DOCUMENTATION OF ACTIVITIES FOR ADVANCED DENTAL EDUCATION PROGRAM SITE VISITS

The Commission on Dental Accreditation expects that written documentation of all educational program activities will be ensured by the program director and available for review during the on-site evaluation. It is impossible for Commission site visitors to assess whether programs meet established standards unless program activities are documented. Program records should clearly indicate which activities are required of students/residents and which are optional.

The following records should be maintained and available for review at the time of the site visit:

- One paper copy and one electronic copy of the self-study for each discipline
- All materials identified as “available on-site” within the self-study
- Documentation to demonstrate compliance with Commission’s policies on “Complaints,” “Third Party Comments,” “Program Change” and, as applicable, “Distance Education”
- Evidence of institutional accreditation
- Written agreements with co-sponsoring and affiliated institutions (signed/fully executed)
- Program goals and objectives, and outcomes assessment data, including examples of program improvements
- Objectives for rotations on other services of the hospital and assignments to affiliated institutions, if applicable
- Objectives and content outlines for formal coursework, if applicable
- Topic outlines and schedules for all lectures, seminars, conferences and demonstrations included in the dental teaching program
- Departmental statistical records documenting numbers and types of procedures performed and variety of patients per student/resident
- Records of each student’s/resident’s clinical and didactic accomplishments
- Documentation of the evaluation of students/residents, teaching staff and the educational program
- Schedules of attending staff’s clinical assignments
- Documentation of attending staff supervision
- Minutes of committee meetings
- CPR/PALS etc. for all students, faculty and staff, as applicable
- Outpatients records and, if applicable, inpatient records
- Copies of the state practice acts, programs/institution’s policies and protocol on ionizing radiation, asepsis, infection and hazard control, and evidence of continuous monitoring

For OMS:
- attending staff and resident evaluation records
- logs or other records demonstrating the cumulative anesthetic experience of each graduating resident, as well as last year’s graduates, as required by OMS Standard 4-9.1
- for a 12-month period within the last 18 months, provide records of the number of procedures performed by residents as the operating surgeon or first assistant to an oral and maxillofacial surgery attending staff member in the major oral and maxillofacial surgery categories as required by OMS Standard 4-11

Privacy and Data Security Reminder: The program is reminded that the program’s documentation submitted to CODA and CODA Site Visitors must not contain any patient protected health information (“PHI”) or sensitive personally identifiable information (“PII”). The site visit team may only review documents containing PHI and PII while on-site during a site visit. If the program submits documentation that does not comply with the Privacy and Data Security Summary for Institutions/Programs (linked below), CODA will assess a penalty fee of $4000 per program submission to the institution; a program’s resubmission that continues to contain prohibited data will be assessed an additional $4000 fee. [https://www.ada.org/en/coda/policies-and-guidelines/hipaa](https://www.ada.org/en/coda/policies-and-guidelines/hipaa)