**Documentation of Activities in Advanced Dental Education Programs**

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:

- Documentation to demonstrate compliance with Commission’s policies on “Complaints” and "Third Party Comments”
- Complaint Log
- Written agreements with co-sponsoring and affiliated institutions
- Program goals and objectives
- 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
- Departmental statistical records documenting numbers and types of procedures performed
- Topic outlines and schedules for all lectures, seminars, conferences and demonstrations included in the dental teaching program
- Records of each student’s/resident’s clinical and didactic accomplishments
- Documentation of the evaluation of residents, teaching staff and the educational program
- Schedules of attending staff’s clinical assignments
- Documentation of attending staff supervision
- Outpatients records and, if applicable, inpatient records (for OMS: approximately 20-30 outpatient and inpatient records) **For VA Programs:** Patient records may only be reviewed onsite in a secure location and may only be used for the purpose of the site visit. Patient records may not be removed from the facility, nor may the records be electronically transmitted to CODA site visitors.
For OMS:

- attending staff and resident evaluation records

- records of numbers and types of procedures performed by the residents including general anesthesia/deep sedation records

- operating log