

**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):

AEGD Educator by ADEA*

General Dentist (Graduate of GPR or AEGD)

Dental Anesthesiology Educator by ASDA*

GPR Educator by SCDA*

Dental Assisting Educator*

Hospital Administrator

Dental Assisting Practitioner

Higher Educator Administrator

Dental Hygiene Educator*

Oral Medicine Educator by AAOM*

Dental Hygiene Practitioner

Orofacial Pain Educator by AAOP*

Dental Laboratory Technology Educator*

Predoctoral Educator*

Dental Therapy Educator*

Specialty Dentist Educator*

Dental Laboratory Owner by NADL

Specialty Dentist Practitioner

General Dentist Educator*

Nominated by Specialty Organization/Certifying Board

General Dentist Practitioner

**Educator nominees must have prior or current experience as a Commission site visitor*

Please provide information for all categories that apply:

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)

Statement:

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

List Two Professional References:

Name	Address/Email	Position

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)

Submission Date:

Signature:

Please Return to:
hooperm@ada.org
Commission on Dental Accreditation

