 Commission on Dental Accreditation

**Review Committee Nomination Form**

**(Electronic copies only please; do NOT submit CV/Resume)**

**Name:**

**Accredited Program Affiliation:**

**Business Address:** Preferred**[ ]  Phone#:**

**Fax #:**

**Home Address:** Preferred **[ ]  Phone #:**

**Fax #:**

**Email Address:**

**Position Applying For (check one):**

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| **[ ]** AEGD Educator by ADEA\* | **[ ]** General Dentist (Graduate of GPR or AEGD) |
| **[ ]** General Dentist Practitioner  | **[ ]** GPR Educator by SCDA\* |
| **[ ]** Dental Assisting Educator\* | **[ ]** Hospital Administrator |
| **[ ]** Dental Assisting Practitioner  | **[ ]** Higher Educator Administrator |
| **[ ]** Dental Hygiene Educator\* | **[ ]** Predoctoral Educator\* |
| **[ ]** Dental Hygiene Practitioner  | **[ ]** Non-General\*\* Dentist Educator\* |
| **[ ]** Dental Laboratory Technology Educator\* | **[ ]** Non-General\*\* Dentist Practitioner |
| **[ ]** Dental Therapy Educator\* | **[ ]** Dentist Nominated by Discipline-Specific Organization/Certifying Board  |
| **[ ]** Dental Laboratory Owner by NADL |   |
| **[ ]** General Dentist Educator\* |  |

*\*Educator nominees with prior or current experience as a Commission site visitor are preferred*

*\*\* A dentist who has completed an advanced dental education program in dental anesthesiology, dental public health, endodontics, oral and maxillofacial radiology, oral and maxillofacial pathology, oral and maxillofacial surgery, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, or prosthodontics.*

**All nominees must agree to the following (please check each box to confirm agreement):**

**[ ]**  Ability to commit to one (1) four (4) year term

**[ ]**  Willingness to commit ten (10) to twenty (20) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters

**[ ]**  Ability to evaluate an educational program objectively in terms of such broad areas as curriculum, faculty, facilities, student evaluation and outcomes assessment

**[ ]**  Stated willingness to comply with all Commission policies and procedures (e.g. Agreement of Confidentiality; Conflict of Interest Policy; Operational Guidelines; Simultaneous Service; HIPAA Training, Licensure Attestation and Professional Conduct Policy and Prohibition Against Harassment)

**[ ]**  Ability to conduct business through electronic means (email, Commission Web Sites)

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| **Membership:** ADA # (Not required to serve):       | **State:**       |
| **Certification:**       |
| **Previous CODA Committee and/or Site Visitor:**  |
| List Committee(s) and/or Site Visitor Dates:       |

**Educational Background (Begin with College Level):**

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| --- | --- | --- | --- |
| Name of School, City& State | Year of Grad. | Certificate or Degree | Area of Study |
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**Private Practice Experience for Past 10 Years:**

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| --- | --- | --- | --- | --- | --- |
| Employer(include self-employed) | Address/Email | Type of Practice | From (Year) | To (Year) | FT/PT?\*\* |
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# \*\*Please indicate the number of days/week

**Teaching Appointments/Hospital Appointments for Past 10 Years (Begin with Current):**

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| --- | --- | --- | --- | --- | --- |
| Name of Institution, City& State | Rank (e.g., Assistant Professor, etc.) | Discipline | From (Year) | To (Year) | FT/PT?\*\* |
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# \*\*Please indicate the number of days/week

**Please provide information for all categories that apply:**

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| Program Director (List Programs):  |
| Course Director (List all Courses Last 5 Years):  |
| Administration (List Positions):  |
| Clinical Teaching Experience (List Number of Years and # of Days/Week):  |
| Preclinical Teaching Experience (List Number of Years and # of Days/Week):  |
| CE Coursed Presented (List All Presentations Last 3 Years):  |
| Research (List All Publications in Referred Journals Last 3 Years):  |

**Organizational Affiliations for Past 10 Years:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Organization | Offices Held | From (Year) | To (Year) |
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**Statement:**

Write a short paragraph summarizing on your unique qualifications and interest in serving with the Commission on Dental Accreditation.

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**Licensure Action Attestation:**

I hereby attest that (*check one*):

**[ ]  NO** licensure action (e.g. revocation, suspension, or censure) has been taken against me

 within the past twelve (12) months.

**[ ]** Licensure action (e.g. revocation, suspension, or censure) **HAS BEEN** taken against me

 within the past twelve (12) months.

Please describe:

**[ ]  Not Applicable** (I do not hold licensure in a dental or dental-related discipline)

The Commission encourages nominations to achieve diversity, including underrepresented groups, geographic diversity and varied educational philosophies.

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| Submission Date:       |

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| --- |
| Signature:       |

Please Return to:

hooperm@ada.org

Commission on Dental Accreditation