



Academy of Veterinary Dental Technicians

Credentials Packet 2015-2016

Class of 2017

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Hours

The mentee must spend at least 4000 hours during the Specialist program practicing veterinary technology. At least 3000 of these hours must be spent within the dental setting. Dentistry hours are accumulated providing client consultation, performing/assisting in procedures, creating dental radiographs and discharging patients.

Specialty Training

In addition to meeting the general requirements, the mentee must successfully complete wet lab training and attend lectures in advanced dentistry procedures. *Teaching a wet lab or lecture or writing a veterinary dentistry continuing education article does not qualify as CE attendance.*

Training and CE credit is accepted from **credentialed** members of the following organizations:

- Academy of Veterinary Dental Technicians (www.avdt.us); American Veterinary Dental College (www.avdc.org); Academy of Veterinary Dentistry (www.avdonline.org);
- If dentistry related: all other Veterinary Technician Specialist Academies. See the National Veterinary Technicians in America's website, www.navta.net, for a list of all the Veterinary Technician Specialist Academies.

A list of CE meetings can be found at each of the above websites, at the Veterinary Dental Forum website (www.veterinarydentalforum.com), or in the *Journal of Veterinary Dentistry*.

The mentee must complete the "Specialty Training Form" (Forms 3a and b) and give proof of attendance for each event you attended to show you have completed both the **25 hours** of wet lab training and attended **15 hours** of advanced dentistry lectures. A photocopy of a document provided by the organization or speaker is proof of attendance. Cancelled checks or other documents will not be accepted as proof of attendance. You **must provide detailed course descriptions** provided by the organization presenting the CE as proof that the continuing education was related to veterinary dental care, and the lab or lectures must fit into one of the categories listed below. ***Participation and attendance at wet labs and lectures must be completed during the two-year Specialist training program.***

Wet Labs

The mentee must complete a total of **25 hours of wet labs within each of the following disciplines:**

- Dental Prophylaxis – 5 hours
- Periodontics – 5 hours
- Prosthodontics – 2.5 hours
- Radiology – 6 hours
- Endodontics – 2.5 hours
- Dental Local and Regional Anesthesia – 4 hours

Advanced Dental Procedures Lectures

The mentee must attend a total of **15 hours of lectures in advanced dentistry procedures:**

- Endodontics – 2.5 hours
- Prosthodontics – 2.5 hours
- Orthodontics – 2.5 hours
- Oral Surgery – 2.5 hours
- Oral Pathology – 2.5 hours
- Advanced Periodontal Therapy – 2.5 hours

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AVDT approved wet labs and lectures may be available at the following conferences or training centers:

1. National Conference of Veterinary Technician Specialty Academies
2. Animal Dental Training Center (www.animaldentalcenter.com)
3. Veterinary Dental Forum (www.veterinarydentalforum.com)
4. North American Veterinary Conference (www.navc.com)
5. Western States Veterinary Conference (www.wvc.org)
6. Central States Veterinary Conference (www.thecvc.com)
7. American Veterinary Medical Association (www.avma.org)
8. American Animal Hospital Association (www.aahanet.org)
9. Animal Dental Care Training Center (www.vetdentalclasses.com)

To receive credit for other courses, a written request to and written approval from the AVDT Credentials Chair is required. All CE obtained at the Veterinary Dental Forum will be accepted if it fits into the categories above.

Case Logs

Completed Chronological and Categorical Case Logs with a minimum of 50 dentistry cases. **If only 50 cases are submitted, a single unacceptable case could result in your credentials packet being rejected.**

Categorical case log forms and chronological case log forms are provided to you. Make sure each entry in your log is complete. If the animal's weight (lbs. or kg.), age, or sex is unknown, enter "unknown" in the case log. Only include cases seen between January 1, 2014 and December 31, 2015. Remember, all experience must be within the two-year Specialist program. Please **highlight** the five cases used for your case reports. Standard diagnostic and procedural abbreviations, as defined by the AVDC (revised 2009), are included on page 16. If your clinic commonly uses abbreviations that do not appear on the list, please define these within your log.

MINIMUM REQUIRED CASELOAD

The AVDT prefers the mentee assist in procedures marked (*). However, if that is not possible, proof of CE in this area is required. This must be highlighted on the case log and indicated on Forms 4a and/or 4b, as appropriate. *A cadaver may be used in a maximum of two cases from any category marked (**). These cases are left to the discretion of the mentee, but must be certified and supervised by a Diplomate of the American Veterinary Dental College or a Fellow of the Academy of Veterinary Dentistry (Form 6).*

Oral Medicine

OM Cases requiring involved diagnostic tests (e.g. anesthesia and biopsy and/or radiographs, sialography, masticatory muscle EMG, or where laboratory tests beyond complete blood count and biochemical profile are used) but which do not include a specific treatment procedure that is included under a treatment code below.....1

Periodontics

PE1 Complete prophylaxis not requiring involved periodontal treatment.....10

PE2 Involved periodontal scaling and root planing to include placement of a perioceutic medication when no PE3 or PE4 procedure is performed.....3

PE3 Simple periodontal surgery (gingivectomy/gingivoplasty, open curettage or flap procedure, except those combined with bone grafting).....1

PE4* Involved periodontal treatment (osseous surgery, increasing attachment height, bone augmentation, gingival grafting, and guided tissue regeneration, periodontal splinting).....1

Note: extraction followed by placement of a bone promoting or substitute material is not a PE4 case.

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Endodontics ** (all including routine restoration of access openings)

EN1	Mature canal endodontic obturation - nonsurgical.....	7
EN2	Vital pulp therapy (partial vital pulpotomy).....	2
EN3*	Surgical endodontic treatment, apexification, replacement of avulsed or luxated teeth, splinting of tooth with horizontally fractured root with follow up endodontic evaluation.....	1

Restorative Dentistry **

RE	Restorative procedures (requiring gingival flap exposure, occlusal table cavity preparation, other involved restoration including routine restoration of endodontic access openings, dentin bonding only is NOT considered a RE case).....	5
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Oral Surgery

OS1	Simple (closed) dental extractions, crown amputations (tooth resorption).....	7
OS2	Involved dental extractions (open or closed, requiring tooth sectioning, bone removal or other procedures in addition to elevator and forceps work). A full mouth extraction patient may be logged as one OS2 case.....	5
OS3**	Mandibular or maxillary fracture fixation (using dental acrylic splint, body of mandible fracture fixation with wire, pins, screws or plate, symphyseal separation fixation).....	1
OS4**	Involved oral surgical procedures (TMJ condylectomy, repair of existing palatal defects and oronasal fistulas, maxillectomy, mandibulectomy).....	1
OS5**	Miscellaneous soft tissue oral surgery (resection of traumatic cheek or sublingual granuloma hyperplasia; salivary gland surgery, removal of oral masses not requiring maxillectomy or mandibulectomy, laser surgery for stomatitis, operculectomy, does not include therapy laser treatments that do not directly treat the oral cavity).....	1

Prosthodontics

PR*	Crown and/or bridge preparation, impression and cementation (including canine, incisor and carnassial teeth).....	1
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Orthodontics

OR*	Malocclusion treatment plans (including detailed consultation and evaluation of the bite or bite registration), extraction of deciduous teeth or permanent teeth causing malocclusion, management of clinical malocclusion (crown amputation, application of incline plane), and management of clinical malocclusions (use of and active force orthodontic device).....	1
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Other Species

EX	Dental procedures on animals other than dog and cat.....	2
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CASE LOG GUIDELINES

This document is a guideline for the mentor of an AVDT applicant and for the applicant. It is a basis for review of logs, but does not mean that all case logs the mentor reviews will be approved by the Credentials Committee of the AVDT.

To make construction and management of the case logs as user friendly as possible for applicants, the AVDT provides Excel based spreadsheet files with templates and instructions for logging cases and related activities. Use of this spreadsheet is required by the Credentials Committee.

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This document contains the following:

1. Case Log Categories
2. Guidelines for Counting Cases
3. Format for Submission of Case logs

Required Case Logs

A detailed list of a minimum of 50 veterinary dental cases seen during the AVDT approved training period is required. Cases that were treated prior to the applicant's AVDT training program acceptance date cannot be included in the case log. The case log is to conform to the guidelines, nomenclature and abbreviations described below. A completed dental chart must be available for all logged cases but need not be submitted unless requested by the AVDT. The cases are to be listed under the categories stated in the AVDT case log categories listing.

For submission as part of a credentials application package, the full Categorical and Chronological log is required including cases logged during the entire AVDT training period.

Chronological Log: The cases are to be numbered sequentially and listed chronologically. The required format is that the chronological log should contain all of the appropriate AVDC codes that pertain to the case.

Categorical Log: The cases are to be listed under the categories and subcategories stated in the AVDT case log categories listing. The Categorical Case Log is to begin with a table listing the number of cases seen in each category. For each case listed, the case number is to be the same number assigned to the listing of that case in the chronological list. The categorical log should contain ONLY the codes pertaining to the category that the case is included in.

The completed chronological logs demonstrate your understanding of how to log the complete case whereas the categorical log demonstrates more focused understanding of the specific logged procedure.

If an applicant remains in a training program for more than two years, cases in the log that are more than two years old cannot be counted towards meeting the AVDT total case logs. However, the applicant is not required to revise the individual case log numbers following deletion of cases that are no longer allowable. Any report to the AVDT that includes a case log in which the most recent two year chronological log list does not start with case number one is to note the reason for not starting with one as the initial case in the chronological log.

Miscellaneous Cases

When a case does not appear to fit into any of the AVDT categories, the applicant is to request clarification from the AVDT Credentials Committee Chair via email. When necessary, the Credentials Chair will forward the query to the Board for consideration.

Guidelines for Counting Cases

An AVDT case is defined as either the performance or assistance in a dental discipline. A maximum of one case may be logged from any single treatment episode of a particular animal. If this patient is anesthetized later for another dental procedure, it may be used as an additional entry.

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Review of Case Logs and Reports by Mentor

Categorical and Chronological Logs of cases performed during the two year Specialist program are to be submitted as part of the applicant's report to their mentor. One half of logs and case reports should be completed for midterm review by your mentor. The completed logs and reports must be submitted to your mentor for approval at least one month prior to packet submission.

Requirements for Case Logs

1. Category
List the category you are assigning this case to, using the Case Log Categories to determine the category (see pages 4&5).
2. Number
Consecutive throughout an applicants program, listed in date order. If an applicant remains in the training program for more than two years, cases in the log that are now more than two years old can no longer be counted.
3. Date
Month, day, and year procedures were performed.
4. Patient Name
List the patient's name or clinic case number.
5. Signalment
Species, age, breed, weight, and gender of the patient.
6. Diagnosis
List the diagnosis(es) made using the approved AVDC abbreviations. If you use any other abbreviations, a key to these abbreviations must be included in your submitted packet.
7. Dental Procedure
List the dental procedures performed using the approved AVDC abbreviations. If you use any other abbreviations, a key to these abbreviations must be included in your submitted packet. Individual teeth treated are to be identified. *The AVDT requires that the modified Triadan system of tooth identification be used.*
8. Radiographs
This column is checked if radiographs were taken.
9. Anesthetic
List anesthetic protocol (generic drug names preferred). **DO NOT** list preanesthetic or local anesthetic drugs given.
11. Use of the AVDT Excel based case log template is required for applicants.

Case Reports

Five Case Reports. Included in this packet are two examples of case reports submitted by a successful applicant. Case report guidelines are outlined below. The case reports should be **typed, double spaced, and not more than five pages in length (not including references and photos)**. Cases for your reports must appear in your case log. Be sure that information such as patient's name, owner's name, identification number, and the date the case was seen is included in the report. This information is used to determine if the case is entered in the case log. The case reports should describe, in detail, how the patient was diagnosed and treated. The case reports must also be used to demonstrate how you used your knowledge and experience to assist the veterinarian in diagnosing and treating the patient. It is important that the information in your case reports be

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clearly understood. Present each case in a logical manner, check spelling and grammar, and define any abbreviations. It is important that you show that you participated in the case and were not just an observer. Pertinent anesthesia information should be included; i.e. route and dose of sedation drugs, induction drugs, maintenance drugs, and any local or regional drugs administered. Consider some of the following ways of demonstrating your knowledge and expertise:

1. Show how your observations, examination and history taking assisted the veterinarian with the development of an effective dental plan.
2. Explain why an observation was important or why you asked a certain question during the procedure.
3. Describe how an observation you made helped to avoid a possible complication.
4. Describe the procedures you performed and assisted with. Explain why the procedure was performed.
5. Describe the anesthetic protocol that was chosen for this patient and how you maintained the patient's condition during the procedure.
6. Show your understanding of the problem being treated.

CASE REPORT GUIDELINES

A case report is an opportunity to show good dental concepts and the ability to deliver a well written and well-documented scientific paper about a case performed well by current standards. The use of advanced technology or skill in the reported cases is not required. Your mentor and the Credentials Committee will evaluate each of the items below.

Introduction

Present the topic of the case report.

Case Report

1. History

- A. Include a signalment and presenting problem or chief complaint.
- B. Describe lesions/problem.
- C. Describe past dental history.
- D. Describe past medical history if relevant.
- E. Describe any other relevant problems.

2. Diagnosis

- A. Include results of physical and oral examinations, radiographs, MRI, etc.
- B. Demonstrate attention to the patient as a whole. Perform appropriate preoperative diagnostics and laboratory tests.

3. Problem List

- A. Provide an accurate assessment.
- B. Mention all oral lesions observed.
- C. Mention differential diagnosis and their rule-outs.

4 Treatment Plan

- A. Discuss different modalities for treatment and their prognosis.

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- B. If other lesions are apparent, you should mention them and note if treated or not treated.
- C. Address any potential genetic impact of the condition, if applicable.

5. Treatment

- A. Describe the procedure including technique, instruments, and materials in detail using proper terminology. Highlight your involvement in the procedure.
- B. Include your anesthetic management: using appropriate anesthetic protocol, drugs (generic name preferred), dosages, route of administration, and monitoring.
- C. Demonstrate appropriate peri-operative care: vital functions monitoring and support, intravenous fluid administration, control of body temperature, etc. Adequate pain management is very important.
- D. Include dosages and administration routes of any medication used or prescribed. Use generic name when possible. If trade name is used, note generic name and manufacturer.
- E. Include postoperative radiographs and their assessment if indicated.
- F. Describe the handling of any complications.
- G. Provide adequate photos to support your report. Provide adequate and accurate captions, labeled pre- and postoperative radiographs for procedures and intra operative radiographs for root canal therapy.

6. Postoperative Care

- A. Describe instructions given to client, including medication dispensed for home use and dental home care procedure.

Discussion

- A. Discuss any point relative to your case.
- B. Briefly review the literature on the disease condition and/or procedure in question, if appropriate.
- C. Discuss pertinent aspects of the diagnostic work up.
- D. Provide references to support your statements. Number references consecutively in the order which they are first mentioned in the text. Identify them by Arabic numerals in superscript.
- E. Discuss any particular ways the case was different from expected, and how the problems were managed.

Conclusion

What conclusion, if any, could be drawn from the case?

Technical Details

- A. Each case report should be no longer than five pages. References and pictures should be limited to one additional page.
- B. It is required that your mentor review your case reports.
- C. Read your manuscript while playing the role of a critic. ***Keep it technical. Please remember that this is scientific writing, and spelling and grammar are very important. Plagiarism will be result in severe penalties.***
- D. Above all, prepare your case reports early enough to seek pre-approval by your mentor, leaving enough time to edit and return it again well before your Credentials Packet deadline.

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“Katie” Burdick—a periodontal disease case
Case Log #122—8/16/2012

“Katie”, an 11 year old, 29.9kg, spayed female Chesapeake Bay Retriever dog, presented for an oral examination due to heavy dental calculus and halitosis. Earlier that week, she had pre-anesthetic laboratory testing consisted of a chemistry panel and a CBC, both which were within normal limits. The owner was not currently providing home dental care. The patient was up-to-date on her vaccinations, and did not take any medication other than a monthly heartworm and flea preventative. Her most recent professional dental cleaning with full mouth radiographs had been performed over four years previously. Findings from that procedure included moderate dental calculus, several worn teeth, and a 6mm periodontal pocket between the right maxillary fourth premolar and first molar (108 and 109) that had been treated with closed ultrasonic periodontal debridement and perioceutic application. She had not returned for her recommended re-evaluation later that year.

Conscious physical examination was performed and was within normal limits. The patient was in good body condition and was normally hydrated. Her heart rate was 82 bpm, respiratory rate was 18 rpm, and body temperature was 100.3°F. The external examination was within normal limits. Her conscious oral examination revealed a normal occlusion, heavy dental calculus, mild gingivitis, and several worn teeth. The level of dental calculus on many of her teeth made it difficult to evaluate the crowns for discoloration or fractures. She had very conspicuous halitosis. There were no other abnormalities noted on conscious oral examination. The owner was presented with a treatment plan including general anesthesia for an oral examination, a professional scaling and polishing of the teeth, and full mouth dental radiographs. The owner consented to this treatment plan and asked to be called during the procedure if any additional treatments were indicated.

The patient’s eyes were lubricated with a petrolatum ophthalmic ointment, and she was administered an intramuscular pre-anesthetic sedative consisting of dexmedetomidine (0.1mg at 4µg/kg) and butorphanol (6.5mg at 0.2mg/kg). The technician administered a subcutaneous injection of carprofen (65mg at 2.2mg/kg) as an analgesic. Once the patient was sedate enough to accept 100% oxygen administered through a mask, the technician placed her in sternal recumbancy on a circulating warm water blanket and covered her with an additional warm water blanket to maintain body temperature. The technician then aseptically placed a 22 gauge intravenous catheter in the right cephalic vein, and administered a balanced electrolyte solution (299mL/hr, at 10mL/kg/hr) throughout anesthesia to support normal blood pressure. Once the patient was connected to intravenous fluids, the technician drew up propofol at 3mg/kg and administered it slowly via the catheter until the patient was relaxed enough to allow intubation (10mg total). The technician then placed a size 14 cuffed endotracheal tube, and connected the patient to a rebreathing anesthetic circuit. The technician maintained anesthesia with a mixture of isoflurane (1.75% to 2.0%) and oxygen—isoflurane concentration was adjusted as needed based on the patient’s vital signs and response to stimuli. Anesthetic monitoring included visual assessment, reflex activity, body temperature, oxygen saturation (pulse oximetry), heart rate, respiratory rate, blood pressure, and end-tidal carbon dioxide. The technician monitored these values continuously, and recorded the latter five parameters in the patient’s anesthetic log every five to ten minutes.

Once the patient was in a stable plane of anesthesia, the technician rinsed the patient’s mouth with a 0.12% chlorhexidine oral rinse. The technician then took full mouth dental radiographs using a size 2 direct digital sensor plate. All teeth appeared normal radiographically, including the right maxillary quadrant where the patient had been treated with ultrasonic periodontal debridement and perioceutic application in 2008 (Fig. 1). Due to the patient’s heavy dental calculus (Fig.2), the veterinarian and technician decided

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to proceed with the dental cleaning before performing a comprehensive oral examination. The technician performed a complete supragingival and subgingival scaling, using a broad-tipped insert for the ultrasonic scaler supragingivally and a periodontal-specific insert on low power subgingivally. While scaling subgingivally, the technician noticed a potentially deep periodontal pocket on the mesiopalatal aspect of the right maxillary fourth premolar (108), and checked its depth with a periodontal probe (Fig. 3). The pocket registered at 9mm, which the technician recorded on the patient's dental chart and brought to the attention of the veterinarian. Because teeth with periodontal pockets of this depth require either extensive open periodontal surgery or extraction, the technician did not attempt further closed root planing or subgingival scaling of 108¹. After the technician gently dried all of the teeth using the three-way syringe to check for any chalky-looking calculus deposits left behind, the teeth were polished using a fine-grit flour pumice paste and an oscillating disposable prophylaxis head. Any leftover paste was rinsed away with distilled water from the three-way syringe.

The veterinarian and technician performed a comprehensive oral examination with gingival probing and dental charting. Because the patient's heavy dental calculus had been removed during her scaling and polishing, all surfaces of her teeth were able to be evaluated for abnormalities. As noted on the conscious oral examination, the patient had several worn teeth and gingivitis. Because her gingiva bled when probed, her gingivitis was considered to be moderate instead of mild or marginal². Other than the 9mm pocket associated with 108, periodontal probing did not reveal any sulcal depths greater than 3mm. There was about 2mm of gingival recession associated with the mesiobuccal aspect of 109, although the gingiva between 108 and 109 that had been treated in 2008 only had a sulcal probing depth of 2mm. None of the patient's worn teeth had pulp exposure or radiographic changes, and all appeared to have intact tertiary dentin. No treatment was indicated for these teeth². The patient's halitosis had improved after the scaling and polishing, but had not entirely disappeared. Halitosis associated with periodontal disease is mainly caused by volatile sulfur compounds that are produced during anaerobic bacterial respiration and tissue destruction². Based on the oral examination and gingival probing, the veterinarian was able to make a diagnosis of stage 4 periodontal disease. In stage 4 periodontal disease, the attachment loss between tooth root and alveolar bone is greater than 50%, which in dogs can mean periodontal pockets that exceed 7mm³. Periodontal disease is staged by both attachment loss as well as radiographic changes, although in "Katie's" case there did not appear to be any radiographic abnormalities associated with her 9mm pocket. Because a radiograph is only a two-dimensional image, it may be difficult to detect vertical bone loss radiographically, especially on an area with significant bony superimposition such as the palatal aspect of a multi-rooted tooth⁴.

After making the diagnosis of stage 4 periodontal disease, the veterinarian called the owner to discuss treatment options. Extraction of the affected tooth or teeth is frequently warranted for stage 4 periodontal disease. This level of disease can be addressed with aggressive periodontal surgery to debride the tooth roots and promote tissue reattachment, but it still carries a poor prognosis³. To try and preserve a tooth with stage 4 periodontal disease, professional dental care will need to be supplemented with regular, thorough home care. Depending on the patient's individual response, reevaluation and follow-up professional care might be needed as often as every 3-4 months^{3,5}. After discussion of all of these factors, the owner chose to have 108 extracted rather than try and preserve it with periodontal surgery.

At this point, the technician administered an intramuscular injection of morphine (9mg at 0.3mg/kg) to the patient and prepared a mayo stand with instruments and supplies for the extraction of 108. A local nerve block of 0.8mL of a 1:4 mixture of 2% lidocaine to 0.5% bupivacaine was injected into the right infraorbital foramen. The veterinarian used a #15 scalpel blade to gently sever the gingival attachment around 108. After this, he made a single vertical releasing incision just mesial to the juga of the mesiobuccal root to create a buccal mucoperiosteal flap. Because the maxillary fourth premolars are large, multi-rooted teeth, and two

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out of the three roots of 108 were still fully surrounded by alveolar bone, nonsurgical extraction was not an option⁶. The gingival tissues were elevated using a periosteal elevator, and about 1/3 of the alveolar buccal bone was removed using a #4 cutting round bur. A #557 crosscut fissure bur was then used to section the tooth into three pieces, each with its own root, and the individual roots were elevated using a luxator and surgical elevators in sizes 1-4. Once the roots were mobile, they were removed with extraction forceps. Alveoloplasty was performed using a diamond round bur to smooth the alveolar buccal bone in preparation for flap closure. After increasing flap elasticity by incising the periosteum with a #15 scalpel blade, the veterinarian sutured the flap closed with 4-0 chromic gut, in a simple interrupted pattern (Fig. 4). The technician took a post-extraction radiograph to confirm removal of all tooth and root structures (Fig. 5). As a final step, the technician applied a waxy polymer plaque preventative to all of the patient's teeth to reduce the amount of plaque build-up during extraction site healing process.

In preparation for recovering the patient, the technician rinsed the patient's mouth using distilled water from the three-way syringe, and checked the oral cavity for any remaining gauze or debris. The technician turned the isoflurane vaporizer off, and the patient was left in lateral recumbancy on 100% oxygen for five minutes. The patient's post-operative temperature was 97.7°F. She remained connected to all aforementioned anesthetic monitoring equipment until she was extubated. After five minutes on 100% oxygen, the patient was disconnected entirely from the anesthesia machine and recovered until extubation on room air. Once the patient's swallowing reflex returned, the patient was extubated and moved into a recovery cage for continued monitoring. She recovered from anesthesia uneventfully, and was bright, alert and responsive and walking on a leash without difficulty at time of discharge. During the discharge appointment, the technician instructed the owner on proper dental homecare for the patient, including tooth brushing technique and application of the waxy polymer plaque preventative. The technician also suggested trying a Veterinary Oral Health Council-approved water additive to help control plaque formation. The owner was instructed to feed the patient a soft diet for 10 to 14 days following the extraction, and to avoid chew toys and tooth brushing during that time, to prevent disruption of the sutures. The patient was sent home with carprofen tablets (100mg at 3.3mg/kg PO BID x 5 days) to be started that evening. The patient was scheduled to return for an extraction site recheck for 14 days following her procedure. The owner was told that the prognosis for periodontal disease is extremely variable, and depends on the patient's own immune response as well as both the professional oral care and home care that the patient receives². Because of this, the owner was encouraged to schedule to patient for an anesthetized oral examination and radiographs in 6 months to monitor potential progression of periodontal disease.

Periodontal disease is the inflammation of the supporting structures of the teeth—the periodontium. The periodontium consists of gingiva, the periodontal ligament, the cementum, and the alveolar bone. Several studies have shown periodontal disease to be the most commonly diagnosed disease of dogs and cats³. Although periodontal disease has complex, multi-faceted pathophysiology, it has its beginnings in the bacteria that inhabit the pellicle—the thin layer of glycoproteins deposited on teeth by saliva. As the bacteria count rises, their by-products cause the pellicle to thicken into plaque—this process takes about 24 hours. These bacteria are mostly aerobic and gram-positive³. As the plaque thickens, it develops subgingivally, where it causes inflammation of the tissues there and results in gingivitis. Plaque is soft and sticky and can be removed by tooth brushing—gingivitis is reversible if plaque is removed. If plaque is not removed, over the next 2-3 days, calcium compounds from the saliva mineralize and harden the plaque—at which point it is termed dental calculus. Calculus cannot be removed by tooth brushing⁵. As the calculus thickens, it irritates the gingiva, provides a rough surface for more plaque to adhere, and provides an oxygen-poor environment for new species of bacteria to populate. These bacteria are typically anaerobic and gram-negative, and their metabolic by-products create more severe inflammation and tissue destruction of a tooth's supporting structures. At this point, reversible gingivitis has become irreversible

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periodontitis—the active destruction of periodontal tissues. Only about 25% of bacteria cultured from healthy canine subgingival tissues are anaerobic, but when periodontal disease is present the anaerobes make up as much as 95% of the bacterial population. There is a host component to this process as well—as the patient’s immune system tries to destroy the invading bacteria it may end up damaging the periodontal tissues as well. Because different animals will have different immune responses, two dogs with similar plaque burdens may develop widely differing degrees of periodontal disease³. As periodontal disease progresses, the gingiva detach and recede from the alveolar bone and form periodontal pockets, where more plaque and anaerobic bacteria develop. Eventually, the periodontal ligament and alveolar bone degenerate and the teeth become mobile—this ultimately results in tooth loss³.

Animals with periodontal disease may present with a wide range of signs and symptoms, depending on the severity of their condition. In earlier stages, gingivitis, halitosis and calculus deposition may be the only signs. As periodontal disease worsens, patients may develop such additional symptoms as gingival recession, root exposure, purulent discharge around teeth, mobile teeth, oral pain, and ulcerated gingiva^{3,5}. Because the disease is often undetected by owners in its early stages, the halitosis associated with advanced periodontal disease is commonly the initiating factor for the visit to the veterinarian, as it was in “Katie’s” case⁵. The goal in treating periodontal disease is to remove all sources of inflammation from the patient’s oral cavity and reestablish healthy periodontal tissues. This is accomplished by removing all supra- and subgingival plaque and calculus from teeth not needing extraction, providing periodontal therapy or surgery if indicated by the presence of periodontal pockets or gingival recession, and extracting teeth that cannot be preserved with treatment or surgery³. Following professional dental care, there are many products available for owners to use at home to help combat plaque formation. These include specially formulated diets and treats, water additives, plaque preventative gels and waxes, oral rinses, and tooth brushes/pastes². Dedicated home care on the part of the owner will help maintain a healthy periodontium between professional dental cleanings, and is an essential component in the long-term preservation of oral health.

Figure 1: radiographs of 108

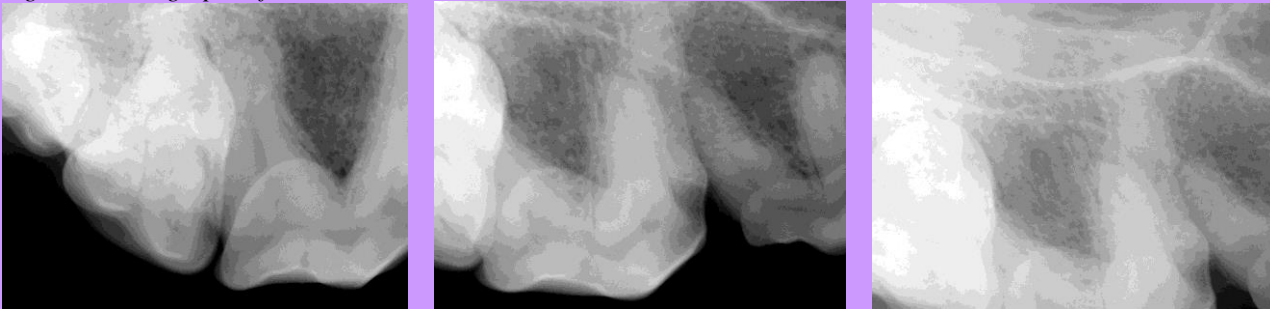


Figure 2: the right maxilla, pre-dental cleaning

Figure 3: a 9mm periodontal pocket associated with 108



Figure 4: post-extraction and scaling/polishing



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Figure 5: post-extraction radiograph



References

1. Holmstrom SE, Frost P, Eisner ER. Dental Prophylaxis and Periodontal Disease Stages. *Veterinary Dental Techniques for the Small Animal Practitioner*. 3rd ed., Philadelphia: Saunders; 2004: 175-232.
2. Lobprise, Heidi B. *Blackwell's Five-Minute Veterinary Consult Clinical Companion—Small Animal Dentistry*. Ames: Blackwell Publishing Professional, 2007; 3-13, 163-165, 172-180.
3. Wiggs RB, Lobprise HB, Periodontology. *Veterinary Dentistry—Principles and Practice*. Philadelphia: Lippincott-Raven; 1997: 186-231.
4. DuPont G, DeBowes L. *Atlas of Dental Radiography in Dogs and Cats*. St. Louis: Saunders; 2009: 134-141.
5. Perrone JR. *Small Animal Dental Procedures for Veterinary Technicians and Nurses*. Ames: Wiley-Blackwell, 2013; 106-115.
6. Holmstrom SE, Frost P, Eisner ER. Exodontics. *Veterinary Dental Techniques for the Small Animal Practitioner*. 3rd ed., Philadelphia: Saunders; 2004: 291-338.

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Case Report Examples
Example 2

“Hurley” Gavin, a persistent deciduous tooth case

Case Log #7—1/20/2011

“Hurley” had been recently adopted by his owner and had persistent deciduous teeth that were noticed on a routine conscious oral examination.

The patient, a 7-month-old, 17.7kg, castrated/male Pointer mix dog, presented for persistent deciduous teeth, including a complicated crown fracture of his deciduous right maxillary canine (504) (Fig. 1). The other deciduous teeth present were the deciduous mandibular canines (704 and 804)—these did not appear to be fractured or mobile upon conscious examination. His adoption paperwork did not mention any previous dental findings or treatments, nor had his owner taken him to any other veterinarian following his adoption. His owner had not reported any health problems since his adoption, and he was current on all vaccinations. The patient was on a monthly heartworm and flea preventative. He was not on any other medication.

The rest of the patient’s conscious oral examination findings were normal other than mild abrasions on the distal aspect of both permanent mandibular canines (304 and 404). He had no visible calculus, but there was moderate gingivitis associated with all of the persistent deciduous canines, and debris impacted between the permanent and deciduous canine teeth (between 104 and 504, 304 and 704, and 404 and 804). His permanent teeth met in a normal occlusion, and his lymph nodes and salivary glands all palpated normally. There were no abnormalities noted in the bones and muscles of his head and neck. General physical examination revealed that the patient was in excellent overall health, with a pre-anesthetic heart rate of 82 bpm, respiratory rate of 16 rpm and temperature of 99.0°F. Due to the patient’s young age and excellent health, the patient’s pre-anesthetic blood work consisted of a packed cell volume and total protein. These were within normal limits, with a packed cell volume of 42% and a total protein of 5.5 g/dl, so no other tests were ordered.

The patient’s overall oral assessment revealed three persistent deciduous canine teeth (504, 704 and 804), one of which had a complicated crown fracture (504). Other lesions noted were the mild abrasions on the distal surfaces of 304 and 404, and moderate focal gingivitis and debris impaction associated with the crowding caused by the persistent deciduous teeth. There were no other significant findings during the conscious oral exam, so differential diagnosis and other rule outs were not considered until a more involved anesthetized oral exam and full mouth dental radiographs could be performed.

The treatment plan presented to the owner was to anesthetize “Hurley”, perform a complete oral exam, take full mouth dental radiographs, and extract all three persistent deciduous canine teeth. With treatment, his prognosis for recovery was excellent. The only other concerns were the abrasions on the distal surface of 304 and 404—these were possibly connected to crate or kennel chewing in the patient’s past, although the owner did not think that he was continuing this behavior in her care. These teeth would be thoroughly examined, and radiographed under anesthesia to confirm the absence of both root fractures and endodontic pathology. As the abrasions on 304 and 404 were a chronic condition, the crowns were not fractured, and the abraded distal aspects of the teeth

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showed smooth, light-brown reparative dentin, treatment to bond and seal these teeth was not considered necessary¹. The owner consented to the entire treatment plan.

The patient was administered acepromazine (0.8mg at 0.05mg/kg) and butorphanol (5mg at 0.3mg/kg) intramuscularly and his eyes were lubricated with a petrolatum ophthalmic ointment to prevent drying and protect them under anesthesia. Once the patient was sedate enough to accept 100% oxygen administered through a mask, he was placed in sternal recumbancy on a circulating warm water blanket and covered with a thick towel to maintain body temperature. The technician placed a 22-gauge intravenous catheter in the right cephalic vein, and a balanced electrolyte solution was administered intravenously (177mL/hr at 10mL/kg/hr) throughout anesthesia to support normal blood pressure. Once the patient was connected to intravenous fluids, propofol was drawn up at 3mg/kg and titrated to induce anesthesia (50mg total). The technician placed a cuffed 12mm endotracheal tube, and the patient was connected to a rebreathing anesthetic circuit. Anesthesia was maintained with a mixture of isoflurane (1.5 to 3%) and oxygen—isoﬂurane concentration was adjusted as needed based on the patient’s vital signs and response to stimuli. Anesthetic monitoring by the technician included visual assessment, reflex activity, body temperature, oxygen saturation (pulse oximetry), heart rate, respiratory rate, blood pressure, and end-tidal carbon dioxide. The latter four parameters were recorded in the patient’s anesthetic log every five minutes. Carprofen (74mg subcutaneously at 4.2mg/kg) and morphine (8mg intramuscularly at 0.4mg/kg to 0.5mg/kg) were administered immediately after induction to manage pain and inflammation. A local block of 0.4ml of a 1:4 mixture of 2% lidocaine to 0.5% bupivacaine was administered in three locations: the left and right inferior alveolar canal and the right infraorbital foramen (total volume administered not to exceed 1mg/kg of the combination). A comprehensive oral exam with gingival probing and dental charting was performed by veterinarian and technician, after which the technician took full mouth dental radiographs using a size 2 direct digital sensor plate.

Oral examination performed under general anesthesia revealed normal occlusion and no calculus. The patient had a rigid mandibular symphysis, and normal tissues of his tongue, oropharynx and hard palate. There were no abnormalities of his oral mucosa. The abrasions on the distal surfaces of the mandibular canines were probed gently with a shepherd’s hook explorer and found to be smooth and evenly worn. Moderate gingivitis was only associated with the persistent deciduous canine teeth—there was also debris impacted between the permanent canine teeth and the deciduous canine teeth. The technician gently flushed out the debris during oral examination by using a curved tip syringe filled with 0.12% chlorhexidine oral rinse. Two of the deciduous canines (704 and 804) were intact, while the third (504) had a complicated crown fracture with pulp exposure. There was a fistulous tract with a probing depth of 6mm located on the attached gingiva over the distal aspect of the right maxillary first premolar (105) (Fig. 2). All of the permanent teeth were fully erupted with no apparent structural defects, with the exception of the abrasions on 304 and 404. Full mouth dental radiographs were unremarkable with the exception of the persistent deciduous teeth (Fig. 3). The abraded mandibular canines did not show any radiographic evidence of endodontic disease. After concluding the oral examination and reviewing all intraoral radiographs, the decision was made to continue with the original plan—extracting all three persistent deciduous teeth.

Because intraoral radiographs of 504, 704 and 804 showed some degree of root resorption, the decision was made to perform closed extractions unless complications occurred². Because it was fractured and infected, 504 was chosen as the first tooth to be extracted. The technician set up a mayo stand with the necessary instruments and equipment for the extractions. The veterinarian used a #15 scalpel blade to gently sever the gingival attachment around 504, taking care to avoid damaging the periodontal tissues around

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the corresponding permanent canine tooth (104). The #15 blade was also used to make a small incision over the distobuccal aspect of 504's attached gingiva, which would help prevent root fracture during elevation³. At this point, a straight fine root elevator and an extra fine luxating-type elevator were used to gently fatigue the periodontal ligament, working all the way around the tooth. During this process, care was taken to avoid elevating at the most mesial aspect of 504 to prevent damage to the adjacent permanent canine^{2,3}. Once the tooth was mobile, small extraction forceps were used to carefully lift 504 out of its alveolus. The technician took a post-operative dental radiograph to confirm complete extraction of 504 (Fig. 4). 4-0 chromic gut was used to place one simple interrupted suture at the extraction site to close the small incision that had been made in the attached gingiva (Fig. 5). With the patient still in left lateral recumbancy, the same technique used to extract 504 was used to extract 804. The technician took a post-operative dental radiograph to confirm complete extraction of 804. The patient was briefly disconnected from the anesthesia circuit, and placed in right lateral recumbancy. The only persistent deciduous tooth to extract on the left side of the patient's mouth was 704, and this tooth was extracted using the same technique as for 504 and 804, with a post-operative radiograph taken afterwards. After the final suture was placed, the patient's mouth was rinsed by the technician with distilled water, and the oral cavity checked for any remaining gauze or suture material. The technician began recovering the patient from anesthesia--the isoflurane vaporizer was turned off, and the patient was left in lateral recumbancy on 100% oxygen for five minutes. During this time, as during the entire procedure, the patient remained sandwiched between two circulating warm water blankets. The patient's post-operative temperature was 98.2°F. He remained connected to all aforementioned anesthetic monitoring equipment until he was extubated. After five minutes on 100% oxygen, the patient was disconnected entirely from the anesthesia machine and recovered until extubation on room air. The patient's oxygen saturation remained above 96% this entire time. Once the patient's swallowing reflex returned, the patient was extubated and moved into a recovery cage for continued monitoring. He recovered from anesthesia uneventfully, and was quiet, alert and responsive and walking without difficulty at time of discharge. The owner was instructed to feed the patient a soft diet for 7 to 10 days following surgery, and to avoid chew toys and tooth brushing during that time, to prevent disruption of the sutures. The owner was also instructed to not to lift the patient's lips to look at the extraction sites, but to monitor the patient's attitude and behavior for signs of pain and/or infection until a recheck examination in two weeks. The patient was sent home with clindamycin (150mg at 11mg/kg PO SID x 7 days) to be started that evening and carprofen (75 mg at 4.2mg/kg PO SID x 3 days) to be started the following morning.

The *rule of dental succession* states that “no successional and deciduous precursor teeth should be erupted simultaneously or in competition for the same dental arcade space at any time”⁴. When the patient presented with three persistent deciduous teeth, this meant that those teeth needed to be extracted even if 504 had not had a complicated crown fracture. There are two main concerns with any persistent deciduous teeth—malocclusion and periodontal disease.

Persistent deciduous teeth may cause a malocclusion because they prevent the emerging permanent teeth from erupting into the location where they need to be to occlude properly with the rest of the dentition. In relation to their deciduous precursors, permanent mandibular canine teeth erupt lingually, and permanent maxillary canine teeth erupt mesially⁴. When the deciduous teeth do not exfoliate as they should, and instead compete with their successors for space, they push the permanent teeth into a position where they may cause trauma either to soft tissue or other teeth. In the case of the permanent canine teeth, this can lead to palatal trauma. When the permanent maxillary canines erupt mesial to where they should be, it narrows the diastema between the canine and the lateral incisor. This diastema is where the mandibular canine should reside when the mouth is closed, so when it is too narrow, the mandibular canine either makes abnormal contact with the maxillary teeth, or moves lingually, where it can traumatize the hard palate.

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If the permanent mandibular canines are forced to erupt lingually by persistent deciduous teeth, they may occlude against the hard palate every time the animal closes its mouth, eventually resulting in palatal trauma and possibly even oronasal fistulae^{1,2}.

Increased risk of periodontal disease is due to the crowding and abnormal periodontal attachment caused by persistent deciduous teeth^{1,2}. Neither periodontal disease nor traumatic malocclusion had resulted from this particular patient's persistent deciduous teeth. He was still young, so periodontal disease had not had time to develop in the crowded areas of his mouth, although he did have significant gingivitis and bleeding associated with this crowding. He was also a larger breed dog, so he had more room for his teeth to erupt, even when moving into an abnormal position, so he avoided developing a traumatic occlusion. In this patient's case, the complicated crown fracture of 504 meant that it needed to be extracted as soon as possible. Complicated crown fractures, of both permanent teeth and deciduous teeth, expose the pulp of the tooth, which is painful, and cause the pulp to become infected and die. With a deciduous tooth, this infection can actually damage the corresponding permanent tooth as it is developing. Osteomyelitis and draining fistulae can be caused by any infection resulting from a complicated crown fracture⁵.

Because deciduous canine teeth are so delicate, they must be extracted extremely carefully to avoid fracturing their long, thin roots^{2,3,5}. There is also the risk that the corresponding permanent tooth could be damaged during the extraction. These outcomes can be prevented by elevating slowly and carefully with small, fine elevators, and by staying away from the periodontal ligament in the region of the permanent tooth³. In this patient's case, great care was taken to ensure that the persistent deciduous teeth were extracted completely, and without causing damage to the adjacent permanent teeth.

Figure 1—photograph showing the persistent deciduous canine teeth (left photo-504 and 804, right photo-704)

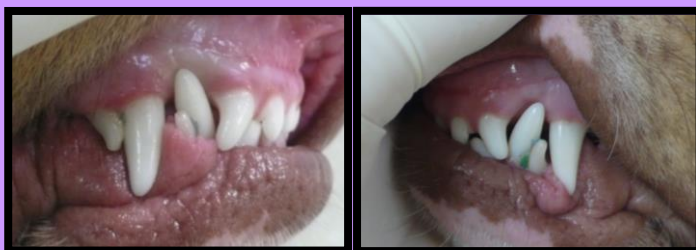
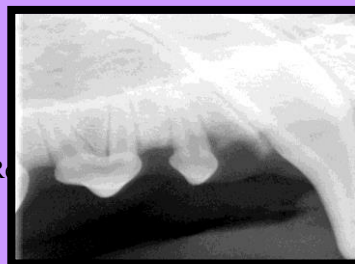
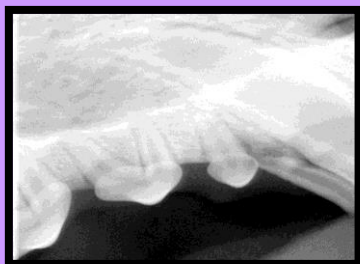


Figure 2—photographs showing the fistulous tract over 105



Figure 3—pre-operative radiographs of 504

Figure 4—post-operative radiograph of the 504 extraction site



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Figure 5—post-operative photographs of the 504 extraction site



References

1. Lobprise, Heidi B. *Blackwell's Five-Minute Veterinary Consult Clinical Companion—Small Animal Dentistry*. Ames: Blackwell Publishing Professional, 2007; 225-229.
2. Hobson, P. Extraction of Retained Primary Canine Teeth in the Dog. *J Vet Dent* 22 (2): 132-137, 2005.
3. Holmstrom SE, Frost P, Eisner ER. *Veterinary Dental Techniques for the Small Animal Practitioner*. 3rd ed, Philadelphia: Saunders; 2004: 328-329.
4. Wiggs RB, Lobprise HB, Pedodontics. *Veterinary Dentistry--Principles and Practice*. Philadelphia: Lippincott-Raven; 1997: 172-174.
5. Hale, F. Juvenile veterinary dentistry. *Vet Clin Small Anim* 35 (4): 789-817, 2005.

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Dental Radiography Requirement

The mentee must provide one complete set of **intra-oral** dental radiographs of a dog and one complete set of **intra-oral** dental radiographs of a cat to show proficiency in dental radiography. Digital radiographs are acceptable and encouraged. Digital films must NOT be altered or enhanced in any way.

The radiographic requirement is fulfilled as follows: full-mouth series of a live dog and cat or dog and cat cadaver with **permanent and complete dentition. Radiographs must include all roots.** Whole skull radiographs are unacceptable. Cadaver radiographs are accepted provided that an intact whole body cadaver, with an endotracheal tube in place, was radiographed, and that the mentee and mentor certify that the whole cadaver was used (see Form 7). Radiographs should be mounted and labeled appropriately: identifying client, patient, date, animal age and breed. Labeling requirements are noted in *Veterinary Dental Techniques, 3rd Ed*; (Holmstrom, S.E., Frost P., Eisner E.R., WB Saunders, 2004)

AVDT CHECKLIST FOR SUBMITTING RADIOGRAPHS

- All adult teeth to be evaluated are clearly visible. **Radiographs must include complete permanent dentition.**
- The maxillary teeth should have the crowns facing downward and the roots upwards.
- The mandibular teeth have the crowns facing upward and the root downwards.
- When viewing the right side of the mouth, the anterior teeth are on the right side.
- When viewing the left side of the mouth, the anterior teeth are on the left side of the radiograph.
- Proper angulation is used.
- There is no foreshortening or elongation.
- Adequate visualization crowns and apices—at least 2mm space around each
- Exposure/developing technique is adequate.
- No artifacts are seen on the image.
- Correct contrast and density of the radiograph.
- File sheets should be labeled according to AVDC guidelines—radiographs should be mounted and labeled appropriately, identifying client, patient, date, animal age, breed and Triadan number

Submitting a Radiograph Set

High quality .jpg images or images imbedded in a Word.doc are required. This can be done by submitting digital dental radiographs, by scanning radiographs using a high resolution scanner, or using a digital camera to photograph radiographs directly off a view box. To improve the quality of photographed images:

- Use a camera with a “macro” focus capability so that the radiograph fills the entire frame;
- Block off unwanted areas on the view box with black or other dark colored paper;
- Check that the long axis of the lens is perpendicular to the radiograph surface;
- Turn off the camera flash;
- Turn off the lights in the room;

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- Use a tripod – this will result in a sharper image when a longer exposure time is needed. Keep the radiograph at the edge of the view box so that the image can remain perpendicular to the axis of the camera lens.

Equipment List and Photographs

A copy of equipment list (Form 4) and accurately labeled photographs of all veterinary dental equipment, instruments and supplies currently available to the mentee, arranged by procedure category (e.g. major equipment, periodontics, endodontics, restoratives, orthodontics, oral surgery, other) is required. Photographs are *not required* if the mentee is currently working at a practice or teaching establishment *under the supervision of an AVDC Diplomate* (Form 5).

READING LISTS

Required reading list:

- Bellows, Jan. *Feline Dentistry: Oral Assessment, Treatment, and Preventative Care*. Wiley-Blackwell, 2010.
- Dupont, Gregg A. and DeBowes, Linda J. *Atlas of Dental Radiography in Dogs and Cats*. Saunders, 2009.
- Holmstrom, Steven E. *Veterinary Dentistry for the Technician & Office Staff*, First Edition. WB Saunders, 2000.
- Kesel, M. Lynne. *Veterinary Dentistry for the Small Animal Technician, First Edition*. Iowa State Press, 2000.
- Niemiec, Brook A. *Small Animal Dental, Oral & Maxillofacial Disease: A Color Handbook*. Manson Publishing, 2012.
- Perrone, Jeanne R. *Small Animal Dental Procedures for Veterinary Technicians and Nurses*. Wiley-Blackwell, 2012.

Suggested reading list:

Journal of Veterinary Dentistry (previous 2 years prior to exam): AVDS membership required. (800-332-AVDS)

Bartolomucci, Linda R. *Dental Instruments: A Pocket Guide, 4th Edition*. Saunders, 2011.

Wiggs, Robert B. and Lobprise, Heidi B. *Veterinary Dentistry Principles & Practice*. Lippincott-Raven, 1997.

Step by Step Compendium. May be ordered through the AVDS (800-332-AVDS)

Mentees should also look at other dental handbooks and periodicals available, including technician magazines, which offer special features on dentistry.

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2009 AVDC/AVDT APPROVED CASE LOG ABBREVIATIONS

Tooth Identification:

Use of the Triadan tooth numbering system is required in case logs. Define any other abbreviations commonly used in your practice.

Abbreviations for use in the case log “Diagnosis” column are shown in BLUE.

Abbreviations for use in the case log “Procedure” column are shown in RED.

		Definition
AB		Abrasion
APG		Apexogenesis
APX		Apexification
AT		Attrition
B		Biopsy
	B/E	biopsy excisional
	B/I	biopsy incisional
BG		bone graft (includes placement of bone substitute or bone stimulant material)
C		Canine
CA		Caries
CBU		core build up
CFL		cleft lip
	CFL/R	cleft lip repair
CFP		cleft palate
	CFP/R	cleft palate repair
CMO		cranio-mandibular osteopathy
CR		Crown
CRA		crown amputation
	CR/M	crown metal
CRL		crown lengthening
	CR/PFM	crown porcelain fused to metal
	CR/P	crown preparation
CRR		crown reduction
CS		culture/susceptibility
DT		deciduous (primary) tooth
DTC		dentigerous cyst
E		Enamel
	E/D	enamel defect
	E/H	enamel hypocalcification or hypoplasia
FB		foreign body
F		flap
	F/AR	apically repositioned periodontal flap
	F/CR	coronally repositioned periodontal flap
	F/L	lateral sliding periodontal flap
FGG		free gingival graft
FRE		frenoplasty (frenotomy, frenectomy)
FX		fracture (tooth or jaw)
		For tooth fracture abbreviations, see under T/FX

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	FX/R	repair of jaw fracture
	FX/R/P	pin repair of jaw fracture
	FX/R/PL	plate repair of jaw fracture
	FX/R/S	screw repair of jaw fracture
	FX/R/WIR	wire repair of jaw fracture
	FX/R/WIR/C	cerclage wire repair of jaw fracture
	FX/R/WIR/ID	interdental wire repair of jaw fracture
	FX/R/WIR/OS	osseous wire repair of jaw fracture
G		Granuloma
	G/B	buccal granuloma (cheek chewing lesion)
	G/L	sublingual granuloma (tongue chewing lesion)
	G/E/L	eosinophilic granuloma - lip
	G/E/P	eosinophilic granuloma - palate
	G/E/T	eosinophilic granuloma - tongue
GH		gingival hyperplasia/hypertrophy
GR		gingival recession
GTR		guided tissue regeneration
GV		gingivoplasty (gingivectomy)
IM		impression and model
IMP		Implant
I1,2,3		Incisor teeth
IO		interceptive (extraction) orthodontics
	IO/D	deciduous (primary) tooth interceptive orthodontics
	IO/P	permanent (secondary) tooth interceptive orthodontics
IP		inclined plane
	IP/AC	acrylic inclined plane
	IP/C	composite inclined plane
	IP/M	metal (i.e. lab produced) inclined plane
LAC		Laceration
	LAC/B	laceration buccal (cheek)
	LAC/L	laceration lip
	LAC/T	laceration tongue
M1,2,3		molar teeth
MAL		Malocclusion – see definitions in Nomenclature document.
	MAL/1	class 1 malocclusion (neuroclclusion - normal jaw relationship, specific teeth are incorrectly positioned)
	MAL/2	class 2 malocclusion (mandibular distocclusion - mandible shorter than maxilla)
	MAL/3	class 3 malocclusion (mandibular mesiocclusion - maxilla shorter than mandible)
	MAL/1-3/BV	Buccoversion
	MAL/1-3/CXB	caudal crossbite
	MAL/1-3/DV	Distoversion
	MAL/1-3/LABV	Labioversion
	MAL/1-3/LV	Linguoversion
	MAL/1-3/MV	Mesioversion
	MAL/1-3/OB	open bite
	MAL/1-3/RXB	rostral crossbite

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	MAL/1-3/XB	crossbite – see CXB or RXB (use of the term 'wry bite' is not recommended, and WRY is not an AVDC-approved abbreviation)
MN		mandible or mandibular
	MN/FX	mandibular fracture
MX		maxilla or maxillary
	MX/FX	maxillary fracture
OA		orthodontic appliance
OAA		adjust orthodontic appliance
	OA/BKT	bracket orthodontic appliance
	OA/BU	button orthodontic appliance
	OA/EC	elastic (power chain) orthodontic appliance
	OA/WIR	wire orthodontic appliance
OAI		install orthodontic appliance
OAR		remove orthodontic appliance
OC		orthodontic/genetic consultation
OM		oral mass
	OM/AD	Adenocarcinoma
	OM/EPA	acanthomatous ameloblastoma (epulis)
	OM/EPF	fibromatous epulis
	OM/EPO	osseifying epulis
	OM/FS	Fibrosarcoma
	OM/LS	Lymphosarcoma
	OM/MM	malignant melanoma
	OM/OS	Osteosarcoma
	OM/PAP	Papillomatosis
	OM/SCC	squamous cell carcinoma
ONF		oronasal fistula
	ONF/R	oronasal fistula repair
OR		orthodontic recheck
OST		Osteomyelitis
PC		pulp capping
	PC/D	direct pulp capping
	PC/I	indirect pulp capping
PDI		periodontal disease index
	PD0	normal periodontium
	PD1	gingivitis only
	PD2	< 25% attachment loss
	PD3	25-50% attachment loss
	PD4	>50% attachment loss
PE		pulp exposure
PM1,2,3,4		premolar teeth
PRO		periodontal prophylaxis (examination, scaling, polishing, irrigation)
R		restoration of tooth
	R/A	restoration with amalgam
	R/C	restoration with composite
	R/CP	restoration with compomer
	R/I	restoration with glass ionomer

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RAD		Radiograph
RC		root canal therapy
	RC/S	surgical root canal therapy
RD		retained deciduous (primary) tooth
		RL is no longer used for resorptive lesion. See TR for tooth resorption.
RPC		root planing – closed
RPO		root planing – open
RRX		root resection (crown left intact)
RR		internal root resorption
RRT		retained root tip
RTR		retained tooth root
S		surgery
	S/M	Mandibulectomy
	S/P	palate surgery
	S/X	Maxilectomy
SC		subgingival curettage
SN		Supernumerary
SPL		splint
	SPL/AC	acrylic splint
	SPL/C	composite splint
	SPL/WIR	wire reinforced splint
ST		Stomatitis
	ST/CU	stomatitis – contact ulcers
	ST/FFS	stomatitis – feline faucitis-stomatitis
SYM		Symphysis
	SYM/S	symphyseal separation
	SYM/WIR	wire repair of symphyseal separation
T		Tooth
	T/A	avulsed tooth
	T/FX	fractured tooth (see next seven listings for fracture types)
	T/FX/EI	Enamel infraction
	T/FX/EF	Enamel fracture
	T/FX/UCF	Uncomplicated crown fracture
	T/FX/CCF	Complicated crown fracture
	T/FX/UCRF	Uncomplicated crown-root fracture
	T/FX/CCRF	Complicated crown-root fracture
	T/FX/RF	Root fracture
		For further information on the tooth fracture definitions, see the Tooth Fracture section in the Nomenclature web page.
	T/I	impacted tooth
	T/LUX	luxated tooth
	T/NE	near pulp exposure
	T/NV	non-vital tooth
	T/PE	pulp exposure
	T/V	vital tooth
TMJ		temporomandibular joint
	TMJ/C	temporomandibular joint condylectomy
	TMJ/D	TMJ dysplasia

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	TMJ/FX	TMJ fracture
	TMJ/LUX	TMJ luxation
	TMJ/R	reduction of TMJ luxation
TP		treatment plan
TR		Tooth resorption
	TR1	TR Stage 1: Mild dental hard tissue loss (cementum or cementum and enamel).
	TR2	TR Stage 2: Moderate dental hard tissue loss (cementum or cementum and enamel with loss of dentin that does not extend to the pulp cavity).
	TR3	TR Stage 3: Deep dental hard tissue loss (cementum or cementum and enamel with loss of dentin that extends to the pulp cavity); most of the tooth retains its integrity.
	TR4	TR Stage 4: Extensive dental hard tissue loss (cementum or cementum and enamel with loss of dentin that extends to the pulp cavity); most of the tooth has lost its integrity. (TR4a) Crown and root are equally affected; (TR4b) Crown is more severely affected than the root; (TR4c) Root is more severely affected than the crown.
	TR5	TR Stage 5: Remnants of dental hard tissue are visible only as irregular radiopacities, and gingival covering is complete.
TRX		tooth partial resection (e.g. hemisection)
VP		vital pulp therapy
X		simple closed extraction of a tooth
XS		extraction with tooth sectioning, non-surgical
XSS		surgical (open) extraction of a tooth

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Form 1

WAIVER, RELEASE, AND INDEMNITY AGREEMENT

I hereby submit my credentials to the Academy of Veterinary Dental Technicians for consideration for examination in accordance with its rules, and enclose the required fee. I agree that prior to, or subsequent to my examination, the Board may investigate my standing as a technician, including my reputation for complying with the standards of ethics of the profession. I understand and agree that the credential fee is nonrefundable.

I agree to abide by the decisions of the Board of Directors of the Academy of Veterinary Dental Technicians and thereby voluntarily release, discharge, and relinquish any and all actions or causes of actions against the Academy of Veterinary Dental Technicians and each and all of its member, directors, officers, examiners and assigns from and against any liability whatsoever in respect of any decisions or acts that they may make in connection with this credentials packet, the grades on such examinations and/or granting or issuance, or failure thereof, of any certificate, except as specifically provided by the Constitution and Bylaws of this organization. I agree to exempt and relieve, defend and indemnify, and hold harmless the Academy of Veterinary Technicians, and each and all of its members, directors, officers and assigns against any and all claims, demands and/or proceedings, including court costs and attorney's fees, brought by or prosecuted for my benefit, extended to all claims of every kind and nature whatsoever whether known or unknown at this time. I further agree that any certificate that may be granted and issued to me shall be and remain the property of the Academy of Veterinary Dental Technicians. Active membership in the AVDT, once accepted, will remain in effect as long as my paid dues are current and I fulfill all recertification requirements.

I certify that all information provided by me in this credentials packet is true and correct. I acknowledge that I have read, understand, and agree to abide by the above two paragraphs.

(Signature)

(Date)

(Please print your name)

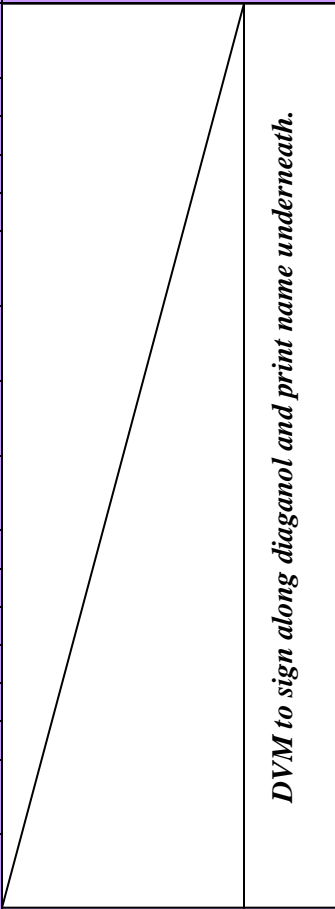
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**Form 2
SKILLS FORM**

Name _____

You are required to state whether or not you have mastered the skills on this form. **Mastery is defined as being able to perform the task safely, with a high degree of success, without being coached or prompted. Mastery requires having performed the task in a wide variety of patients and situations.** The AVDT is aware that some states and provinces may not allow a task to be performed by a credentialed veterinary technician. The AVDT requires that a veterinarian who has mastered the skill attest to your ability to perform the task.

Skill (Applies to both dogs and cats)	Mastered	DVM who can attest to mentee's mastery of skill
Identify normal dentition and eruption schedules		
Identify abnormal pathology		
Charting techniques		
Use of hand instruments		
Use of power scaling units		
Subgingival scaling, root planing and curettage		
Taking whole mouth alginate impressions. Experience needed – <i>mastery not required.</i>		
Making stone laboratory models. Experience desired – <i>mastery not required.</i>		
Instrument identification and use sequence in:		
a. Pulpotomy		
b. Pulpectomy		
c. Extractions (non-surgical)		
d. Extractions (surgical)		
e. Periodontal surgery		
f. Oral surgery		
Intraoral Radiology positioning, film processing and mounting		
Maintenance of hand instruments, equipment and dental delivery systems		

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**Form 3a
SPECIALTY TRAINING FORM
WET LABS**

Name/Applicant Number: _____

SUBJECT	REQUIRED HOURS	HOURS DOCUMENTED	TITLE/SPEAKER/LOCATION/COURSE DESCRIPTION * (highlight if used in case log)
Dental Prophylaxis	5		
Periodontics	5		
Prosthodontics	2.5		
Radiology	6		
Endodontics	2.5		
Regional/Local Anesthesia	4.0		

*More pages may be attached if needed. See page 3, Specialty Training, for required documentation.

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**Form 3b
SPECIALTY TRAINING FORM
ADVANCED DENTAL PROCEDURES LECTURES**

Name/Applicant Number: _____

SUBJECT	REQUIRED HOURS	HOURS DOCUMENTED	TITLE/SPEAKER/LOCATION/COURSE DESCRIPTION * (highlight if used in case log)
Endodontics	2.5		
Prosthodontics	2.5		
Orthodontics	2.5		
Oral Surgery	2.5		
Oral Pathology	2.5		
Advanced Perio. Therapy	2.5		

*More pages may be attached if needed. See page 3, Specialty Training, for required documentation.

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**Form 4
EQUIPMENT LIST
Equipment Requirements for AVDT**

Name/Applicant Number: _____

I. Basic Prophylaxis	Required	Knowledge of	Check if present
Safety Glasses/Face Shield	X		
Respirator Mask and Surgical Mask	X		
Exam Gloves	X		
Ultrasonic or Sonic Scaler with Tips	X		
Hand Sickle Scaler	X		
Hand Curette	X		
Periodontal Probe	X		
Compressed Air System	X		
3 Way Syringe	X		
High Speed Handpiece	X		
Low Speed Handpiece	X		
Contra-angle		X	
Prophy Angle	X		
Prophy Cups	X		
Prophy Paste – Coarse		X	
Prophy Paste – Fine	X		
Disclosing Solution		X	
Perioceutic Medication	X		
Dental Mirror	X		
Chlorhexidine Rinse	X		
Flouride Treatment		X	
II. Maintenance	Required	Knowledge of	Check if present
Prophy Angle Lubricant	X		
High Speed Handpiece Spray		X	
Arkansas Sharpening Stone	X		
Arkansas Conical Sharpening Stone		X	
III. Periodontal Disease	Required	Knowledge of	Check if present
Periosteal Elevator	X		
Bleeding Point Forceps		X	
Surgical Elevator	X		
Luxator		X	
Root Tip Pick	X		

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Extraction Forceps	X		
Hi Speed Cutting Burs and Low Speed Finishing Burs and Instruments	X		
Feline Extraction Forceps	X		
Suture material – chromic gut, monofilament, braided, (absorbability, strength)	X		
Bone Filling Material		X	
Surgical Wire	X		
Dental Suture Kit	X		
Electrosurgical Unit	X		
III. Radiology Either digital sensor and software or Film and a Developer are required	Required	Knowledge of	Check if present
Dental X-ray Unit	X		
Digital Sensors and Software		X	
Chairside Developer		X	
Automatic Developer		X	
Film Clips		X	
Size 0 Film		X	
Size 2 Film		X	
Size 4 Film		X	
View Box		X	
IV. Endodontics	Required	Knowledge of	Check if present
Endodontic File Organizer	X		
Endodontic File Stops	X		
Paper Points	X		
Endodontic Broaches	X		
Endodontic Files & Reamers	X		
File Sterilizer		X	
Automated Files		X	
High Pressure Syringe		X	
Finger Plugger	X		
Finger Spreader	X		
Electronically Heated Spreader		X	
Irrigation Needles	X		
Irrigation Solution	X		
Chelating Agent		X	
Gutta Percha Heater	X		
Gutta Percha Points	X		
Dental Ruler	X		
Calcium Hydroxide Powder/Cement	X		
ZOE or Other Sealant/Cement	X		
V. Restorative	Required	Knowledge of	Check if present
Dental Chisel		X	

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Dental Hatchet		X	
Excavator		X	
Light Cure Gun	X		
Amalgamator		X	
Amalgam Condenser (Plugger)		X	
Amalgam Carver		X	
Mixing Spatula	X		
Mixing Pads	X		
Curved Tip Syringes		X	
Dentinal Bonding Agent	X		
Glass Ionomer Products	X		
Finishing Burs	X		
VI. Orthodontics	Required	Knowledge of	Check if present
Impression Trays	X		
Rubber Mixing Bowl	X		
Large Mixing Spatula	X		
Vibrator	X		
Model Trimmer		X	
Articulator		X	
Plastic Filling Instrument	X		
Welder		X	
Dental Pliers	X		
Dental Wire cutters	X		
Spring Calipers		X	
Orthodontic Wire	X		
Stainless Steel Wire	X		
Orthodontic Buttons	X		
Orthodontic Chain	X		
Articulating paper	X		
Bite wax	X		
Dental Acrylic	X		
VII. Anesthesia and Monitoring	Required	Knowledge of	Check if present
Isoflurane or Sevoflurane	X		
Pulse Oximeter	X		
ECG	X		
Blood Pressure Monitor		X	
Patient Warming Equipment	X		
IV Infusion Pump	X		
Pre-anesthetic evaluation plan	X		

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Form 5*
Equipment List Photo Waiver

I, _____, hereby certify that I am currently at a practice or teaching establishment under the supervision of an AVDC Diplomate.

Mentee Signature

Date

Mentee Name

Mentor Signature

Date

Mentor Name

Supervising Diplomate, AVDC

Date

Supervisor Name

***Form is only required if mentee is not submitting Equipment List photographs.**

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Form 8
MENTOR/MENTEE CONTACTS and CASE LOG/CE VERIFICATION

The mentor and mentee met on the following dates via the following form of communication:

Date	Mentee Initials	Mentor Initials	Method of Communication (i.e.: in person, email, phone, etc.)	Nature of Meeting – Topic(s) Covered

Mentee Signature

Mentor Signature ±

Mentee Name

Mentor Name

± By signing this form, the Mentor is verifying regular contact with the Mentee, as well as verifying having reviewed the Mentee’s Credentials Packet (including all logs) and CE documentation.

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CREDENTIALS PACKET FORMAT

You must submit two copies of your credentials packet on your USB flash drive: the AVDT Master Folder and one additional “anonymous” folder with your randomly assigned number.

Final instructions on submission of your credentials packet will be sent to you by December 31, 2015. **At that time**, you will be assigned a random number to be used as identification on one copy of your packet. This “anonymous” packet will be sent to two reviewers for grading. Your Master packet (the AVDT Master Folder) should include your full identification. **It is very important that your anonymous packet not contain your name or initials on ANY document.** *Note: It is your responsibility to notify, in writing, the secretary of the AVDT within 30 days of any changes to this contact information. Please notify the Credentials Chair immediately with any changes to your email address.*

1. AVDT USB Drive only: Signed copy of "Waiver, Release and Indemnity Agreement" (Form 1). Scan or photograph this form and save as a Word or PDF file, **and name it: First Last (names) - Form1.**†
2. AVDT USB Drive only: Letter of recommendation from supervising veterinarian. This letter should detail such things as training program, ethical behavior, quality of skills, and your relationship to the person writing the letter. Scan or photograph your letter and save as a Word or PDF file **and name it: First Last – LetterofRec.**†
3. AVDT USB Drive only: Signed copy of “Mentor/Mentee Contacts and Case Log/CE Verification” (Form 8). Scan or photograph this form and save as a Word or PDF file, **and name it: First Last - Form8.**†
4. Completed “Skills Form” (Form 2). You are required to state whether or not you have mastered the skill on the form. **Mastery is defined as being able to perform the task safely, with a high degree of success, without being coached or prompted.** Mastery requires having performed the task in a wide variety of patients and situations. AVDT is aware that some states or provinces may not allow a task to be performed by a veterinary technician. AVDT requires that a veterinarian, who has mastered the skill, attest to your ability to perform the task. Scan or photograph this form and save as a Word or PDF file, **and name it: First Last - Form2 on your Master USB and Applicant### - Form2 on your Anonymous USBs.**†
5. Completed “Specialty Training Forms” (Forms 3a and b). A copy of this form is saved in both your Master Folder and Anonymous Folder. **After adding CE certificates, please change the names of the files to: First Last – Form3a OR 3b in your Master Folder and Applicant### - Form3a OR 3b in your Anonymous Folder.**
6. A copy of “Equipment List” (Form 4) and accurately labeled photographs. A copy of this form is saved on both your Master Folder and Anonymous Folder. **After adding your photos, please change the names of the files to: First Last - Form4 on your Master USB and Applicant### - Form4 on your Anonymous USBs.**
7. A copy of “Equipment List Photo Waiver” (Form 5). This is only if you are currently working at a practice or teaching establishment under the supervision of an AVDC Diplomate. Scan or photograph

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this form, and save it as a Word or PDF file, **and name it: First Last - Form5 on your Master USB and Applicant ##### - Form5 on your Anonymous USBs.**†

CREDENTIALS PACKET FORMAT (cont.)

8. A copy of “Case Log Cadaver Verification” (Form 6). This is only if cadavers are used. Scan or photograph this form and save it as a Word or PDF file, **and name it: First Last - Form6 on your Master USB and Applicant#### - Form6 on your Anonymous USBs.**†
9. A copy of “Dental Radiography - Cavader Use” (Form 7). This is only if cadavers are used. Scan or photograph this form and save it as a Word, JPEG or PDF file, **and name it: First Last - Form5 on your Master USB and Applicant#### - Form5 on your Anonymous USBs.**†
10. Completed Categorical Case Logs and Chronological Case Logs with a minimum of 50 cases. Copies of these logs are saved on both your Master USB and Anonymous USBs. **Please change the names of the files to: First Last - Cat Log on your Master USB and Applicant#### - Cat Log on your Anonymous USBs. Please change the names of the files to: First Last - Chrono Log on your Master USB and Applicant#### - Chrono Log on your Anonymous USBs.**
11. A copy of **blank** dental record forms (feline, canine, or other). DentaLabels® are not acceptable as a complete dental record. Save as Word or PDF files in both your Master Folder and Anonymous Folder. **Please name the files: First Last - Canine Chart (or Feline) on the Master USB and Applicant#### - Canine Chart (or Feline) on your Anonymous USBs.**
12. Five Case Reports. Save as Word or PDF files, **and name them: First Last - Report 1 on your Master USB and Applicant#### - Report 1 on your Anonymous USBs. Name them Report 1, Report 2, Report 3, etc.**
13. Dental Radiography Requirement. Save as a JPEG file or embedded in a Word.doc, **and name them: First Last - CanineRads (or Feline) on the Master USB and Applicant##### - CanineRads (or Feline) on your Anonymous USBs.**
14. Credential packet administrative fee - currently \$75.

***** Please follow these instructions carefully!! Also, make sure to white out or block your name on any files included in your anonymous packet. Failure to comply with these instructions will result in denial of your packet! *****

† Please note that documents requiring a signature must be scanned or photographed. Forms not requiring signatures may be typed directly on inside the file. All files must be saved with the appropriate names. Please call or email the Credentials Chair with any questions.

CREENTIAL PACKET SUBMISSION PROCESS

If you choose to duplicate any form using a word processing program, use the same size and style of font, and the same number of pages. It is required that you keep a back up copy of your credentials packet in case of technology failure and for your own reference. All information included in the original should be in your copy. No packets will be returned to you at the end of the review process. All packets will be destroyed after review. **Do not modify any form.**

The USB flash drive of your credentials packet, **with a check for \$75 made out to AVDT**, should be sent via certified mail to:

Tammi Smith, CVT, VTS (Dentistry)
AVDT Credentials Chair
Stuart Animal Hospital
3003 SE Federal Hwy
Stuart, FL 34994

The credentials packet must be received on or before **January 31, 2016**. Packets received after this date will not be considered for the 2016 examination process. **Please keep the Credentials Chair and your mentor up to date on your email address, as this will be used as our primary source of communication.**

Mentor/Mentee Checklist

Master Folder Only:

Form 1: Waiver, Release, and Indemnity Agreement

Signed by Mentee

Letter of Recommendation from supervising veterinarian

Form 8: Mentor/Mentee Contacts and Case Log Verification Form

Signed by Mentor and Mentee

Anonymous Folder:

Form 2: Skills Form

Signed by supervising DVM

Form 3a: Specialty Training Wet Lab Form

Form 3b: Specialty Training Lecture Form

Proof of CE Attendance

Form 4: Equipment List with labeled photos

Form 5: Equipment List Photo Waiver

Signed by Mentor, Mentee, and supervising DAVDC

Form 6: Case Log Cadaver Verification Form

Signed by Mentor, Mentee, and supervising DAVDC or FAVD

Form 7: Dental Radiograph Cadaver Form

Signed by Mentor and Mentee

Categorical Case Logs

Blank Dental Record (Canine and Feline)

Five Case Reports

Dental Radiography Requirement (Canine and Feline)