 Commission on Dental Accreditation

**Public Member Nomination Form**

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

**Name:**

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

**Fax #:**

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

**Fax #:**

**Email Address:**

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| [ ]  | Nominating Organization (identify):       |
| [ ]  | Self-Nomination |
| [ ]  | How did you learn about this opportunity?       |

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

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

[ ]  Willingness to commit five (5) to ten (10) days per year to Review Committee activities, including training, comprehensive review of print and electronically delivered materials and travel to Commission headquarters

[ ]  Ability to objectively evaluate an educational program 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; and Professional Conduct Policy and Prohibition Against Harassment)

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

**Public/Consumer Nominees must meet the following criteria:**

A commitment to bring the public/consumer perspective to Review Committee/Commission deliberations.

***(Please check each box to confirm you meet the criteria)***

In order to serve, the nominee must:

[ ]  ***NOT*** be a dentist, dental specialist, dental assistant, dental hygienist, dental therapist, or dental laboratory technician,

[ ]  ***NOT*** be a member of a dental, advanced dental or allied dental education program faculty,

[ ]  ***NOT*** be an employee, member of the governing board, owner, or shareholder of, or consultant to, a dental education program that is accredited, has applied for accreditation or is not accredited by CODA,

[ ]  ***NOT*** be a member or employee of any professional/trade association, licensing/regulatory agency or membership organization related to, affiliated with or associated with the Commission, dental education or dentistry, and

[ ]  ***NOT*** be a spouse, parent, child or sibling of an individual identified above.

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name of School, City& State | Year of Grad. | Certificate or Degree | Area of Study |
|       |       |       |       |
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## Employment Background for Past 10 Years

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| Employer |  Address/E-mail | Position | From (Year) | To (Year) |
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**Organizational Affiliations for Past 10 Years**

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| Name of Organization | Offices Held | From (Year) | To(Year) |
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| **List all experiences with higher education organizations and/or experiences serving on boards or committees:**       |
| **List any current or past relationship with any organization/business affiliated with the profession of dentistry:**       |
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**Statement:**

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

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|        |

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