**Board of Commissioners: Public Member Application**

*Form to be completed and signed by applicant.*

**Name:**

**Business Address (**Check if preferred mailing address **):**

Phone:

**Home Address (**Check if preferred mailing address **):**

Phone:

**Email Address:**

How did you learn about this opportunity?

If an organization suggested you apply, name of organization:

**All applicants 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 to ten (10) to twenty (20) days per year to Commission activities, including but not limited to training, comprehensive review of print and electronic materials, and participation in and travel to Commission meetings;

Ability to evaluate a continuing dental education program objectively in terms defined by recognition standards;

Stated willingness to comply with all Commission policies and procedures;

Ability to conduct business through electronic means (email, Commission web sites).

**Public Member Applicant Eligibility**Public members of the Commission must have a commitment to bring the public/consumer perspective to CCEPR deliberations. In order to serve, the nominee must **NOT** be:

* 1. A dentist or member of an allied dental discipline;
  2. An instructor in a dental or allied dental education institution;
  3. An employee, member of the governing board, owner, or shareholder of, or independent consultant to a continuing dental education provider or a company that produces dental products or services;
  4. In a leadership position for an entity that has a certification or accreditation program for continuing dental education providers or courses, or be involved in the administration of a certification or accreditation program for continuing dental education providers or courses; or
  5. 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.

I attest that I meet the criteria above to serve as a public member for the Commission for Continuing Education Provider Recognition.

**Educational Background** (beginning 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 continuing education organizations, and previous experiences serving on boards or committees.**

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**List any current or past relationship with any organization/business affiliated with the profession of dentistry.**

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**Write a short paragraph summarizing your unique qualifications and interest in serving as a public member with the Commission for Continuing Education Provider Recognition.**

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**List Two References**

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| Name | Address/Email | Position |
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| --- | --- |
| **Signature:** | **Date:** |

*Please return completed form to:*

cousinsk@ada.org

ADA Commission for Continuing Education Provider Recognition