and have been properly exposed. All required views and components as identified in checklist are present.

#### Level 3

Radiographs/images are adequate but demonstrate slight variations in contrast. Casts are adequate but lack optimal quality. Photographs meet basic requirements though with less than ideal contrast and sharpness.

### Level 4 (any one of the following items constitutes Level 4 performance)

Radiographs/images are inadequate. Cone cuts, distortions, improper film placement or apical “cut off” severely compromise diagnostic quality. Casts are incomplete, lack essential elements for proper

articulation or are insecurely mounted. Casts are porous, dirty. The mounting is not smooth and neat. Articulation instrument is inadequately programmed or inappropriately used. Photographs exhibit poor contrast and sharpness. One or more required views and components are missing.

### MAJOR CATEGORY: Diagnosis and Treatment Plan

#### Level 2

Diagnosis is appropriate and supported by a systematic method of identifying oral disease. Treatment plan is organized and chronologically sequenced to prevent and correct oral disease.

#### Level 3

Diagnosis is adequate though method used to formulate it is questionable. Treatment plan is marginally adequate but not well organized.

### Level 4 (any one of the following items constitutes Level 4 performance)

Diagnosis is incomplete or inappropriate and is not supported by clinical findings. Treatment plan is inappropriate. Treatment plan is poorly organized and improperly sequenced.

**Level 5 (multiple items from the following constitute Level 5 performance)**

Diagnosis is clearly incomplete or inappropriate and is not supported by clinical findings. Treatment plan is inappropriate or inadequate with errors in content and sequencing. Teeth have been inappropriately extracted or restored.

**MAJOR CATEGORY:  
Implant Placement Surgery****Level 1**

Implant position ideally supports the prosthetic plan. Soft tissue management, flap design, trajectory, depth, implant dimensions, implant site development, and osteotomy demonstrate ideal treatment.

**Level 2**

Implant position supports the prosthetic plan. Soft tissue management, flap design, trajectory, depth, implant dimensions, implant site development, and osteotomy demonstrate acceptable treatment.

**Level 3**

Implant position and angulation requires prosthodontic modification to achieve prosthetic plan.

**Level 4 (any one of the following items constitutes Level 4 performance)**

Compromised implant position results in prosthetic modifications that lead to potential

adverse outcomes. Soft tissue management, flap design, trajectory, depth, implant dimensions, implant site development, osteotomy or other considerations demonstrate unacceptable treatment.

**Level 5 (multiple items from the following constitute Level 5 performance)**

Compromised implant position results in prosthetic modifications that lead to potential adverse outcome. Soft tissue management, flap design, trajectory, depth, implant dimensions, implant site development, osteotomy or other considerations demonstrate unacceptable treatment that can produce adverse outcomes.

**MAJOR CATEGORY:  
Implants and Implant Abutments****Level 1**

An appropriate number of implants (and associated abutments) of proper length and diameter have been well placed in the edentulous area, demonstrating excellent adaptation (implant to abutment or restoration) and appear to be physiologically compatible.

**Level 2**

An appropriate number of implants (and associated abutments) with generally adequate length and diameter have been placed in the edentulous area, demonstrating ad-

equated adaptation (implant to abutment or restoration) and appear to be physiologically compatible.

**Level 3**

The number, length, diameter, placement of the implants (and associated abutments) is marginal but they appear to be physiologically compatible.

**Level 4 (any one of the following items constitutes Level 4 performance)**

The number, length, diameter, placement of the implants (and associated abutments) is unacceptable and that may affect their physiologic compatibility. There is soft tissue inflammation (peri-implant mucositis) that may be the result of retained cement, inadequate abutment contour, or other factors.

**Level 5 (multiple items from the following constitute Level 5 performance)**

The number, length, diameter, distribution of the implants (and associated abutments) is unacceptable or the implants appear to not be physiologically compatible. There is soft tissue inflammation and bone loss (peri-implantitis) that may be the result of retained cement, inadequate abutment contour, or other factors.

**MINOR CATEGORY:****Pontic(s)****Level 2**

Pontic type, contour, and/or tissue relationship are well designed. Patient presentation clearly demonstrates appropriateness of pontic design.

**Level 3**

Pontic type, design, contour, and/or tissue relationship are marginally acceptable.

**Level 4 (any one aspect from the following constitutes Level 4 performance)**

There are inadequacies in pontic design, contour, and/or tissue relationships. Demonstration of the appropriateness of pontic design is not available in the patient presentation.

**MAJOR CATEGORY:****Occlusion****Level 1**

The definitive occlusion is appropriate. Occlusal contacts are harmonious in maximal intercuspal and eccentric positions. The occlusal plane and occluding surfaces (material and morphology) enhance the stability of the prosthesis.

**Level 2**

The definitive occlusion is generally acceptable. Occlusal contacts are generally harmonious in maximal intercuspal and eccentric positions, but minor discrepancies exist.

**Level 3**

The definitive occlusion may be compromised. Occlusal contacts are compromised in either maximal intercuspal or eccentric positions. Clinical management of occlusal plane, tooth position(s), and occluding surfaces (material and morphology) is questionable.

**Level 4 (any one of the following items constitutes Level 4 performance)**

The definitive occlusion displays discrepancies. Occlusal contacts may be lacking in maximal intercuspal position. Undesirable occlusal contacts are present and may result in potential adverse outcomes. There is a lack of uniform occlusal contacts in maximal intercuspal position or inappropriate eccentric tooth contacts exist. Clinical management of occlusal plane, tooth position(s), and occluding surfaces (material and morphology) is inappropriate.

**Level 5 (multiple items from the following constitute Level 5 performance)**

The definitive occlusion displays major discrepancies. Occlusal contacts may be lacking in maximal intercuspal position. Undesirable occlusal contacts are present and may result in potential adverse outcomes. There is a lack of uniform occlusal contacts in maximal intercuspal position or inappropriate eccentric tooth contacts exist. Clinical management of occlusal plane,

tooth position(s), and occluding surfaces (material and morphology) is inappropriate.

**MAJOR CATEGORY:****Completed Restorations****Level 1**

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

**Level 2**

Restoration is generally physiologically or esthetically compatible and integrates with other elements of care but exhibits some compromising aspects.

**Level 3**

Restoration is physiologically or esthetically marginally acceptable. Some aspects exhibit less than desired physiologic compatibility. Other elements of care considered but desired integration is lacking.

**Level 4 (any one of the following items constitutes Level 4 performance)**

Adverse outcomes may potentially occur. Physiologic or esthetic integration with other elements of care is lacking.

**Level 5 (multiple items from the following constitute Level 5 performance)**

Adverse outcomes have occurred. Physiologic or esthetic integration with other elements of care is lacking.

**MINOR CATEGORY:****Prognosis, Outcomes and Maintenance Plan****Level 2**

Prognosis is realistic, based on an appropriate diagnosis, a well-organized treatment plan, appropriate treatment, and planned maintenance.

**Level 3**

Prognosis and planned maintenance are acceptable.

**Level 4 (any one of the following items constitutes Level 4 performance)**

Prognosis is unrealistic. Planned maintenance is not compatible with the patient's needs.

**MAJOR CATEGORY:****Oral Examination Performance****Level 1**

The candidate responds well to questioning associated with the patient presentation. The

candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates a superior understanding of the broad scope of Prosthodontics.

**Level 2**

The candidate responds well to questioning associated with the patient presentation. The candidate fully understands the rationale for treatment and the technical aspects of care associated with the patient treatment. The candidate demonstrates an adequate understanding of the broad scope of Prosthodontics.

**Level 3**

The candidate responds adequately to questioning associated with the patient presentation. The candidate understands the rationale for treatment and the technical aspects of care associated with

the patient treatment. The candidate's understanding of the broad scope of Prosthodontics is marginal.

**Level 4 (any one of the following items constitutes Level 4 performance)**

Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of implant placement and prosthodontics is not adequate.

**Level 5 (multiple items from the following constitute Level 5 performance)**

Although the candidate presents a technically acceptable patient presentation, he/she cannot justify the rationale for the specific treatment provided. The candidate's understanding of the broad scope of implant placement and prosthodontics is not adequate.



## 6.8 SECTION D EXAMINATION - CHECKLIST

- ❑ The candidate will provide a PowerPoint or Keynote presentation (not PDF) depicting two implant-supported fixed prosthodontic treatments (may or may not be on the same patient) that must involve:

1. a tooth-bounded edentulous space; and
2. an unbounded edentulous space, which may include an edentulous arch.

- ❑ The candidate must have surgically placed the implants for the treatments being examined. A document will be available for candidate signature on the day of the examination.

- ❑ For the implant treatments being examined, the following well-composed, high quality, color images are required (missing elements will result in candidate disqualification and forfeiture of the examination fee):

Pretreatment photographic documentation of maxilla, mandible, and of anticipated surgical site:

- ❑ Teeth in maximal intercuspal position (front, left lateral and right lateral views)
- ❑ Occlusal view of surgical site.

Pre-treatment radiographic imaging, to include anticipated implant site(s):

- ❑ Dental radiographic images appropriate for comprehensive analysis
  - Forms of documentation of the anticipated surgical site:
    - ❑ 2-dimensional imaging with documentation of volume underlying bone; and/or
    - ❑ 3-dimensional imaging of anticipated implant site(s) (cross sectional images extending to adjacent structures — within approximately 6 mm mesial and distal of the site)

Treatment Documentation:

- Demonstration of surgical site(s) with osteotomy(s) after implant placement showing implant position and trajectory consistent with prosthetic treatment plan. At least one of the following methods of documentation must be provided:
  - ❑ Surgical guide(s) used and cast(s) created after implant treatment that include implant analogue(s) with removable guide pin(s)
  - ❑ Post-treatment sagittal and coronal views developed from 3-dimensional imaging
  - ❑ Photographic images immediately following implant placement with guide pin or transfer component in place (facial and occlusal views)
- ❑ If soft tissue flap is elevated, photographic images of occlusal and lateral view of implant position and surgical closure are required.
- ❑ For all treatments presented, lateral and occlusal photographs demonstrating developed soft tissue contours with and without fixed interim prostheses.

Post-treatment Intraoral Photographic Images:

- ❑ Front, left lateral and right lateral views of teeth in maximal intercuspal position
- ❑ Occlusal view of definitive prostheses

Post-treatment demonstration of care consistent with comprehensive planning and treatment:

- ❑ Must have photographic images (front, left lateral and right lateral views)
- ❑ Must have mounted dental casts that include all dental prostheses
- ❑ Must have 2-and/or 3-dimensional dental radiographic images appropriate for demonstration of comprehensive care

Additional photographic/radiographic documentation may be provided at the candidate's discretion.

- ❑ When cement-retained prostheses are part of the treatment being examined, clear photographic documentation of all abutments (stock or custom), prior to cementation, must be included in the presentation.
- ❑ Only high quality digital images are acceptable. All images presented by candidates must be original with no alterations except peripheral cropping. Presentation of images with unauthorized alterations (including but not limited to “instant alpha” or similar, background elimination, or like manipulations) will result in automatic disqualification of the candidate and forfeiture of the examination fee.
- ❑ For both implant treatments, additional documentation may be presented. Although there is no limit to the number of images included, the presentation segment of the examination must be completed in 20 minutes or less.
- ❑ Articulated diagnostic and post treatment casts for both patient treatments are required and must be available for review during the examination. Magnetic mounting plates are the preferred method for cast mountings.

**PLEASE NOTE:** The presentation should include one photographic image per screen. Periapical and bite-wing radiographic images may be grouped to include more than one image per screen. However, each panoramic or CBCT image incorporated in the presentation must be displayed on separate screens and not grouped.

**PLEASE NOTE:** Failure to abide by the instructions and examination policies provided here may lead to disqualification from the current exam. Disqualification means that the examination session is terminated and the examination fee is forfeited. A disqualification is not recorded as a failed examination. The same patient treatment presentation, with full and proper documentation, can be presented at a future examination date with payment of a new examination fee.

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\* Deceased



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