Operative Section Overview

A Class II restoration must be completed to pass the WREB Exam. The restoration can be any one (1) of the following:

- Direct Posterior Class II Composite Restoration (MO, DO, or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO, or MOD)

A second procedure, if required, may be any of the following:

- Direct Posterior Class II Composite Restoration (MO, DO, or MOD)
- Direct Posterior Class II Amalgam Restoration (MO, DO, or MOD)
- Direct Anterior Class III Composite Restoration (ML, DL, MF, DF)

If you are successful, (3.00 or higher), on the first procedure, the section is passed, with no need to complete another procedure. If the first procedure scores below a 3.00, and no critical error has been recorded, you may proceed with a second procedure, which will be averaged with the first procedure. For states requiring two (2) operative procedures, Candidates will have the option to complete a second procedure, even if the first procedure scored above a 3.00. If two procedures are completed, the two procedure scores will be averaged. The average of the two procedure scores must be 3.00 or higher to pass the section. If a second procedure is completed and the average scores below 3.00, the Operative Section is failed. In this instance, the Candidate must pay to retake the full Operative Section at a different site. No onsite retakes are available for the Operative Section.

Rubber dam isolation is required for preparation grading and modification requests.

WREB Scoring Criteria (pgs. 54-57) accommodates Candidates with varying educational backgrounds coming from schools that may teach different procedural methods. WREB will score all operative procedures according to these scoring criteria.

Examiners may utilize 2.5 X magnification or greater for grading.

Case Selection Criteria

Direct Posterior Class II (Composite or Amalgam)

A. The restoration must be a Class II restoration on any permanent posterior tooth except the mesial of a lower first premolar. An MOD on a lower first premolar is acceptable with a qualifying distal lesion.
B. Caries on an unrestored proximal surface is required. The caries must have clearly reached or penetrated the dentino-enamel junction (DEJ) on at least one of the two required radiographs. Refer to the illustrations on page 37.

- All caries on the occlusal surface must be restored. You may do one (1) preparation to include all caries, or separate preparations if there is adequate, sound tooth structure between the preparations. Separate preparations must be restored with the same restorative material. Cusp tips are considered part of the occlusal surface.
- If there are qualifying carious lesions on both mesial and distal surfaces, both lesions must be restored. At your discretion, you may do separate preparations if they are separated by adequate, sound tooth structure. Separate preparations submitted on the same tooth will be graded as one submission. They must be restored with the same restorative material.
- Any proximal carious lesion on the accepted tooth that reaches or penetrates the DEJ must be restored. If the tooth has a lesion that reaches or penetrates the DEJ on one (1) proximal surface, and a second lesion on the other proximal surface that does not reach the DEJ (non-qualifying), you may treat or not treat the non-qualifying lesion at your discretion. If you choose to treat the non-qualifying lesion, request approval for the qualifying proximal lesion only and (in the “Note to Examiners” on the worksheet) write your intent to include the additional proximal lesion in your treatment.
- If there is a qualifying lesion on one proximal surface and the tooth also has a restoration with no recurrent caries, the restoration may remain if there is sound tooth structure between the preparation and the existing restoration.

C. A tooth with any temporary restoration, bonded facial veneer, orthodontic bracket, or engager is not acceptable.

D. There must be at least one pre-existing interproximal contact between the surface(s) with the qualifying carious lesion(s) and an adjacent tooth.

E. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. A temporary restoration or removable partial denture is not an acceptable adjacent surface. Caries may be present on the adjacent tooth as long as it does not compromise pre-existing interproximal contact or re-establishment of contact with the planned restoration.

F. The occlusal surface of the tooth must have some contact with the opposing dentition. Cusp tips are considered part of the occlusal surface. Occlusion against a stainless steel crown, complete denture, or partial denture (cast or acrylic) is acceptable. Teeth occluding with the tooth being restored may not have a temporary restoration on the occluding surface.

G. The tooth must be vital and asymptomatic with no clinical evidence of fistulae and no radiographic evidence of apical or pulpal pathology.
Direct Anterior Class III (Composite)

A. The restoration must be a Class III restoration on any permanent anterior tooth.

B. The restoration may be a ML, DL, MF, or DF restoration. Usually lingual access is the indicated approach for a Class III restoration. In rare instances, facial access may be indicated. If you feel that facial access is in the best interest of the patient, you must provide a suitable rationale in “Note to Examiners” at Acceptance. If Examiners feel the proposed access is not appropriate, the submission may be rejected.

C. Caries on an unrestored proximal surface is required. The caries must have clearly reached or penetrated the DEJ on the required radiograph.
   - Any carious lesion or existing restoration that communicates with the planned restoration must be included in the preparation.
   - All caries on the accepted surfaces must be restored (i.e., DL and separate lingual pit).
   - If there are qualifying carious lesions on both mesial and distal surfaces, both lesions must be restored. Separate preparations submitted on the same tooth will be graded as one (1) submission. They must be restored with the same restorative material.
   - A tooth with radiographic caries that extends apically beyond the cementoenamel junction (CEJ) is not acceptable.

D. A tooth with any temporary restoration, bonded facial veneer, orthodontic bracket or engager is not acceptable.

E. There must be pre-existing interproximal contact between all or part of the qualifying carious lesion and the adjacent tooth. Caries wholly gingival to and not involving any part of the proximal contact area is not acceptable, even if the caries reaches or penetrates the DEJ.

F. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. A temporary restoration or removable partial denture is not an acceptable adjacent surface. Caries may be present on the adjacent tooth as long as it does not compromise pre-existing interproximal contact or re-establishment of contact with the planned restoration.

G. Contact between the tooth to be restored and the opposing dentition is not required.

H. The tooth must be vital and asymptomatic with no clinical evidence of fistulae and no radiographic evidence of apical or pulpal pathology.

Patient Acceptance at the Exam Site

Prior to beginning any restorative procedure, your tooth selection (without rubber dam) must be approved by the Grading Examiners or a Floor Examiner, if provisionally accepted. Your patient may be submitted for acceptance by either you or your dental assistant, but you are responsible for all required paperwork and instruments being available and complete. For detailed information on Provisional Acceptance, refer to page 40.
You may use the same patient for two (2) restorative procedures. Both procedures may be submitted for acceptance at the same time unless 1) they are on adjacent teeth or 2) they share opposing occlusion such that complete loss of occlusal contact will occur when one tooth is prepared. In either of these situations, one tooth must be prepared and restored before the second tooth can be accepted. The second tooth may be accepted and approved at the same time that the first restored tooth is graded.

If neither of the above situations applies, you may submit two (2) procedures for acceptance at the same time. You may also submit both preparations and both finished restorations at the same time.

Electronic devices, including cell phones and smart watches, are prohibited in the grading area. Patients with electronic devices will not be graded, but returned to you to leave the device, resulting in lost time.

To receive acceptance to begin treatment, send your patient to the grading area with the following (missing information, forms, or instruments will delay the grading process):

A. **Worksheet:** Worksheets are color-coded (Class II Composite – Tan, Class II Amalgam – Blue, Class III Composite – Lilac). Instructions for completing these forms are the same for all restorative procedures. Using only blue or black ink (not pencil), complete the worksheet for the restoration to be done:
   - To avoid a wrong material penalty, verify that you are using the correct worksheet for the procedure you intend to perform.
   - Write your Candidate ID Number in the upper right corner.
   - Write your patient’s first name only.
   - Indicate the tooth number (#1 through #32).
   - Check the appropriate box for the surfaces to be restored.
   - Check the “Acceptance” box.

   On the back of the worksheet, list all medications (type, concentration, and dosage) your patient has taken today. Also, in the appropriate space, list the local anesthetic (type, concentration of vasoconstrictor [if used], and number of cartridges) you administer for that procedure. Write “none” if no medications are taken or anesthetic administered.

B. **Radiographs:** WREB accepts the use of conventional film or digital radiographs if they meet the criteria as specified in the section “Radiographs” on pages 19-21.

   The Class II operative procedure will require the Candidate to submit two (2) radiographs: one periapical that includes the apex of the tooth, and one bitewing. The radiographs must show the current condition of the tooth to be treated and must have been taken in the last six (6) months. The qualifying lesion(s) must be clearly visible at the interproximal contact on one of the two (2) required radiographs. Candidates must radiographically demonstrate for Examiners the presence of a WREB qualifying lesion on at least one interproximal surface and a clear radiographic diagnosis of the presence or absence of
any qualifying lesion at the contact on the other interproximal surface. These two features need not appear in the same radiograph. For example, the periapical radiograph may show a qualifying lesion on the mesial of a posterior tooth with an overlapped contact on the distal view of the tooth. The other required radiograph, (periapical or bitewing), can be used then to clearly demonstrate that there is no qualifying lesion that should be included by the Candidate in the diagnosis on the distal surface, regardless of an overlapping mesial contact.

The Class III composite procedure requires one periapical radiograph for acceptance unless a second radiograph, (periapical or bitewing), is required to demonstrate the qualifying lesion.

**Radiographic Criteria for Caries**

**Minimally Qualifying Lesion**
Caries has clearly reached the DEJ radiographically.

**Qualifying Lesion**
Caries has clearly penetrated the DEJ radiographically.
It is strongly recommended that duo-pak film, (for conventional film radiographs), be used during initial patient screening. The radiographs, (if conventional film), must be original. Duplicate radiographs are not acceptable. Radiographs will not be returned if a patient is not accepted for treatment.

If using conventional film radiographs, place them “button-out” in a mount and staple the mount to the back of the worksheet. Mounts will be provided upon request. If using digital radiographs, load or print them as if the button were out and mark the patient’s left and right on the side of the radiograph. Staple printed digital radiographs to the back of the worksheet. The radiographs will be returned with your patient, but they must be included in your Candidate Packet at the end of the exam.

If digital radiographs will be accessed by Grading Examiners via computer, check the box on the worksheet. Only the radiographs being submitted for acceptance should be saved in the folder accessed by Examiners. Additional radiographs should not be included as they cause confusion and may result in time lost. The file name for each tooth should include your Candidate ID Number, the patient’s first name only, the procedure, tooth number, and surface to be treated. A sample file name for an Amalgam would be: A115 Tonya Amalgam #5DO. The individual films do not need to be labeled.

Even if two restorative procedures are performed in the same quadrant, separate bitewing and periapical radiographs must be available for each procedure. Both sets of radiographs must be originals, duplicate digital prints, or duplicate storage of digital images. As mentioned, duo-pak film is strongly recommended for conventional radiographs.

If the submitted radiographs are incorrect, undiagnostic, or do not show the current condition of the tooth, the worksheet will be returned to you. You may then resubmit your patient with the correct radiographs. There will be no point deduction for this error.
C. Patient Medical History/Patient Consent Form: A Patient Medical History (including current blood pressure and pulse) and Patient Consent Form must be completed for each patient. Refer to the sample form on page 31. If you use the same patient for more than one procedure, only one Patient Medical History/Patient Consent Form is necessary. Mark the box on the upper right corner of the form for each procedure being submitted. Note that each procedure must also be listed on the Patient Consent Form on the reverse side. Make sure your patient signs the Patient Consent Form.

The Patient Medical History/Patient Consent Form must be reviewed and initialed by a Floor Examiner before administering local anesthetic or sending your patient to the grading area for acceptance. Provide both the Operative Worksheet and Patient Medical History/Patient Consent Form, including blood pressure and pulse, for a Floor Examiner to review; in some cases, the Floor Examiner will also sign the worksheet if the patient was provisionally accepted. When your patient first visits the grading area, the Patient Medical History/Patient Consent Form will be retained at the patient check-in desk; Grading Examiners will not see it.

D. Patient Tray: Make sure the following required items are available on the patient tray:

- New/unscratched #4 or #5 front-surface metal mouth mirror
- New/sharp pigtail explorer
- New/sharp shepherd’s hook explorer
- Three 2” x 2” gauze pads
- Articulating paper (in a holder)
- Floss

The mirror and explorers must be in an open autoclave bag. Place your paperwork (items A-C) on top of the instruments on the tray. Instruments that fail to meet the requirements (new and sharp) may be returned to you for replacements, resulting in time lost.

E. Patient Bib: Attach your Candidate ID Number label to the upper right corner (patient’s right side) of the patient bib.

F. Patient Eye Protection: Prescription glasses or safety glasses must be worn by all patients while in the dental chair or in the grading area.

If your patient is accepted, he/she will return to you with the radiographs, your instruments, and the worksheet initialed by one Grading Examiner next to “Accepted By,” indicating approval of your submission. Check the worksheet to be sure that the “Accepted By” line has been initialed and that any comments you made in the “Note to Examiners” have also been initialed. If you feel any initials are missing, notify a Floor Examiner before proceeding.

You may now proceed with treatment. Note that once the preparation is started, it must be completed and graded the same day. If the procedure is accepted but will be performed on a subsequent day, you must receive Floor Examiner approval prior to releasing your patient. Refer to “Dismissal for Day” Approval on page 47.
If your patient is not accepted, he/she will return with your instruments and the following:

- Pink copy of an “Patient Unaccepted for Treatment” form indicating the reason the patient was not accepted
- New Patient Medical History/Patient Consent Forms
- New worksheet with the box for 2nd (or 3rd) submission marked

The worksheet and radiographs for the rejected submission will be retained in the grading area. While radiographs will not be returned to you, they will be available to the Grading Examiners if they are applicable to an alternate submission. In such a case, enter an explanatory note in the “Note to Examiners” on the new worksheet (i.e., “rejected submission was a DO; resubmitting as an MOD”).

If your first submission is rejected, points will be deducted from the preparation score. You may submit alternate patients (or the same patient with a different restoration selected) until the criteria are met. A second unaccepted submission will result in an additional point deduction. No additional points will be lost for subsequent rejected submissions after the first two. **NOTE:** A rejected submission may not be resubmitted with new radiographs for the same restoration.

There may be a rare occasion when the treatment submitted meets the acceptance criteria listed, but is not accepted by the Grading Examiners. If Examiners believe the submitted treatment is not in the best interest of the patient or the examination process, the treatment will not be accepted.

**Provisional Acceptance**

The following section applies to Candidates participating in the provisional acceptance process. If you are not participating in this process, please skip to "Definitions” on page 49.

Provisional acceptance, for the Operative Section only, is available only at participating sites. For a complete list of participating sites, please visit wreb.org, under Dental Candidates. If your site does not participate or restricts provisional acceptance to matriculating students, you will submit your patient at the exam as instructed under “Patient Acceptance,” page 35.

Provisional acceptance means your patient is radiographically accepted by calibrated WREB Grading Examiners prior to the exam. If provisionally accepted, all you will need is clinical confirmation by a Floor Examiner at the exam to begin treatment.

Preoperative radiographs for up to two (2) operative procedures will be submitted as outlined below.

**Submitting Radiographs**
Radiographs will be uploaded to WREB’s secure website by a designated staff member at the school. Uploads can only be done by the designated staff member(s) during an assigned window. Windows begin approximately four (4) weeks prior to the exam and last approximately two (2)
weeks, but you should verify the exact dates with your school. To help manage the workload, some schools may have an internal deadline prior to the WREB window end date. If this is the case, submissions should be submitted by the school’s internal deadline. It is your responsibility to make an appointment with your school for submission within the window, and to verify that the information submitted is correct. Once the window has closed, no additional radiographs will be accepted. If you do not submit during the window, you will submit your patient(s) at the clinical exam site. Similarly, if after provisional acceptance, any information is found to be incorrect or must be changed on a submission (i.e., tooth number, procedure type), the provisional acceptance is void and the patient must be submitted at the clinical exam site.

You may upload two (2) submissions. Once a procedure is submitted, changes can only be made by the school designate within the submission window. Candidates are solely responsible for providing diagnostic quality radiographs, correct tooth numbers, and a diagnosis of the restorative procedures for all qualifying lesions on the teeth submitted for acceptance.

Requirements to submit:

- Your full name and Candidate ID Number.
- For each radiograph, you will need: patient’s first name only, procedure, tooth number, and surfaces you plan to treat.
- Radiographs must be digital in jpg format. Scanned conventional film radiographs will not be accepted.
- The radiographs must show the current condition of the tooth to be treated and must have been taken within the past six (6) months.
- For each restorative procedure, except the Class III Composite, two (2) preoperative radiographs of the tooth to be restored are required: one bitewing and one periapical. The Class III Composite procedure requires only a periapical radiograph for acceptance.

Once radiographs are submitted, you will receive an email from WREB confirming what was submitted. This email will include your information, along with your patients’ information. You should review the information in this email carefully. If any errors are found, you must notify the school designate prior to the end of the submission window. Once the window closes, submissions may not be modified.

After Submission
Radiographs will be evaluated by calibrated Grading Examiners based on the Operative Case Selection Criteria found at the beginning of this section. You will receive an email approximately one (1) week after the submission window closes notifying you of acceptance/rejection.

There is no penalty associated with provisional acceptance. If a submission is rejected, no penalty will apply. A patient who was provisionally rejected can be resubmitted with the same diagnosis (same procedure, tooth, and surfaces) at the exam site. These patients will proceed through the acceptance process at the exam site and will be subject to the patient submission rejection penalty.
At the Exam
Provisional acceptance does not transfer between Candidates. If a patient is provisionally accepted and not treated, another Candidate may choose to treat them but must submit the patient for acceptance separately. When submitting the patient for acceptance at the site, the Candidate ID Number for whom the provisional acceptance was approved can be included in the “Note to Examiners” as shown below and initialed by a Floor Examiner. Onsite acceptance of a previously provisionally accepted patient is not guaranteed.

If you use a different patient other than one that was provisionally accepted, there is no penalty for submitting a new patient at the exam site. If you are submitting a new patient in the place of a provisionally accepted patient, please note this on the worksheet as shown below. Write the provisionally accepted patient’s first name, tooth number, and surfaces on the line provided.

Starting at 7:30 a.m., Floor Examiners will be available to review Patient Medical History/Patient Consent Forms and approve provisionally accepted patients who meet clinical acceptance criteria. Work on preparations should not begin until 8:00 a.m. Your patient is not approved for treatment until a Floor Examiner performs the clinical check, so DO NOT begin your preparation until you have a Floor Examiner initial the “Accepted By” line on your worksheet.

Floor Examiners will verify the following:

- Radiographic images, patient identity, tooth numbers, and surfaces for provisionally accepted procedures are consistent and correctly written on the Operative Worksheet.
- There is interproximal contact between the surface(s) to be restored and the adjacent tooth or teeth.
- Caries on the adjacent tooth cannot compromise pre-existing interproximal contact or re-establishment of contact with the planned restoration.
- The tooth to be restored does not demonstrate a fistulae.
• **Class II**
  o The occlusal surface of the tooth must have some contact with the opposing dentition.
  o The lesion must be on a permanent posterior tooth and not only on the mesial of a lower first premolar.

• **Class III**
  o There must be pre-existing interproximal contact between all or part of the qualifying lesion and the adjacent tooth. Caries wholly gingival to and not involving any part of the proximal contact area is not acceptable.

Before calling the Floor Examiner to check your patient, the following should be ready:

- Completed worksheet.
- Radiographs that were submitted for provisional acceptance should be up on the screen for Floor Examiner reference.
- Completed *Patient Medical History/Patient Consent Form*. The Floor Examiner will not collect the form, but will need to review it. You will submit the form to the patient check-in desk when your patient is submitted for preparation grading (or a modification request).
- Patient Tray: Include all items listed on the back of the worksheet for acceptance, including articulating paper (in a holder) and dental floss.

If the Floor Examiner finds the patient is clinically questionable, he/she will initial the “Referred for Clinical Review By” line on your worksheet and you will submit your patient to the grading area for Grading Examiner review. Your patient will proceed through the onsite acceptance process and, if found to be unacceptable, you will incur the patient submission rejection penalty as outlined on page 52.

If the Floor Examiner verifies that your patient meets all clinical acceptance criteria, you do not need to send the patient back to the grading area. The Floor Examiner will initial your worksheet on the “Accepted By” line and you may proceed with your preparation (provided it is at least 8:00 a.m.).

**Cavity Preparation**

WREB Examiners are calibrated to *WREB Preparation Scoring Criteria* (see pgs. 54-56). Grading Examiners understand that some variations to outline and internal form may occur, but these should be small variations for the lesion treated. The management of major variations is covered in the Modification Procedure section.

It is imperative that all caries, affected dentin, and unsound demineralized enamel be totally removed. However, when caries is very deep (within 0.5 mm of the pulp chamber) the preferred treatment is to leave a small layer of caries and place an indirect pulp cap. Detection is typically accomplished with a sharp explorer to determine if softened dentin remains. All caries must be
removed from the preparation, except that directly over the pulp chamber which, if removed, would result in a pulp exposure. If caries or affected dentin is intentionally left over the pulp, describe this in the “Note to Examiners” on the worksheet.

Beveling for composite preparations is not a WREB requirement. However, if placed, bevels will be considered part of the outline and extension of the preparation.

If the preparation includes removal of a previous restoration, the entire previous restoration (including any base, sealant, and/or liner) must be removed. If removal of previous pulp capping material is likely to expose the pulp, remove it to within 0.5 mm of the pulp and document this in “Note to Examiners” on your worksheet. Retentive pins may remain if they are adequately retained in dentin. Pins not adequately retained should be removed or made “flush” with the dentin surface of the preparation.

Treatment of the preparation with desensitizers, disinfectants, or chemical agents of any kind can be done only after the preparation is graded. WREB strongly discourages the use of caries indicating solution. Examiners are trained to identify caries tactilely – not with indicating solution.

If a pulp exposure occurs, write Pulp Exposure in “Note to Examiners” under “Preparation Grade” on the worksheet and describe how you intend to manage the exposure. A rubber dam should be in place and a Floor Examiner must be called prior to placing pulp protection. The Floor Examiner will write and initial a note on the worksheet, then direct you to place the pulp cap and complete the preparation. Any additional pulp protection will be placed after the preparation is graded.

**WREB considers all pulp exposures to be avoidable.** There will be a deduction in score from the preparation points for any exposure, regardless of whether it is initially recognized by the Candidate or the Examiners.

For grading purposes, WREB differentiates between affected dentin and caries. Refer to the definitions on page 49. In the interest of patient protection, all identified caries, affected dentin and unsound demineralized enamel will be removed prior to placement of the restoration.

**Caries Remaining** (other than the 0.5 mm of caries left for an indirect pulp cap) validated by two or more Grading Examiners is an automatic failure of the Operative Section. While it is most commonly diagnosed through direct access (as described on page 49), it may also be diagnosed from clinical or radiographic evidence that you have failed to completely access the lesion. Regardless of how it is diagnosed, you will be required to discuss caries management with a Floor Examiner. You may finish the restoration, although no points will be earned, or you may place a temporary and have the patient contact the dentist on the Follow-Up Care Agreement form for completion of the restoration. If you choose to finish the restoration, the Floor Examiner will check the final restoration. If remaining caries is identified by only one Grading Examiner you will be instructed to remove the caries, but since the finding was not validated by a second Grading Examiner, you will be allowed to finish the restoration for grading. When affected dentin or unsound demineralized enamel is documented by Grading Examiners, you will be instructed to remove the affected dentin or unsound demineralized enamel and continue the procedure.
While WREB does not require placement of a base following the removal of deep caries, you are expected to place adequate pulp protection when indicated. With the exception of a direct pulp cap placed over an exposure (approved and initialed by a Floor Examiner), no pulp protection should be placed until after the preparation is graded.

Modification Procedure

Just as experienced practitioners often encounter unexpected circumstances that can modify treatment, you also may need to modify the outline, extension, and/or internal form of a planned preparation because of affected dentin, unsound demineralized enamel, or caries. (Occasionally, you may need a modification request to remove existing restorative material.) If you need to modify your preparation beyond the measurement criteria for a score of “5”, you must communicate your intentions to Floor Examiners and Grading Examiners through a properly written Modification Request. A modification request should not be initiated until the outline/extension and internal form are at the upper limit of the criteria for a score of “5.” Briefly describe on your worksheet under “Modification Request” the following:

- **Type** of modification (external outline, internal form, etc.):
  - External outline form modification includes the internal form that would normally support the new outline. Internal form modification relates to internal form only and has no effect on the preparation’s outline form.

- **Location** (proximal wall, pulpal floor, axial wall, etc.)

- **Extent** (amount of deviation from criteria for score of “5”)

- **Reason** (caries, unsound demineralized enamel, affected dentin, restorative material)

Use the terms indicated on the last two pages of this Guide.

All requests for modification must be written in ink on the worksheet under “Modification Request.” All other notes (at acceptance, preparation, and finish grading) must be written under “Note to Examiners” in the appropriate sections.

- Leave some caries, affected dentin, unsound demineralized enamel, or existing composite to show why the modification is being requested.
  - If a planned variation in internal form is due to caries, the modification request should consider removal of caries only, not sound dentin.

- The extent of a modification request is referenced from the maximum extensions and depths listed in the preparation criteria for a score of “5” (pgs. 54-56). The Candidate’s preparation should reflect those maximum extensions prior to requesting a modification.

- Even though the facial extension of a Class III preparation need not break contact by criteria (pg. 55) any modification request involving the facial extension of this preparation should be referenced from the point where facial contact is broken by 0.5 mm.
• Document the extent of the modification in multiples of 0.5 mm increments (i.e., 0.5 mm, 1.0 mm, etc.). Round up to the nearest 0.5 mm. This does not mean you request 0.5 mm modifications until the reason for modification no longer exists. Since space for listing modifications on the worksheet is limited, you are encouraged to initially specify the total extent of the modification required to remove the lesion.

• A rubber dam must be in place for all modification requests.

• A planned “finger extension” (see definition) requires a modification request.

After writing your modification request on the worksheet, call a Floor Examiner. He/she may initial your modification note on the worksheet and instruct you to proceed. If the Floor Examiner feels the Grading Examiners should review the request, your patient will be sent to the grading area with a Modification Request Form and a special gray card to indicate that only the modification request, not the completed preparation, should be evaluated.

After evaluation of the request by the Grading Examiners, the returned Modification Request Form will indicate if the modification requested was appropriate or not appropriate. The Floor Examiner will initial both pink and yellow copies of the form and return the pink copy to you. If you have requested multiple modifications, each numbered modification will be indicated as appropriate or not appropriate. There will also be at least two Grading Examiners’ initials on your worksheet. If any initials are missing, notify a Floor Examiner.

If the modification has been validated as appropriate, you may complete the preparation and submit for grading. The preparation (including any approved modification) will be graded according to WREB Scoring Criteria. If the modification is validated as not appropriate, you should proceed without the modification. There will be a deduction from the preparation score if any modification request is validated not appropriate by Grading Examiners.

The Preparation Grade
Rubber dam isolation is required for preparation grading. The prepared tooth and at least one tooth on either side (excluding third molars), if present, must be isolated, clean, and dry. The rubber dam should be stabilized to withstand movement and time while your patient is being evaluated. If an approximating tooth is partially erupted or otherwise cannot hold a rubber dam and you have varied your rubber dam placement as a result, the variation should be described in “Note to Examiners” under “Preparation Grade” on the worksheet.

When the preparation is ready to be graded, be sure that the tooth remains sufficiently anesthetized for patient comfort during the evaluation process. Be sure to record the type and amount of anesthetic on the worksheet. Send your patient to the grading area with the following:

A. Worksheet and attached radiographs with:
   • “Preparation Grade” box checked

B. Patient Tray with:
   • New/unchratched #4 or #5 front-surface metal mouth mirror
   • New/sharp pigtail explorer
• New/sharp shepherd’s hook explorer
• Three 2” x 2” gauze pads

The mirror and explorers must be in an open autoclave bag. Place your worksheet on top of the tray.

C. **Patient Bib**: Attach your Candidate ID Number label to the upper right corner (patient’s right side) of the patient bib.

D. **Patient Eye Protection**: Prescription glasses or safety glasses must be worn by all patients while in the grading area.

Electronic devices, including cell phones and smart watches, are prohibited in the grading area. Patients with electronic devices will not be graded, but returned to you to leave the device, resulting in lost time.

After the preparation is graded, your patient will return with the worksheet initialed by one Grading Examiner on the “Preparation Graded:” line, indicating that the preparation has been graded. At least three (3) Grading Examiners must initial all notes in the “Note to Examiners” on the worksheet. If your worksheet does not have the required initials, notify a Floor Examiner before proceeding.

Adjustment of the approximating surface of an adjacent tooth may only be done after the preparation has been graded. Pulp protection also may only be done after the preparation has been graded (except for a direct pulp cap over an exposure).

**“Dismissal for the Day” Approval**

Remember that any graded procedure that is started must be graded on the same day. If you received approval to start but have not begun the preparation, or if you received a preparation grade but wish to place the direct restoration on a subsequent day, you must see a Floor Examiner. A **Floor Examiner Check Sheet** will be completed and the pink and yellow copies given to you.

When you are ready to dismiss your patient for the day, bring your worksheet to a Floor Examiner for approval. If appropriate, the Floor Examiner will sign “Dismissal for the Day” on the worksheet and your patient may be dismissed. Dismissal approval must be completed by 4:30 p.m. However, if your patient is detained in the grading area past 4:30 p.m. and “Dismissal for the Day” approval is necessary, it will be completed when the patient has returned to the clinic.

If a **Floor Examiner Check Sheet** was issued, a Floor Examiner must evaluate your patient prior to any treatment at the next appointment. At that next appointment, the Floor Examiner will initial both pink and yellow copies and return the pink copy to you. **Failure to obtain the Floor Examiner’s initials will result in loss of all points for the procedure.**
The Finish Grade

The finished restoration is graded **without** a rubber dam and must be completed and graded the same day the restorative material is placed. Violation of this procedure will result in the loss of all points for the finish portion of the operative procedure.

Placing a material other than what was approved at acceptance will result in failure of the Operative Section.

A sealant or unfilled resin may **not** be placed over a composite restoration prior to finish grading.

If you do so, your patient will be returned to you and you will be asked to remove the sealant and then resubmit your patient. After the finish is graded, you may apply a sealant to adjacent fissures and/or the restoration at your discretion.

When the restoration is ready to be graded, send your patient to the grading area with the following:

A. **Worksheet** and attached radiographs with:
   - “Finish Restoration Grade” box checked

B. **Patient Tray** with:
   - New/unchratched #4 or #5 front-surface metal mouth mirror
   - New/sharp pigtail explorer
   - New/sharp shepherd’s hook explorer
   - Miller-type articulating paper forceps, without articulating paper
   - Three 2” x 2” gauze pads

   The instruments must be in an open autoclave bag. Place your paperwork and radiographs on top of the tray.

C. **Patient Bib:** Attach your Candidate ID Number label to the upper right corner (patient’s right side) of the patient bib.

D. **Patient Eye Protection:** Prescription glasses or safety glasses must be worn by all patients while in the grading area.

Grading Examiners will check interproximal contacts with Floss Singles® and occlusion with Bausch® 40-micron articulating paper. Both are provided to the Examiners by WREB.

After the finish is graded, your patient will return with the worksheet initialed by one Grading Examiner on the “Finish Graded:” line, indicating that the finish has been graded. At least three (3) Grading Examiners must initial all notes in the “Note to Examiners” on the worksheet. If your worksheet does not have the required initials, notify a Floor Examiner before proceeding.
**Releasing Your Patient**

Before releasing your patient, do a final review of your worksheet to make sure that all necessary initials are present. The following initials are required:

- “Accepted By” (one Examiner)
- “Preparation Graded” (one Examiner)
- “Finish Graded” (one Examiner)
- All “Note to Examiners” entries (one Examiner for Acceptance and three (3) Examiners for Preparation and Finish)

If any initials are missing, notify a Floor Examiner. Missing initials not brought to the attention of a Floor Examiner cannot be grounds for an appeal.

Give your patient the yellow copy of the *Follow-Up Care Agreement* form. Have him/her complete and turn in the *Patient Questionnaire*. Ask a Floor Examiner to initial “Patient may be released from the exam” line on the bottom of the worksheet. The Floor Examiner will verify that any follow-up requested by the Grading Examiners has been completed and will then initial the worksheet. Your patient may then be dismissed. **Do not dismiss your patient without Floor Examiner permission.**

**Definitions**

The following definitions are provided to assist your understanding of the scoring criteria and your communication with Examiners:

**Affected Dentin:** A clinical diagnosis made by tactile sensation using light pressure with an explorer and encountering dentin that is slightly penetrable. (Light pressure with an explorer is the amount of pressure it takes to blanch your fingernail with an explorer.) Affected dentin has slight resistance to the perpendicular withdrawal of the explorer.

**Caries Remaining:** A clinical diagnosis made by tactile sensation using light pressure with an explorer and encountering dentin that is soft and penetrable. (Light pressure with an explorer is the amount of pressure it takes to blanch your fingernail with an explorer.) Caries has definite resistance to the perpendicular withdrawal of the explorer and may have a dry leathery appearance.

**NOTE:** If insufficient or improper extension of the preparation results in failure to access the entire lesion, a diagnosis of caries remaining can be supported from clinical or radiographic evidence even though the caries may not be accessible to direct tactile sensation.
**Class II Slot Design:** A conservative preparation created by the confluence of a gingival floor, axial wall, and proximal walls. It does not have a pulpal floor in its internal form. The proximal box has a definite axial wall that follows the external contours of the tooth to form definite buccal and lingual proximal line angles. A slot design may be indicated if, in your judgment, there is qualifying caries on the proximal surface but no lesion present clinically or radiographically on the occlusal surface.

For the amalgam preparation, there must be distinct retentive grooves of no more than 0.5 mm depth that follow the DEJ extending from the gingival floor up to and/or including the occlusal surface.

**Class II Conventional Preparation:** The traditional Class II preparation that extends from the proximal box into some or all of the grooves and fissures of the occlusal surface. Unlike the slot design, it has a definite pulpal floor.

**Finger Extension:** The removal of a small area of caries, affected dentin, or unsound demineralized enamel on the facial proximal or lingual proximal cavosurface margin to avoid overextending a direct preparation. If you wish to include a finger extension in your preparation, you must follow the Modification Procedure discussed on pages 45-46.

**Fissure:** A developmental cleft resulting from the incomplete fusion of adjoining dental lobes that is usually found at the base of a groove. Any fissure diagnosed as carious should be included as part of a conventional design preparation. If the fissure is deep and possibly stained but not carious, a conservative proximal slot design preparation may be acceptable. A non-carious fissure may be sealed or left untreated; a fissurotomy is not acceptable during this exam. If you wish to place a sealant, you may do so after the finish is graded.

**Indirect Pulp Cap:** Caries or affected dentin deliberately left directly over the pulp chamber to avoid an exposure. It should be within 0.5 mm of the pulp. With the exception of caries or affected dentin left in place for indirect pulp capping, there should be no other caries or affected dentin in the preparation.
**Indirect Pulp Cap Declared When Not Indicated:** Candidate indicates in “Note to Examiners” intent to place an indirect pulp cap when no caries or affected dentin remains.

**Major Tissue Trauma:** Any undue iatrogenic damage to extraoral and/or intraoral tissues resulting in significant injury. Examples include lacerations greater than 3.0 mm, soft tissue burns, amputated papillae, and large tissue tags. Tissue trauma during an operative procedure is scored as part of the Finish, Function and Damage section of the finished restoration, even if the trauma is to tissue outside the immediate area of the restoration.

**Pulp Exposure:** A direct communication between the pulp chamber and the oral cavity caused by the loss of the normally intervening dentin barrier.

**Pulp Protection:** The application of a suitable protective material over a minimal thickness of dentin on the pulpal floor or axial wall of a deep preparation (indirect pulp cap) or directly over a small exposure of the pulp (direct pulp cap) to protect the pulp from external influences.

**Sclerotic Dentin:** A dentinal formation occurring ahead of the demineralization front of a slowly advancing carious lesion. It may be shiny and dark in color. It feels hard and impenetrable with an explorer.

**Sealant:** For purposes of the WREB Exam, a sealant is considered to be a restorative material.

**Unsound Demineralized Enamel:** Enamel characterized by a decrease or loss of mineral constituents resulting in coloration that can range from white to dark brown. Color variation alone does not warrant removal of the affected area; there must be tactile evidence that the enamel is unsound. Unsound demineralized enamel is tactically different from the adjacent unaffected enamel and should be removed.

**Reference Material**

OPERATIVE SCORING

If you are successful, (3.00 or higher), on the first procedure, the section is passed, with no need to complete another procedure. If the first procedure scores below a 3.00, and no critical error has been recorded, you may proceed with a second procedure, which will be averaged with the first procedure. For states requiring two operative procedures, Candidates will have the option to complete a second procedure, even if the first procedure scored above a 3.00. If two procedures are completed, the two procedure scores will be averaged. The average of the two procedure scores must be 3.00 or higher to pass the section. If a second procedure is completed and the average scores below 3.00, the Operative Section is failed. No onsite retakes are available for the Operative Section.

The Operative Exam is graded by three independent Grading Examiners. Grading Examiners grade according to the Operative Scoring Criteria Rating Scales on pages 54-57. The recorded score for each category is based on the median (middle) score of the three (3) scores assigned by the Grading Examiners. The median grades are then weighted and summed for the preparation and finish respectively, then averaged for the total procedure score.

<table>
<thead>
<tr>
<th>PREPARATION WEIGHTING</th>
<th>FINISH WEIGHTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline and Extension:</td>
<td>46%</td>
</tr>
<tr>
<td>Internal Form:</td>
<td>39%</td>
</tr>
<tr>
<td>Operative Environment:</td>
<td>15%</td>
</tr>
<tr>
<td>Anatomical Form:</td>
<td>36.5%</td>
</tr>
<tr>
<td>Margins:</td>
<td>36.5%</td>
</tr>
<tr>
<td>Finish, Function and Damage:</td>
<td>27%</td>
</tr>
</tbody>
</table>

SCORE DEDUCTIONS

<table>
<thead>
<tr>
<th>Patient Submission Rejection (Validated by two or more Grading Examiners.)</th>
<th>= 0.3 deducted per rejected submission from the applicable preparation score. Maximum 0.6 deduction.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulp Exposure (Recognized by a Candidate or Floor Examiner or found during grading and validated by the Grading Examiners.)</td>
<td>= 0.5 deducted from the applicable preparation score.</td>
</tr>
<tr>
<td>Modification Request Not Appropriate (Validated by two or more Grading Examiners.)</td>
<td>= 0.5 deducted for each modification request validated not appropriate from the applicable preparation score. No maximum.</td>
</tr>
</tbody>
</table>
**LATE PENALTIES**

<table>
<thead>
<tr>
<th>Time Range</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 minutes late</td>
<td>0.2 deduction</td>
</tr>
<tr>
<td>6 to 10 minutes late</td>
<td>0.4 deduction</td>
</tr>
<tr>
<td>11 to 15 minutes late</td>
<td>0.6 deduction</td>
</tr>
<tr>
<td>16 or more minutes late</td>
<td>The applicable preparation or finish will not be graded. No points earned.</td>
</tr>
</tbody>
</table>

**UNUSUAL SITUATIONS**

- Preparing the wrong surface or surface that has not been approved. (If the wrong surface is prepared, the original accepted lesion must be included in the preparation.)
  - Loss of all points for outline and extension and internal form
- After patient submission is accepted, (by Grading Examiners, or by a Floor Examiner if provisionally accepted), Candidate fails to complete the approved treatment on the tooth.
  - 0.3 deduction from the applicable preparation score
- Failing to submit a patient to the grading area for review of a modification request after instructed to do so by a Floor Examiner.
  - Loss of all points for the preparation

**CRITICAL ERRORS**

The following critical errors result in failure and immediate termination of the Operative Section for the Candidate. The Candidate cannot proceed to a second procedure:

- Caries Remaining (validated by two or more Grading Examiners)
- Preparing a tooth without acceptance
- Preparing the wrong tooth
- Restoring an operative procedure with a material other than what has been approved at acceptance (e.g., tooth accepted for an amalgam and restored with composite or vice versa)
<table>
<thead>
<tr>
<th>5—Optimal</th>
<th>4—Appropriate</th>
<th>3—Acceptable</th>
<th>2—Inadequate</th>
<th>1—Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline is generally smooth and flowing, and does not weaken tooth in any manner.</td>
<td>Outline is slightly irregular, but does not weaken tooth. Isthmus is slightly wider than required for lesion.</td>
<td>Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion.</td>
<td>Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit. Unsound demineralized enamel that is tactilely different from the adjacent unaffected enamel is present.</td>
<td>Outline is grossly improper and/or lacks any definite form. Tactilely unsound demineralized enamel penetrates the DEJ. Caries remains in the enamel or is not completely accessed. Unapproved surface prepared.</td>
</tr>
<tr>
<td>Proximal and gingival extensions are visually open and break contact up to 1.0 mm.</td>
<td>Proximal and/or gingival extensions are slightly overextended.</td>
<td>Proximal and/or gingival extensions are moderately overextended.</td>
<td>Proximal and/or gingival extensions are in contact or obviously overextended.</td>
<td>Proximal and/or gingival extensions are grossly overextended.</td>
</tr>
<tr>
<td>Optimal treatment of fissures.</td>
<td>Near optimal treatment of fissures.</td>
<td>Adequate treatment of fissures. Neither the tooth nor restoration is compromised.</td>
<td>Inadequate treatment of fissures will compromise the tooth or restoration. Lack of treatment of fissures will seriously compromise the tooth and restoration.</td>
<td>Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.</td>
</tr>
<tr>
<td>Proximal cavosurface angles are equal to or slightly greater than 90°. The integrity of both tooth and restoration is maintained.</td>
<td>Cavosurface angles are not optimal, but do not compromise the integrity of the tooth or restoration. Cavosurface has small areas of minor roughness.</td>
<td>Cavosurface angles possibly compromise the integrity of the tooth or restoration. Cavosurface is moderately rough, but will not adversely affect the final restoration.</td>
<td>Improper cavosurface angles or rough cavosurface will cause the final restoration to fail.</td>
<td>Cavosurface angles are grossly improper. Cavosurface has multiple major areas of roughness and/or enamel weakness that will cause the restoration to fail.</td>
</tr>
<tr>
<td>Pulpal floor depth as determined by the lesion or defect does not exceed 2.0 mm from the cavosurface. Enamel may remain on the pulpal floor. Axial wall depth at the gingival floor is 1.0 mm.1.5 mm.</td>
<td>Pulpal floor and/or axial wall is slightly shallow or deep.</td>
<td>Pulpal floor and/or axial wall is moderately shallow or deep.</td>
<td>Pulpal floor and/or axial wall is critically shallow or critically deep. Affected dentin remains. Indirect pulp cap declared when no caries or affected dentin remains.</td>
<td>Wall(s) and/or floors are grossly deep with total lack of concern for the pulp. Caries remains in the dentin or is not completely accessed. Unapproved surface prepared.</td>
</tr>
<tr>
<td>Conventional design; Internal form is smooth and flowing and has no sharp angles that could weaken or cause voids in the final restoration. Slot design: Proximal box is present. Proximal line angles are ideal.</td>
<td>Conventional design; Internal form is mostly smooth and flowing, but some minor roughness and/or sharp angles are present. Slot design: Proximal box is present. Proximal line angles are slightly more or less rounded than ideal.</td>
<td>Conventional design; Internal form is generally smooth and flowing, but some moderate roughness and/or sharp angles are present. Slot design: Proximal box form has moderate variation from ideal.</td>
<td>Conventional design; Internal form is rough and unfinished with major areas of roughness or sharp angles that will lead to restoration failure. Slot design: There is excessive rounding of all line angles. Excessive deviation from ideal proximal box form.</td>
<td>Conventional design; Internal form is grossly rough and/or has gross sharp angles that will lead to restoration failure. Slot design: There is gross lack of internal form.</td>
</tr>
<tr>
<td>Rubber dam isolation is stable and optimal; the dam is inverted and has no rips, tears, bunching or exposed tissue. The preparation is clean and dry.</td>
<td>Rubber dam isolation is not optimal, but the preparation is clean and dry.</td>
<td>Rubber dam isolation is adequate, but the wrong teeth are isolated. The preparation can be cleaned and dried.</td>
<td>Rubber dam isolation is inadequate. The preparation is difficult to access or visualize due to blood or saliva on the preparation or partial coverage by the dam.</td>
<td>The rubber dam is grossly sloppy and torn, or portions of the preparation are not visible due to blood, saliva, or improper isolation.</td>
</tr>
<tr>
<td>No damage to the adjacent tooth.</td>
<td>Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.</td>
<td>Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.</td>
<td>Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.</td>
<td>Damage to the adjacent tooth will definitely require restoration.</td>
</tr>
<tr>
<td>5-Optimal</td>
<td>4-Appropriate</td>
<td>3-Acceptable</td>
<td>2-Inadequate</td>
<td>1-Unacceptable</td>
</tr>
<tr>
<td>------------------------------------------------</td>
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<td>---------------------------------------------------</td>
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<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Outline provides optimal access for caries removal and insertion of restorative material.</td>
<td>Outline is slightly over or under extended.</td>
<td>Outline is moderately over or under extended, but does not weaken the tooth.</td>
<td>Outline is severely over or underextended.</td>
<td>Outline is grossly improper and/or lacks any definite form.</td>
</tr>
<tr>
<td>Gingival extension is visually open up to 0.5 mm. Facial (or lingual) extension may break proximal contact up to 0.5 mm.</td>
<td>Gingival is slightly irregular, but does not weaken the tooth.</td>
<td>Gingival wall is in contact or obviously overextended.</td>
<td>Gingival margin is moderately overextended.</td>
<td>Gingival wall is grossly overextended.</td>
</tr>
<tr>
<td>Incisal contact is not broken.</td>
<td>Cavo-surface is slightly irregular and rough.</td>
<td>Cavo-surface is moderately irregular and rough. A few sharp angles are present.</td>
<td>Cavo-surface is severely irregular and/or with sharp angles.</td>
<td>Cavo-surface has multiple gross irregularities and/or enamel weaknesses that will cause the restoration to fail.</td>
</tr>
<tr>
<td>Cavo-surface forms a smooth continuous curve with no sharp angles.</td>
<td>Cavo-surface angles are not optimal, but do not compromise the integrity of the tooth or restoration.</td>
<td>Cavo-surface angles possibly compromise the integrity of the tooth or restoration.</td>
<td>Cavo-surface angles will lead to enamel fracture or fracture of the restoration.</td>
<td>Cavo-surface angles are grossly inappropriate for the situation and will lead to fracture of the restoration.</td>
</tr>
<tr>
<td>There are no acute cavo-surface angles.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Axial wall follows external contour of tooth.</td>
<td>Axial wall generally follows external contour of tooth.</td>
<td>Axial wall does not follow contour of tooth.</td>
<td>Axial wall depth exceeds 2.0 mm beyond the DEJ.</td>
<td>Gross removal of tooth structure jeopardizes the health of the tooth.</td>
</tr>
<tr>
<td>Depth does not exceed 1.0 mm beyond the DEJ.</td>
<td>Depth does not exceed 1.5 mm beyond the DEJ.</td>
<td>Depth does not exceed 2.0 mm beyond the DEJ.</td>
<td>Depth does not exceed 2.0 mm beyond the DEJ.</td>
<td>Depth does not exceed 2.0 mm beyond the DEJ.</td>
</tr>
<tr>
<td>Internal line angles are rounded and smooth. Internal walls are well defined and rounded, but have some slight irregularities.</td>
<td>Internal walls are well defined and rounded, but have some slight irregularities.</td>
<td>Internal walls are rounded, but moderately rough, irregular, and not defined.</td>
<td>Internal walls are severely irregular and not defined.</td>
<td>Internal walls are severely irregular and not defined.</td>
</tr>
<tr>
<td>Operative environment: Rubber dam isolation is stable and optimal; the dam is inverted and has no rips, tears, bunching or exposed tissue. The preparation is clean and dry.</td>
<td>Rubber dam isolation is not optimal, but the preparation is clean and dry.</td>
<td>Rubber dam isolation is adequate, but the wrong teeth are isolated.</td>
<td>Rubber dam isolation is inadequate. The preparation is difficult to access or visualize due to blood or saliva on the preparation or partial coverage over the dam.</td>
<td>The rubber dam is grossly sloppy and torn, or portions of the preparation are not visible due to blood, saliva, or improper isolation.</td>
</tr>
<tr>
<td>No damage to the adjacent tooth.</td>
<td>Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.</td>
<td>Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.</td>
<td>Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.</td>
<td>Damage to the adjacent tooth will definitely require restoration.</td>
</tr>
<tr>
<td>DIRECT POSTERIOR CLASS II – AMALGAM PREPARATION</td>
<td>SCORING CRITERIA RATING SCALE</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OUTLINE &amp; EXTENSION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5—Optimal</strong></td>
<td><strong>4—Appropriate</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline is generally smooth and flowing, and does not weaken tooth in any manner.</td>
<td>Outline is slightly irregular, but does not weaken tooth. Esmarch is slightly wider than required for insertion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximal and gingival extensions are visually open and break contact up to 1.0 mm.</td>
<td>Proximal and/or gingival extensions are slightly overextended.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximal cavi-surface angles are approximately 90°. The integrity of both tooth and restoration is maintained.</td>
<td>Cavi-surface angles are not optimal, but do not compromise the integrity of the tooth or restoration. Cavi-surface has small areas of minor roughness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximal walls are clearly convergent obliquely.</td>
<td>Proximal walls are barely convergent obliquely.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Axial wall and/or pulpal floor is 1.5 mm-2.0 mm from the cavi-surface and provides adequate bulk for strength of restorative material. Axial wall depth at the gingival floor is 1.0 mm-1.5 mm.</td>
<td>Axial wall and/or pulpal floor is critically shallow or deep, or does not provide adequate bulk for strength of restorative material.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional design: Internal form is smooth and has no sharp angles. Retentive grooves, if placed, are near ideal. Axial wall follows external contour of the tooth. Slot design: Proximal box is present, Axial wall contour is near optimal. Retentive grooves extend from gingival floor up to, or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.</td>
<td>Conventional design: Internal form is smooth, but some minor roughness. Retentive grooves, if placed, are adequate. Axial wall contour is near optimal. Slot design: Proximal box is present, Axial wall contour is near optimal. Retentive grooves are minimal and extend up to and including the occlusal surface.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional design: Internal form is smooth and has no sharp angles. Retentive grooves, if placed, are near ideal. Axial wall follows external contour of the tooth. Slot design: Proximal box is present, Axial wall contour is near optimal. Retentive grooves extend from gingival floor up to, or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.</td>
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<td></td>
</tr>
<tr>
<td><strong>INTERNAL FORM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2—Inadequate</strong></td>
<td><strong>1—Unacceptable</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit. Unsound demineralized enamel that is tactilely different from the adjacent unaffected enamel is present.</td>
<td>Outline is grossly improper and/or lacks any definite form. Tactilely unsound demineralized enamel penetrates the DEJ. Cases remains in the enamel or is not completely accessed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unapproved surface prepared.</td>
<td>Unapproved surface prepared.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OPERATIVE ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No damage to the adjacent tooth. Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.</td>
<td>Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubber dam isolation is stable and optimal; the dam is inverted and has no gifts, tears, bunching or exposed tissue. The preparation is clean and dry.</td>
<td>Rubber dam isolation is inadequate. The preparation is difficult to access or visualize due to blood or saliva on the preparation or partial coverage by the dam.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubber dam isolation is not optimal, but the preparation is clean and dry.</td>
<td>Rubber dam isolation is inadequate. The preparation is not optimal, but the preparation is clean and dry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>Damage to the adjacent tooth will be difficult to polish out and still maintain appropriate proximal contour. The adjacent tooth will likely require restoration.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Damage to the adjacent tooth will definitely require restoration.</td>
<td>Damage to the adjacent tooth will definitely require restoration.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
## DIRECT FINISH

### SCORING CRITERIA RATING SCALE

<table>
<thead>
<tr>
<th></th>
<th>5—Optimal</th>
<th>4—Appropriate</th>
<th>3—Acceptable</th>
<th>2—Inadequate</th>
<th>1—Unacceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANATOMICAL FORM</strong></td>
<td>Anatomical form is consistent and harmonious with contiguous tooth structure.</td>
<td>Slight variation in normal anatomical form is present.</td>
<td>Moderate variation in normal anatomical form is present.</td>
<td>Anatomical form is improper. Marginal ridge is poorly shaped.</td>
<td>There is gross lack of anatomical form.</td>
</tr>
<tr>
<td></td>
<td>Proper proximal contour and shape are restored.</td>
<td>There is slight variation of proximal contour and shape.</td>
<td>There is moderate variation of proximal contour and shape.</td>
<td>Proximal contour is poor. Embasures are severely over or under contoured.</td>
<td>Grossly improper proximal contour or shape.</td>
</tr>
<tr>
<td></td>
<td>Normal proximal contact area and position are restored.</td>
<td>There is slight variation of normal contact area and position.</td>
<td>There is moderate variation of normal contact area and position.</td>
<td>Contact is visually open, or floss will not pass through the contact.</td>
<td>Contact is grossly open, or the contact area is bonded to the adjacent tooth.</td>
</tr>
<tr>
<td></td>
<td>Contact is visually closed and resists the passage of lightly waxed floss.</td>
<td>Lightly waxed floss will pass through the contact with slight resistance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MARGINS</strong></td>
<td>There are no excesses or deficiencies anywhere along margins.</td>
<td>Slight marginal excesses and/or deficiencies are present.</td>
<td>Moderate marginal excesses and/or deficiencies are present.</td>
<td>A deep open margin is present, or critical excesses or deficiencies are present.</td>
<td>Multiple open margins, or gross excesses, or deficiencies, are present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A marginal overhang catches floss.</td>
<td>A gross marginal overhang sheds floss.</td>
</tr>
<tr>
<td><strong>FINISH, FUNCTION &amp; DAMAGE</strong></td>
<td>The surface is smooth with no pits, voids or irregularities.</td>
<td>Slight surface irregularities, pitting, or voids are present.</td>
<td>Moderate surface irregularities, pitting, or voids are present.</td>
<td>Critical surface irregularities, pitting, or voids are present.</td>
<td>Gross surface defects are present and/or the restoration is grossly fractured.</td>
</tr>
<tr>
<td></td>
<td>Occlusion is restored to proper centric with no lateral interferences.</td>
<td></td>
<td></td>
<td>There is severe hyperocclusion in centric or lateral excursions.</td>
<td>Occlusion is grossly inadequate.</td>
</tr>
<tr>
<td></td>
<td>There is no damage to hard or soft tissue.</td>
<td>Minor damage to hard or soft tissue is evident.</td>
<td>Moderate damage to hard or soft tissue is evident.</td>
<td>Severe damage to hard or soft tissue is evident.</td>
<td>Gross mutilation of hard or soft tissue is evident.</td>
</tr>
</tbody>
</table>
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Posterior Composite Worksheet
Direct Posterior Class II

Candidate ID#: __________

☐ 2nd Submission  ☐ 3rd Submission

Patient’s First Name: ___________________  Tooth #: __________  ☐ DO  ☐ MO  ☐ MOD  ☐ MO & DO  ☐ Other: __________

☐ Radiographs submitted on computer

Referred for Clinical Review By: __________

☐ ACCEPTANCE

Note to Examiners (If necessary)

Accepted By: __________

Accepting Examiner Initials: __________

Modification Request – (Floor Examiner may instruct you to proceed or may send your patient back to the grading area.)

Indicate:

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☐ PREPARATION GRADE

Note to Examiners (If necessary)

Preparation Graded: __________

Grading Examiner Initials: __________

DISMISSAL FOR THE DAY – Approval by Floor Examiner required if: ☐ Material not placed; temporary in place; or ☐ Treatment approved; not started

Clinic Day 1: __________  Floor Examiner: __________

Clinic Day 2: __________  Floor Examiner: __________

☐ FINISH RESTORATION GRADE  ☐ Slot Design

Note to Examiners (If necessary)

Finish Graded: __________

Grading Examiner Initials: __________

Patient may be released from the exam: __________

Floor Examiner: __________

2020 – Revised

Record Medications Taken Today and Local Anesthetic Administered for this Procedure on Reverse.
Back

Medications Taken by Patient Today

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<th>Drug Name and Concentration</th>
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Local Anesthetic Administered for this Procedure

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Checklist of Required Items

**Submitting Patient for Acceptance**
- Worksheet with radiographs
  - Box checked for “Acceptance”
  - Candidate ID # in the upper right corner
  - Patient’s first name
  - Tooth number and surface to restore
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered
- Completed Patient Medical History/Patient Consent Form
  - Pulse and blood pressure
  - Floor Examiner initials
  - Patient procedure(s)
  - Patient address and signature
- Patient tray
- 40 micron Articulating Paper on Miller Type forceps
- Floss Singles
- Candidate ID # label on patient bib
- Patient eye protection

**Submitting Patient for a Modification Request**
- Worksheet with radiographs
  - Medication taken, # cartridges local anesthetic administered (updated as needed)
- Notes to Examiners on the worksheet
  - Type of modification
  - Location of modification
  - Exact extent of modification
  - Reason the modification is needed
- Completed Patient Medical History/Patient Consent Form (If Provisionally Accepted)
- Rubber dam in place
- Patient tray
- Candidate ID # label on patient bib
- Patient eye protection
- Call 2nd Floor Examiner

**Submitting Patient for Preparation Grade**
- Worksheet with radiographs
  - Box checked for “Preparation Grade”
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered
- Completed Patient Medical History/Patient Consent Form (If Provisionally Accepted)
- Rubber dam in place
- Patient tray
- Candidate ID # label on patient bib
- Patient eye protection

**Submitting Patient for Finish Restoration Grade (No rubber dam)**
- Worksheet with radiographs
  - Box checked for “Finish Restoration Grade”
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered
- Patient tray
  - Add Miller Type Articulating Paper Forceps
- Candidate ID # label on patient bib
- Patient eye protection

**Patient Tray for All Procedures**
- Instruments
  - New #4 or #5 metal front surface mouth mirror
  - New pigtails explorer
  - New shepherd’s hook explorer
  - Three 2”x2” gauze pads
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray
Composite Worksheet
Direct Anterior Class III

☐ 2nd Submission  ☐ 3rd Submission  Candidate ID#: ____________

Patient's First Name: ___________________________  Tooth #: ________  ☐ ML  ☐ DL  ☐ MF  ☐ DF  ☐ Other

If the patient above is replacing a provisionally accepted patient, please provide first name, tooth #, and surfaces of patient being replaced.

☐ Radiographs submitted on computer

☐ ACCEPTANCE

Referred for Clinical Review By: ____________

Note to Examiners (if necessary)

Accepted By: ____________

Accepting Examiner Initials: __________________

Modification Request – (Floor Examiner may instruct you to proceed or may send your patient back to the grading area.)

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☐ PREPARATION GRADE

Note to Examiners (if necessary)

Preparation Graded: __________________

Grading Examiner Initials: __________________

DISMISSAL FOR THE DAY – Approval by Floor Examiner required if: ☐ Material not placed; temporary in place; or ☐ Treatment approved; not started

Clinic Day 1: __________________  Floor Examiner: __________________

Clinic Day 2: __________________  Floor Examiner: __________________

☐ FINISH RESTORATION GRADE  ☐ Slot Design

Note to Examiners (if necessary)

Finish Graded: __________________

Grading Examiner Initials: __________________

Patient may be released from the exam: __________________

Floor Examiner: __________________

2020 – Revised

Record Medications Taken Today and Local Anesthetic Administered for this Procedure on Reverse.
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Submitting Patient for Acceptance

- Worksheet with radiographs
  - Box checked for "Acceptance"
  - Candidate ID # in the upper right corner
  - Patient's first name
  - Tooth number and surface to restore
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered

- Completed Patient Medical History/Patient Consent Form
  - Name of patient
  - Date of birth
  - Address and signature

- Patient tray
- 40-micron Articulating Paper on Miller Type Forceps
- Floss Singles
- Candidate ID # label on patient bib
- Patient eye protection

Submitting Patient for a Modification Request

- Worksheet with radiographs
  - Medication taken, # cartridges local anesthetic administered (updated as needed)

- Notes to Examiners on the worksheet
  - Type of modification
  - Location of modification
  - Exact extent of modification
  - Reason the modification is needed

- Completed Patient Medical History/Patient Consent Form (If Provisionally Accepted)
- Rubber dam in place
- Patient tray
- Candidate ID # label on patient bib
- Patient eye protection
- Call a Floor Examiner

Submitting Patient for Preparation Grade

- Worksheet with radiographs
  - Box checked for "Preparation Grade"
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered

- Completed Patient Medical History/Patient Consent Form (If Provisionally Accepted)
- Rubber dam in place
- Patient tray
- Candidate ID # label on patient bib
- Patient eye protection

Submitting Patient for Finish Restoration Grade (No rubber dam)

- Worksheet with radiographs
  - Box checked for "Finish Restoration Grade"
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered

- Patient tray
  - Add Miller Type Articulating Paper Forceps
- Candidate ID # label on patient bib
- Patient eye protection

Patient Tray for All Procedures

- Instruments
  - New #4 or #5 front surface metal mouth mirror
  - New pigtail explorer
  - New shepherd's hook explorer
  - Three 2"x2" gauze pads

- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray
Amalgam Worksheet
Direct Posterior Class II

Candidate ID#:__________

Patient's First Name:_________________ Tooth #:_________ □ DO □ MO □ MOD □ MO & DO □ Other__________

If the patient above is replacing a provisionally accepted patient, please provide first name, tooth #, and surfaces of patient being replaced.

☐ Radiographs submitted on computer

☐ ACCEPTANCE

Referred for Clinical Review By:______________

Note to Examiners (if necessary)

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Accepting Examiner Initials

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☐ PREPARATION GRADE

Preparation Graded:______________

Note to Examiners (if necessary)

Grading Examiner Initials

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Clinic Day 1:_________________ Floor Examiner___________

Clinic Day 2:_________________ Floor Examiner___________

☐ FINISH RESTORATION GRADE □ Slot Design

Finish Graded:______________

Note to Examiners (if necessary)

Grading Examiner Initials

Patient may be released from the exam:

Floor Examiner

2020 – Revised

Record Medications Taken Today and Local Anesthetic Administered for this Procedure on Reverse.
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- [ ] Patient tray
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- [ ] Floss Singles
- [ ] Candidate ID # label on patient bib
- [ ] Patient eye protection

### Submitting Patient for Preparation Grade
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### Submitting Patient for Finish Restoration Grade (No rubber dam)
- [ ] Worksheet with radiographs
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  - Notes to Examiners, if needed
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### Patient Tray for All Procedures
- [ ] Instruments
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- [ ] Instruments must be in an open autoclave bag
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