### Commission on Dental Accreditation

**SITE VISITOR**

EVALUATION REPORT FORM

Clinical Fellowship Training Program in Oral and Maxillofacial Surgery

**Site Visitor Evaluation Report Form**

**For the Evaluation of a Clinical Fellowship Training Program in Oral and Maxillofacial Surgery**

**Commission on Dental Accreditation**

**211 East Chicago Avenue**

**Chicago, Illinois 60611**

**(312) 440-4653**

**<https://coda.ada.org/>**

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Commission on Dental Accreditation

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**Document Revision History**

|  |  |  |
| --- | --- | --- |
| **Date** | **Item** | **Action** |
| February 12, 2021 | Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery | Adopted and Implemented |
| August 9, 2024 | Revised Definitions of Terms and Standard 1 related to Sponsoring Institution and Authority to Operate | Adopted |
| January 1, 2025 | Revised Definitions of Terms and Standard 1 related to Sponsoring Institution and Authority to Operate | Implemented |

COMMISSION ON DENTAL ACCREDITATION

SITE VISITOR EVALUATION REPORT FORM

(SVER)

ORAL AND MAXILLOFACIAL SURGERY CLINICAL FELLOWSHIP

SITE VISITOR’S INSTRUCTIONS

**Previous Recommendations and Compliance with Commission Policies**

At the beginning of this document are areas related to the program’s compliance with previous recommendations and Compliance with Commission Policies. You are to review these areas during the site visit, include findings in the draft site visit report and note at the final conference.

**Program Effectiveness**

Immediately following the section related to Compliance with Commission Policies. This section must be completed by the site visit team. Please be sure to include ways in which the program has made changes to the program (changes in instruction, clinical training, policies, etc.) based on analysis of data gained through the outcomes assessment process.

**Verification of Compliance with Accreditation Standards**

Each statement in this form corresponds to a specific standard (“must” statement) contained in the Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery. Standards are referenced after each statement. For example, the reference (5-1) indicates that the statement is based on standard number 5-1. Intent statements are presented to provide clarification to the program in the application of and in connection with compliance with the Accreditation Standards. The statements of intent set forth some of the reasons and purposes for the particular standards. As such, these statements are not exclusive or exhaustive. Other purposes may apply.

As a site visitor, you are to verify through documentary evidence (on-site or attached to self-study document) whether the program is in compliance with each statement. Additionally, interviews and on-site observations should provide you with an opportunity to verify the description or process by which the program complies.

**Please highlight, underline, circle or place a box around either YES or NO for each statement.** If you indicate **YES** following a particular statement, it will be assumed that the program meets the requirements set forth in the Standards. No further comment is necessary. However, you may, at your option, use the “Comments” section to make a suggestion for program enhancement. Suggestions should reflect minimal compliance with accreditation standards (rather than clear deficiencies) and indicate the need to monitor and enhance designated aspects of the program. Institutions are not required to respond formally to suggestions.

If non-compliance with the Standards can be substantiated, **highlight, underline, circle or place a box around NO** following the particular statement in this document. If you indicate **NO,** you must use the “Comments” area at the end of each section to reference the statement (Question #) and ***provide as much information as possible, clearly describing the nature and seriousness of the deficiency(ies) in as much detail as possible, including a rationale for citing the deficiency.*** If a standard isn’t being met, state the current situation and the resulting situation. Describe the educational impact of this deficiency. In addition, you must make a recommendation, which should be written as a restatement of the particular statement you have indicated **NO**. Space for any additional comments is provided at the end of this document. If no deficiencies are identified in a particular section, it will be assumed that, in your opinion, the area meets the requirements described in the Standards. Institutions are required to take actions that will address and correct deficiencies in the recommendations.

**After the Site Visit:** Within **one (1) week of the site visit**, the site visit chair must return this completed evaluation report form, including the team’s report of recommendations and suggestions, ***VIA EMAIL. Paper Site Visitor Evaluation Reports (SVER) will not be accepted.***

In Summary: If you indicate NO, you must fully describe the deficiency in as much detail as possible, including a rationale for citing the deficiency, and make a recommendation which will be a RESTATEMENT of the statement for which you have indicated NO. If you indicate YES, you may or may not make a suggestion.

If you have any questions during the site visit, you are encouraged to contact Commission staff at 312-440-2714.

COMMISSION ON DENTAL ACCREDITATION

**SITE VISITOR EVALUATION REPORT**

**CLINICAL FELLOWSHIP TRAINING PROGRAM IN ORAL AND MAXILLOFACIAL SURGERY**

|  |  |
| --- | --- |
| Institution Name: |  |
| Institution Address: |  |
| Dean (if applicable): |  |
| Hospital Administrator: (if applicable) |  |
| Chief of Dental Service: (if applicable) |  |
| Program Director: |  |
| Check if program director is: |  |
| a. board eligible: |  |
| b. board certified: |  |
| Verify the year the program director was appointed: |  |

|  |  |
| --- | --- |
| Site Visitor:(s) | Phone: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Site Visitor:(s) | | Phone: | | | |
| State Board Rep (if applicable) | |  | |  |  |  | |

Date of Visit:

**Indicate the area of Fellowship (select only one):**

Cosmetic Facial Surgery \_\_\_\_\_\_\_\_

Oral/Head and Neck Oncologic Surgery \_\_\_\_\_\_\_\_

Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery) \_\_\_\_\_\_\_\_

Microvascular Reconstructive Surgery \_\_\_\_\_\_\_\_

Endoscopic Maxillofacial Surgery \_\_\_\_\_\_\_\_

Current Enrollment:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Year |  | Full-Time |  | Part-Time |
| 1 |  |  |  |  |
| 2 |  |  |  |  |

|  |  |
| --- | --- |
| Identify the program’s CODA-authorized enrollment (per year): |  |

Verify program duration for:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Full-time fellows |  | (months) |
|  | Part-time fellows (if applicable) |  | (months) |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Verify that the program grants: |  | Certificate |  | Degree |  | Both |  |

If degree, indicate degree type and what institution grants the degree.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If degree, indicate whether it is optional or required.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the clinical phases of the program, verify the number of faculty members specifically assigned to the advanced dental education program in each of the following categories and their educational qualifications:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Total  Number |  | # Board  Certified |  | # Educationally  Qualified\* |  | # Other\*\* |
| Full-time |  |  |  |  |  |  |  |
| Half-time |  |  |  |  |  |  |  |
| Less than half-time |  |  |  |  |  |  |  |

\* Individual is eligible but has not applied to the American Board of Oral and Maxillofacial Surgery (ABOMS)

\*\*Individual is neither a Diplomate nor Candidate for board certification by the ABOMS

Verify the cumulative full-time equivalent (F.T.E.) for all faculty specifically assigned to this advanced dental education program. For example: a program with the following staffing pattern – one full-time (1.00) + one half-time (.50) + one two days per week (.40) + one half-day per week (.10) – would have an F.T.E. of 2.00.

|  |  |
| --- | --- |
| Cumulative F.T.E.: |  |

Persons Interviewed:

|  |  |  |  |
| --- | --- | --- | --- |
| Chief of Dental Service | |  | |
| Program Director |  | |
| Other Dental Faculty |  | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |
| Fellows |  | |
|  |  | |
|  |  | |
| Others |  | |
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If fellows from other accredited oral and maxillofacial surgery fellowship programs rotate through this institution, provide the name of the other program, purpose of the affiliation and amount of time each fellow is assigned to this institution.

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**Previous Recommendations**

|  |  |  |
| --- | --- | --- |
| **1.** | **Recommendations noted in the last site visit report, that are current standards, have been remedied.** | **N/A** |
| **YES** | **NO** |

Please note, if the last site visit was conducted prior to the implementation of the most current Standards (see document revision history) some recommendations may no longer apply. Should further guidance be required, please contact Commission on Dental Accreditation staff.

If no, please identify by standard the ongoing area(s) of non-compliance.

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**COMPLIANCE WITH COMMISSION POLICIES**

**PROGRAM CHANGE**

**1. The program has reported to the Commission all changes which have**

**occurred within the program since the program’s previous site visit.** **YES NO**

Depending on the specific program change, reports **must** be submitted to the Commission by **May 1 or November 1** or at least thirty (30) days prior to a regularly scheduled semi-annual Review Committee meeting. The Commission recognizes that unexpected changes may occur. Unexpected changes may be the result of sudden changes in institutional commitment, affiliated agreements between institutions, faculty support, or facility compromise resulting from natural disaster. Failure to proactively plan for change will not be considered unexpected change. Depending upon the timing and nature of the change, appropriate investigative procedures including a site visit may be warranted.

Other types of Program Changes include but are not limited to enrollment increase the addition of off-campus sites, and use of Distance Education.

For enrollment increases, the program must adhere to the Policy on Enrollment Increases in Advanced Dental Education.

For the addition of off-campus sites, the program must adhere to the Policy on Reporting and Approval of Sites Where Educational Activity Occurs.

For the use of Distance Education, the program must report the use of Distance Education technology, as described in the Commission’s Policy on Distance Education. If distance education was not reported, the SVER should be marked “NO” for program change; however, the program may comply with the Distance Education policy, as noted below.

For the full policy statements on enrollment increase, off-campus sites, and distance education, see the Commission’s “Evaluation and Operational Policies and Procedures” (EOPP) manual.

If **NO**, please explain below, include the concern in the draft site visit report and note at the final conference.

**THIRD PARTY COMMENTS**

|  |  |  |
| --- | --- | --- |
| **2.** | **The program is complying with the Commission’s policy on “Third Party Comments.”** |  |
| **YES** | **NO** |

The program is responsible for soliciting third-party comments from communities of interest such as fellows and patients that pertain to the standards or policies and procedures used in the Commission’s accreditation process. An announcement for soliciting third-party comments is to be published at least 90 days prior to the site visit. The notice should indicate that third-party comments are due in the Commission’s office no later than 60 days prior to the site visit. The policy on Third Party Comments can be found in the Commission’s “Evaluation and Operational Policies and Procedures” (EOPP) manual.

If **NO**, please explain below, include the concern in the draft site visit report and note at the final conference.

**COMPLAINTS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **3.** | **The program is complying with the Commission’s policy on “Complaints.”** |  | **YES** | **NO** |

The program is responsible for developing and implementing a procedure demonstrating that fellows are notified, at least annually, of the opportunity and the procedures to file complaints with the Commission. Additionally, the program must maintain a record of fellow complaints received since the Commission’s last comprehensive review of the program. The policy on Complaints can be found in the Commission’s “Evaluation and Operational Policies and Procedures”(EOPP) manual.

If **NO**, please answer a. and b. below and explain. In addition, please include the concern in the draft site visit report and note at the final conference.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **a.** | **Fellows notified of the Commission’s address** |  | **YES** | **NO** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **b.** | **Record of fellow complaints maintained** |  | **YES** | **NO** |

**Additional Requirements for compliance with the policy on “Complaints”:**

**Following review of the program’s complaint records, there are no patterns or**

**themes related to the program’s compliance with the Accreditation Standards?**

**YES NO**

***(Answer YES if this statement is true.)***

|  |
| --- |
| If **NO**, describe the specific standards in question and identify any recommendations or suggestions that resulted from this review. |

**DISTANCE EDUCATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **4.** | **The program is complying with the Commission’s “Policy on Distance Education”** | **YES** | **NO** | **N/A** |

Programs that offer distance education must ensure regular and substantive interaction between a fellow and an instructor or instructors prior to the fellow’s completion of a course or competency. For purposes of this definition, substantive interaction is engaging fellows in teaching, learning, and assessment, consistent with the content under discussion, and also includes at least two of the following:

* Providing direct instruction;
* Assessing or providing feedback on a fellow’s coursework;
* Providing information or responding to questions about the content of a course or competency;
* Facilitating a group discussion regarding the content of a course or competency; or
* Other instructional activities approved by the institution’s or program’s accrediting agency.

Please answer the statements below. If **NO**, please explain and include the concern in the draft site visit report and note at the final conference. If the program does not utilize distance education methods, **skip** the remaining items related to Distance Education.

|  |  |  |  |
| --- | --- | --- | --- |
| a. | The program provides the opportunity for substantive interactions with the fellow on a predictable and scheduled basis commensurate with the length of time and the amount of content in the course or competency. | **YES** | **NO** |
| b. | The program monitors the fellow’s academic engagement and success and ensures that an instructor is responsible for promptly and proactively engaging in substantive interaction with the fellow when needed on the basis of such monitoring, or upon request by the fellow. | **YES** | **NO** |

Programs that offer distance education must also have processes in place through which the program establishes that the fellow who registers in a distance education course or program is the same fellow who participates in and completes the course or program and receives the academic credit. In addition, programs must notify fellows of any projected additional charges associated with the verification of fellow identity at the time of registration or enrollment. The entire policy on Distance Education can be found in the Commission’s “Evaluation and Operational Policies and Procedures” (EOPP) manual.

Please answer the statements below. If **NO**, please explain and include the concern in the draft site visit report and note at the final conference. If the program does not utilize distance education methods, **skip** the remaining items related to Distance Education.

|  |  |  |  |
| --- | --- | --- | --- |
| a. | The identity of each fellow who registers for the course is verified as the one who participates in, completes, and receives academic credit for the course. | **YES** | **NO** |
| b. | The verification process used includes methods such as secure login and passcode, proctored examinations, and/or other technologies effective in verifying fellow identity. | **YES** | **NO** |
| c. | Program provides a written statement to make it clear that the verification processes used are to protect fellow privacy. | **YES** | **NO** |
| d. | Fellows are notified of additional charges associated with the fellow identity verification at the time of registration or enrollment. | **YES** | **NO** |

**Additional Requirements for compliance with the policy on “Distance Education”:**

If the program is utilizing distance education, the program’s distance education method(s) (curriculum and modalities of transmission) adhere to the requirements of the accreditation standards?

**YES NO**

**If NO**, describe the specific standards in question and identify any recommendations or suggestions that resulted from this review.

|  |
| --- |
|  |

**PROGRAM EFFECTIVENESS**

**Program Performance with Respect to Fellow Achievement:**

|  |  |
| --- | --- |
| **1** | **Confirm that the institution/program is assessing fellow achievement and provide a detailed analysis of the program’s performance with respect to fellow achievement. Include a description of the assessment tools used by the program and a summary of data and conclusions.** |
| **2** | **Describe the positive and negative program outcomes related to the program’s fellow achievement measures.** |
| **3** | **Describe program changes made in accordance with outcomes data collected. Conversely, describe areas where program change has not been made in accordance with outcomes data collected.** |
| **4** | **Identify specific standards where recommendations or suggestions are written related to fellow achievement.** |

**Complete the narrative below by taking the summary data you have described above and placing the information in each of the highlighted areas to capture all assessments measures (#1), positive and negative outcomes (#2), and corrective actions (#3) made by the program:**

**Standard 1. Institutional Effectiveness**

The program has/has not documented its effectiveness using a formal and ongoing outcomes assessment process to include measures of clinical fellowship training program in oral and maxillofacial surgery-type fellow achievement. Based on a review of the program’s outcomes assessment process and fellow achievement measures, the visiting committee found the program uses assessment measures to include: [insert assessment measures used – Q1]. The program has demonstrated positive programmatic fellow achievement outcomes through [include positive outcomes measures – Q2]. The program has not demonstrated positive fellow achievement outcomes in [insert negative outcome areas – Q2]. The visiting committee noted the program recently made enhancements to [insert examples where program change made based on OA process – Q3] based on the fellow achievement data collected and analyzed in the outcomes assessment plan. *(Or conversely, the visiting committee did not identify areas within the program where fellow achievement data has been utilized to affect change.)* ***Following this paragraph, if a recommendation or suggestion is warranted, add additional content.***

Recommendations/Suggestions were/were not written related to fellow achievement.

**STANDARD 1 – INSTITUTIONAL COMMITMENT/PROGRAM EFFECTIVENESS**

|  |  |  |
| --- | --- | --- |
| The program develops clearly stated goals and objectives appropriate to advanced dental education, addressing education, patient care, research and service. (1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Planning for, evaluation of and improvement of educational quality for the program is broad-based, systematic, continuous and designed to promote achievement of program goals related to education, patient care, research and service. (1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The program documents its effectiveness using a formal and ongoing outcomes assessment process to include measures of fellowship student achievement. (1) | YES | NO |

***Intent:*** *The Commission on Dental Accreditation expects each program to define its own goals and objectives for preparing individuals for the practice of oral and maxillofacial surgery and that one of the program goals is to comprehensively prepare competent individuals to initially practice oral and maxillofacial surgery. The outcomes process includes steps to: (a) develop clear, measurable goals and objectives consistent with the program’s purpose/mission; (b) develop procedures for evaluating the extent to which the goals and objectives are met; (c) collect and maintain data in an ongoing and systematic manner; (d) analyze the data collected and share the results with appropriate audiences; (e) identify and implement corrective actions to strengthen the program; and (f )review the assessment plan, revise as appropriate, and continue the cyclical process.*

|  |  |  |
| --- | --- | --- |
| The financial resources are sufficient to support the program’s stated goals and objectives. (1) | YES | NO |

***Intent****: The institution should have the financial resources required to develop and sustain the program on a continuing basis*. *The program should have the ability to employ an adequate number of full‑time faculty, purchase and maintain equipment, procure supplies, reference material and teaching aids as reflected in annual budget appropriations. Financial allocations should ensure that the program will be in a competitive position to recruit and retain qualified faculty and s*

*s. Annual appropriations should provide for innovations and changes necessary to reflect current concepts of education in the advanced dental education discipline. The Commission will assess the adequacy of financial support on the basis of current appropriations and the stability of sources of funding for the program.*

|  |  |  |  |
| --- | --- | --- | --- |
| **If a hospital is the fellowship sponsor**, the hospital is accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid (CMS). (1) | YES | NO | N/A |

*Note:  If a hospital is the sponsor, the program must provide documentary evidence that its institutional accreditor is currently recognized by CMS.*

|  |  |  |  |
| --- | --- | --- | --- |
| **If an educational institution is the sponsor**, the educational institution is accredited by an agency recognized by the United States Department of Education or its equivalent. (1) | YES | NO | N/A |

*Note: The program must provide documentary evidence of an institutional accreditor recognized by the United States Department of Education.*

|  |  |  |  |
| --- | --- | --- | --- |
| **If a health care organization is the sponsor (must meet one item below):** |  |  |  |
| The health care organization is accredited by an agency recognized by the United States Department of Education. (1) | YES | NO | NA |
| The health care organization accredited by an accreditation organization is recognized by the Centers for Medicare and Medicaid Services (CMS). (1) | YES | NO | NA |
| The health care organization receives regular on-site inspections through the Health Resources and Services Administration Operational Site Visit (HRSA-OSV) process. (1) | YES | NO | NA |

*Note: The program must provide documentary evidence of an institutional accreditor recognized by the United States Department of Education,* ***or*** *documentary evidence that its institutional accreditor is currently recognized by CMS,* ***or*** *that it has received HRSA-OSV inspection.*

|  |  |  |  |
| --- | --- | --- | --- |
| If applicable, the bylaws, rules and regulations of the hospitals or health care organizations that sponsor or provide a substantial portion of the fellowship program assures that dentists are eligible for medical staff membership and privileges including the right to vote, hold office, serve on medical staff committees and admit, manage and discharge patients. (1) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| If applicable, the United States military program not sponsored or co-sponsored by military medical treatment facilities, United States-based educational institutions, hospitals or health care organizations accredited by an agency recognized by the United States Department of Education or accredited by an accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS) demonstrates successful achievement of Service-specific organizational inspection criteria. (1) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| **If the advanced dental education program confers a certificate (complete both items below):** |  |  |  |
| The program/institution has state or federal approval to operate. (1) | YES | NO |  |
| As applicable, the program/institution has state or federal approval to confer a certificate. (1) | YES | NO | NA |

*Note: The program must provide a) documentation of receipt of federal aid as evidence to operate, or b) documentation of a state business license as evidence to operate.* *Additionally, as required by the state, the program must provide evidence of authority through an appropriate state agency when issuing a certificate of completion.*

***Intent:*** *The educational program demonstrates either: a) documentation of receipt of federal aid as evidence to operate, or b) documentation of a state business license as evidence to operate. Additionally, as required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion. If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.*

|  |  |  |  |
| --- | --- | --- | --- |
| The advanced dental education program conferring a degree has institutional accreditation and authority to confer a degree. (1) | YES | NO | NA |

*Note: The program must provide the institution’s letter of accreditation from its institutional accreditor, and authority to confer the degree awarded by the program.*

***Intent:*** *The educational program demonstrates either: a) documentation of receipt of federal aid as evidence to operate, or b) documentation of a state business license as evidence to operate. Additionally, as required by the state, the program demonstrates authority through an appropriate state agency when issuing a certificate of completion. If conferring a degree, the program demonstrates authorization from its institutional accrediting agency.*

|  |  |  |
| --- | --- | --- |
| The position of the program in the administrative structure is consistent with that of other parallel programs within the institution. (1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The administrator has the authority, responsibility and privileges necessary to manage the program. (1) | YES | NO |

|  |  |  |  |
| --- | --- | --- | --- |
| If applicable, fellowships which are based in institutions or centers that also sponsor oral and maxillofacial surgery residency training programs demonstrate that the fellowship and residency programs are not in conflict. (1-1) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| If applicable, the fellowship experience does not compete with the residency training program for surgical procedures. (1-1) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| If applicable, separate statistics are maintained for each program. (1-1) | YES | NO | N/A |

|  |  |  |
| --- | --- | --- |
| Members of the teaching staff participating in the accredited fellowship program are able to practice the full scope of the discipline in the focused area and in accordance with their training, experience and demonstrated competence. (1-2) | YES | NO |

## USE OF SITES WHERE EDUCATIONAL ACTIVITY OCCURS

(If the program does not use sites where educational activity occurs, please skip to Standard 2.)

|  |  |  |
| --- | --- | --- |
| The primary sponsor of the fellowship program accepts full responsibility for the quality of education provided in all sites where educational activity occurs. (1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| All arrangements with major and minor activity sites, not owned by the sponsoring institution, are formalized by means of current written agreements that clearly define the roles and responsibilities of the parties involved. (1-3) | YES | NO |

***Intent****: Ownership may entail clinical operations, and not necessarily the physical facility.*

|  |  |  |
| --- | --- | --- |
| Documentary evidence of agreements, for major and minor activity sites not owned by the sponsoring institution, is available. (1-4) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The following items are covered in such inter-institutional agreements: | | |
| 1. Designation of a single program director; | YES | NO |
| 1. The teaching staff; | YES | NO |
| 1. The educational objectives of the program; | YES | NO |
| 1. The period of assignment of fellows; and | YES | NO |
| 1. Each institution's financial commitment. (1-4) | YES | NO |

***Intent:*** *The items that are covered in inter-institutional agreements do not have to be contained in a single document. They may be included in multiple agreements, both formal and informal (e.g., addenda and letters of mutual understanding).*

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 2 - PROGRAM DIRECTOR AND TEACHING STAFF**

|  |  |  |
| --- | --- | --- |
| The program is administered by a director who is board certified. (2) | YES | NO |

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| --- | --- | --- |
| Program Director: The program is directed by a single individual. (2-1) | YES | NO |

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| --- | --- | --- |
| Program Director: The responsibilities of the program director include: | | |
| Development of the goals and objectives of the program and definition of a systematic method of assessing these goals by appropriate outcomes measures. (2-1.1) | YES | NO |
| Ensuring the provision of adequate physical facilities for the educational process. (2-1.2) | YES | NO |
| Participation in selection and supervision of the teaching staff. (2-1.3) | YES | NO |
| Perform periodic, at least annual, written evaluations of the teaching staff. (2-1.3) | YES | NO |
| Responsibility for adequate educational resource materials for education of the fellows, including access to adequate learning resources. (2-1.4) | YES | NO |
| Responsibility for selection of fellows and ensuring that all appointed fellows meet the minimum eligibility requirements. (2-1.5) | YES | NO |
| Maintenance of appropriate records of the program, including fellow and patient statistics, institutional agreements, and fellow records. (2-1.6) | YES | NO |

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| --- | --- | --- |
| Teaching Staff: The teaching staff is of adequate size. (2-2) | YES | NO |

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| --- | --- | --- |
| Teaching Staff: The teaching staff provides direct supervision in all patient care settings appropriate to a fellow's competence and level of training. (2-2.1) | YES | NO |

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| --- | --- | --- |
| Scholarly Activity of Faculty: There is evidence of scholarly activity among the fellowship faculty. (2-3) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The program shows evidence of an ongoing faculty development process. (2-4) | YES | NO |

***Intent:*** *Ongoing faculty development is a requirement to improve teaching and learning, to foster curricular change, to enhance retention and job satisfaction of faculty, and to maintain the vitality of academic dentistry as the wellspring of a learned profession.*

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 3 – FACILITIES AND RESOURCES**

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| --- | --- | --- |
| Facilities and resources are adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program as specified in these Standards. (3) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Equipment and supplies for use in managing medical emergencies are readily accessible and functional. (3) | YES | NO |

***Intent:*** *The facilities and resources (e.g., support/secretarial staff, allied personnel and/or technical staff) should permit the attainment of program goals and objectives. To ensure health and safety for patients, fellows, faculty and staff, the physical facilities and equipment should effectively accommodate the clinic and/or laboratory schedule.*

|  |  |  |
| --- | --- | --- |
| The program documents its compliance with any applicable regulations of local, state and federal agencies including but not limited to radiation hygiene and protection, ionizing radiation, hazardous materials, and bloodborne and infectious diseases. (3) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Policies are provided to all fellows, faculty and appropriate support staff and continuously monitored for compliance. (3) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Additionally, policies on bloodborne and infectious diseases are made available to applicants for admission and patients. (3) | YES | NO |

***Intent:*** *The program may document compliance by including the applicable program policies. The program demonstrates how the policies are provided to the fellows, faculty and appropriate support staff and who is responsible for monitoring compliance. Applicable policy states how it is made available to applicants for admission and patients should a request to review the policy be made.*

|  |  |  |
| --- | --- | --- |
| Fellows, faculty and appropriate support staff are encouraged to be immunized against and/or tested for infectious diseases, such as mumps, measles, rubella and hepatitis B, prior to contact with patients and/or infectious objects or materials, in an effort to minimize the risk to patients and personnel. (3) | YES | NO |

***Intent:*** *The program should have written policy that encourages (e.g., delineates the advantages of) immunization for fellows, faculty and appropriate support staff.*

|  |  |  |
| --- | --- | --- |
| Fellows, faculty and support staff involved in the direct provision of patient care are continuously recognized/certified in basic life support procedures, including cardiopulmonary resuscitation. (3) | YES | NO |

***Intent:*** *Continuously recognized/certified in basic life support procedures means the appropriate individuals are currently recognized/certified.*

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 4 – CURRICULUM AND PROGRAM DURATION**

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| --- | --- | --- |
| The fellowship program is designed to provide special knowledge and skills beyond residency training. (4) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Documentation of all program activities is assured by the program director and available for review. (4) | YES | NO |

The fellowship program is a structured post‑residency program which is designed to provide special knowledge and skills. (4-1)

|  |  |  |
| --- | --- | --- |
| The goals of the fellowship are clearly identified and documented. (4-1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The duration of the fellowship is a minimum of twelve months. (4-2) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The fellowship program includes a formally structured curriculum. (4-3) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The fellowship program provides a complete sequence of patient experiences which includes: | | |
| 1. pre-operative evaluation; | YES | NO |
| 1. adequate operating experience; | YES | NO |
| 1. diagnosis and management of complications; | YES | NO |
| 1. post-operative evaluation. (4-4) | YES | NO |

|  |  |  |
| --- | --- | --- |
| The fellow maintains a surgical case log of all procedures. (4-5) | YES | NO |

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 5 – FELLOW ELIGIBILITY AND SELECTION**

Oral and maxillofacial surgeons who have completed their formal oral and maxillofacial surgery residency training are eligible for fellowship consideration. (5)

|  |  |  |
| --- | --- | --- |
| Nondiscriminatory policies are followed in selecting fellows. (5-1) | YES | NO |

|  |  |  |
| --- | --- | --- |
| There is no discrimination in the selection process based on professional degree(s). (5-2) | YES | NO |

[Answer “yes” if there is NO discrimination in the selection process based on professional degree(s)]

**EVALUATION**

|  |  |  |
| --- | --- | --- |
| A system of ongoing evaluation and advancement assures that, through the director and faculty, each program: | | |
| 1. Periodically, but at least semiannually, evaluates the knowledge, skills and professional growth of its fellowship students, using appropriate written criteria and procedures; | YES | NO |
| 1. Provides to fellowship students an assessment of their performance, at least semiannually; | YES | NO |
| 1. Maintains a personal record of evaluation for each fellowship student which is accessible to the fellowship student and available for review during site visits. (5) | YES | NO |

***Intent****: A copy of the final written evaluation stating that the fellow has demonstrated competency to practice independently should be provided to each individual upon completion of the fellowship.*

**DUE PROCESS**

|  |  |  |
| --- | --- | --- |
| There are specific written due process policies and procedures for adjudication of academic and disciplinary complaints, which parallel those established by the sponsoring institution. (5) | YES | NO |

**RIGHTS AND RESPONSIBILITIES**

|  |  |  |
| --- | --- | --- |
| At the time of enrollment, the fellowship students are apprised in writing of the educational experience to be provided, including the nature of assignments to other departments or institutions and teaching commitments. (5) | YES | NO |

|  |  |  |
| --- | --- | --- |
| Additionally, all fellowship students are provided with written information which affirms their obligations and responsibilities to the institution, the program and program faculty. (5) | YES | NO |

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 6 – FELLOWSHIP PROGRAMS**

Those enrolled in an accredited clinical fellowship in oral and maxillofacial surgery complete advanced training in a focused area.

**Fellowship Program:**

A fellowship is a structured post-residency educational experience devoted to enhancement and acquisition of skills in a focused area. (6-1)

|  |  |  |
| --- | --- | --- |
| A fellowship is taught to a level of competence. (6-1) | YES | NO |

[Complete the Standard 6 questions below that apply to the area of fellowship: Cosmetic Facial Surgery, Oral/Head and Neck Oncologic Surgery, Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery), Microvascular Reconstructive Surgery, or Endoscopic Maxillofacial Surgery. **Only answer questions in a single area of fellowship**.]

**Cosmetic Facial Surgery:**

is that area of oral and maxillofacial surgery that treats congenital and acquired deformities of the integument and its underlying musculoskeletal system within the maxillofacial area and associated structures. (6-2)

Goals/Objectives:To provide comprehensive clinical and didactic training as primary surgeon in the broad scope of cosmetic maxillofacial surgery. (6-2.1)

Surgical Experience:

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes the following procedures in sufficient number and variety to ensure that objectives of the training are met. These procedures include, but are not limited to: | | | |
| 1. blepharoplasty, | YES | NO | N/A |
| 1. brow lifts, | YES | NO | N/A |
| 1. treatment of skin lesions, | YES | NO | N/A |
| 1. skin resurfacing, | YES | NO | N/A |
| 1. cheiloplasty, | YES | NO | N/A |
| 1. genioplasty, | YES | NO | N/A |
| 1. liposuction, | YES | NO | N/A |
| 1. otoplasty, | YES | NO | N/A |
| 1. rhinoplasty, | YES | NO | N/A |
| 1. rhytidectomy, | YES | NO | N/A |
| 1. hard and soft tissue augmentation and contouring procedures. (6-2.2) | YES | NO | N/A |

No absolute number can ensure adequate training but experience suggests that a minimum of 125 maxillofacial cosmetic procedures is required. (6-2.2)

**Oral/Head and Neck Oncologic Surgery:**

is that area of oral and maxillofacial surgery which manages patients with tumors of the head and neck. (6-3)

Goals/Objectives:To provide comprehensive clinical and didactic training which will allow the maxillofacial surgeon to function as a primary oncologic surgeon in a head and neck cancer team at the completion of training. (6-3.1)

Surgical Experience:

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes the following procedures in sufficient number and variety to ensure that objectives of the training are met. These procedures include, but are not limited to: | | | |
| 1. extirpative surgery for malignant and benign tumors, | YES | NO | N/A |
| 1. neck dissections, | YES | NO | N/A |
| 1. major soft and hard tissue reconstruction, | YES | NO | N/A |
| 1. free, local and regional flap procedures. (6-3.2) | YES | NO | N/A |

No absolute number can ensure adequate training but experience suggests that at least 90 major surgical procedures should be documented. (6-3.2)

Category I (Minimum 60 total procedures for categories a & b)

a. Excision of benign/malignant tumors involving hard and soft tissues.

b. Excision of benign and malignant salivary gland tumors

Category II (Minimum 20 procedures)

a. Neck dissections.

Category III (Minimum 10 procedures)

a. Surgical Airway Management.

|  |  |  |  |
| --- | --- | --- | --- |
| The fellow is trained in the role of radiation therapy and chemotherapy in the treatment and management of malignant tumors of the maxillofacial region. (6-3.3) | YES | NO | N/A |

**Microvascular Reconstructive Surgery:**

is that area of oral and maxillofacial surgery that uses microvascular surgical techniques to permit transplantation of tissues from distant sites of the body in order to reconstruct defects of the head and neck. (6-3.4)

Goals/Objectives: To provide comprehensive clinical and didactic training that will allow the oral and maxillofacial surgeon to perform microvascular reconstructions. (6-3.4.1)

Surgical Experience:

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes a minimum of 40 hours of microsurgical laboratory training. (6-3-4.2) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes primary or first assist surgeon in at least 30 microvascular surgical reconstruction procedures, which includes flap harvest, inset and microvascular anastomosis. (6-3.4.2) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| The fellowship program declares the scope of the training program. (6-3.5) | YES | NO | N/A |

Type I: Oral/Head and Neck Oncologic Surgery \_\_

Type II: Oral/Head and Neck Oncologic Surgery and Microvascular Reconstructive Surgery\_\_

**(PLEASE CHECK WHICH TYPE)**

***Intent:*** *Programs will be responsible for meeting the portion of the standard that applies to the declared type of program.*

**Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery):**

is that area of oral and maxillofacial surgery that focuses on the diagnosis, as well as the surgical and adjunctive treatment in the neonate, infant, child and adolescent, of the following:

* congenital or developmental cleft and craniofacial deformities
* pathology of the craniomaxillofacial region
* trauma to the craniomaxillofacial region (6-4)

Goals/Objectives: To provide a structured, didactic curriculum and broad experience in fundamental areas of craniofacial and pediatric oral and maxillofacial surgery. The goal is to prepare the fellow to function as a primary surgeon on an American Cleft Palate/Craniofacial Association (ACPCA)-recognized cleft and craniofacial team. The educational program should include anesthetic techniques and perioperative medical management of pediatric surgical patients. (6-4.1)

Craniofacial surgery: is the type of surgery that may traverse the cranial base and refers to combined oral and maxillofacial surgery/neurosurgery to treat, e.g., hypertelorism, Crouzon syndrome, Apert syndrome, and isolated craniosynostosis. (6-4.2)

|  |  |  |  |
| --- | --- | --- | --- |
| The fellowship program has declared the scope of the training program. (6-4.3) | YES | NO | N/A |

Type I: Craniofacial and Cleft (Categories I, II, II, IV) \_\_

Type II: Craniofacial (Categories II, III, IV) \_\_

Type III: Cleft (Categories (I, III, IV) \_\_

**(PLEASE CHECK WHICH TYPE)**

Surgical Experience:

|  |  |  |  |
| --- | --- | --- | --- |
| The experience includes a minimum of 20 procedures in each of the categories delineated by the declared program Type (I, II, III). (6-4.4) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| The cumulative surgical experience includes a minimum of 80 procedures. (6-4.4) | YES | NO | N/A |

Category I (Minimum 20 Procedures)

Cleft Lip/Palate Related Surgery

(to include primary and secondary procedures)

Category II (Minimum 20 Procedures)

Craniomaxillofacial Surgery to include Orthognathic Surgery, Transcranial Surgery, Reconstruction, Distraction Osteogenesis, and other skeletofacial surgery.

(Of the 20 procedures, orthognathic procedures must not exceed 5.)

Category III (Minimum 20 Procedures)

Pediatric Hard and Soft Tissue Trauma

Category IV (Minimum 20 Procedures)

Hard and Soft Tissue Pathology

|  |  |  |  |
| --- | --- | --- | --- |
| Of the 20 procedures in Category II, orthognathic procedures do not exceed 5. (6-4.4) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| In Type I and II programs, the surgical experience includes a minimum of 5 transcranial procedures. (6-4.4.1) | YES | NO | N/A |

PALS:

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| --- | --- | --- | --- |
| The fellow maintains certification in Pediatric Advanced Life Support (PALS). (6-4.5) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| The program participates in a craniofacial and/or cleft treatment team respectively. (6-4.3.6) | YES | NO | N/A |

**Microvascular Reconstructive Surgery:**

Microvascular Reconstructive Surgery is that area of oral and maxillofacial surgery that uses microvascular surgical techniques to permit transplantation of tissues from distant sites of the body in order to reconstruct defects of the head and neck. (6-5)

Goals/Objectives: To provide comprehensive clinical and didactic training that will allow the oral and maxillofacial surgeon to perform microvascular reconstructions. (6-5.1)

Surgical Experience:

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes a minimum of 40 hours of microsurgical laboratory training. (6-5.2) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical experience includes primary or first assist surgeon in at least 30 microvascular surgical reconstruction procedures, which includes flap harvest, inset and microvascular anastomosis. (6-5.2) | YES | NO | N/A |

**Endoscopic Maxillofacial Fellowship:**

Endoscopic Maxillofacial Surgery is that area of oral and maxillofacial surgery that utilizes high definition video technology coupled with minimal access exposure to execute precise surgical maneuvers. (6-6)

Goals/Objectives: To provide comprehensive clinical and didactic training in minimally invasive endoscopic techniques either as the primary procedure or endoscopic assisted procedures. To advance technology and surgical procedures in order to provide precise intervention and reduce morbidity. The goal is to prepare the fellow to be competent in doing endoscopic assisted procedures. (6-6.1)

|  |  |  |  |
| --- | --- | --- | --- |
| Surgical procedures performed by the fellow, as a first assistant or primary surgeon, include a minimum of 100 endoscopic maxillofacial surgical procedures to ensure that the objectives of the training are achieved. (6-6.3) | YES | NO | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| The 100 endoscopic maxillofacial surgical procedures include no less than: | | | |
| 1. 30 double puncture, advanced, temporomandibular joint arthroscopic procedures | YES | NO | N/A |
| 1. 10 Sialoendoscopic procedures | YES | NO | N/A |
| 1. 10 Sinus endoscopic procedures (6-6.3) | YES | NO | N/A |

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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**STANDARD 7 – INVESTIGATIVE STUDY**

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| --- | --- | --- |
| Fellows engage in scholarly activity. (7) | YES | NO |

**COMMENTS: RECOMMENDATIONS AND/OR SUGGESTIONS**

Please use this area for writing recommendations and/or suggestions. If you are writing a suggestion, please provide a rationale. If you are making a recommendation, provide a detailed description of the deficiency identified for each NO indicated in the preceding section and a recommendation indicating that it should be corrected. (Please write legibly or print neatly. If you require additional sheet(s) you may attach to back of SVER, with appropriate SVER reference number[s].)

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(If Fellowship Area is Cosmetic Facial Surgery complete # of cases in right-hand column)

Cosmetic Facial Surgery

**# of procedures**

**12-month period within last 18 months**

**(enter dates)**

**Types of Cosmetic Facial Surgery cases:**

Blepharoplasty Enter #

**Brow lifts Enter #**

**Treatment of skin lesions Enter #**

Skin resurfacing Enter #

Cheiloplasty Enter #

**Genioplasty Enter #**

**Liposuction Enter #**

**Otoplasty Enter #**

**Rhinoplasty Enter #**

**Rhytidectomy Enter #**

**Hard & Soft Tissue Augmentation Contour Enter #**

**Procedures**

**Other Enter #**

## TOTAL \_\_\_\_ (125 suggested minimum)

(If Fellowship Area is Oral/Head and Neck Oncologic Surgery, complete # of procedures in right-hand column)

Oral/Head and Neck Oncologic Surgery

**# of procedures**

**12-month period within last 18 months**

**(enter dates)**

*Category I*

1. Excision of benign/malignant tumors **Enter #**

involving hard and soft tissues

2. Excision of benign and malignant **Enter #**

salivary gland tumors

**Enter Subtotal (60 suggested minimum)**

*Category II*

Neck Dissections **Enter # (20 suggested minimum)**

*Category III*

Surgical Airway Management

**Enter # (10 suggested minimum)**

Other **Enter #**

## TOTAL \_\_\_\_\_ (90 suggested minimum)

Type II programs only:

Microvascular surgical reconstruction procedures, **Enter # (30 minimum)**

which includes flap harvest, inset and

microvascular anastomosis

(If Fellowship Area is Pediatric Craniomaxillofacial Surgery, complete # of procedures in right-hand column)

Pediatric Craniomaxillofacial Surgery (Cleft and Craniofacial Surgery)

**# of procedures**

**12-month period within last 18 months**

**(enter dates)**

**Category I**

Cleft Lip/Palate Related Surgery **Enter # (20 required minimum)**

(to include primary and secondary procedures)

**Category II**

Craniomaxillofacial Surgery to include:

Orthognathic Surgery **Enter # (must not exceed 5 of the 20)**

Transcranial Surgery **Enter# (5 minimum Type I and II program)**

Reconstruction **Enter#**

Distraction Osteogenesis **Enter#**

Other Skeletofacial Surgery **Enter#**

**Enter Subtotal (20 required minimum)**

**Category III**

Pediatric Hard and Soft Tissue Trauma **Enter # (20 required minimum)**

**Category IV**

Hard and Soft Tissue Pathology **Enter # (20 required minimum)**

Other **Enter #**

## TOTAL \_\_\_\_ (80 required minimum)

(If Fellowship Area is OMS Microvascular, complete # of procedures in right-hand column)

Microvascular Reconstructive Surgery

**# of procedures**

**12-month period within last 18 months**

**(enter dates)**

**Types of Microvascular Reconstructive Surgery cases:**

Flap harvest Enter #

**Inset Enter #**

**Microvascular anastomosis Enter #**

**Other Enter #**

## TOTAL \_\_\_\_ (30 required minimum)

(If Fellowship Area is OMS Endoscopic, complete # of procedures in right-hand column)

Endoscopic Maxillofacial Surgery

**# of procedures**

**12-month period within last 18 months**

**(enter dates)**

**Types of Endoscopic Maxillofacial Surgical Cases:**

Double puncture, advanced, temporomandibular

joint arthroscopic procedures **Enter # (30 required minimum)**

Sialoendoscopic procedures **Enter # (10 required minimum)**

Sinus endoscopic procedures **Enter # (10 required minimum)**

Other **Enter #**

## TOTAL \_\_\_\_ (100 required minimum)

**Have You:**

**1. Indicated a response for EACH question?**

**2. Written a detailed rationale for each NO answer indicated?**

**3. Written a recommendation for each NO answer?**

**Remember: Every NO indicated must be reported during the final conference.**

**After the Final Conference…**

**Be sure to return the completed**

**Site Visitor Evaluation Form**

**Within 2 weeks after the site visit.**