SRTA

DENTAL MANIKIN-BASED LICENSING EXAMINATION

2025 CANDIDATE MANUAL

2nd Edition

QUESTIONS? PLEASE CONTACT US AT:
EMAIL: **HELP@SRTA.ORG**
OFFICE: **757 318 9082**

STATES RESOURCES FOR TESTING AND ASSESSMENTS (SRTA)
4698 HONEYGROVE RD, SUITE 2
VIRGINIA BEACH, VA 23455

CHANGES TO THE SRTA DENTAL MANIKIN-BASED EXAMINATION

1. **Typodonts:** We will be utilizing Kilgore typodonts for all exam sections.
2. **Periodontal Section:** Candidates are required to scale an assigned quadrant, perform periodontal pocket probing on assigned teeth, and detect calculus on assigned teeth.
3. **Adjustment to Allotted Time for Examination:**
    a. One restorative section: 2.5 hours total
    b. Two restorative sections: 5 hours total
    c. Two restorative sections and periodontal section: 7 hours total

CRITERIA CHANGES:

4. Fixed Prosthodontics Ceramic Crown #9
   Walls, Taper & Shoulder 5. Incisal Reduction Acceptable: 1.0 mm to **3.0mm**
5. Anterior Endodontics
   Canal Obturation 1. Obturation Distance Acceptable The root canal is obturated with gutta percha no more than **1.0mm** past the anatomical apex or up to 2.0 mm short of the root apex.
6. Restorative Class III Anterior Composite Preparation
   External Form 1. Outline Form Acceptable: The outline form is sufficient in size to have access to remove caries and to manipulate and finish the restorative material. **Must be a true Class III with interproximal enamel removed.**
7. Restorative Class II Amalgam & Composite Preparation
   Internal Form 1. Pulpal Floor Acceptable: Equal to or greater than **1.0mm** from the cavosurface margin, and the pulpal floor depth is no more than **3.0mm** from the cavosurface margin; there may be remaining enamel.

STATES RESOURCES FOR TESTING AND ASSESSMENTS

States Resources for Testing and Assessments (SRTA) is a nonprofit corporation committed to being a leader at the national level in examination development and administration by providing the following –

- Uniformly administered examinations and confidential results that are consistently reliable for use by the dental licensing boards or other agencies.
- Protection for the public
- Appropriate care in the examination process
- Providing the most technologically advanced examination for its member states and participating examination sites
- Providing valid examinations in the most candidate-focused environment possible, for the next generation of our colleagues in the Dental and Dental Hygiene Professions

MISSION STATEMENT

SRTA will continue to provide valid, reliable, legally defensible examinations and results while striving to implement new testing methodologies in a candidate-focused environment for the next generation of dental and dental hygiene professionals.

EXAMINATION PURPOSE

This year's SRTA Dental Examination has been developed, administered, and reviewed in accordance with guidelines from the American Dental Association (ADA), the American Association of Dental Boards (AADB), the American Psychological Association (APA), the American Educational Research Association and the National Council on Measurement in Education. SRTA collects input from practicing dentists nationwide every five years through a Task Analysis Survey, which is the basis for all content decisions. The SRTA Examination was developed to provide a reliable clinical assessment for use by state boards in making valid licensing decisions. Prior to registering for the examination, candidates are strongly encouraged to verify the examination is accepted in the state in which they seek immediate licensure. **After actively practicing three to five years, many states will allow licensure by credentials (or reciprocity). Candidates are advised to check with state boards on licensure requirements.**

ANONYMITY

The SRTA Dental and Dental Hygiene Examination is conducted anonymously. All examination materials are identified by the candidate's SRTA number. The candidate's name and school information should not appear on any testing materials. All examiners are vetted current or past State Dental Board members with diverse backgrounds. We also utilize faculty examiners, the knowledge they gain through their examination experience is imparted to the students. Examiners are trained and standardized before each examination and are evaluated to ensure they are grading to established criteria.

TABLE OF CONTENTS

I. EXAMINATION OVERVIEW

EXAMINATION SECTIONS

The States Resources for Testing and Assessments (SRTA) Dental Examination consists of six required sections – **Endodontics, Fixed Prosthodontics, Anterior Restorative, Posterior Restorative, Periodontal and a computer simulated exam (DSE)** taken off-site. Sections will be as follows –

A. Candidates will have one **7-hour day** to complete both the **Endodontic and Fixed Prosthodontic sections** of the examination. If only one of these sections needs to be taken, then Candidates will get 3 hours to complete the endodontics section **or** 4 hours to complete the Fixed Prosthodontic section.
B. Candidates will have one **7-hour day** to complete the **Anterior Restorative, Posterior Restorative, and Periodontal sections.**
C. Candidates will schedule their computer simulated examination with ExamRoom.AI. directly.

DIAGNOSTIC SKILLS EXAMINATION (DSE)

The SRTA DSE is an 80 multiple-choice computer-based examination constructed by an Examination Committee that consists of examiners, educators, and other state board consultants. As this examination covers a range of categories, no single textbook or publication can be used as a reference or study guide, however any current textbook relevant to the exam subject matter may be used as a suitable study reference. This portion of the examination is taken offsite and covers the following categories:

Categories include:

- Patient Evaluations
- Comprehensive Treatment Planning
- Periodontics, Prosthodontics and Medical Considerations

Simulations of actual patients are utilized through computer-enhanced photographs, radiographs, optical images of study and working models, laboratory data and other clinical digitized reproductions.

Candidates may schedule to take the DSE portion of the examination after registering and submitting payment for the examination on SRTA's Candidate Clinical Exam Portal. The DSE is administered by a third-party agency, ExamRoomAI, which allows candidates to take the exam from the comfort of their own environment. ExamRoomAI provides a real time, live proctor to monitor the candidate taking the examination.

Candidates will receive an email from ExamRoomAI and must coordinate with them to schedule to take the DSE.

The DSE Section may be taken either before or after the manikin-based examination sections. It is given in one day and is approximately 1.5 to 2-hours long.

Candidates may take the DSE section up to three times within the 18-month exam period. (Remember: all sections must be completed successfully within 18 months after the first section is initiated.) Results are available within 10 business days from the time taken.

Once SRTA authorizes a candidate to take the examination, they will be sent email instructions from ExamRoomAI on how to schedule for the examination online.

A valid, government-issued photo ID is required for all test-takers during check-in (driver's license, passport, or school ID).

The following are the **MINIMUM** requirements that your computer needs to use our ExamRoom.AI at-home proctoring service:

- Recent operating system (less than 3-4 years old)
- MAC, PC, or Chromebook
- Google Chrome web browser
- Functioning computer web-camera and microphone
- Consistent Internet connection capable of uploading files in excess of 3 Mbps.

The exam is monitored by a live proctor and recorded.

Candidates who need to cancel and/or reschedule their appointment must call at least 30 calendar days prior to the test date. ExamRoomAI charges a $25 fee for cancellations made between five and 29 days prior to the exam date. Candidates who cancel less than five calendar days prior to the exam or start their appointment more than 15 minutes late will forfeit their fee.

Candidates who fail the DSE must complete a registration for reexamination before receiving authorization to schedule an appointment with ExamRoomAI to retake the exam. Please contact the SRTA office to register for this portion of the examination again.

The score for the DSE Section is based on the percentage of items answered correctly and scaled to equate scores from year to year. A scaled score of 75 or higher is required to pass.

SCORING PROCESS

For SRTA's Clinical Dental Skills Examinations, candidates are required to demonstrate job-related skills in simulated patient-based settings. To score these complex performance tasks, SRTA has developed scoring criteria for each of these examinations to define important characteristics of minimally competent performance. Using these scoring criteria, SRTA then trains and calibrates examiners to independently evaluate candidates' performance on the range of tasks and related procedures that comprise each examination. All examiners are currently licensed dentists who are current or past members of a state board of dentistry or approved educators. All are familiar with the content of the examination, the expectations of minimally competent performance, and the characteristics of the target population of candidates.

To ensure that examiners interpret the scoring criteria consistently, SRTA relies on an industry-standard practice of having two or more examiners independently review a candidate's work product. Examiners use analytic scoring methods where candidate performances are defined

as a series of criteria that will influence the acceptability of the characteristics of the product that the candidate produces. Each examiner specifies any observed major errors (i.e., domain critical errors) using electronic data entry. For an error to influence a candidate's score, it must be independently confirmed by at least one other examiner. This process helps to ensure that any decision about the pass/fail status for a candidate is based on the independent evaluations of at least two of three examiners.

Because of the efforts to train and calibrate examiners, decisions about errors will generally be made based on the judgment of the first two examiners. However, as a measure of internal quality control and in instances where there is a disagreement about whether the performance constituted an overall pass or fail decision, a third examiner will also make independent judgments about the candidate's performance. Because the third examiner will not know whether their judgments are part of internal data collection for feedback or as an adjudication judgment, there is no reason for an examiner to think that their judgment carries more weight than any other examiner in the process.

SRTA uses analytic judgment (i.e., judgment based on a series of multiple steps and evaluation points rather than on an overall impression) rather than holistic judgment for three purposes. First, because a task comprises of a number of skills, analytic judgment allows the examiner to separately evaluate the different phases of process and product that occur for a given task. Because each examination is unique, a slightly different number of skills have been defined and are scored in each section. Second, analytic judgment enables some limited feedback to the candidate about areas of strength or weakness and how these factors contributed to the overall pass/fail decision. Third, analytic judgment requires that examiners justify their ratings, given the specificity required for the judgments.

Overall, pass/fail decisions are conjunctive across examinations. This means that for a candidate to successfully pass the entire examination, they must pass each individual examination section. This policy decision is based on empirical evidence suggesting that skills from one section of the examination are not sufficiently related to skills in another section such that someone would be able to compensate in practice. This decision also reflects the desire to be able to use examination results to decide about a candidate’s minimum competency within each of the important sub-domains of the dental profession.

II. POLICIES & PROCEDURES

PROFESSIONAL STANDARDS & COMPETENCY

The purpose of this examination is to assess professional competency. The candidate is expected to maintain professional standards in the following areas –

- Suitable operating attire, inclusive of the full barrier technique.
- Candidates must follow OSHA and CDC Guidelines
- Consideration and cooperation with examiners, examination site personnel and other candidates.
- Aseptic techniques and general cleanliness of the operatory during all procedures.
- Candidates must maintain proper infection control throughout the entire examination.
- Protection of and concern for tooth structure and supporting tissue during typodont treatment.

Violation of these standards and guidelines is ground for immediate dismissal (failure) from the examination, and the candidate may be denied reexamination for 12 months.

CANDIDATE ACCESSIBILITY

Any candidate with a documented physical and/or learning disability that impairs sensory, manual, or speaking skills and that requires a reasonable deviation from the normal administration of the examination may be accommodated. A written statement from a qualified physician must be provided at the time of application. The limitation(s) must be clearly defined, and the assistance required to ensure appropriate accommodations must be detailed. Requests will be evaluated on a case-by-case basis. Accommodations/deviations will not be allowed for components and skills the examination must measure.

Information received regarding the physical/learning challenges of a candidate will remain confidential except in the case of disabilities that may require emergency treatment. In this case, onsite safety personnel will be advised.

CANDIDATE ELIGIBILITY

Candidates for the examination must be graduates of an American or Canadian dental college accredited by the American Dental Association Commission on Dental Accreditation.

A candidate who has not formally graduated from their university is required to secure certification from the dean of their program stating that:

1. The candidate is eligible and qualifies for the DDS or DMD degree requirements.
2. The candidate will complete the DDS or DMD degree requirements within 36 months of the examination date.

This certification must be in the form of a letter from the dean submitted with the application or provided to SRTA by the dean prior to the receipt of the candidate's application.

Candidates who graduated from a school outside of the United States and Canada and currently enrolled in a graduate program from a CODA accredited program may apply and be considered for the examination, pending receipt of the appropriate university program

authorization. The candidate must furnish a letter from the Dean of the university/college of dentistry. This letter should indicate that the candidate is eligible and in good standing to sit for the examination. In addition, a copy of the candidate's diploma with an English translation must be provided.

CANDIDATE INELIGIBILITY

If a candidate becomes ineligible to take the examination, they must notify the SRTA office, in writing, two weeks prior to the scheduled examination. A letter from the dean of the candidate's institution will be required as proof of ineligibility. SRTA will retain the complete application fee for any candidate declared ineligible by their dean. Candidates declared ineligible will be allowed to examine at a future site within a 12-month period upon payment of facility fees and a $200 administrative processing fee. A diploma or letter from the dean stating the candidate's eligibility is required for a rescheduled exam.

CANDIDATE RECOURSE – APPEALS PROCESS

Refer to www.srta.org from information regarding the appeals process.

UNETHICAL CONDUCT

Professional behavior is a critical quality in the practice of dentistry. If a candidate is suspected of unethical conduct as defined by SRTA guidelines, they will fail the examination.

Examples of unethical conduct include, but are not limited to:

- Using unauthorized equipment at any time during the exam
- Using unauthorized assistants
- Altering teeth used in the manikin procedures
- Engaging in dishonesty
- Altering candidate progress forms
- Any other behavior that compromises the standards of professional behavior

When SRTA charges a candidate with unethical conduct, it is SRTA's policy to notify all participating state boards of the situation. Many state statutes have criteria that include "good moral character" as a requirement for licensure. If a state board finds a candidate guilty of the alleged unethical conduct, the candidate may be ineligible for licensure in that state at any time in the future. While SRTA allows candidates to retake the SRTA Examination, they may be unable to obtain licensure in any participating state. Candidates are encouraged to address these matters with the state in which they desire licensure prior to retaking the examination.

OTHER DISMISSAL REASONS

This list **is not** all-inclusive. Listed below are the reasons for which a candidate may receive a failing evaluation or dismissal. Some procedures may be deemed unsatisfactory for other reasons. Additionally, a combination of several unsatisfactory evaluations may result in failure. Reexamination will be denied for one year (12 months) from the date of dismissal from the examination. Infractions that may lead to dismissal or failure include –

- Lack of protection and concern for tooth structure and supporting tissue during treatment.
- Lack of professional judgment.

- Evidence of dishonesty or misrepresentation during the application process, including false or misleading statements or false documentation presented by the candidate or on the candidate's behalf.
- Evidence of dishonesty or misrepresentation during candidate registration or during the examination.
- Rude, abusive, or uncooperative behavior exhibited by the candidate and/or those accompanying the candidate to the examination site.
- Continuing to work after published cutoff time.
- Working on a manikin model in a manner that does not simulate actual patient conditions.
- Working on Fixed Prosthodontics, Endodontics sextants, or Restorative sextants not provided by SRTA. Any evidence of tampering with or attempting to remove the screws from the sextants will result in failure of the entire examination and will be grounds for dismissal from the exam.
- Failure to complete the examination within the allotted time (No make-up time, grace period or second effort will be allowed for any part of this examination.)
- Receiving assistance from a dentist, another candidate, university representative(s), etc., during the course of the examination.
- Preparing a tooth other than the one approved by the examiners. This is considered major hard tissue damage.
- Thievery during the examination
- Performance of any unauthorized work outside of the examination site designated areas.
- Noncompliance with established guidelines for asepsis and infectious disease control
- **Use of cellular telephones, pagers, cameras, or other electronic equipment by the candidate while in the clinic or scoring areas**

RESTORATIVE MANIKIN-BASED SUBMISSIONS

If the candidate is scheduled to perform the Restorative Section as the first procedure of the day, they may begin setting up as soon as the clinic opens at 6:00 AM. Between 7:00 AM and 8:00 AM candidates will obtain their typodonts from a SRTA Dental Administrator (DA) or Clinic Floor Coordinator (CFC) and secure it to the manikin head. A Clinic Floor Coordinator (CFC) will need to confirm and document that the typodont is secure and provide a start check time. Restorative treatment begins at 8:00 AM. The CFC will note the start and finish times of both restorative preparations and restorations. Candidates will complete both preparations for a Class III Anterior Composite and a Class II Posterior Amalgam or Conventional Composite. After completing both preparations, candidates will contact the Clinic Floor Coordinator prior to starting the restoration portion of the procedure. Once a candidate receives a start time for the restoration portion, the candidate will proceed restoring both Anterior and Posterior procedures on new/pre-prepped teeth. **It is important that the candidate DOES NOT RESTORE THE TEETH THAT THEY HAVE COMPLETED THE PREPARATIONS ON.** Candidates will prepare two teeth and restore two **separate** teeth to allow for offsite evaluations.

If there are any questions during the restorative procedures, please contact the CFC immediately. Both Anterior and Posterior preparations and restorations must be submitted within the 5-hour allotted time limit.

REFUNDS

Candidates who fail to appear for a scheduled examination will lose their entire examination fees unless SRTA has received written notification **at least 48 hours prior to the exam start date**. Candidates requesting a refund will have a $200 administrative processing fee deducted from the refund. If you are requesting a refund, please email help@srta.org.

Any refunds requested prior to three weeks of the scheduled examination will result in:

75% Exam Fee minus $200 Administrative Processing Fee

Any refunds requested within three weeks prior to the scheduled examination will result in:

50% Exam Fee minus $200 Administrative Processing Fee

For candidates with a medical deferment, SRTA will retain the original fee and permit examination within 12 months. A physician's statement must substantiate the deferment.

REMEDIATION

If the candidate has not passed all sections of the examination after three attempts, they must contact the State Board of Dentistry where they plan to seek licensure to discuss remediation requirements. An original letter of approval/permission from the State Board(s) is required for a fourth and any subsequent examination effort. This letter must be submitted with the SRTA application for examination.

RE-EXAMINATION REQUIREMENTS

SRTA will offer candidates the ability to retake **one section** of their second attempt at no charge. The candidate must retake the one section within 1 year of the initial examination date. Facility fees cannot be waived, due to these fees being established by the examination sites. If a candidate is unsuccessful in more than one section, or subsequent attempts, regular retake fees will apply.

All sections of the SRTA Examination Series must be completed successfully within the 18 -24 months period after the first section of the series is initiated. Candidates may retake each section up to three times within the 18 or 24-month exam period. If not successful after 3 attempted retakes of any one section, the entire examination must be taken/repeated. If a candidate needs to retake one or more sections of the exam, all sections must be taken at the same examination site. This does not apply to the simulated computerized examination which is taken off-site.

Time allowed for Endodontics procedure is three (3) hours; Fixed Prosthodontics procedure is four (4) hours; One Restorative procedure is three (3) hours; Two Restorative procedures is five (5) hours; Periodontal is two (2) hours; Two Restorative procedures and Periodontal is seven (7) hours.

SRTA will assign the candidate a day and time for sectional reexaminations. This information will be emailed directly to the candidate. Candidates who do not attend registration and orientation must register with the Clinic Floor Coordinator (CFC) between 7:00 AM and 8:00 AM in the appropriate clinic on the day of the examination.

SUPPLIES PROVIDED BY EXAMINATION SITE*

Alcohol torches
Amalgam capsules
Articulating paper
Autoclave tape
Cement
Chair covers
Cotton pellets
Cotton rolls
2" x 2" cotton squares
Cotton swabs
Deck paper
Disinfectant
Disposable irrigation syringe for sodium hypochlorite
Drinking cups
Evacuator tips
Facemasks
Facial tissue
Film mounts
Floss
Gloves
Hemodent
Impression material
Instrument trays (disposable or metal)
Isopropyl alcohol
Local anesthetic
Mask
Matches
Mouth wash
Needles, short and long
Operator eyewear
Operator gowns
Paper towels
Polishing materials
Prophy paste
Red rope wax
RC prep (EDTA or other appropriate material)
Rubber dam
Rubber dam napkins
Saliva ejectors
Soap
Sodium hypochlorite
Topical anesthetic
Trash bags
Tray covers
X-ray developer and fixer
X-ray film
X-ray film clips

*Disclaimer: listed items may or may not all be supplied by the examination site. Please refer to the University Letter for available supplies provided.

Listed items may or may not be supplied by all examination sies. Please refer to the Candidate Letter for the specific items provided by the individual site. Candidates are responsible for supplying all materials, equipment and supplies not listed above for whichever techniques they choose to use. Candidates should download the Candidate Letter published by the examination site for any exceptions to this list.

STATE BOARD OF DENTISTRY & LICENSURE INFORMATION

Candidates taking the SRTA Examination must also file applications with those states in which they desire licensure, in addition to meeting the states' individual licensure requirements. Candidates should apply directly to the State Boards in which licensure is sought.

Licensure application forms for the participating State Boards of Dentistry are not available through SRTA and must be obtained from the various State Boards.

Individual state laws regarding remedial training may vary. Candidates should contact the states in which licensure is sought for their requirements on remedial education.

The States Resources for Testing and Assessments' policy allows score certification of the most recent examination attempt for a period of five years. The individual State Boards of Dentistry determine acceptance of scores. The State Boards of Dentistry listed in the following chart automatically receive your examination results. This only applies for those candidates taking the examination within the current examination cycle.

SRTA MEMBER STATES	
Alabama Alabama Board of Dental Examiners 2229 Rocky Ridge Rd Birmingham, AL 35216 T: 205 985 7267 www.dentalboard.org	**Arkansas** Arkansas State Board of Dental Examiners 101 East Capitol Avenue, Suite 111 Little Rock, AR 72201 T: 501 682 2085 www.asbde.org
South Carolina South Carolina Board of Dentistry Department of Labor, Licensing & Regulation Synergy Business Park, Kingstree Building 110 Centerview Drive Columbia, SC 29210 T: 803 896 4599 www.llr.state.sc.us	**Tennessee** Tennessee Board of Dentistry Bureau of Health, Licensure & Regulation Division of Health-Related Boards 665 Mainstream Drive Nashville, TN 37243 T: 800 778 4123 or 615-532-5073 https://www.tn.gov/health/health-program-areas/health-professional-boards/dentistry-board.html
Texas Texas State Board of Dental Examiners 1801 Congress Avenue, Suite 8.600 Austin, TX 78701 T: 512 463 6400 https://tsbde.texas.gov	**West Virginia** West Virginia Board of Dental Examiners 1319 Robert C. Byrd Drive, PO Box 1447 Crab Orchard, WV 25327 T: 877 914 8266 or 304 252 8266 www.wvdentalboard.org

SCORING CERTIFICATION

If you would like to request examination scores to be sent to your home or to a non-participating State Board, you may do so for a nominal fee. Some State Boards may require a notarized copy of the final report, which SRTA will also provide for a minimal fee. Please visit www.srta.org and fill out a Score Card Request Form.

QUESTIONS

Questions concerning jurisprudence, licensing, reciprocity, and licensure by credentials should be directed to the appropriate State Board of Dentistry where licensure is sought.

Questions concerning examination facilities and equipment should be directed to the appropriate examination site. Please contact SRTA for examination site liaison information.

All questions concerning examination procedures, content, applications, and test dates should be directed to States Resources for Testing and Assessments. See the front cover of this manual for address and telephone information.

If you prefer to email your questions, contact help@srta.org for general questions. Be sure to include your contact information. Once an application has been processed for a particular site, any questions must be initiated by only the candidate.

III. MANIKIN-BASED EXAMINATION

The examination sections will all be administered on a Kilgore typodont. Typodonts and examination teeth will be provided by SRTA. **All sections will be performed as if the manikin were a live patient.** The manikin head and facial shroud must be maintained in an acceptable operating position, and the candidate must follow all appropriate infection control procedures.

When unpacking the typodont, all packing materials should be saved and used in repacking the typodont when finished. If there are any problems with the typodont during the examination, notify a Clinic Floor Coordinator (CFC) immediately.

Manikin heads may be mounted in simulation labs as part of a simulated patient work area, or they may be chair mounted in a clinic setting. In either scenario, the manikin head may not be disassembled or removed from the dental chair for any reason without prior permission of a CFC.

Candidates will have **four hours** to complete the Fixed Prosthodontics Section, and **three hours** to complete the Endodontic Section. Candidates will have **five hours** to complete both Restorative Sections, **two hours** for the Periodontal Section for a combined total of **seven hours**.

The Fixed Prosthodontics Section is followed by the Endodontics Section. After finishing the Fixed Prosthodontic Section, a Clinic Floor Coordinator (CFC) must be called to check for completion. If a candidate finishes the Fixed Prosthodontic Section early, they may proceed to the Endodontic Section without waiting and will only be allowed the standard three hours for this section from the designated start time.

The Restorative Section will begin with the preparations of the Class III and Class II lesions, followed by the restoration of the Class II and Class III, and then the Periodontal Section.

Air/Water spray: The Candidate should use ***both air and water spray when preparing the teeth.*** If water spray is utilized, a mechanism to collect and remove the water must be in place during the use of the water spray.

Assigned teeth: Only the assigned teeth may be treated. If the candidate begins a procedure on the wrong tooth, they must notify the CFC. Candidates may mark the teeth to be treated (on the facial surface) but only after the actual examination has started and while employing all infection control guidelines.

Rubber dam: A rubber dam is required when working on the restorative preparations, restorations and endodontics procedures.

Security requirements: No written materials may be in the operating area other than a copy of the Candidate Manual or parts thereof, notes written in the manual, and the examination forms.

Note: Any validated unacceptable criteria recorded in either endodontics, fixed prosthodontics, periodontal, or restorative will result in a failure of that entire procedure.

FIXED PROSTHODONTIC SECTION

The Fixed Prosthodontics Section consists of three procedures:

1. **Porcelain-fused-to-metal crown preparation** as an anterior abutment for the 3-unit bridge, plus an evaluation of the line of draw for the bridge abutment preparations (tooth #5)
2. **Cast metal / All-Zirconia crown preparation** as a posterior abutment for the 3-unit bridge (tooth #3)
3. **All-ceramic crown preparation** on an anterior central incisor (tooth #9)

Equilibration prohibited: No equilibration will be permitted on the typodont prior to or subsequent to any crown preparation.

Isolation dam: No isolation dam is required for the crown preparations.

Reduction guide: A reduction guide/stent must be fabricated during the set-up time. This can be done without the use of gloves prior to typodont mounting. Other impressions can be taken during the exam but can only be made using appropriate infection control procedures. All impressions, casts or models must be turned in at the end of the exam.

Reiteration: Stents and Reduction Guides can be fabricated during set up time. Upon completion of the exam, candidates must write their candidate number using a black permanent marker (indelible ink) on all sections of the stent. These are placed in a plastic bag with a candidate label adhered to the bag. This bag is then turned in when the typodont is submitted for scoring. If the candidate incorrectly fabricates stents, the ability to appeal is forfeited.

Prohibited materials: Prefabricated impressions, registrations, overlays, clear plastic shells, models or prefabricated preparations are not permitted to be brought to the examination site**. Failure to follow these requirements will result in confiscation of the materials as well as dismissal from and failure of the examination.**

Note: Before the typodont is submitted for scoring, you must be sure it is clear of all dust and debris. At the discretion of the examiner, the stents may be used to aid in grading the typodont.

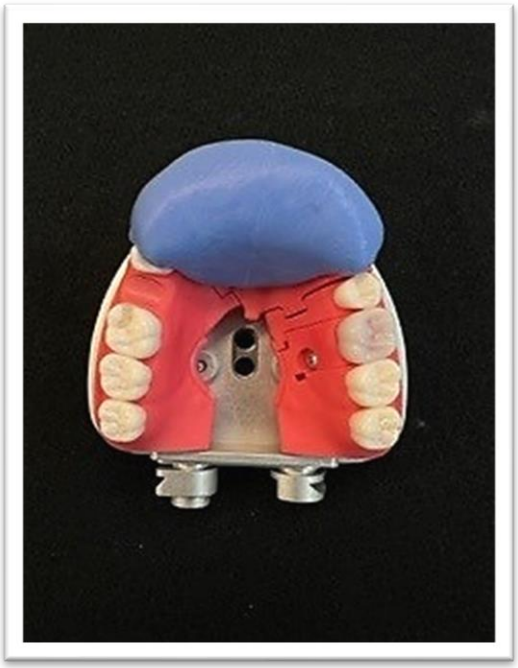
STENT FABRICATION

**Note: The fabrication of stents is required. Stents should be made during set-up time.

For the Fixed Prosthodontic Section, candidates may form stents for three assigned teeth **(#3, #5, and #9)** using heavy-bodied putty PVS (poly vinyl siloxane). The stent for #3 and #5 can be made with one piece of putty. The stent should cover #1 and extend to #7, extending down past the facial and lingual surfaces of the teeth to be prepped and their adjacent teeth. For #9, the stent should cover #7 to #11 extending past the facial and lingual surfaces of the teeth to be prepped, and the adjacent teeth.

Teeth #3 & #5

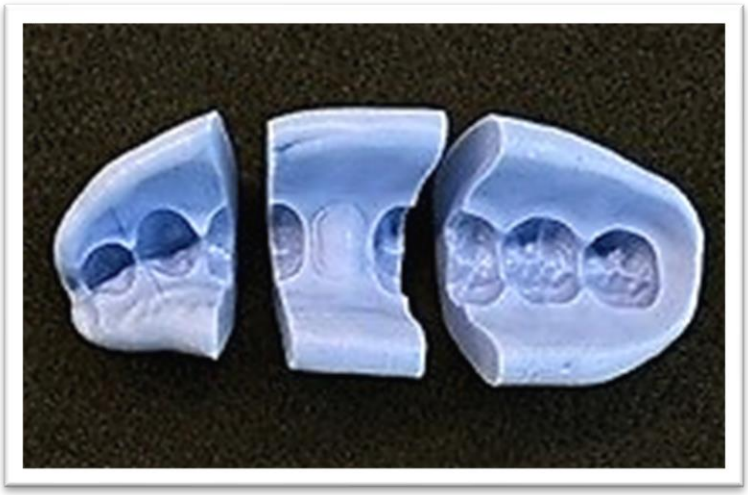
Tooth #9



Form the stent to cover entirely from #1 to #7. Be certain to smear a small amount of the putty into the central grooves immediately prior to placing the bulk of the putty over the sextant. This will ensure the central groove area is captured in the putty stent.

Tooth #3 and #5

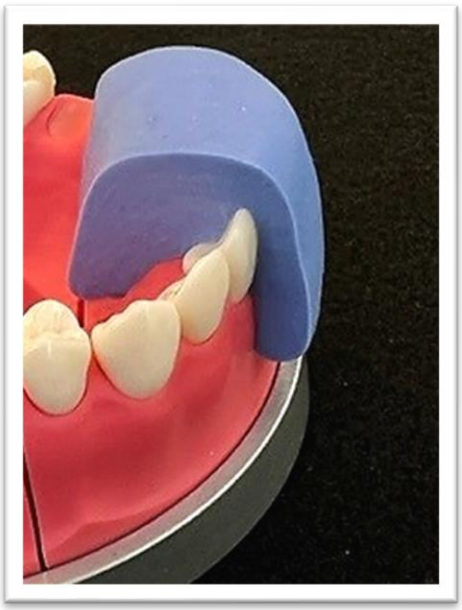
With a scalpel/knife (Bard Parker blade works well) make a cut connecting the buccal and the lingual cusp tips of #3 through the center of the putty stent. Make the same cut through the buccal and lingual cusp tips of #5 through the center of the putty stent. The resulting three sections should be easily reassembled over the teeth to ensure that the stent is well adapted to all the contours of the tooth and supporting gingival area.



Tooth #9

Mark the mesial-distal center of the incisal edge of tooth #9. Using a scalpel/knife, make a cut entirely through the putty stent, perpendicular to the incisal edge. The two resulting sections of the stent should be easily reassembled over the teeth to ensure that the stent is well adapted to all the contours of the tooth and supporting gingival area.

Fit of the stents



The stents should fit intimately to the teeth and adjacent soft tissue.

Remember: Write your candidate number- using a black permanent marker (indelible ink) on all sections of the stent. Place the stents in a plastic bag with a candidate label affixed to the bag. Turn in the bag when the typodont is submitted for scoring. If stents are fabricated incorrectly or are not submitted, you will forfeit the ability to pursue an appeal based on reduction.

Fixed Prosthodontics: PFM Crown # 5

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Damage to adjacent/opposing teeth	The adjacent teeth and/or restorations are free from damage.	Damage to the adjacent tooth/teeth and/or opposing teeth can be removed by polishing without adversely altering the shape of the contour and/or contact.	There is damage to adjacent tooth/teeth requiring a restoration.
2. Damage to simulated gingiva and/or typodont	The simulated gingiva and/or typodont is/are free from damage.	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
3. Correct Tooth Treated	Correct tooth treated	Correct tooth treated.	Wrong tooth treated
CERVICAL MARGIN	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Location (mm from CEJ or Crest of Free Gingival Margin)	The cervical margins should be 1.0 mm occlusal to the simulated free gingival margin.	The cervical margin is less than 0.5 mm below or no greater than 1.5 mm above the simulated free gingival margin. If greater than 0.5 mm there is no visual damage.	The cervical margin is greater than 0.5 mm below with visual damage or greater than 1.5 mm above the simulated free gingival margin.
2. Margin Refinement	The cervical margin is smooth, continuous, and well defined.	The cervical margin is continuous but may be slightly rough and lacks some definition.	The cervical margin has no continuity and/or definition and will prevent fabrication of an adequate restoration.
3. Margin Design	The margin design is a chamfer/rounded shoulder.	The margin is a chamfer/rounded shoulder.	The cervical margin is cupped or j-shaped resulting in unsupported enamel that will prevent fabrication of an adequate restoration.
4. Facial Cervical Margin (width mm)	The facial margin is 1.5 mm in width.	The facial margin is greater than 0.5 mm to 2.5 mm in width.	The facial margin is less than 0.5 mm or greater than 2.5 mm in width.
5. Lingual Cervical Margin (width mm)	The lingual margin is 1.0 mm.	The lingual margin is 0.5 mm to 2.0 mm in width.	The lingual margin is less than 0.5 mm, is feathered and/or not explorer detectable or more than 2.0 mm in width.
WALLS, TAPER, & SHOULDER	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Axial Reduction - Facial (mm) Lingual (mm)	The facial axial tissue removal is 1.5 mm to be sufficient for convenience, retention and resistance form. The lingual axial tissue removal is 1.0 mm to be sufficient for convenience, retention and resistance form.	The facial axial tissue removal is 0.5 mm to 2.5 mm.	The facial axial tissue removal is less than 0.5 mm or greater than 2.5 mm.
2. Walls / Axial Refinement	The walls are smooth and well defined and/or internal line angles and/or cusp tip areas are rounded.	The walls may be slightly rough and lack some definition and/ or internal line angles and/or cusp tip areas are rounded and have a slight tendency of being sharp.	The walls are grossly rough and lack definition and/or internal line angles and/or cusp tip areas are sharp with no evidence of rounding.
3. Taper (Degrees TOC)	Taper, total occlusal convergence (TOC) is 10°– 16°.	Taper, total occlusal convergence (TOC) is 16° or less.	Taper, total occlusal convergence (TOC) is greater than 16° TOC.
4. Undercuts	There are no undercuts.	Slight undercut(s) exists, but an adequate restoration can be fabricated.	Undercut(s) exists greater than 0.5 mm and an adequate restoration cannot be fabricated.
5. Occlusal Reduction (mm)	Occlusal reduction is 2.0 mm.	Occlusal reduction 1.0 mm to 3.0 mm	Occlusal reduction is less than 1.0 mm; more than 3.0 mm.
6. Crown Path of Insertion (Degrees from Long Axis)	The appropriate path of insertion varies less than 10° from parallel to the long axis of the tooth on all axial surfaces, and a line of draw is established.	The path of insertion or line of draw deviates 10° to less than 30° from the long axis of the tooth.	The path of insertion or line of draw is unacceptable, deviating 30° or more from the long axis of the tooth.

Fixed Prosthodontics: Cast Metal / All Zirconia Crown # 3

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Damage to adjacent/ opposing teeth	The adjacent teeth and/or restorations are free from damage.	Damage to the adjacent tooth/teeth and/or opposing teeth can be removed by polishing without adversely altering the shape of the contour and/or contact.	There is damage to adjacent tooth/teeth and/or opposing teeth requiring a restoration.
2. Damage to simulated gingiva and/or typodont	The simulated gingiva and/or typodont is/are free from damage.	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
CERVICAL MARGIN	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Location (mm from CEJ or Crest of Free Gingival Margin)	The cervical margins should be 1.0 mm occlusal to the simulated free gingival margin.	The cervical margin is less than 0.5 mm below or no more than 1.5 mm above the simulated free gingival margin. If greater than 0.5 mm there is no visual damage.	The cervical margin is greater than 0.5 mm below causing visual damage or greater than 1.5 mm above the simulated free gingival margin.
2. Margin Refinement	The cervical margin is smooth, continuous and well defined.	The cervical margin is continuous but may be slightly rough and lacks some definition.	The cervical margin has no continuity and/or definition and will prevent fabrication of an adequate restoration.
3. Margin Design	The cervical margin meets the external surface of the tooth at approximately a right angle.	The cervical margin meets the external surface of the tooth at approximately a right angle.	The cervical margin meets the external surface of the tooth at an angle greater than 120°. The cervical margin is cupped or j-shaped resulting in unsupported enamel that will prevent fabrication of an adequate restoration.
4. Cervical Margin (width mm)	The cervical margin is 1.0 mm in width.	The cervical margin Is a chamfer and varies slightly in width, is detectable visually or with an explorer, and is less than or equal to 2.0 mm in width.	The cervical margin is not a chamfer, is not detectable and/or is greater than 2.0 mm in width.
WALLS, TAPER, & SHOULDER	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Axial Tissue Reduction (mm)	Axial tissue removal is optimally 1.0 mm to be sufficient for convenience, retention and resistance form.	Axial tissue removal is greater than 0.5 mm but less than 2.5 mm.	Axial tissue removal is less than 0.5 mm or greater than 2.5 mm.
2. Walls / Axial Refinement	The walls are smooth and well defined and/or internal line angles and/or cusp tip areas are rounded.	The walls are slightly rough and lack some definition and/or internal line angles and/or cusp tip areas are rounded and have a slight tendency of being sharp.	The walls are rough and lack definition and/or internal line angles and/or cusp tip areas are sharp with no evidence of rounding.
3. Taper (Degrees TOC)	Taper, total occlusal convergence (TOC) is 10°– 16°.	Taper, total occlusal convergence (TOC) is 16° or less.	Taper, total occlusal convergence (TOC) is greater than 16°.
4. Undercuts	There are no undercuts.	Slight undercut(s) exists, but it will not interfere with fabrication of an adequate restoration.	Undercut(s) exists greater than 0.5 mm and an adequate restoration cannot be fabricated
5. Occlusal Reduction (mm)	Occlusal reduction is 1.5 mm.	Occlusal reduction is greater than 1.0 mm or less than or equal to 2.5 mm.	Occlusal reduction is Less than 1.0 mm or more than 2.5 mm.
6. Crown Path of Insertion (Degrees From Long Axis)	The appropriate path of insertion varies less than 10° from parallel to the long axis of the tooth on all axial surfaces, and a line of draw is established	Path of insertion or line of draw deviates 10° to less than 30° from the long axis of the tooth.	Path of insertion or line of draw is unacceptable, deviating 30° or more from the long axis of the tooth.

Fixed Prosthodontics: Bridge Factor			
TREATMENT MANAGEMENT	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
Bridge Factor	The line of draw or path of insertion would allow for the full seating of a fixed prosthesis in a direct vertical plane without rotation.	A line of draw exists whereby an adequate prosthesis may be fabricated.	An adequate prosthesis may not be fabricated without removal of additional tooth structure.

Fixed Prosthodontics: Ceramic Crown # 9

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Damage to adjacent/ opposing teeth	The adjacent teeth and/or restorations are free from damage.	Damage to the adjacent tooth/teeth and/or opposing teeth can be removed by polishing without adversely altering the shape of the contour and/or contact.	There is gross damage to adjacent tooth/teeth and/or opposing teeth requiring a restoration.
2. Damage to simulated gingiva and/or typodont	The simulated gingiva and/or typodont is/are free from damage.	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
CERVICAL MARGIN & DRAW	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Location (mm from CEJ or Crest of Free Gingival Margin)	The cervical margins should be 1.0 mm occlusal to the simulated free gingival margin.	Less than 0.5 mm below or no more than 1.5 mm above the simulated free gingival margin. If greater than 0.5 mm below, there is no visual damage.	Greater than 0.5 mm below with visual damage or greater than 1.5 mm above the simulated free gingival margin.
2. Margin Refinement	The cervical margin is smooth, continuous and well defined.	The cervical margin is continuous but may be slightly rough and lacks some definition.	The cervical margin has no continuity and/or definition and will prevent fabrication of an adequate restoration.
3. Margin Design	The cervical margin meets the external surface of the tooth at approximately a right angle.	The cervical margin meets the external surface of the tooth at approximately a right angle.	The cervical margin meets the external surface of the tooth at an angle > 120°. The cervical margin is cupped or j-shaped resulting in unsupported enamel that will prevent fabrication of an adequate restoration.
4. Cervical Margin (width mm)	The cervical margin is 1.25 mm in width	0.5 mm to 2.0 mm in width.	< 0.5 mm or > 2.0 mm in width.
WALLS, TAPER, & SHOULDER	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Axial Reduction (mm)	The axial tissue removal is 1.0 mm to be sufficient for convenience, retention and resistance form.	The facial and proximal axial reduction is = or > 1.0 mm and = or < 2.5 mm. The lingual axial reduction is = or > 0.5 mm or = or < 2.0 mm	The facial and proximal axial reduction is < 1.0 mm or > 2.5 mm. The lingual axial reduction is < 0.5 mm or > 2.0 mm
2. Walls / Axial Refinement	The walls are smooth and well defined and/or internal line angles and/or incisal edge area are rounded.	The walls may be slightly rough and lack some definition and/or internal line angles and/or incisal edge are rounded and have a slight tendency of being sharp.	The walls are grossly rough and lack definition and/or internal line angles and/or incisal edge are sharp with no evidence of rounding.
3. Taper (Degrees TOC)	Total occlusal convergence (TOC) is 10°– 16°.	Taper, (TOC) is 16° or less.	Taper, (TOC) is greater than 16°.
4. Undercuts	There is no undercut present.	There may be slight undercut(s), but it will not interfere with fabrication of an adequate restoration.	Undercut(s) exists and is > 0.5 mm and an adequate restoration cannot be fabricated.
5. Incisal Reduction (mm)	The incisal reduction is 2.0 mm.	1.0 mm to 3.0 mm.	Less than 1.0 mm; more than 3.0 mm.
6. Lingual Wall	The lingual wall is 2.0 mm in height.	Greater than 1.0 mm in height.	Less than 1.0 mm in height.
7. Crown Path of Insertion (Degrees from Long Axis)	The appropriate path of insertion varies less than 10° from parallel to the long axis of the tooth on all axial surfaces, and a line of draw is established	The path of insertion or line of draw deviates 10° to less than 30° from the long axis of the tooth.	The path of insertion or line of draw is unacceptable, deviating 30° or more from the long axis of the tooth.

ENDODONTICS SECTION

The Endodontics Section consists of two procedures:

1. **Anterior Endodontics** – Access opening, canal instrumentation and obturation on an anterior tooth. This anterior tooth is considered to have a normal size pulp chamber for a 21-year-old. The access opening must be triangular in shape, in the middle third of the tooth, both inciso-gingivally and mesio-distally and otherwise appropriate for a young adult.
2. **Posterior Endodontics** – Access opening on a posterior tooth. Candidate must achieve direct access to all three canals.

Filling material: No temporary filling material, cotton pellet or restorative material should be placed in the pulp chamber.

Instruments: Other than the instruments and materials provided by the examination site, the candidate is responsible for providing the instruments, files and materials of their choice. Rotary instruments are permissible during the Endodontics Section.

Isolation dam: The use of an isolation dam is only required for endodontic procedures. A single dam may be used to isolate both teeth simultaneously or separate dams for each tooth may be used to isolate each independently. **An isolation dam clamp should not be placed on the teeth you will be working on. Doing so may cause the crown to separate from the root of the manikin tooth.** Clamping of adjacent teeth or ligation is acceptable. All treatment must be done with the dam in place.

Caution: The use of warm gutta-percha or carrier-based, thermoplasticized gutta-percha techniques is not recommended, as they may cause damage to the plastic endodontic tooth.

Radiographs: Since the tooth/canal length of the Anterior tooth is directly measured prior to the procedure, no radiographs are permitted at any point during this section.

Reference point: The cemento-enamel junction (CEJ) on the facial surface should be used as the reference point to determine the fill depth in the pulp chamber.

Tooth Fractures: If the Anterior Endodontic tooth fractures during filling, contact the Clinic Floor Coordinator (CFC) before the treatment is continued/completed. If the crown fractures during treatment, contact the CFC immediately.

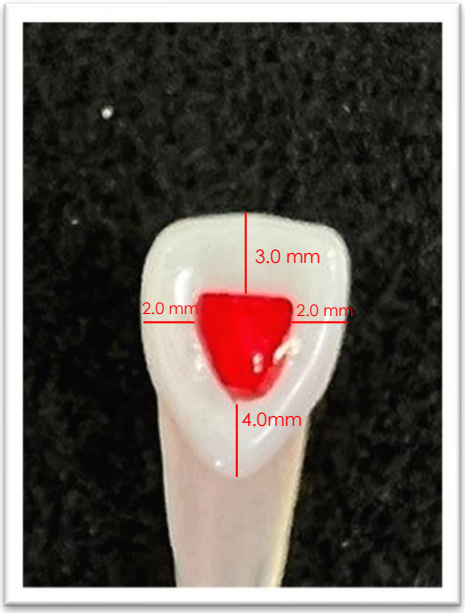
Anterior Endodontics

Treatment Management	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Damage to adjacent/ opposing teeth	The adjacent teeth and/or restorations are free from damage.	Damage to adjacent tooth/teeth can be removed by polishing without adversely altering the shape of the contour and/or contact.	There is gross damage to adjacent tooth/teeth, requiring a restoration.
2. Damage to simulated gingiva and/or typodont	The simulated gingiva and/or typodont is/are free from damage.	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
3. Correct Tooth Treated	Correct tooth related.	Correct tooth treated.	Wrong tooth treated.
Access Opening	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Access Placement	The placement of the access opening is on the lingual surface over the pulp chamber and allows for: • Pulp horns to be removed • Debridement of the pulp chamber • Provides straight line access to the root canal system	The placement of the access opening is on the lingual surface over the pulp chamber and allows for: • Debridement of the pulp chamber • Provides straight line access to the root canal system.	The placement of the access opening is NOT over the pulp chamber and/or does NOT allow: • Complete debridement of the pulp chamber OR • Access to debride the root canal system
2. Access Size	The size of the access opening: • Allows for complete removal of the pulp horns • The incisal aspect of the access opening is 3.0mm from the incisal edge which provides for a fully supported incisal edge • The cervical aspect of the access opening is 4.0mm from the lingual CEJ which provides for a fully supported cingulum • The widest portion of the preparation mesio-distally provides for fully supported 2.0mm marginal ridges	The size of the access opening: • Allows for complete removal of the pulp horns • The incisal aspect of the access opening is not less than 2.0 mm from the incisal edge which provides for a fully supported incisal edge • The cervical aspect of the access opening is not less than 3.0 mm from the lingual CEJ which provides for a fully supported cingulum • The widest portion of the preparation provides for fully supported marginal ridges.	The size of the access opening: • Does NOT allow removal of the pulp horns • The incisal aspect of the access opening is less than 2.0 mm from the incisal edge which compromises the incisal edge • The cervical aspect of the access opening is less than 3.0 mm from the lingual CEJ which compromises the cingulum • The mesial/distal extent of the access preparation is less than 1.0mm to the external surface of the tooth.
3. Internal Form	From the lingual surface to the cervical portion, the internal form smoothly tapers to the canal opening.	From the lingual surface to the cervical portion, the internal form tapers to the canal opening with only slight irregularities.	The internal form exhibits excessive gouges, which compromises the integrity of the tooth.

Anterior Endodontics (continued)

Canal Instrumentation	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Canal Shape	The canal is shaped to a continuous taper to allow adequate debridement and obturation.	The canal is shaped to a continuous taper to allow adequate debridement and obturation.	The shape of the canal preparation does not allow adequate debridement and obturation.
2. Cervical Portion	The cervical portion of the canal is of appropriate location and size to allow access to the apical root canal system.	The cervical portion of the canal is of appropriate location and size to allow access to the apical root canal system.	The cervical portion of the canal is grossly over prepared affecting the integrity of the tooth structure.
3. Mid-Root Portion	The mid root portion of the canal blends smoothly with the cervical portion.	The mid root portion of the canal blends smoothly with the cervical portion. If canal irregularities are present, they will not prevent canal obturation.	The mid root portion of the canal has significant instrumentation irregularities that will compromise obturation.
4. Mid-Root & Apical Portion Transported	The mid root and apical preparations are not transported and are congruent with the anatomical apex.	The mid root or apical portion of the canal may be transported during preparation, but the apical portion of the preparation is still congruent with the anatomical apex.	The apical portion of the canal preparation is transported to the extent that the apical portion of the canal is not instrumented.
5. Perforation	No portion of the tooth is perforated.	No portion of the tooth perforated.	Any portion of the tooth is perforated.
6. Tooth Fracture	No portion of the tooth is fractured.	No portion of the tooth fractured.	Any portion of the tooth is fractured.
7. Apical Portion	The apical portion of the canal is prepared to the anatomical apex of the tooth.	Apical portion of the canal is prepared to the anatomical apex of the tooth or < or = 2.0 mm short of the anatomical apex.	Apical portion is underprepared > 2.0 mm short of the anatomical apex.
Canal Obturation	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Obturation Distance from Apex	The root canal is obturated with gutta percha and sealer 1.0 mm short of the anatomical root apex.	The root canal is obturated with gutta percha no more than 1.0 mm past the anatomical apex or up to 2.0 mm short of the root apex.	The root canal is obturated with gutta percha extending more than 1.0 mm past the anatomical apex or more than 2.0 mm short or beyond the anatomical apex.
2.Obturation Density	The obturation in the root canal is dense without voids.	The apical third of the obturation in the root canal is dense but may contain minor voids.	There are significant voids throughout the obturation of the root canal or there is no gutta percha present in the root canal or a material other than gutta percha was used to obturate the root canal.
3.Termination of Gutta Percha	The coronal extent of the gutta percha in the root canal is removed to the level of the CEJ when measured from the facial.	The gutta percha in the root canal is up to 3.0 mm apical to the CEJ when measured from the facial.	The gutta percha in the root canal is more than 3.0 mm apical to the CEJ when measured from the facial.
4.Pulp Chamber	The pulp chamber is clean without remnants of gutta percha or sealer.	Gutta percha and/or sealer is/are evident in the pulp chamber extending equal to or > 2.0 mm coronal to the CEJ when measured from the facial.	Gutta percha and/or sealer is/are evident in the pulp chamber extending more than 2.0 mm coronal to the CEJ when measured from the facial.
5.File Separation	No file separation.	A file is separated in the root canal but does not affect the obturation of the root canal.	A file is separated in the root canal and either prevents obturation or allows obturation at a critically deficient level.
6.Pulp Chamber	No restorative material present in pulp chamber.	No restorative material present in the pulp chamber.	Restorative material present in the pulp chamber.

TREATMENT GOAL FOR ACCESS OPENING – ANTERIOR TOOTH



Posterior Endodontics

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Damage to adjacent/opposing teeth	The adjacent teeth and/or restorations are free from damage.	Damage to the adjacent tooth/teeth can be removed by polishing without adversely altering the shape of the contour and/or contact.	There is damage to adjacent tooth/teeth requiring a restoration.
2. Damage to simulated gingiva and/or typodont	The simulated gingiva and/or typodont is/are free from damage.	There is slight damage to simulated gingiva and/or typodont consistent with the procedure.	There is gross iatrogenic damage to the simulated gingiva and/or typodont inconsistent with the procedure.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
ACCESS OPENING	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Access Placement	The placement of the access opening is over the pulp chamber allowing debridement of the pulp chamber and straight-line access to the three root canals located in the tooth. The access opening allows access to the three root canals to the extent that instruments can be placed to the apex of the roots.	The placement of the access opening is ideally over the pulp chamber allowing debridement of the pulp chamber and straight-line access to the three root canals located in the tooth. The placement of the access opening may not be directly over the pulp chamber and may hinder but will allow complete debridement of the pulp chamber. The access opening must allow access to the three root canals to the extent that instruments can be placed to the apex of the roots.	The placement of the access opening is not over the pulp chamber and does not allow complete debridement of the pulp chamber or access to the three root canals to the extent that instruments can be placed to the apex of the roots.
2. Access Opening	The access opening is in the mesial triangular pit and central fossa of the tooth and: • The mesial extent of the access preparation is 3.0 mm from the external surface of the mesial marginal ridge of the tooth. • The buccal extent of the access preparation is 2.0 mm from the line bisecting the mesiobuccal and distobuccal cusp tips. • The distal extent of the access preparation is 1.5 mm from the distal oblique grove. • The palatal extent of the access preparation is 2.0 mm from the palatal cusp tip. • The access size is 3.0 mm at its widest mesio-distally and/or buccal-lingually.	The access opening is in the mesial triangular pit and central fossa of the tooth and: • The mesial extent of the access preparation is not less than 2.0 mm from the external surface of the mesial marginal ridge of the tooth. • The buccal extent of the access preparation is not less than 1.0 mm from the line bisecting the mesiobuccal and distobuccal cusp tips. • The distal extent of the access preparation is not less than 1.0 mm from the distal oblique groove. • The palatal extent of the access preparation is not less than 1.0 mm from the palatal cusp tip. • The access size is equal to or greater than 2.5 mm at its widest mesio-distally and/or buccal-lingually.	The access opening is either grossly under-or-over-extended in one or more of the following categories: • The mesial extent of the access preparation is less than 2.0mm to the external surface of the tooth. • The buccal extent of the access preparation is less than 1.0 mm to the line bisecting the mesiobuccal and distobuccal cusp tips. • The distal extent of the access preparation is less than 1.0 mm from the distal oblique groove. • The palatal extent of the access preparation is less than 1.0 mm from the palatal cusp tip. • The access size is too small; less than 2.5 mm at its widest mesio-distally and/or less than 2.5mm at its widest buccal-lingually.

Posterior Endodontics (continued)

ACCESS OPENING	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
3. Access Depth	The depth of the access preparation removes the entire roof of the pulp chamber, and all three canals can be accessed. The depth of the access preparation is 8.0 mm when measured from the buccal cavosurface margin of the access preparation.	The depth and size of the access preparation removes the entire roof of the pulp chamber, and all three canals can be straight-line accessed. The depth of the access preparation is a maximum of 10.0 mm when measured from the buccal cavosurface margin of the access preparation.	The depth and size of the access preparation does not remove the roof of the pulp chamber to the extent that all pulp tissue can be removed, and all 3 canals cannot be straight-line accessed, or the depth of the access preparation is more than 10.0 mm deep when measured from the buccal cavosurface margin of the access preparation.
4. Internal Form	The internal form of the access preparation leaves 2.0 mm of supported lateral tooth structure at any point of the preparation and tapers to the canal orifices with no gouges.	The internal form of the access preparation leaves at least 1.0 mm of supported lateral tooth structure at any point of the preparation and tapers to the canal orifices with no or slight gouges.	The internal form of the access preparation leaves less than 1.0 mm of lateral supported tooth structure at any point of the preparation and/or tapers to the canal orifices with gross ledges that will inhibit access to the root canal orifices.
5. Perforation	No portion of the tooth is perforated.	No portion of the tooth is perforated.	Any portion of the tooth is perforated.
6. Tooth Fracture	No portion of the tooth is fractured.	No portion of the tooth is fractured.	Any portion of the tooth is fractured.

TREATMENT GOAL ACCESS OPENING – POSTERIOR TOOTH

RESTORATIVE SECTION

The Restorative examination consists of two sections –

1. **Anterior Restorative Section: Class III Composite preparation and restoration.** Surface sealants must not be placed on the finished composite restoration.
2. **Posterior Restorative Section: Conventional Class II preparation and restoration.** Slot preps may not be prepared. The candidate may choose to restore either an Amalgam or Conventional Composite restoration.

   ***For amalgam only:** The condensed and carved amalgam surface should **not** be polished or altered by abrasive rotary instrumentation except for the purpose of adjusting occlusion. Proximal contact is a critical part of the evaluation, and the candidate should be aware that the examiners will be checking the contact with floss.

   Please note that, for this examination, proximal contacts must be **visually** closed. Some resistance to the passage of floss is not sufficient for judging a contact to be closed. Also, contacts must not prevent floss from passing through. Proximal contacts that are not visibly closed or that do not permit the passage of floss are evaluated as *Unacceptable*. The candidate must be familiar with the properties of the amalgam being used and should be sure to allow sufficient time for the amalgam to set.
   ****Candidates will be prepping two teeth and restoring two different/separate teeth! DO NOT restore the teeth you have prepped! If you restore the teeth you have prepped, examiners will NOT be able to evaluate your preparations and will result in a failing score for the restorative procedure(s) of the examination.**

If a candidate is taking only one restorative procedure, they will be given **2.5 hours**. If a candidate is taking both restorative procedures, they will have **5 hours** to complete. Candidates taking anterior, posterior & periodontal, will have **7 hours** to complete.

If the candidate does not pass one of the preparations, they will be required to complete the one preparation and restorative that was failed, at the next available grading site.

TREATMENT GUIDELINES

Pulpal exposure: If a candidate anticipates a pulpal exposure, a **modification request** must be completed describing what the candidate intends to do prior to continuing with the preparation, then contact the CFC to review the modification request.

In the event of a pulpal exposure, the candidate should write in the Notes section on the Progress Form that a pulpal exposure has occurred, indicate the time, and briefly describe how the situation should be treated. A CFC is called and the typodont is reviewed.

MODIFICATION REQUESTS

"Bundling" of modification requests is not allowed. Each request must be separate and answer the question where, how much, and why. The forms are available from the CFC Assistant.

The tooth must be prepared to ideal dimensions prior to submission of a Modification Request Form.

To request a modification, the candidate must briefly write each modification on the Modification Request Form. The candidate may obtain a Modification Request Form from a CFC. The request for each modification should include:

- **What** is the candidate requesting to do? (Type of modification)
- **Where**? (e.g., gingival axial line angle, mesial box)
- **How Much** is to be removed? (e.g., 0.5 mm from the axial wall)
- **Why** is the modification needed? (e.g., due to caries, decalcification)

If any of the four spaces for modification requests are not needed, cross out the additional requests lines not used. After viewing and logging the Modification request, the CFC will place a red dot in the designated circle at the top-left of the Progress Form to indicate a requested modification.

A request for modification may be denied on the basis of any one part of the request. For example, if a candidate's request to "extend the box; to the lingual; 2.0 mm; to remove caries" is denied, they should not assume that the request was denied because there is no caries. The denial may be because the request to remove 2.0 mm is excessive.

The typodont and modification is evaluated by the CFC.

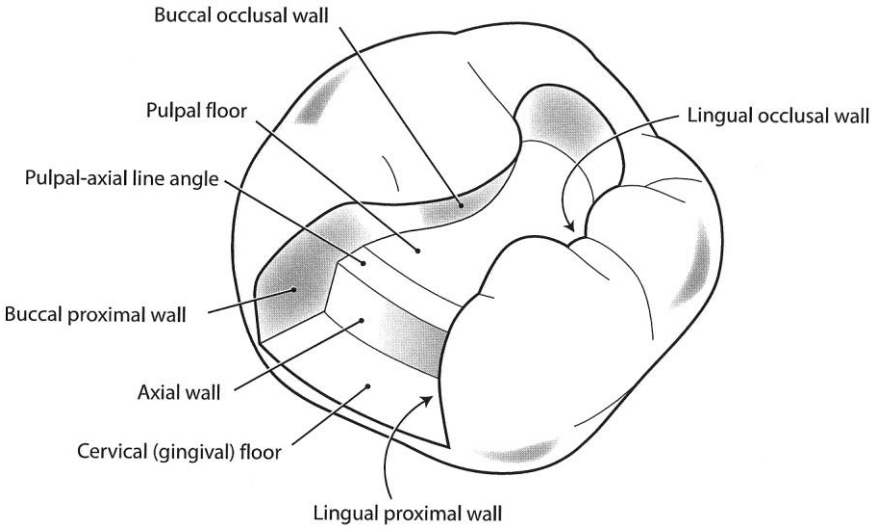
The CFC will place a green dot over the red dot on the Progress Form to indicate that they have assessed the request and write their PIN on the modification as reviewed. The Modification Request Form will be returned to the candidate by the CFC to indicate whether the modification(s) has been granted or not granted.

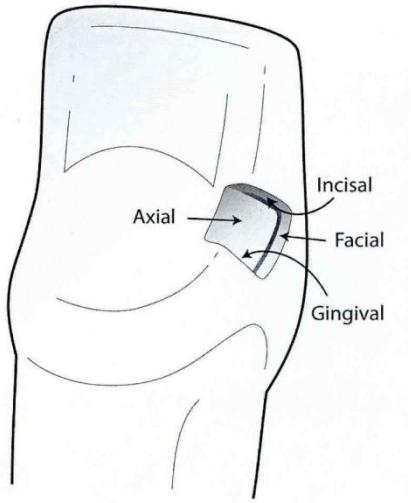
Carefully review the criteria for modification requests. Inappropriate requests for modification(s) will result in a small penalty for each modification not granted. A larger penalty will be assigned for requests for a modification for the removal of caries or decalcification when no caries or decalcification exists or for repeated modification requests in an apparent attempt to have the examiners confirm when all caries are removed. Modifications that have been approved and appropriately accomplished will not result in any penalties.

Whether the modification is granted or not granted, the candidate must utilize their clinical judgement and complete the preparation as necessary.

If the candidate subsequently has additional requests for modification on the same preparation, a new red dot is placed over the green dot on the Progress Form, and the same procedure is followed. If more than one modification is anticipated at any time, it is to the candidate's advantage to submit them at the same time, as no additional time is provided for evaluation of modification requests, and multiple submissions may significantly decrease treatment time.

Terminology to be used when requesting modifications:





PROCEDURE MANAGEMENT GUIDELINES

Restorative Procedures: Candidates will begin with both the Anterior and Posterior preparations first, followed by the restoration procedures on two separate teeth. Candidates must have the CFC approve the mounting of the typodont before starting the Preparation stage. After a candidate has completed the two preparations, please notify the CFC and they will designate a finish time for the restorations.

Completion of Anterior and Posterior Preparations and Restorative Procedures: Once a candidate has completed both preparations and restorative procedures, please notify the CFC. The CFC will confirm, and place the Kilgore restorative segments in the candidate's assigned box, close/seal with enclosed packing materials for final evaluation. Candidates will then continue with the Periodontal portion of the examination.

Class III Anterior Composite Preparation

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	The adjacent teeth and/or restorations are free from damage.	Any damage to adjacent tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	The soft tissue is free from damage, or there is tissue damage that is consistent with the procedure.	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated	Correct tooth treated.	Wrong tooth treated
4. Preparation Design	Traditional Class III	Preparation has Class III Design with no Interproximal tooth structure remaining	Preparation is a Class I Design with intact Interproximal tooth structure remaining
EXTERNAL FORM	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Outline Form (Access Size)	The outline form is sufficient in size to have access to remove caries and to manipulate and finish the restorative material. Must be a true Class III with interproximal enamel removed.	The outline form is sufficient in size to have access to remove caries and to manipulate and finish the restorative material. Must be a true Class III with interproximal enamel removed.	The outline form is under-extended, making it impossible to remove caries or to manipulate and finish the restorative material. Is NOT a true Class III.
2. Outline Form (Mesial-Distal)	The outline form is not overextended beyond what is necessary for complete removal of caries.	May be extended mesiodistally up to 3.0 mm	Extended mesiodistally by more than 3.0 mm
3. Outline Form (Incisal-Gingival)	The outline form is not overextended beyond what is necessary for complete removal of caries.	May be extended inciso-gingivally up to 5.0 mm	Outline form is extended inciso-gingivally by more than 5.0 mm
4. Incisal Cavosurface Margin	The incisal cavosurface margin does not compromise the incisal angle.	The incisal cavosurface margin does not compromise the incisal angle.	The incisal cavosurface margin is over-extended so that the incisal angle is compromised, removed or fractured. A Class IV restoration is now necessary without prior justification.
5. Wall opposite the access	The wall opposite the access, if broken, does not extend more than 0.5 mm beyond the contact area.	The wall opposite the access, if broken, may extend no more than 2.0 mm beyond the contact area.	The wall opposite the access opening extends more than 2.0 mm beyond the contact area.
6. Caries	There is no caries remaining.	There is no caries remaining.	There is caries remaining.
7. Cavosurface Margin	The cavosurface margins are not irregular and there is no explorer-penetrable decalcification remaining on the cavosurface margin.	The cavosurface margins may be slightly irregular but there is no explorer-penetrable decalcification remaining on the cavosurface margin.	The cavosurface margin does not terminate in sound natural tooth structure. There is explorer–penetrable decalcification at the cavosurface margin.
8. Unsupported Enamel	There is no unsupported enamel.	There may be small areas of unsupported enamel, which is necessary to preserve facial esthetics	Large or multiple areas of unsupported enamel that are not necessary to preserve facial aesthetics

9. Enamel Cavosurface Margin Bevel	Enamel cavosurface margin may be beveled.	Enamel cavosurface margin bevels, if present; do not exceed 1.0 mm in width.	Enamel cavosurface margin bevels, if present, exceed 1.0 mm in width, are not uniform or are inappropriate for the size of the restoration
10. Gingival Clearance	The gingival clearance may be open or closed.	The gingival clearance may be closed or open up to 2.0 mm.	The gingival clearance is open greater than 2.0 mm.

Class III Anterior Composite Preparation (continued)

INTERNAL FORM	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Caries	The preparation is free of caries.	Preparation is free of caries.	Preparation has remaining caries.
2. Axial Wall Depth (mm) (Beyond the DEJ)	The depth of the axial wall is just inside the DEJ	The depth of the axial wall is no more than 2.5 mm beyond the DEJ.	The axial wall is greater than 2.5 mm beyond the DEJ.
3. Pulp Exposure	No pulp exposure	Properly managed justified pulp exposure.	Any pulp exposure that is not properly managed or unjustified.

Class III Anterior Composite Restoration

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	The adjacent and/or opposing hard tissue is free from evidence of damage and/or alteration.	Any hard tissue damage to adjacent or opposing tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	The soft tissue is free from damage, or there is soft tissue damage consistent with the procedure.	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated.
CONTOUR, CONTACT, OCCLUSION	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Interproximal Contacts	Interproximal contact is present. The contact is visually closed and properly shaped and positioned. There is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.	Interproximal contact is visually closed. Adequate in size, shape or position but may demonstrate little resistance to dental floss.	Interproximal contact is visually open or will not allow floss to pass through the contact area.
2. Anatomy	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal anatomy and marginal ridge anatomy.	The restoration may not reproduce the normal lingual anatomy, proximal contours of the tooth or marginal ridge anatomy but would not be expected to adversely affect the tissue health.	The restoration does not reproduce the normal lingual anatomy, proximal contour of the tooth or marginal ridge anatomy and as such it would be expected to adversely affect the health of the surrounding soft tissue.
3. Occlusion	When checked with articulating paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth in that quadrant.	When checked with articulating paper, the restoration may be in slight hyperocclusion. The restoration only requires minor occlusal adjusting.	There is gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.
MARGIN INTEGRITY-& SURFACE FINISH	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Margin	There is no open margin	There is no open margin	An open margin is detectable (either visually or with the tine of an explorer) at the restoration tooth interface
2. Marginal Deficiency	There is no marginal deficiency.	May be absent or detectable (either visually or with the tine of an explorer) at the restoration-tooth-interface but us not > 0.5 mm.	Is detectable (either visually or with the tine of an explorer) at the restoration tooth interface and is greater than 0.5 mm.
3. Marginal Excess	There is no marginal excess.	Marginal excess may be absent or detectable at the restoration-tooth interface, but is not > 1.0 mm	Greater than 1.0 mm
4. Integrity of Restoration	The restoration is not fractured and is bonded to the prepared tooth structure.	Restoration is not fractured, debonded and/or movable in the preparation.	Restoration is fractured, debonded and/or movable in the preparation.
5. Enameloplasty	There is no evidence of unwarranted or unnecessary removal, or recontouring of tooth structure adjacent to the restoration, without a previous modification approval.	There is no or minimal evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the restoration (enameloplasty).	There is evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the tooth being restored (enameloplasty).

Class II Posterior Amalgam Preparation

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	The adjacent and/or opposing hard tissue is free from evidence of damage and/or alteration.	Any hard tissue damage to adjacent or opposing tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	The soft tissue is free from damage, or there is soft tissue damage consistent with the procedure	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated	Correct tooth treated.	Wrong tooth treated
4. Preparation Design	Traditional Class II Prep	Traditional Class II Prep	Slot Prep
EXTERNAL FORM	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Proximal Contact Clearance at the Height of Contour (mm)	The proximal clearance at the height of contour is visibly open.	Visibly open or extends no more than 3.0 mm on either one or both proximal walls.	Not visibly open or extends beyond 3.0 mm on either one or both proximal walls.
2. Proximal Cavosurface Margin	The proximal cavosurface margin is 90^0 to the external surface of the tooth. There are no areas of unsupported enamel.	May deviate from 90° but is unlikely to jeopardize the longevity of the tooth or restoration; Includes small areas of unsupported enamel	Deviates from 90°. Will jeopardize the longevity of the tooth or restoration; includes unsupported enamel
3. Gingival Contact Clearance	The gingival clearance is visibly open.	Visibly open or not greater than 3.0 mm.	Not visibly open or is greater than 3.0 mm.
4. Isthmus (mm)	The isthmus is a minimum of 1.0 mm wide to no more than one-third the intercuspal width.	From 1.0 mm wide to no more than one-half the intercuspal width	< 1.0 mm or > 1/2 Intercuspal Width
5. Cavosurface Margin Termination	The cavosurface margins terminates in sound tooth structure, are not irregular and there is no explorer-penetrable decalcification remaining.	The cavosurface margins should terminate in sound natural tooth structure, and may be slightly irregular, but there is no explorer-penetrable decalcification remaining.	The cavosurface margins do not terminate in sound tooth structure and there is explorer- penetrable decalcification.
6. Outline Form	The outline form includes all carious and non-coalesced fissures and is smooth, rounded and flowing.	The outline form does not compromise the marginal ridge.	The marginal ridge is undermined and/or less than 1.0 mm in width.

Class II Posterior Amalgam Preparation (continued)

INTERNAL FORM	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Pulpal Floor (mm) (From the cavosurface margin)	The pulpal floor depth is 2.0 mm beyond the cavosurface margin.	Equal to or greater than 1.0 mm from the cavosurface margin, and the pulpal floor depth is no more than 3.0 mm from the cavosurface margin; there may be remaining enamel.	Pulpal floor depth is greater than 3.0 mm from the cavosurface margin or is less than 1.0 mm.
2. Axial Wall Depth (mm) (Beyond the DEJ)	The depth of the axial wall is just inside the DEJ.	The depth of the axial wall is no more than 2.5 mm beyond the DEJ.	The axial wall is greater than 2.5 mm beyond the DEJ or is still in the enamel and does not include the DEJ.
3. Wall Angulation	The walls of the proximal box are convergent and appropriate internal retention is present.	The walls of the proximal box should be convergent but may be parallel. Appropriate Internal retention is present.	The walls of the proximal box diverge occlusally, offering no retention and jeopardizing the longevity of the tooth or restoration.
4. Caries	There is no evidence of caries.	No evidence of caries.	Remaining caries.
5. Retention	Retention, when used, does not undermine the enamel.	Retention, when used, may not undermine the enamel, which is not likely to jeopardize the longevity of the tooth or restoration.	Retention excessively undermines the enamel and is likely to jeopardize the longevity of the tooth or restoration.
6. Refinement	Prepared surfaces are smooth.	Prepared surfaces may be slightly rough, irregular, or sharp.	A prepared surface of the tooth is excessively rough, irregular or sharp and is likely to jeopardize the longevity of the tooth restoration.
7. Pulp Exposure	No pulp exposure	Properly managed justified pulp exposure.	Any pulp exposure that is not properly managed or unjustified.

Class II Posterior Amalgam Restoration

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	The adjacent and/or opposing hard tissue is free from evidence of damage and/or alteration.	Any hard tissue damage to adjacent or opposing tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	The soft tissue is free from damage, or there is soft tissue damage consistent with the procedure.	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
CONTOUR, CONTACT, OCCLUSION	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Interproximal Contacts	Interproximal contact is present. The contact is visually closed and properly shaped and positioned. There is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.	Interproximal contact is visually closed, and the contact may be deficient in size, shape or position but may demonstrate little resistance to dental floss or shreds the floss.	Interproximal contact is visually open or will not allow floss to pass through the contact area.
2. Occlusion	When checked with articulating paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth in that quadrant.	When checked with articulating paper, the restoration may be in slight hyperocclusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth and the restoration may require adjustment.	Gross hyperocclusion so that the restoration is the only point of occlusion in that quadrant.
3. Anatomy	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal anatomy and marginal ridge anatomy.	Restoration may not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.	Restoration does not reproduce the normal occlusal anatomy, proximal contours of the tooth or marginal ridge anatomy and will adversely affect the tissue health.
MARGIN INTEGRITY-SURFACE FINISH	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Marginal Deficiency	There is no marginal deficiency.	Marginal deficiency may be absent or detectable (either visually or with the tine of an explorer) at the restoration-tooth interface, but it is no greater than 0.5 mm.	Marginal deficiency is detectable (either visually or with the tine of an explorer) at the restoration-tooth interface, and is greater than 0.5 mm.
2. Marginal Excess	There is no marginal excess detectable, either visually or with the tine of an explorer, at the restoration-tooth interface.	Marginal excess may be absent or detectable at the restoration-tooth interface, but it is no greater than 1.0 mm	Marginal excess is greater than 1.0 mm
3. Surface of Restoration	The surface of the restoration is free of pits and voids.	The surface of the restoration may be slightly grainy or rough, but it is free of pits and voids.	The surface of the restoration is rough and exhibits significant surface irregularities, pits or voids.
4. Integrity of Restoration	Restoration is not fractured.	Restoration is not fractured	Restoration is fractured
5. Enameloplasty	There is no evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the restoration (enameloplasty).	There is no or minimal evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the restoration (enameloplasty).	Evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the tooth being restored (enameloplasty).
6. Margins	There is no evidence of open margins.	No evidence of open margins.	Open margin detectable with the tine of an explorer.

Class II Posterior Conventional Composite Preparation

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	There is no hard tissue damage to adjacent or opposing tooth/teeth.	Any hard tissue damage to adjacent or opposing tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	There is no iatrogenic trauma to the soft tissue inconsistent with the procedure.	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
4. Preparation Design	Traditional Class II Prep	Traditional Class II Prep	Slot Prep
EXTERNAL FORM	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Proximal Contact Clearance at the Height of Contour(mm)	The proximal contact is either closed, or visibly open.	Closed, or visibly open and proximal clearance at the height of contour does not extend more than 2.5 mm on either one or both proximal walls.	Height of contour extends beyond 2.5 mm on either one or both proximal walls.
2. Gingival Contact Clearance (mm)	The gingival clearance is visibly open.	Open and is less than or equal to 2.0 mm.	Closed or greater than 2.0 mm.
3. Outline Form	The outline form is not sharp and irregular. The outline form is not overextended so that it compromises the remaining transverse ridge, marginal ridge, and/or cusp(s).	The outline form may be sharp and irregular. The outline form may be inappropriately overextended so that it compromises the remaining transverse ridge, marginal ridge and/or cusp(s).	Outline form is grossly over-extended so that it compromises or undermines the remaining marginal ridge to the extent that the cavosurface margin is unsupported by dentin or the width of the transverse and marginal ridge is 0.5 mm or less.
4. Isthmus (mm)	The isthmus is at least 1.0 mm and may not exceed one-half the intercuspal width.	At least 1.0 mm and may not exceed one-half the intercuspal width.	Less than 1.0 mm or greater than one-half the intercuspal distance.
5. Proximal Cavosurface Margin	The cavosurface margin is 90° to the external surface of the tooth. There is no unsupported enamel.	The cavosurface margin may deviate from 90° but is unlikely to jeopardize the longevity of the tooth or restoration; Includes small areas of unsupported enamel. This includes unsupported enamel and/or excessive bevel(s).	The cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This includes unsupported enamel and/or excessive bevel(s).
6. Cavosurface Margin Termination	The cavosurface margins terminates in sound tooth structure, are not irregular and there is no explorer-penetrable decalcification remaining.	The cavosurface margin should terminate in sound natural tooth structure and may be slightly irregular but there is no explorer-penetrable decalcification remaining.	The cavosurface margins do not terminate in sound tooth structure, are grossly irregular and there is explorer–penetrable decalcification.
7. Non-Coalesced Fissure(s)	There is no remaining non-coalesced fissure(s) that extend to the DEJ and are contiguous with the outline form.	There are no remaining non-coalesced fissure(s) that extend to the DEJ and are contiguous with the outline form.	There are remaining non-coalesced fissure(s) that extend to the DEJ and are contiguous with the outline form.
INTERNAL FORM	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Pulpal Floor (mm) (From the cavosurface margin)	The pulpal floor depth is equal to 2.0 mm from the cavosurface margin and there is no remaining enamel.	Equal to or greater than 1.0 mm from the cavosurface margin, and the pulpal floor depth is no more than 3.0 mm from the cavosurface margin; there may be remaining enamel.	Pulpal floor depth is greater than 3.0 mm from the cavosurface margin or is less than 1.0 mm.

2. Axial Wall Depth (mm) (Beyond the DEJ)	The depth of the axial wall is just inside the DEJ.	The depth of the axial wall is no more than 2.5 mm beyond the DEJ.	The axial wall is greater than 2.5 mm beyond the DEJ or is entirely in enamel.

Class II Posterior Conventional Composite Preparation (continued)

INTERNAL FORM	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
3. Proximal Walls	The walls of the proximal box may be divergent or convergent but there is no undermined enamel.	Walls of the proximal box may be divergent or convergent, and which may result in some undermined enamel.	Walls of the proximal box are excessively divergent or convergent, resulting in excessively undermined enamel, which is likely to jeopardize the longevity of the tooth or restoration.
4. Caries	There is no evidence of caries.	No evidence of caries.	Remaining caries.
5. Retention	Retention, when used, does not undermine the enamel.	Retention, when used, may not undermine the enamel which is not likely to jeopardize the longevity of the tooth or restoration.	Retention excessively undermines the enamel and is likely to jeopardize the longevity of the tooth or restoration.
6. Refinement	Prepared surfaces are smooth.	Prepared surfaces may be rough, sharp, or irregular	Prepared surfaces are excessively rough, irregular or sharp and likely to jeopardize the longevity of the tooth restoration.
7. Pulp Exposure	No pulp exposure.	Properly managed justified pulp exposure.	Any pulp exposure that is not properly managed or unjustified.

Class II Posterior Conventional Composite Restoration

TREATMENT MANAGEMENT	TREATMENT GOALS	ACCEPTABLE	UNACCEPTABLE
1. Adjacent and/or Opposing Tooth	The adjacent and/or opposing hard tissue is free from evidence of damage and/or alteration.	Any damage to adjacent or opposing tooth/teeth that can be removed by polishing or may require recontouring that does not adversely change the shape or contact.	There is evidence of gross damage and/or alteration to adjacent and/or opposing hard tissue inconsistent with the procedure which may require additional evaluation, intervention or treatment as a result of the damage.
2. Soft Tissue	The soft tissue is free from damage, or there is soft tissue damage consistent with the procedure.	There may be slight iatrogenic trauma to the soft tissue inconsistent with the procedure.	There is gross iatrogenic damage to the soft tissue inconsistent with the procedure and preexisting condition of the soft tissue, which may require additional evaluation, intervention or treatment as a result of the damage.
3. Correct Tooth Treated	Correct tooth treated.	Correct tooth treated.	Wrong tooth treated
CONTOUR, CONTACT, OCCLUSION	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Interproximal Contacts	Interproximal contact is present. The contact is visually closed and is properly shaped and positioned. There is definite, but not excessive, resistance to dental floss when passed through the interproximal contact area.	Interproximal contact is visually closed, but the contact may be deficient in size, shape or position, and may demonstrate little resistance to dental floss or shreds the floss.	Interproximal contact is visually open or will not allow floss to pass through the contact area.
2. Occlusion	When checked with articulating paper, all centric and excursive contacts on the restoration are consistent in size, shape and intensity with such contacts on other teeth in that quadrant.	When checked with articulating paper, the restoration may be in hyperocclusion inconsistent in size, shape and intensity with the occlusal contacts on surrounding teeth. The restoration requires adjustment.	Restoration is in gross hyperocclusion, such that the restoration is the only point of occlusion in that quadrant.
3. Anatomy	The restoration reproduces the normal physiological proximal contours of the tooth, occlusal anatomy and marginal ridge anatomy.	Restoration may not reproduce the normal occlusal anatomy, proximal contours of the tooth, or marginal ridge anatomy, but would not be expected to adversely affect the tissue health.	Restoration may not reproduce the normal occlusal anatomy, proximal contours of the tooth, or marginal ridge anatomy, and adversely affects tissue health.
MARGIN INTEGRITY-SURFACE FINISH	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Marginal Deficiency	There is no marginal deficiency.	Marginal deficiency may be absent or detectable (either visually or with the tine of an explorer) at the restoration-tooth interface, but it is no greater than 0.5 mm.	Marginal deficiency is detectable (either visually or with the tine of an explorer) at the restoration-tooth interface, and is greater than 0.5 mm.
2. Marginal Excess	There is no marginal excess detectable, either visually or with the tine of an explorer, at the restoration-tooth interface.	Marginal excess may be absent or detectable at the restoration-tooth interface, but it is no greater than 1.0 mm	Marginal excess is greater than 1.0 mm
3. Integrity of Restoration	The restoration is bonded to the prepared tooth structure.	Restoration is not fractured, debonded and/or movable in the preparation.	Restoration is fractured, debonded and/or movable in the preparation.

4. Enameloplasty	There is no evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the restoration.	There is no or minimal evidence of unwarranted or unnecessary removal, or recontouring of tooth structure adjacent to the restoration (enameloplasty).	There is evidence of unwarranted or unnecessary removal, modification or recontouring of tooth structure adjacent to the tooth being restored (enameloplasty).
5. Margins	There is no evidence of open margins.	No evidence of open margins.	Open margin detectable with the tine of an explorer.

PERIODONTAL SECTION

Candidates will measure and record pocket depths on two (2) assigned teeth, detect calculus on three (3) assigned teeth and scale an assigned quadrant.

For the Periodontal section, 2 hours total is allotted for typodont treatment.

CLINICAL SKILLS EVALUATED

During the two-hour clinical treatment portion of the examination, candidates must demonstrate the clinical skills listed below –

- Calculus detection
- Periodontal pocket depth measurement
- Calculus removal
- Tissue management

In addition to these scored criteria, candidates must follow standard infection control precautions and demonstrate a thorough understanding of all requirements outlined in this manual.

POINTS

Points are awarded on a 100-point scale. Candidates must earn 75 or more points to pass. All candidates will start the SRTA examination with zero points and earn them as examiners validate that the criteria are met based on the following system below –

CATEGORY	POINTS
Periodontal requirements (1 point each pocket)	6
Detection of calculus (1 point each surface)	16
Removal of calculus (6 points each surface)	72
Tissue Management (6 total points)	6
TOTAL POINTS	**100**

PERIODONTAL REQUIREMENTS (1 POINT PER POCKET)

At the start of clinical treatment time and **prior to removal** of any calculus, the candidate will measure and record pocket depths for two assigned teeth on the mesio-lingual (ML), lingual (L), and disto-lingual (DL) surfaces. SRTA's computer scoring system compares a candidate's measurements with the examiners' measurements. Candidates earn one point for each

measurement that is no more than +/- 1.0 mm from the examiners' average measurement. Six points (one point per surface) can be earned.

Candidates are to record each measurement in the appropriate spaces on the Progress Form. For example, the measurement for the mesio-lingual surfaces of the assigned tooth must be recorded in the space labeled "ML." Errors are assessed for any space left blank.

Candidates found using previously recorded and/or copied periodontal charts or found copying other candidates' periodontal measurements will be dismissed for unprofessional conduct and will automatically fail the examination.

DETECTION OF CALCULUS

At the start of clinical treatment time and **prior to removal** of any calculus, evaluate the four surfaces of the four assigned teeth. If **any** supra-or subgingival calculus-whether light, moderate or heavy- is present on a surface, indicate "Yes" on the Progress Form. If no calculus is found on a surface, enter "No" on the form. For the detection exercise, **any calculus** present on the surface should be marked "Yes". It does not have to be moderate to heavy. Use the explorer and compressed air to determine the presence or absence of calculus on each surface.

One point can be earned for each surface where findings match the confirmed presence or absence of calculus for a total of twelve (12) points. If two of the three examiners find calculus on a surface and a candidate finds calculus on the same surface, one point is earned. If examiners find no calculus on a surface and a candidate finds no calculus on that surface, one point is also earned. No points are earned if you do not select an answer at all or if you select both "Yes" and "No."

CALCULUS REMOVAL

Candidates can earn up to 72 points for complete removal of moderate to heavy, explorer-detectable calculus.

All calculus must be removed from all surfaces of the teeth in the assigned quadrant listed on the Progress Form.

After completing periodontal measurements and calculus detection, clean all surfaces of all teeth in the assigned quadrant. All surfaces of all teeth in the assigned quadrant will be evaluated for remaining calculus, both subgingival and supragingival. Remaining subgingival and supragingival calculus will be scored equally.

Scaling: After the candidate performs the periodontal procedure, the subgingival surfaces of the assigned quadrant must be smooth, with no deposits detectable with an explorer. Air may be used to deflect the tissue to locate areas for tactile confirmation. (All subgingival surfaces on the assigned quadrant must be scaled.)

Supragingival deposits (polishing): All supragingival calculus, plaque, and stain must be removed from **all coronal surfaces** of the assigned quadrant so that all surfaces are visually clean when air-dried and tactilely smooth upon examination with an explorer. The use of disclosing solution is **not** permitted.

TISSUE MANAGEMENT

Tissue management is evaluated for irreversible tissue trauma.

AUTOMATIC FAILURE (-100 POINTS)

A 100-point deduction will be assigned for major critical errors.

Major Infection Control Violation

- Although you will be working with a manikin, all infection control procedures will be evaluated and monitored as if working with a patient.
- Examples of major infection control violations include, but are not limited to forms, gauze, and/or barriers visibly contaminated, use of non-sterile instruments, and other violations that would put a patient, candidate, or staff members at risk for injury or exposure.
- The CFC, and DA will be monitoring and evaluating whether candidates follow the CDC recommended procedures for infection control.
- Major infection control violations noted by the CFC or DA during clinical treatment will be validated, photographed, and witnessed by the two SRTA officials, and when possible, a testing site staff member/educator.

Irreversible Tissue Trauma Caused by Candidate

- Although you will be working on a manikin, all tissue will be evaluated as patient tissue.
- This includes any injury that is inconsistent with the procedure that will not heal on its own without professional treatment by a dentist or physician. Four or more validated areas of reversible tissue trauma result in automatic failure. **"Reversible tissue trauma"** is damage caused by the candidate that could have been avoidable but can be expected to heal on its own.
- Examples of irreversible tissue trauma are, but not limited to, amputated papilla, severely lacerated soft tissue, exposure of the alveolar process, broken instrument tip evident in the sulcus or soft tissue, and root surface abrasion that requires professional treatment.
- Must be independently validated during final evaluation by two examiners.

Do not begin scaling the typodont until you have received an official finish time.

PROCEDURE & TYPODONT MANAGEMENT GUIDELINES

1. The Periodontal Progress Form will be provided at the examination site. When the candidate receives the Progress Form, they should place a candidate identification label on the form and enter their cubicle number. The Progress form will have: **the assigned quadrant to scale, 2 teeth listed for the periodontal probing and 4 teeth listed for calculus detection.**
2. The procedures, instruments and materials used are the choice of the candidate, as long as they are currently accepted and taught by accredited dental schools and the candidate has been trained in their use. It is the responsibility of the candidate to provide the instruments used in this examination and listed in this Candidate Manual unless such instruments are furnished by the school.
3. The candidate may begin the periodontal procedure after both the Class II and Class III restorative procedures are completed. **The candidate will do periodontal probing and calculus detection before beginning the scaling on the assigned quadrant.**
4. If any problems arise during the examination, the candidate should immediately notify a CFC. The CFC is also present to aid in any emergencies that may occur.
5. The approximate total time for the Periodontal Section is 2 hours. The typodont treatment time is a maximum of 2 hours and a minimum of 45 minutes. Supragingival calculus, plaque and stain must be removed from all surfaces of the assigned quadrant. No other teeth need to be scaled or polished during the examination, and once the examination is completed.
6. The examiners will evaluate tissue management and subgingival calculus removal from the assigned quadrant and evaluate supragingival calculus and plaque removal from all surfaces on the assigned quadrant.
7. The candidate must clean the clinic area following accepted infection control procedures following completion of their last procedure.

INSTRUMENTS

Sonic/ultrasonic instruments are permissible for scaling, but they may not be available at the examination site (check with the examination site). If the candidate elects to provide their own unit, they must check with the examination site regarding the appropriate connection mechanisms. Air-abrasive polishers are **not** permissible.

Candidates may choose any instruments for calculus removal. However, for the calculus detection and periodontal measurements exercises, all candidates and examiners must use the same instruments. This ensures that the examination is standardized for all candidates at all testing sites. The **required instruments are listed below**:

- **Explorer: 11/12 explorer** (i.e., the ODU or EXD 11/12) is used by candidates and examiners for calculus detection. No other type of explorer will be used for detection of calculus.
- **Probe:** A probe marked with **1 mm increments** (i.e., the UNC probe) is used for the probing exercise. SRTA **prefers** probes that have alternating colored markings such as yellow/black, yellow/bare metal, yellow/white plastic, or any other combination of **colored** markings. This improves accuracy of measurements by both the candidates and examiners.
- **Mirror:** Can be single or double sided

Periodontal

	SELECTION CRITERIA		
1. Forms	Progress Form is complete, accurate and current.		
2. Calculus Requirements	The Calculus Detection portion of the Periodontal Evaluation Form is properly completed, indicating: • Six to eight teeth selected, each with at least one surface of calculus charted • At least three posteriors (molars, premolars), including at least one molar, in the selection. • Exactly 12 surfaces of subgingival calculus charted, including at least three surfaces of interproximal calculus on molars/premolars • At least eight of the surfaces on canines, premolars or molars (no more than four surfaces on incisors)		
TREATMENT MANAGEMENT	**TREATMENT GOALS**	**ACCEPTABLE**	**UNACCEPTABLE**
1. Soft Tissue	Instruments, polishing cups or brushes and dental floss are effectively utilized so that no unwarranted soft tissue trauma occurs as a result of the scaling and polishing procedures.	There is minor soft tissue trauma that is inconsistent with the procedure. Soft tissue trauma may include, but is not limited to, abrasions, lacerations or ultrasonic burns.	There is major damage to the soft tissue that is inconsistent with the procedure and preexisting condition which may require additional evaluation, intervention or definitive treatment as a result of the damage. This damage may include, but is not limited to, such trauma as: • Amputated papillae • One or more ultrasonic burns that require follow-up treatment • A broken instrument tip in the sulcus or soft tissue
2. Hard Tissue	Instruments, polishing cups or brushes and dental floss are effectively utilized so that no unwarranted hard tissue trauma occurs as a result of the scaling and polishing procedures.	There is minor hard tissue trauma that is inconsistent with the procedure. Hard tissue trauma may include root surface abrasions that do not require additional definitive treatment.	There is major hard tissue trauma that is inconsistent with the procedure such as: • Root surface abrasion that requires additional treatment
3. Calculus Removal	All calculus has been removed from the candidate's assigned quadrant and/or stain remain on the assigned quadrant.	Calculus remaining on 3 or less surfaces with no plaque and/or stain remaining on teeth in the assigned quadrant.	Calculus remaining on 4 or more surfaces and plaque and/or stain is remaining on the teeth in the assigned quadrant.

IV. EXAMINATION SCHEDULE

PROS & ENDO EXAMINATION SCHEDULE

All clinics will be open at 6:00 AM so setup may begin.

DAY ONE	Registration and Orientation **4:00 PM** or time designated by host examination site		
DAY TWO	**START**	**FINISH**	**PROCEDURE**
	7:00 AM	8:00 AM	Check-in, distribution of typodonts, set up cubicle, measure tooth, call for CFC
	8:00 AM	12:00 PM	Fixed Prosthodontic Procedures
	12:15 PM	3:15 PM	Endodontic Procedures

DAY ONE – REGISTRATION & ORIENTATION
Candidates will receive instructions on the location and time of registration and orientation.

For registration, candidates must present one form of government-issued photo identification (e.g.: Military ID, Driver's License, State-Issued ID, or School ID). Candidates will receive a white envelope that contains the following: peel-off ID labels, two (2) cubicle cards, a badge, and progress forms. Candidates must keep the white envelopes and turn them in at the end of the examination. Orientation will begin after registration and will last approximately 45 minutes. Orientation will deal strictly with manikin-based procedures and will cover the following information:

- Examination schedule
- Equipment troubleshooting
- Scoring and forms
- Helpful examination hints
- How to avoid the most common examination errors

DAY TWO – FIXED PROSTHODONTICS & ENDODONTICS PROCEDURES
Both examination sections are administered together on the same manikin head. All procedures will be performed as if the manikin were a live patient. The manikin head and facial shroud must be maintained in an acceptable operating position, and the candidate must follow all appropriate infection control procedures. If a candidate is retaking **only** the Endodontics Section, they will have 3 hours to complete treatment. If a candidate is retaking **only** the Fixed Prosthodontics Section, they will have 4 hours to complete treatment.

6:00 AM – Candidates can begin setting up their unit when clinics open.

7:00 AM – Typodonts are distributed to candidates. Candidates must present their candidate ID card to receive a typodont. Candidates can fabricate the required stents. This should be done before putting the typodont on the manikin head.

8:00 AM– The fixed prosthodontic procedures will begin for all candidates. Teeth may not be removed or disassembled from the typodont or manikin head without permission from a CFC. Candidates have until 12:00 PM to finish all fixed prosthodontic procedures. When the fixed prosthodontic procedures are complete, the candidate will call for a CFC. The CFC will remove the two sextants containing the exam teeth and place them in a poly bag with the candidate's ID label. The CFC will replace the fixed prosthodontic sextants with new sextants for full dentition for the Endodontic procedures.

If candidates finish the fixed prosthodontic procedures prior to 12:00 PM, and wish to begin the endodontic procedures, they must get permission from the CFC. If given permission, the candidate will still only have three hours from the designated start time to complete the Endodontic Procedures.

12:15 PM – The endodontic procedures will begin. When the endodontic procedures are complete, the candidate will contact a CFC. The candidate along with the typodont and properly completed progress form must be in line at the collection area no later than 3:15 PM. **All treatment must stop at 3:15 PM.**

CHECK OUT PROCESS

Upon completion of the fixed prosthodontics & endodontic sections, candidates must personally submit **the completed Endo/Pros Progress Form(s) and model(s) to the CFC prior to dismissal from the examination site.**

RESTORATIVE, PERIO & TRADITIONAL EXAMINATION SCHEDULE

All clinics will be open at 6:00 AM so setup may begin.

DAY ONE Registration and Orientation **4:00 PM** or time designated by host examination site			
MANIKIN ENDODONTIC/PROSTHODONTIC SCHEDULE			
DAY TWO	**START**	**FINISH**	**PROCEDURE**
	7:00 AM	8:00 AM	Check-in, distribution of typodonts, set up cubicle
	8:00 AM	12:00 PM	Candidates doing Fixed Prosthodontic Procedures have 4 hours.
	12:15 PM	3:15 PM	Candidates doing Endodontic Procedures have 3 hours.
MANIKIN RESTORATIVE AND PERIODONTAL SCHEDULE			
DAY THREE	**START**	**FINISH**	**PROCEDURE**
	7:00 AM	8:00 AM	Candidates can secure their typodonts from the DA and mount them in their units. Candidates can then receive approval from a CFE for set up and 8:00 AM start time.
	8:00 AM**	10:00 AM	Candidates doing only the Periodontal Section.
	8:00 AM*	3:00 PM	Candidates taking the Full Examination (Restorative and Periodontal Sections) have 7 hours

*****Candidates will be assigned a maximum total of 7 hours on Day Two and Three.
******Maximum Perio treatment time of 2 hours.

SRTA reserves the right to amend the schedule as needed. All candidates should remain on site during the examination. All scheduled times as listed could be moved earlier if conditions exist to do so and all candidates permit this by means of vote.

DAY ONE – REGISTRATION & ORIENTATION

Candidates will receive instructions on the location and time of registration and orientation.

For registration, candidates must present one form of government-issued photo identification (e.g.: Military ID, Driver's License, State-Issued ID, or School ID). Candidates will receive a white envelope that contains the following: peel-off ID labels, two (2) cubicle cards, a badge, and progress forms. Candidates must keep the white envelopes and turn them in at the end of the examination. Orientation will begin after registration and will last approximately 45 minutes. Orientation will deal strictly with manikin-based procedures and will cover the following information:

- Examination schedule
- Equipment troubleshooting
- Scoring and forms
- Helpful examination hints
- How to avoid the most common examination errors

DAY TWO/THREE – RESTORATIVE/PERIO & TRADITIONAL EXAMINATION

Any treatment procedure that is started must be completed on the same day before the designated cutoff time. Time management is the candidate's responsibility.

All typodonts must be submitted by the designated cutoff time on the day the procedure was initiated. Any procedure submitted after the designated cutoff time will not be scored, and the candidate will fail that section of the examination.

CHECK OUT PROCESS

Upon completion of the examination, candidates must personally submit all examination packets to the CFC. The following items **must be submitted in the provided white envelope and accounted for prior to dismissal from the examination site:**

- 1 Completed Anterior Restorative Form
- 1 Completed Posterior Restorative Form
- 1 Completed Perio Form
- Radiographs
- 1 Candidate's Badge and Holder
- 1 Signed Online Orientation Notice Form (#1)
- 1 Signed Incident Disclaimer Form (#2)
- 2 Cubicle cards

SECTIONAL EXAMINATION SCHEDULE

Note to candidates: If a candidate has previously taken the Endo or Fixed Pros sections and needs to retake one or both sections, they can apply for a sectional examination at the site where they plan to take Manikin-Based Restorative procedures. The candidate will be assigned 3 hours if retaking only the Endodontic section or 4 hours if retaking only the Fixed Prosthodontics section or 7 hours for both sections.

Candidates will be scheduled on Friday (Day Two) and/or Saturday (Day Three) according to which sections they are taking, the number of sections, and the availability of operatory space.

Candidates scheduled for re-examination(s) must register with the Clinic Floor Coordinator the day of their exam if they did not attend orientation.

CHECKLIST

☐ Read the entire Candidate Manual for the SRTA Dental Manikin Examination

REGISTRATION

☐ Complete the online registration by following the instructions for "Candidate Registration" at www.SRTA.org.

Please upload the following required document(s): 1 headshot.
If applicable, a letter of eligibility or proof of diploma may be required. Complete registration at: https://www.crdts.org/Apply/ExamApplication

REMEMBER TO BRING THE FOLLOWING TO THE CLINICAL EXAMINATION SITE AND REGISTRATION/ORIENTATION

☐ One form of identification, with your signature and photograph.
Acceptable forms of ID include valid current driver's license, passport, military ID, school and employee ID. An out-of-date driver's license is not considered a valid ID for this purpose.

☐ Assigned examination site, time, and candidate number

☐ A ballpoint pen to be used on the Progress Forms

☐ Two #2 lead pencils

☐ All necessary materials and instruments

☐ SRTA Candidate Manual

V. EXAMINATION FORMS

Forms to be completed at the examination: Periodontal Treatment Selection Worksheet, Progress Forms, Modification Form, and Instructions to Candidate Form (ITC).

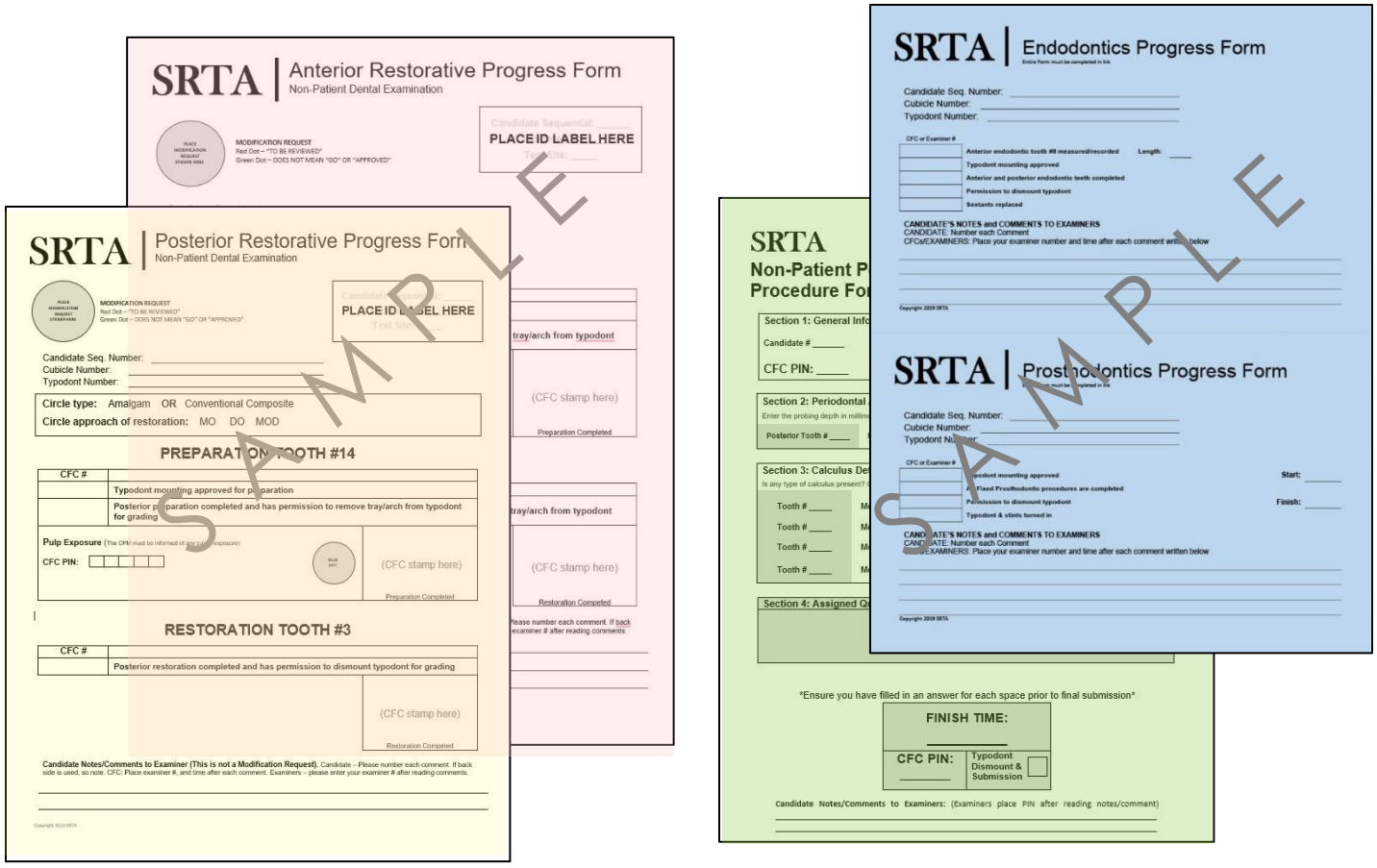
These forms will be distributed to candidates at the examination site. These forms may not be removed from the examining area and may not be reviewed by unauthorized individuals.

PROGRESS FORMS

Color-coded Progress Forms are utilized to track the candidate's progress through each procedure, and treatment provided.

Candidates will be provided with identification labels to place on each procedure's Progress Form, as indicated on the form.

The Endodontic Section Progress Form and Fixed Prosthodontics will be filled out at the beginning of the examination and turned in upon completion of the manikin section of the examination.

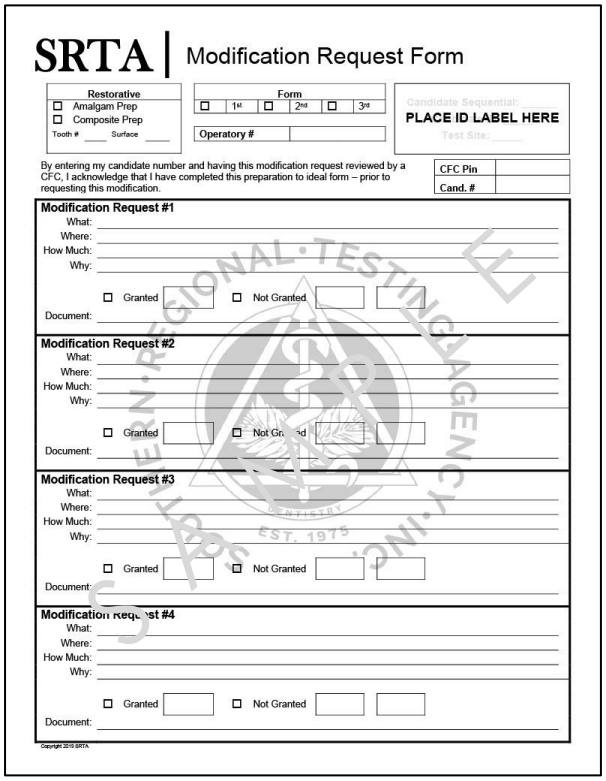


MODIFICATION REQUEST FORM

Modification Request Forms are utilized to request permission to deviate from a *Satisfactory*-level restorative preparation.

Candidates who need to request a modification should place an identification label on the Modification Request Form and indicate their cubicle number, procedure, day, and time.

For more information, please refer to Treatment Guidelines in the Restorative Section.



SRTA | Modification Request Form

Restorative
☐ Amalgam Prep
☐ Composite Prep
Tooth # ____ Surface ____

Form
☐ 1st ☐ 2nd ☐ 3rd

Operatory #

Candidate Sequential: _____
PLACE ID LABEL HERE
Test Site: _____

By entering my candidate number and having this modification request reviewed by a CFC, I acknowledge that I have completed this preparation to ideal form – prior to requesting this modification.

CFC Pin
Cand. #

Modification Request #1
What:
Where:
How Much:
Why:
☐ Granted ☐ Not Granted
Document:

Modification Request #2
What:
Where:
How Much:
Why:
☐ Granted ☐ Not Granted
Document:

Modification Request #3
What:
Where:
How Much:
Why:
☐ Granted ☐ Not Granted
Document:

Modification Request #4
What:
Where:
How Much:
Why:
☐ Granted ☐ Not Granted
Document:

Copyright 2015 SRTA

VI. FAQs & HELPFUL HINTS

FAQs

1. **Can I use a dental assistant?**
   No. Assistants are not permitted for any manikin-based portion of the examination.

2. **What is the cutoff time for my restorative typodont or periodontal typodont at the end of the day?**
   3:00 PM is the cutoff time for candidates doing the Restorative and Periodontics sections. (This applies to all candidates who are taking the complete examination. Reexamination candidates should refer to the schedule of times provided to them.)

3. **For the Class II Procedure, does there have to be proximal contact?**
   Yes, the tooth must be in contact with a sound enamel surface, definitive crown, or chrome crown. Provisionals or denture teeth are not acceptable proximal surfaces.

4. **Do I have to use an isolation dam?**
   During the Restorative Section, cavity preparations and restorations must be instrumented with an isolation dam.

   During the Endodontic section, an isolation dam is required.

5. **Where do I obtain new Progress Forms?**
   Additional copies of these forms are available through the Clinic Floor Coordinator (CFC) and the CFC assistant.

6. **For any restorative procedure, I have cut an ideal preparation, but caries are still present. Do I need to have a CFC to observe the condition and then remove the caries?**
   Yes, you would obtain a Modification Form from the CFC and complete the form stating the reason for deviating from ideal. Once the CFC reviews the modification, follow the appropriate steps to complete your preparation.

7. **I have an exposure. How do I proceed?**
   Write in the Notes section on the Progress Form that a pulp exposure has occurred, indicate the time, and briefly describe how the situation should be treated. Then call a CFC, who will consult with other CFCs to determine the appropriate course of treatment.

8. **What do I do if my manikin head is damaged?**
   Notify the CFC to observe the condition before beginning any work.

9. **If the equipment provided by the examination site malfunctions, what do I do?**
   Notify the CFC immediately so repairs or appropriate arrangements can be made.

10. **How do I know that all the scoring examiners are grading to the same set of standards?**
    All the scoring examiners participate in a detailed standardization program before each examination. This training ensures that all examiners are grading reliably to the same criteria.

11. **If I think my attempt at the examination was unsuccessful and apply for reexamination, and then receive my scores indicating that I passed, how do I obtain a refund?**
    You will not be eligible to receive a refund. We strongly recommend that candidates not apply for reexamination until they check their scores online or receive their final report.

12. **I sent my application a few days prior to the deadline, but I was not placed in my preferred examination site. Why?**
    Typically, sites are filled before the published application deadline. There is no guarantee of placement at any site even though the application is submitted prior to the published date. Plan and collect all required items and submit your application as soon as you determine the need for the examination.

HELPFUL HINTS

- Time management is the candidate's responsibility. Be familiar with the time schedule each day and plan accordingly.
- All procedures must be completed in sufficient time to submit the typodont to the CFCs no later than the published cutoff time.
- You must have a rubber dam in place for the Endodontic and Restorative Procedures.
- If a pulp exposure occurs during the preparation, write in the Notes section on the Progress Form that a pulp exposure has occurred, indicate the time, and briefly describe how the situation should be treated. Then call a CFC, who will determine the appropriate course of treatment.
- Exercise caution if using new burs when preparing the typodont teeth.
- To avoid adjacent damage, use an interproximal wedge and/or shim.
- Allow time for the amalgam to set, in order to prevent open contact created by flossing.
- When you have finished your preparation, get up and stretch or get a drink of water; then, return and take a fresh look at your finished product.
- Be sure to look at your preparations and finished restorations from more than one direction: facial, lingual, and occlusal.
- Work on ALL your typodonts/models as if they were a patient, using the proper position in the operatory chair, rubber dam for Endodontics and Restorative, and a shroud for all procedures.
- Use a marker to make an "X" on the facial, lingual, and possibly the occlusal of the teeth to be treated for the Restorative, Endodontic, and Fixed Prosthodontic procedures to help ensure you do not prepare the wrong tooth.
- **Read this manual, keep it in your operatory, and refer to it throughout the examination.**

VII. GLOSSARY OF WORDS, TERMS & PHRASES

Abrasion — Abnormal wearing of tooth substance or restoration by mechanical factors other than tooth contact.

Abutment — A tooth used to provide support or anchorage for a fixed removable prosthesis.

Adjustment — Selective grinding of teeth or restorations to alter shape or contour and establish stable occlusion.

Angle — A corner.

- **Cavosurface angle**: An angle formed between the cavity wall and surface of the tooth.
- **Line angle:** The angle formed between two cavity walls or tooth surfaces.

Apical — The tip or apex of a root of a tooth and its immediate surroundings.

Attached gingiva — The portion of the gingiva that extends apically from the base of the sulcus to the mucogingival junction.

Axial wall — An internal cavity surface parallel to the long axis of the tooth.

Base — A replacement material for missing dentinal tooth structure, used for bulk build-up and/or for blocking out undercuts. Examples include ZOIB&T, IRM and zinc-phosphate cement.

Bevel — A plane sloping from the horizontal or vertical wall that creates a cavosurface angle greater than 90°.

Bonding agent — A component of a bonded resin restorative system, which is applied to an etched tooth surface and to which, after it is cured, the restorative material is applied and cured. A bonding agent may also be used to seal the surface of a cured composite resin restoration.

Bridge — A permanent restoration that replaces one or more missing natural teeth.

Build-up — A restoration associated with a cast restoration that replaces some, but not all, of the missing tooth structure coronal to the cementoenamel junction. The buildup provides resistance and retention form for the subsequent cast restoration. Also called Pin Amalgam Build Up (PABU) or Foundation.

Calculus — A hard deposit attached to the teeth, usually consisting of mineralized bacterial plaque.

Caries — An infectious microbiological disease that results in localized dissolution and destruction of the calcified tissues of the teeth. The diagnosis of dentinal caries is made by tactile sensation with light pressure on an explorer, described as 1) a defect with a soft, sticky base or 2) a defect that can be penetrated and exhibits definite resistance upon withdrawal of the explorer.

Cavity preparation — Removal and shaping of diseased or weakened tooth tissue to allow placement of a restoration.

Cavosurface margin — The line angle formed by the prepared cavity wall with the unprepared tooth surface. The margin is a continuous entity enclosing the entire external outline of the prepared cavity. Also called the cavosurface line angle.

Cementoenamel junction — Line formed by the junction of the enamel and cementum of a tooth.

Chamfer — A finish line design for tooth preparation in which the gingival aspect meets the external axial surface at an obtuse angle.

Contact area — The area where two adjacent teeth approximate.

Crown	Cast-metal restoration or porcelain restoration covering most of the surfaces of an anatomical crown.
Cusp, functional	Cusps of teeth that provide vertical stops that interdigitate with fossae or marginal ridges of an opposing tooth/teeth when the teeth are occluded.
Cusp, non-functional	Cusps of teeth, which by their present occlusion, do not provide a centric stop that interdigitates with a fossa or marginal ridge of an opposing tooth/teeth.
Debonded restoration	A restoration that exhibits immediate marginal leakage as a result of adhesive failure, which may include, but is not limited to, marginal discoloration, movement of the restoration or foreign substance between the restoration and tooth interface.
Debris	Scattered or fragmented remains of the cavity preparation procedure. All debris should be thoroughly removed from the preparation before the restoration is placed.
Defective restoration	Any dental restoration that is judged to be causing or is likely to cause damage to the remaining tooth structure if not modified or replaced.
Dentin	Calcified tissue surrounding the pulp and forming the bulk of the tooth.
Deposits, subgingival	Deposits that are apical to the gingival margin.
Deposits, supragingival	Deposits that are coronal to the gingival margin.
Divergence	The angle of opposing cavity walls that, when projected in an occlusal to gingival direction, would meet at a point some distance gingival to the crown of the tooth.
Enameloplasty	The selective reshaping of the enamel surfaces of teeth to improve their form.
Fissure	A developmental linear fault in the occlusal, buccal or lingual surface of a tooth, commonly the result of the imperfect fusion of adjoining enamel lobes.
Flash	Excess restorative material extruded from the cavity preparation extending onto the unprepared surface of the tooth.
Gingival recession	The visible apical migration of the gingival margin, which exposes the CEJ and root surface.
Gingival wall	An internal cavity surface perpendicular to the long axis of the tooth near the apical or cervical end of the crown of the tooth or cavity preparation, which in a Class II preparation, is the floor of the proximal box.
Gingivitis	Inflammation of the gingiva.
Grainy	The rough, perhaps porous, poorly detailed surface of a material.
Interproximal contact	The area of contact between two adjacent teeth. Also called proximal contact.
Isthmus	A narrow connection between two areas or parts of a cavity preparation.
Line angle	The angle formed by the junction of two surfaces. In cavity preparations there can be internal and external line angles, which are formed at the junction of two cavity walls.
Line of draw	The path or direction of withdrawal or seating of a removable or cast restoration.
Liner	Resin or cement coating of minimal thickness (usually less than 0.5 mm) to achieve a physical barrier and/or therapeutic effect (a chemical effect that in some way benefits the health of the tooth pulp). Examples include Dycal, Life, Cavitec, Hydroxyline, Vitrebond and Fuji Lining LC.
Liner, treatment	An appropriate dental material placed in deep portions of a cavity preparation to produce desired effects on the pulp, such as insulation, sedation, stimulation of odontoblasts, bacterial reduction, etc. Also called therapeutic liner.

Long axis	An imaginary straight line passing through the center of the whole tooth occlusoapically.
Marginal deficiencies	Failure of the restorative material to meet the cut surface of the cavity preparation properly and completely; the marginal discrepancy does not exceed 0.5 mm, and the margin is sealed. Marginal deficiencies may include voids or under-contour.
Marginal excess	Restorative material that extends beyond the cavosurface margin of the cavity walls. Marginal excess may or may not extend onto the unprepared surface(s) of the tooth. See also: over-contoured, flash, over-extension.
Mobility	The degree of looseness of a tooth.
Occlusion	As used in this manual, occlusion refers to the closed bite relationship of the teeth in which the cusps are maximally interdigitated, i.e., "centric occlusion," also known as CO, maximal intercuspal position (MI/MIP), habitual occlusion or acquired occlusion).
Open margin	A cavity margin or section of margin at which the restorative material is not tightly adapted to the cavity preparation wall(s). Margins are generally determined to be open when they can be penetrated by the tine of a sharp dental explorer.
Outline form, external	The external boundary or perimeter of the finished cavity preparation.
Outline form, internal	The internal details and dimensions of the finished cavity preparation.
Over-contouring	Excessive shaping of the surface of a restoration so as to cause it to extend beyond the normal physiologic contours of the tooth when in health.
Over-extension of preparation	The placement of final cavity preparation walls beyond the position required to restore the tooth properly as determined by the factors that necessitated the treatment.
Over-extension of restoration	Restorative material that extends beyond the cavosurface margin of the cavity walls. Marginal excess may or may not extend onto the unprepared surface(s) of the tooth. See also over-contoured, flash, and marginal excess.
Overhang, restoration	The projection of restorative material beyond the cavosurface margin of the cavity preparation but not extending onto the unprepared surface of the tooth. Also refers to the projection of a restoration outward from the nominal tooth surface. See also flash.
Path of insertion	The path or direction of withdrawal or seating of a removable or cast restoration. See also line of draw.
Periapical	Area around the root end of a tooth.
Periodontitis	Inflammation of the supporting tissues of the teeth. Usually, a progressively destructive change, leading to loss of bone and periodontal ligament. An extension of inflammation from gingiva into the adjacent bone and ligament.
Pits, surface	Small voids on the polished surface (but not at the margins) of a restoration.
Polishing, restoration	The act or procedure of imparting a smooth, lustrous and shiny character to the surface of the restoration.
Porous, restoration	Describes the surface of a restoration with minute orifices or openings that allow fluids or light to pass through.
Previous restorative material	Any preexisting restorative material present on a tooth, including pit and fissure sealants, liners, bases, composites, resin-based materials, alloys or cements.
Provisional restoration	Any restoration that, by intent, is placed for a limited period of time or until some event occurs. Any restorative material can be placed as a provisional restoration. The intent in placing the restoration and not the material determines the provisional status.

Pulp cap, direct

The technique of placing a liner (composed of an appropriate protective material) over the exposed pulp to promote reparative dentin formation and the formation of a dentinal bridge across the exposure. Usually, a base is placed over the liner to provide structural support. The decision to perform a pulp cap or endodontics and the success of the procedure is determined by the conditions under which the pulp was exposed.

Pulp cap, indirect

The technique of deliberate incomplete caries removal in deep excavation to prevent frank pulp exposure, followed by basing of the area with an appropriate pulpal protection material to promote reparative dentin formation. The tooth may or may not be re-entered in six to eight weeks to remove the remaining dentinal caries.

Pulp exposure, carious

The frank exposure of the pulp through clinically carious dentin.

Pulp exposure, general

The exposure of the pulp chamber or former pulp chamber of a tooth with or without evidence of pulp hemorrhage.

Pulp exposure, irreparable

Generally, a pulp exposure in which most or all of the following conditions apply:

- The exposure is greater than 0.5 mm.
- The tooth had been symptomatic.
- The hemorrhage is not easily controlled.
- The exposure occurred in a contaminated field.
- The exposure was relatively traumatic.

Pulp exposure, mechanical/ unwarranted

The frank exposure of the pulp through non-carious dentin caused by operator error, misjudgment, pulp chamber aberration, etc.

Pulp exposure, reparable

Generally, a pulp exposure in which most or all of the following conditions apply:

- The exposure is less than 0.5 mm.
- The tooth had been asymptomatic.
- The pulp hemorrhage is easily controlled.
- The exposure occurred in a clean, uncontaminated field.
- The exposure was relatively atraumatic.

Pulpal wall

An internal cavity surface perpendicular to the long axis of the tooth, which is the floor of the occlusal portion of the cavity preparation. Also referred to as the pulpal floor.

Pulpoaxial line angle

The line angle formed by the junction of the pulpal wall and axial wall of a prepared cavity.

Reduction of the crown, in endodontics

Reduction of the occlusal surface of a posterior tooth or lingual and/or incisal surfaces of an anterior tooth to take the tooth out of occlusion purposely.

Resistance form

The feature of a tooth preparation that resists dislodgment of a restoration in a vertical direction or along the path of placement.

Retention form

The feature of a tooth preparation that resists dislodgment of a crown in a vertical direction or along the path of placement.

Scaling

Instrumentation of the crown and root surfaces of the teeth to remove plaque, calculus and stains from these surfaces.

Surface sealant, composite resin restoration coating

The application and curing of an unfilled resin to the surface of a composite restoration to fill porosities or voids or to provide a smooth surface after polishing the restoration.

Sealers

Cavity sealers provide a protective coating for freshly cut tooth structure of the prepared cavity.

- Varnish: A natural gum, such as copal rosin or a synthetic resin dissolved in an organic solvent, such as acetone, chloroform or ether. Examples include Copalite, Plastodent, Varnish, and Barrier.
- Resin bonding agents: Include the primers and adhesives of dentinal and all-purpose bonding agents. Examples include All-Bond 2, Scotchbond MP+, Optibond, ProBond, Amalgambond, etc.

Shade, restoration	The color of a restoration as defined by hue, value and chroma, which is selected to match as closely as possible the natural color of the tooth being restored.
Sound tooth structure	Enamel that has not been demineralized or eroded; it may include proximal decalcification that does not exceed one-half the thickness of the enamel and cannot be penetrated by an explorer. Previous restorative material or calcareous deposits do not qualify as sound tooth structure.
Stain, extrinsic	Stain that forms on and can become incorporated into the surface of a tooth after development and eruption. These stains can be caused by a number of developmental and environmental factors.
Stain, intrinsic	Stain that becomes incorporated into the internal surfaces of the developing tooth. These stains can be caused by a number of developmental and environmental factors.
Taper	The convergence of two opposing external walls of a tooth preparation as viewed in a given plane. The extension of those average lines within that plane form an angle described as the total angle of convergence. Also known as Total Occlusal Convergence.
Temporary restoration	See provisional restoration.
Tissue trauma	Unwarranted iatrogenic damage to extra/intraoral tissues resulting in significant damage to the typodont tissue, such as lacerations greater than 3 mm, burns, amputated papillae or large tissue tags.
Total Occlusal Convergence	The convergence of two opposing external walls of a tooth preparation as viewed in a given plane. The extension of those average lines within that plane form an angle described as the total angle of convergence. Also known as taper.
Ultrasonic scaler	An instrument tip attached to a transducer through which high frequency current causes ultrasonic vibrations (approximately 30,000 cps). These vibrations, usually accompanied by the use of a stream of water, produce a turbulence, which in turn removes adherent deposits from the teeth.
Under-contouring	Excessive removal of the surface of a restoration so as to cause it to be reduced beyond the normal physiologic contours of the tooth when in health.
Undercut	Feature of tooth preparation that retains the intracoronal restorative material. An undesirable feature of tooth preparation for an extracoronal restoration.
Undermined enamel	During cavity preparation procedures, an enamel tooth surface (particularly enamel rods) that lacks dentinal support. Also called unsupported enamel.
Varnish	See sealers.
Void(s)	An unfilled space within the body of a restoration or at the restoration margin, which may or may not be present at the external surface and therefore may or may not be visible to the naked eye.