 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)**

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| --- | --- | --- | --- |
| 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](mailto:hooperm@ada.org)

Commission on Dental Accreditation