Mission Statement

The mission of WREB is to develop and administer competency assessments for State agencies that license dental professionals.
# TABLE OF CONTENTS

**GENERAL INFORMATION** ......................................................................................................................1

- Welcome to the WREB Dental Exam ........................................................................................................1
- WREB Exam Security and Identification Verification ........................................................................1
- Malpractice Insurance .............................................................................................................................2
- Exam Content: Required Sections ........................................................................................................3
- Exam Content: Elective Sections ............................................................................................................3
- Passing Requirements ............................................................................................................................4
- Remediation ............................................................................................................................................4
- Scoring Information ...............................................................................................................................5
- Provisional Results ..................................................................................................................................7
- Final Results ............................................................................................................................................7
- Testing Candidates with Disabilities ......................................................................................................8
- Dismissal for Improper Performance or Unethical Conduct ...............................................................8
- Clinical Examination Overview .........................................................................................................9
- Schedule Overview ...............................................................................................................................9
- Candidate Clinic Schedule (Operative and Perio Procedures) ..........................................................10
- Simulation Lab Schedule (Endodontic and Prosthodontic Procedures) ...........................................11
- Onsite Retakes .....................................................................................................................................11
- Sample Exam Schedule ......................................................................................................................12
- Sample Schedule ...............................................................................................................................12
- Late Penalties .......................................................................................................................................13
- Exam Personnel and Anonymity ..........................................................................................................13
- General Guidelines ...........................................................................................................................14
- Infection Control Guidelines .............................................................................................................15
- Dental Assistants ..............................................................................................................................16
- Equipment and Materials ...................................................................................................................17
- Scoring Criteria and Patient Welfare ..............................................................................................18
- Patient Selection ...............................................................................................................................19
- Radiographs .........................................................................................................................................19
- Authentication/Security ......................................................................................................................21
- Alteration of Radiographs ..................................................................................................................23
- Exam Preparation Materials .............................................................................................................23

**OPERATIVE** .........................................................................................................................................28

- Operative Section Overview .............................................................................................................28
- Case Selection Criteria .......................................................................................................................28
- Patient Acceptance at the Exam Site .................................................................................................31
- Provisional Acceptance .......................................................................................................................36
- Definitions ...........................................................................................................................................39
- Cavity Preparation .............................................................................................................................41
- Modification Procedure .....................................................................................................................42
- The Preparation Grade ......................................................................................................................44
- “Dismissal for the Day” Approval ....................................................................................................45
- The Finish Grade ...............................................................................................................................46
- Releasing Your Patient .......................................................................................................................47
BE SURE TO VISIT US ONLINE at wreb.org for a complete preparation and understanding of the WREB examination process. This information supplements this Candidate Guide and is made available to you for a successful outcome!

<table>
<thead>
<tr>
<th>Information for Dental Candidates</th>
<th>Current Publications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exam Locations, Schedule, and Fees</td>
<td>• Current Newsletters</td>
</tr>
<tr>
<td>• Site Information</td>
<td>• Published Articles, Position Papers</td>
</tr>
<tr>
<td>• Policies and Procedures</td>
<td></td>
</tr>
<tr>
<td>• Application Process</td>
<td></td>
</tr>
<tr>
<td>• CTP Exam Candidate Guide</td>
<td></td>
</tr>
<tr>
<td>• CTP Exam Candidate Tutorial</td>
<td></td>
</tr>
<tr>
<td>• Clinical Candidate Guide</td>
<td></td>
</tr>
<tr>
<td>• Clinical Exam Candidate Preparation Tutorials</td>
<td></td>
</tr>
<tr>
<td>• Exam Forms</td>
<td></td>
</tr>
<tr>
<td>• Special Accommodations Information</td>
<td></td>
</tr>
<tr>
<td>• Cancellations and Refunds Policy</td>
<td></td>
</tr>
<tr>
<td>• Request Score Reports/Exam Information</td>
<td></td>
</tr>
<tr>
<td>• Appeals Policy and Forms</td>
<td></td>
</tr>
<tr>
<td>• Frequently Asked Questions and Advice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Information</th>
<th>Links and Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>• WREB’s Mission Statement</td>
<td>• Member State Boards</td>
</tr>
<tr>
<td>• History of WREB</td>
<td>• WREB Acceptance and Exam Locations</td>
</tr>
<tr>
<td>• Member State Boards</td>
<td>• Prometric Test Centers for CTP Exam</td>
</tr>
<tr>
<td>• List of States Accepting WREB</td>
<td></td>
</tr>
<tr>
<td>• Frequently Asked Questions and Advice</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Us</th>
</tr>
</thead>
<tbody>
<tr>
<td>WREB</td>
</tr>
<tr>
<td>23460 North 19th Avenue, Suite 210</td>
</tr>
<tr>
<td>Phoenix, AZ 85027</td>
</tr>
<tr>
<td>Telephone: (623) 209-5400</td>
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<tr>
<td>Facsimile: (602) 371-8131</td>
</tr>
<tr>
<td>Email: <a href="mailto:dentalinfo@wreb.org">dentalinfo@wreb.org</a></td>
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</table>
GENERAL INFORMATION

Welcome to the WREB Dental Exam

This Candidate Guide provides information needed for taking the dental exam. Study this Guide carefully. You may refer to this Guide during the exam. Please also visit the WREB website at wreb.org for complete preparation and understanding of the WREB examination process.

The WREB Exam is developed, administered and reviewed in accordance with applicable guidelines from the American Dental Association, the American Association of Dental Boards, the American Psychological Association, the National Council on Measurement in Education and the American Educational Research Association. The exam is developed to provide a reliable clinical assessment for state boards’ use in making valid licensing decisions.

Since WREB member states cover a large geographical region and Candidates come from an even larger area, efforts have been made to make the exam unbiased with respect to regional practice and educational differences. WREB seeks educational diversity in the makeup of the exam review committees, including practitioners and educators who evaluate test content and develop the scoring criteria.

WREB Examiners are experienced practitioners from diverse backgrounds and locations. They are calibrated and tested prior to each exam. After the calibration training, Examiners are individually evaluated to assure they are able to grade according to the established criteria.

All official WREB documents contain the WREB logo. Schools or other individuals may prepare forms and schedules to assist Candidates. However, these documents are not authorized by WREB and may contain inaccurate information. WREB does not sponsor nor endorse examination preparation courses.

You bear all risk for any misunderstanding resulting from the use of or reliance on unofficial information or material.

WREB Exam Security and Identification Verification

You MUST present acceptable and valid identification (ID), as described below, in order to be admitted to the WREB Dental Exam. NOTE: If you have questions about the following identification requirements, you should contact the WREB Dental Department BEFORE attending the exam.

You must provide a personal photo during the exam registration process. This becomes a component of your individual Candidate Profile at WREB and will be included on all score reports to schools and state licensing boards. Your profile photo is used to create an individual WREB Candidate ID Badge for the exam. This profile photo and the identification verification document will be used to verify your identity at the exam by WREB personnel. Identification must be verified prior to admittance to any WREB clinical examination.

Orientation Day, you must appear in person and provide two (2) valid, non-expired forms of identification, one of which must be primary and one may be secondary.
Primary ID must have your photo and your signature. Acceptable forms of primary ID are:

- Government-issued driver’s license
- Passport
- Military ID
- Alien registration card
- Government-issued ID
- Employee ID
- School ID (must have either an expiration date – and be current or have a current date of school year)

Secondary ID must have your name and signature. Acceptable forms of secondary ID are:

- Social Security card
- Bank credit card
- Bank ATM card
- Library card

Make sure your IDs are current and indicate the same name you submitted to the WREB office. This is very important for allowing your admittance to the examination.

At any time during the exam, you may be asked and should be prepared to present the primary ID and WREB Candidate ID Badge to a School Coordinator, Site Coordinator, Auxiliary Coordinator, or Floor Examiner.

Admittance to the exam does not imply that the identification you presented was valid. If it is determined that your ID was fraudulent or otherwise invalid, WREB will report to the appropriate governing agencies or board. Any Candidate or other individual who has misrepresented information or altered documentation in order to fraudulently attempt an exam, will be subject to dismissal from the clinical exam.

**Malpractice Insurance**

AAIC Insurance Company, through the Professional Protector Plan in cooperation with WREB, will extend WREB professional liability coverage with the limit amounts of $1,000,000/$3,000,000 for the patient-based portion of the calendar year 2019 dental exam at no charge to the Candidates. WREB will forward the names and addresses of all Candidates to AAIC.
Exam Content: Required Sections

For this exam, you are required to complete the following:

Comprehensive Treatment Planning (CTP) – A three (3) hour computer-based exam using case materials provided by WREB. The exam is administered through Prometric Testing Centers. The exam consists of three (3) patient cases of varying complexity, one of which is a pediatric patient. For each case, Candidates assess patient history, photographs, radiographs, and clinical information; create and submit a treatment plan; and then answer questions related to each case.

Operative – Up to two restorative procedures on patients to demonstrate competence.

A Class II restoration must be completed to pass the WREB Exam. The restoration can be 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)
  • Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)

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)
  • Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)
  • A Direct Anterior Class III Composite Restoration (ML, DL, MF, DF)

Endodontics – A three (3) hour exam consisting of two (2) procedures:
  1. Anterior Tooth Procedure: Treat one maxillary central incisor simulated tooth, including access, instrumentation, and obturation.

Exam Content: Elective Sections

You may also elect to complete the following, (if the state(s) to which you are applying for licensure requires them):

Periodontal Treatment – A patient is submitted for approval, then root planing and scaling are completed and the patient is submitted for grading.
Prosthodontics – A three and one-half (3.5) hour exam consisting of two (2) procedures on simulated teeth:

1. Preparation of two abutments to support a posterior three-unit fixed partial denture prosthesis.
2. Preparation of an anterior tooth for a full-coverage crown.

In addition to the evaluation of clinical abilities, diagnostic and professional judgment are also factors considered in the evaluation. For example, you are expected to know when a tooth requires a restoration, as well as the extent of restoration required.

Additional details for Operative, Endodontics, Periodontal Treatment, and Prosthodontics are provided later in this Guide. Additional details for Comprehensive Treatment Planning (CTP) are available in the CTP Exam Candidate Guide.

Passing Requirements

Completion of the core exam requires passing the three sections Operative, Endodontics, and CTP within twelve (12) months. The twelve (12) month window begins with the first attempt at the clinical exam. The clinical exam must be attempted within the same exam year as the CTP Section. The CTP Section is typically taken in the fall prior to the clinical exam. For example, if a 2019 CTP Section is taken (registered with a 2019 clinical exam), the first attempt at the clinical exam must be in 2019. If any of the three core sections is failed, the WREB Exam is failed until the failed section(s) is/are passed within the required twelve (12) month period. If the failed section(s) is/are not passed within twelve (12) months, all three core sections must be taken again.

The two core clinical sections of the exam, (Operative and Endodontics), must be taken together. Failure to complete both sections results in failure of the exam. If both sections are failed, the two must be retaken together. Failure of one clinical section allows the opportunity to retake just the failed section within the twelve (12) month window. Exceptions to this policy will apply when the twelve (12) month period spans different testing years and significant changes to the exam occur.

Results for all sections attempted, (core and elective), whether passing or failing, will be reported to state boards. This includes initial, retake, and onsite retake attempts.

State boards vary on section, procedure, and scoring requirements. You are responsible for knowing the licensing requirements of the state where you plan to practice.

Remediation

If you fail any section of the exam, (core or elective), three (3) times, you are required to obtain formal remediation in the areas of failure prior to a fourth attempt. Upon failing a section a fourth time, additional remediation is required. WREB will specify the required hours of remediation. Individual states may have more stringent requirements for remediation. If you have failed any section of the exam two or more times, you should contact the state in which you are seeking licensure to obtain the state requirements.
Scoring Information

Operative, Endodontics, Prosthodontics, and Comprehensive Treatment Planning (CTP): These sections are scored based on a Rating Scale of 1 to 5 where a final score of three (3.00) or higher is required to pass. The value of three (3.00) is defined to reflect minimally competent performance for all scoring criteria, and can be interpreted as corresponding to 75% in states where the passing level is legislated as 75%. The Operative, Endodontics, Prosthodontics, and CTP sections are rated independently by three Grading Examiners. Candidates receive the median (or middle) rating of the three ratings assigned by the Grading Examiners for each category. Median Examiner ratings are multiplied by assigned category weights. Weighted ratings (less any deductions) are added to obtain the score for the Endodontic Section. For Operative, Prosthodontics, and CTP, weighted ratings (less any deductions) are added to obtain scores for each procedure or patient case, and then averaged to obtain the overall section score. Criteria definitions for rating scales, category weights, possible deductions, and other scoring details are available on pgs. 48-49, 73-74, and 94-95. Using the median rating precludes excessive influence by an Examiner whose opinion, in rare cases, may vary greatly from the consensus of the other two. For instance, if the three Grading Examiners assigned a 5, a 4 and a 1, the rating would be 4. Any procedure that is not brought to final completion will receive no points.

Operative

Score 3.00 or higher → PASS (Exempt from Procedure 2)

Procedure 1
Class II
Graded on Preparation and Finish Criteria

Score Below 3.00

Procedure 2
Class II or Class III
Graded on Preparation and Finish Criteria

Average of the Two Procedures is 3.00 or higher → PASS

Average of the Two Procedures is below 3.00 → FAIL
**Periodontal Treatment**: Scoring is expressed as a percentage with 75% or higher considered the passing level. Performance on the Periodontal Treatment Section is rated independently by three Grading Examiners. Periodontal Treatment scoring scale, percentages, possible deductions, and other scoring details can be found on pgs. 83-84.

![Periodontal Treatment Diagram]

**Provisional Results**

Provisional results will be posted to your Candidate profile on wreb.org after each exam day. You will NOT be notified when provisional results are posted and will need to check your online profile at the end of each clinic day. These results are provisional until scores are reviewed and final results are posted by the WREB office. A change in outcome from provisional results to final results will not be considered a basis for appeal. WREB will make every effort to post provisional results for all Candidates, but there may be circumstances in which a Candidate's results will not be posted until the WREB office reviews and posts final official scores.

**Final Results**

It is WREB policy to notify you of final exam results as soon as possible. Final results will be posted online and can be accessed with your Candidate login and password. It is important that you save your login information so you can access your results. You will receive an email notice when your final results are available.

Exam results are confidential and will not be given over the telephone or by email. They will only be posted to your secure WREB login online.

Notification of passing the WREB Exam does not constitute licensure in any of the participating states. It is illegal to render patient treatment until all state licensing requirements are met and the license certificate or letter is received from the state. Links to member states are on the WREB website.

If you do not pass the WREB Exam you may elect to appeal your exam results. For information regarding the Appeals Policy, contact the WREB office or visit the WREB website.

Results for all sections attempted, (core or elective), (pass or fail), will be reported to state boards. This includes onsite retake attempts.
Testing Candidates with Disabilities

The WREB Exam is designed to provide an equal opportunity for all Candidates to demonstrate their knowledge and ability. The exam is administered to ensure that it accurately reflects an individual’s aptitude, achievement level and clinical skills, rather than reflecting an individual’s impaired sensory, manual, or speaking skills, except where those skills are the factors the exam purports to measure.

WREB makes every reasonable effort to offer the exam in a manner which is accessible to persons with disabilities. If special accommodations are required, WREB attempts to make the necessary provisions, unless providing such would fundamentally alter the measurement of skills and knowledge the exam is testing, would result in an undue burden, or would provide an unfair advantage to the Candidate with a disability.

The appropriate professional (physician, psychologist, etc.) must complete a form obtained from the WREB website specifying what special accommodation is requested and attesting to the need for the accommodation. This must be received in the WREB office no later than 45 days prior to the exam.

WREB reserves the right to authorize the use of any accommodation to maintain the integrity and security of the exam.

Dismissal for Improper Performance or Unethical Conduct

Dismissal from the exam, failure of the exam, or reduction in an exam score may result from Improper Performance (as defined below) relative to procedural skills and clinical judgment, and/or Unethical Conduct (as defined below).

If a Candidate engages in improper performance or unethical conduct, the Candidate must obtain permission from the WREB Board of Directors before taking the exam at a later date.

Examples of improper performance include, but are not limited to:

- Case selection that presents conditions which jeopardize successful patient treatment
- Disregard for patient welfare and/or comfort
- Failure to recognize or respond to systemic conditions which potentially jeopardize the health of the patient, assistant or examiners
- Unprofessional, unkempt, or unclean appearance
- Rude, abusive, or uncooperative behavior
- Disregard for aseptic technique
- Performance that causes excessive tissue trauma
- Performance that is grossly inadequate in the validated judgment of the Examiners
- Failure to adhere to published WREB Guidelines
Examples of unethical conduct include, but are not limited to:

- Using unauthorized equipment at any time during the exam
- Using unauthorized assistants
- Using unauthorized patients
- Altering patient records or radiographs submitted in any format
- Treating patients outside clinic hours or receiving assistance from another practitioner
- Altering Endodontic and/or Prosthodontic teeth
- Dishonesty
- Altering Candidate worksheet or treatment notes
- Communicating written or electronic (computer) test item information to other Candidates or individuals
- Altering, omitting, or attempting to disguise treatment performed on a patient
- Any other behavior which compromises the standards of professional behavior

If a Candidate engages in improper performance or unethical conduct, in addition to dismissal from the exam, failure of the exam, or reduction in an exam score, WREB reserves the right to take any other reasonable action WREB deems appropriate, including, but not limited to reporting the Candidate to:

i. state licensing boards,
ii. the Candidate’s dental school,
iii. other dental or dental hygiene testing organizations, or
iv. other professional organizations.

Clinical Examination Overview

Your exam officially starts when:

1. You submit your first Operative procedure for acceptance (to the grading area or a Floor Examiner, if provisionally accepted).
2. You submit your first Periodontal Treatment procedure for acceptance.
3. You are handed your bag of materials in Endodontics or Prosthodontics.

Withdrawal for any reason after this point constitutes failure of the exam or applicable section.

Schedule Overview

The exam consists of an Orientation Day, plus two and a half (2.5) clinic days. Below is a general overview of the exam schedule. Your Candidate ID and Exam Schedule with the exact times and locations for your site will be posted to your wreb.org profile approximately four (4) weeks prior to your exam. Once Candidate ID numbers and Exam Schedules are posted they cannot be changed, there are no exceptions.
The Operative and Periodontal Treatment procedures may be performed any time during the two and a half clinic days when you are not in the Endodontic or Prosthodontic Sections.

**Candidate Clinic Schedule (Operative and Perio Procedures)**

Clinic Days 1 and 2:
- 7:00 a.m. - Clinic opens. You may set up your operatory and prepare your Patient for the day’s procedure(s).
- 7:30 a.m. - Floor Examiners arrive to review *Patient Medical History* forms and evaluate provisionally accepted Patients.
- 7:45 a.m. - Patients may be submitted for check-in.
- 8:00 a.m. - Grading Examiners begin evaluating patients.
- 4:00 p.m. – Patients must be in line to be graded.
- 5:00 p.m. – All Candidates and Patients must be out of the clinic.

Clinic Day 3:
- 7:00 a.m. - Clinic opens. You may set up your operatory and prepare your Patient for the day’s procedures(s).
- 7:30 a.m. - Floor Examiners arrive to review *Patient Medical History* forms and evaluate provisionally accepted Patients.
- 7:45 a.m. - Patients may be submitted for check-in.
- 8:00 a.m. - Grading Examiners begin evaluating patients.
- 8:30 a.m. - Candidates working on Clinic Day 3 are required to arrive on the clinic floor by this time.
- 11:00 a.m. - The exam ends. Patients must be in line to be graded.
- 12:00 p.m. - All Candidates and Patients must be out of the clinic.

Do NOT administer local anesthetic to any patient until the patient’s *Patient Medical History* form is reviewed and initialed by a Floor Examiner. For patient comfort, patients should not be sent to the grading area until the time scheduled for patient submission (7:45 a.m.).

Patients with procedures to be graded must be checked in by 4:00 p.m. on the first two days of the exam, and by 11:00 a.m. on the final day of the exam. After this time, 0.2 points are deducted from each procedure to be graded for each five minutes the patient is late. If a patient is 16 or more minutes late, the procedure will not be graded and no points will be earned.

WREB official time is based on the local time for each exam site. Cell phone time will be used to determine late penalties for Operative and Periodontal procedures. For the Endodontic and Prosthodontic Sections, a separate, official clock will be designated in the lab.
All clinical procedures must be submitted to the grading area by 4:00 p.m. on Clinic Days 1 and 2 and by 11:00 a.m. on Clinic Day 3. After your patient returns from the grading area, you are only permitted to:

- Place a temporary
- Dismiss the patient
- Clean operatory unit
- Leave the clinic

All Candidates and patients must be out of the clinic by 5:00 p.m. on Clinic Days 1 and 2.

Under certain circumstances, approval and completion of restorative procedures may be done on different days. However, to avoid penalty, you must complete the Periodontal Treatment procedure on the day it is approved. Refer to specific procedure sections of this Guide for more information.

It is not unusual to finish the exam by the end of the second clinical day. There is sufficient time to complete all procedures and to accommodate unexpected situations. The final half-day is provided for Candidates encountering unexpected circumstances that require extra time to complete procedures, or for onsite retakes. Candidates having a patient-based section to complete or retake must arrive by 8:30 a.m. on the third clinic day.

The location of Candidate operatories may be consolidated and a different operatory assigned to any remaining Candidates on Clinic Day 3.

**Simulation Lab Schedule (Endodontic and Prosthodontic Procedures)**

You will be assigned a three (3) hour block for the Endodontic Section on Clinic Days 1 or 2.

If taking the Prosthodontic Section, you will be assigned a three and one-half (3.5) hour block for that section.

If taking both, your Prosthodontic Section will be assigned to a different day than your Endodontic Section.

Candidates are divided into four (4) groups for the Endodontic and Prosthodontic Sections. These groups are designated by a Candidate ID number which will be assigned to you and posted to your wreb.org profile approximately four (4) weeks prior to your exam. The Exam Schedule will specify the exact times of your Endodontic and Prosthodontic Sections.

**Onsite Retakes**

Candidates with a failing result in Endodontics, Prosthodontics, or Periodontal Treatment may have an opportunity to retake the failed section onsite at the same exam. This will depend on each Candidate’s scheduled sections and individual time constraints. Candidates that have certain validated critical errors or are dismissed from the exam may not be eligible for onsite retake. See scoring under each section for details. No onsite retakes are available for the Operative Section.
Onsite retakes for Endodontics and Prosthodontics are scheduled on Clinic Day 3 only. Candidates are allowed in the simulation lab at 6:45 a.m. for setup. Both Endodontics and Prosthodontics Sections begin at 7:15 a.m. The Endodontic Section will end at 10:15 a.m. and the Prosthodontic Section will end at 10:45 a.m. Candidates attempting an onsite retake for Endodontics or Prosthodontics must arrive in the lab no later than 7:45 a.m. on Day 3.

Onsite retakes for Periodontal Treatment may be attempted on Clinic Days 2 or 3. These retakes are not pre-scheduled and can be completed any time during open clinic following receipt of provisional results. (The first set of provisional results is posted at the end of Clinic Day 1.)

Sample Exam Schedule

Your exam schedule is determined by the letter of your Candidate ID number. Your Candidate ID number will begin with either A, B, C, or D. To read the schedule, you will follow the column that corresponds to your Candidate ID number and disregard all others.

If you are not taking the Prosthodontic Section, that time remains open clinic time for you.

The following sample schedule does not specify exact times. Times may differ depending on exam site and will be posted with your schedule on wreb.org approximately four (4) weeks prior to your exam.

Sample Schedule

<table>
<thead>
<tr>
<th>YOUR GROUP IS THE FIRST LETTER OF YOUR ASSIGNED CANDIDATE ID</th>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
<th>Group D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation Day</td>
<td>ALL GROUPS (A-D)</td>
<td>• Candidate Orientation</td>
<td>• ID check &amp; distribution of packets</td>
<td>• School Tour</td>
</tr>
<tr>
<td>Clinic Day 1</td>
<td>AM Endo Exam</td>
<td>AM Op/Perio - Open Clinic</td>
<td>AM Op/Perio - Open Clinic</td>
<td>AM Prosth Exam</td>
</tr>
<tr>
<td></td>
<td>PM Op/Perio - Open Clinic</td>
<td>PM Endo Exam</td>
<td>PM Prosth Exam</td>
<td>PM Op/Perio - Open Clinic</td>
</tr>
<tr>
<td>Clinic Day 2</td>
<td>AM Op/Perio - Open Clinic</td>
<td>AM Prosth Exam</td>
<td>AM Endo Exam</td>
<td>AM Op/Perio - Open Clinic</td>
</tr>
<tr>
<td></td>
<td>PM Prosth Exam</td>
<td>PM Op/Perio - Open Clinic</td>
<td>PM Op/Perio - Open Clinic</td>
<td>PM Endo Exam</td>
</tr>
<tr>
<td>Clinic Day 3</td>
<td>Op &amp; Perio – Open Clinic</td>
<td>8:00 - 11:00 a.m.</td>
<td>Prosth and Endo Exam RETAKES ONLY</td>
<td>Setup for Prosth and Endo: 6:45 - 7:15 a.m.</td>
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</tbody>
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**Late Penalties**

Endodontics and Prosthodontics

1 to 5 minutes late: 0.2 deduction

6 to 10 minutes late: 0.4 deduction

11 to 15 minutes late: 0.6 deduction

16 or more minutes late: All points lost.

Operative

1 to 5 minutes late: 0.2 deduction

6 to 10 minutes late: 0.4 deduction

11 to 15 minutes late: 0.6 deduction

16 or more minutes late: The applicable preparation or finish will not be graded. No points earned.

Periodontal Treatment (deducted from total possible for Periodontal Treatment)

1 to 5 minutes late: 4% deducted

6 to 10 minutes late: 8% deducted

11 to 15 minutes late: 12% deducted

16 or more minutes late: Procedure will not be graded. No points earned.

It is possible that the exam might be terminated in less than 2½ days due to a situation beyond the control of WREB, such as loss of power or act of nature. If this should occur, incomplete procedures cannot be carried over to a future exam. WREB cannot be held liable in these circumstances.

**Exam Personnel and Anonymity**

The WREB Exam is conducted in a manner that is intended to provide total anonymity to remove possible bias from the scoring of Candidate work. All exam materials are numbered with a Candidate ID Number. This number is randomly assigned prior to the exam and a sheet of badges with the number is provided at the exam. A badge must be worn at all times during the exam. Your name must not appear on any materials including clothing, worksheets, and radiographs. Only a patient’s first name should be used on materials that are seen by Grading Examiners. Grading Examiners are separated from Candidates so there is no direct contact between Grading Examiners and Candidates. You will assist in keeping the exam anonymous by observing all signs and instructions.
WREB has two (2) categories of Examiners: Grading Examiners and Floor Examiners. Grading Examiners are segregated from Candidates during the examination. Patients are sent to a separate grading area for graded procedures. This allows the Grading Examiners to grade the procedure without knowledge of the Candidate.

Anonymity is preserved between the Grading Examiners and Candidates, not among Examiners themselves. Examiners assign grades independently of each other; however, there are occasions when fairness requires consultation among Examiners. Examiners are encouraged to consult whenever necessary. Examiner consultation generally benefits Candidates and should not be a reason for concern.

There are two (2) to four (4) Floor Examiners at each examination.

Floor Examiners do not serve in a grading capacity so there is no anonymity between Floor Examiners and Candidates. Floor Examiners serve as liaisons between Candidates and Grading Examiners to solve any problems that may arise during the exam. They are on the clinic floor to assist with questions or problems relating to the administration of the exam, and to approve certain phases of clinical procedures. Floor Examiners can help you by answering questions, clarifying exam procedures and acting as liaison between you and Grading Examiners. In addition, Floor Examiners can help with:

- Extra forms, such as Patient Medical History/Consent Form or Follow-Up Care Agreements
- Providing additional worksheets as needed
- Checking and signing Patient Medical History forms
- Distributing communication forms from Grading Examiners
- Checking in patients who have been provisionally accepted
- Checking modification requests (see Operative Modification Procedure)
- Managing a pulp exposure
- Checking and initialing steps on worksheets

Any Floor Examiner in any area of the clinic can assist you. They are not assigned to specific areas. Ask the first available Floor Examiner for assistance.

You should always bring your worksheet when asking questions regarding procedures.

**General Guidelines**

A. Only Candidates, patients and assistants are allowed on the clinic floor. Candidate and assistant identification badges must be visible on the chest or collar on the outer most layer (i.e., disposable gown) at all times during the exam. You will not be allowed in the Simulation Lab for your scheduled exam without showing your Candidate ID.

B. This exam uses the American System of tooth identification. Permanent teeth are recorded clockwise from the upper right quadrant to the lower right quadrant.

<table>
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<tr>
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<tr>
<td>1 2 3 4 5 6 7 8</td>
<td>9 10 11 12 13 14 15 16</td>
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<tr>
<td>32 31 30 29 28 27 26 25</td>
<td>24 23 22 21 20 19 18 17</td>
</tr>
</tbody>
</table>
C. Worksheets must be completed in ink – not pencil. If you make an error prior to patient acceptance, obtain a new worksheet (cross-outs are not accepted at acceptance). If you submit a worksheet that is not neat, clear, and in ink, the patient will be returned to you with a new worksheet to complete, resulting in lost time.

D. All electronic devices should be turned off or set to a mode that will not disturb other Candidates in the main clinic. Electronic devices, including cell phones and smart watches, are prohibited in the Endodontic and Prosthodontic Exams and the grading area. Patients with electronic devices will not be graded, but returned to you to leave the device, resulting in lost time.

E. Neither WREB nor any agency participating in the exam process accepts responsibility for treatment rendered to patients during the exam. A Consent Form must be signed by patients.

F. No surgical procedures may be done.

G. Procedures presented for grading during the exam may be photographed or digitally scanned by WREB personnel. These photographs are for use in training and calibrating Examiners. They have no relation to the grading process and cannot be released to patients or Candidates.

H. The school provides information regarding the facility, supplies, hotels, commercial labs, and other topics which can assist in preparing for the exam. This information is provided directly by the school; WREB is not responsible for its accuracy. Links to specific exam site information are available within the Dental Exam Schedule at wreb.org.

I. Laboratory facilities are available at some schools if you wish to do your own lab work for the indirect procedure. A commercial lab may be used. However, no appellate procedure may be based on the performance of any commercial lab. Representatives of commercial laboratories are not allowed on the clinic floor during the exam. A designated location is set up outside the clinic for transfer of impressions and castings. See Site Information for details on laboratory facilities.

Infection Control Guidelines

Appropriate aseptic technique is an important component of the professional standard of dental care. You are expected to maintain acceptable standards during the exam. Failure to do so may result in a reduction of exam scores. The following are the minimally accepted standards:

• Appropriate attire is required while in the clinic. A lab coat, lab jacket, or disposable gown are all acceptable if they are long sleeved. Scrubs may be worn under a lab coat, lab jacket, or disposable gown. Color and style are not restricted. Your Candidate ID Badge must be worn in a visible location on the outside of clinic attire. Clinic attire should not be worn outside the clinic if it has been contaminated.

• Clinic attire must be changed whenever visibly soiled.

• Antiseptic soap is provided for hand washing.

• Exam gloves must be worn during all patient contact. When performing functions other than direct patient treatment, remove exam gloves or use over-gloves. Gloves must be changed between patients and whenever the integrity of the glove is compromised. Schools provide gloves but cannot accommodate individual preferences. If you require a specific brand or size you should bring your own.
• Masks covering the nose and mouth must be worn during all procedures that generate aerosols. Schools provide masks but cannot accommodate individual preferences. If you have specific mask requirements you must provide your own. Masks must be changed whenever visibly soiled.
• Protective eyewear is required for you and your assistant and must be worn during all procedures. You must provide your own eyewear. Use of a face shield is acceptable in lieu of eyewear.
• Protective eyewear is required for patients (prescription glasses or safety glasses) during all patient procedures, evaluation, and grading. You are responsible for ensuring that your patient is equipped with protective eyewear.
• Schools provide specific written instructions that must be carefully followed regarding:
  • Asperis of the surfaces and equipment in the operatory to assure adequate disinfection of all surfaces and equipment before and after each use.
  • Proper disposal of biohazardous waste.
  • Sterilization procedures for instruments. All instruments, including handpieces, are to be sterilized between patients.
  • “Sharps” containers are located throughout the clinic. All sharps must be disposed of properly.
  • Food and beverages are prohibited in the clinic.

**Dental Assistants**

Dental chair-side assistants may be used during clinical procedures. Dental assistants may work with Floor Examiners on your behalf. Patients may be sent to the grading area by assistants if all paperwork is complete and instruments are present.

Assistants are not allowed to attend Candidate Orientation.

Only one dental assistant and only the one dental chair assigned to you can be used at any time.

Periodontal Treatment dental assistants may not be dentists (including graduates of foreign dental schools), dental hygienists (including graduates of foreign dental hygiene schools), or dental hygiene students. Assistants may be dental assistants or dental students, if they are not in their final year of dental school. For purposes of the exam, WREB considers the final year of dental school as beginning September 1.

Operative dental assistants may not be dentists (including graduates of foreign dental schools) or be in their final year of dental school. For purposes of the exam, WREB considers the final year of dental school as beginning September 1.

Operative dental assistants may be dental assistants or dental hygienists, if they do not hold a permit to place and finish restorative materials.

Use of unauthorized Assistants is grounds for immediate dismissal from the exam.
A Dental Assistant Verification form (sample form pg. 26), provided in your Candidate Packet at the exam, must be completed and signed by you and your assistant(s). If an assistant was not used for the Operative and/or Periodontal Treatment Procedure, mark the appropriate box indicating "No Assistant was used." This form must be completed and submitted to WREB at the end of the exam, even if an assistant is not used. If this form is not returned, final results will be held by the WREB office.

Assistants are required to follow the same guidelines as Candidates. You are responsible for your assistant(s)' adherence to all guidelines.

Equipment and Materials

Equipment information specific to each school can be found in the "Site Information" at wreb.org. Although schools supply some expendable materials, you are responsible for ensuring that you have all materials necessary to perform the required procedures, including high-speed and low-speed handpieces and periodontal scaling devices. Schools may have equipment available for rent if you choose not to bring your own. Information on rental equipment is included in the "Site Information." Instruments must be acceptable even if rented.

A. Special instruments for the Operative procedures are (illustrations, pg. 25):
   - New/uncratched #4 or #5 metal front surface mouth mirror
   - New/sharp pigtail explorer comparable to the Starlight #2, Suter #2, Brasseler 2/6 or Hu-Friedy 2R/2L
   - New/sharp shepherd’s hook explorer comparable to the Thompson #5, or Hu-Friedy EXD #5
   - Miller-type Articulating Paper Forceps (not cotton pliers)

B. Special instruments for the Periodontal Treatment procedure are (illustrations, pg. 25):
   - New/uncratched #4 or #5 metal front surface mouth mirror
   - New/sharp ODU 11/12 explorer (may be American Eagle, Hartzell, Nordent, or Hu-Friedy)
   - New/sharp periodontal probe, color coded with legible 3-6-9-12 mm markings (may be American Eagle, Hu-Friedy, or Marquis)
   - It is recommended that you bring back-up instruments

C. A blood pressure measuring device is required.

D. The schools have agreed to provide the following expendable materials: Anesthetic (local and topical), composite restorative materials, amalgam capsules, articulating paper, autoclave tape, cement, cotton pellets, cotton rolls, cotton swabs, cotton squares, instrument trays, deck paper, disinfectant, drinking cups, evacuator tips, face masks, facial tissue, floss, gloves, headrest covers, hemostatic agents, impression materials, mouthwash, needles (long and short), paper towels, patient bibs, polishing materials for restoration, prophylaxis paste, retraction cord, rubber dams, rubber dam napkins, soap, standard saliva ejectors, trash bags, and tray covers.
Materials provided are brands used by the school. If you wish to use a specific brand you must bring your own. You should provide any materials not specifically listed in the "Site Information."

E. Radiograph developer and fixer are supplied in the simulation lab at schools with conventional radiographic facilities. Automatic and/or hand developers are provided by the school. A list of other materials provided in the lab can be found in the "Site Information." You must supply any items needed to perform the Prosthodontic and Endodontic procedures which are not on the list.

F. If using a sonic or ultrasonic device for periodontal treatment, you must provide your own and it must be adaptable to the hookups at the school. Information regarding hookups can be found in the "Site Information."

G. You will be furnished with a dental chair, an operatory unit, and an operator’s stool. Personnel are available throughout the exam to resolve malfunctions of operatories and equipment provided by the school. If you have an equipment malfunction in the clinic you should notify maintenance personnel and a Floor Examiner immediately. The Floor Examiner may determine that you are eligible for time compensation (on that day only) if the equipment malfunction cannot be resolved within 15 minutes. Time is not compensated for delays of less than 15 minutes. Time is determined from the point at which a Floor Examiner is notified. Many equipment malfunctions are due to improper use. You should become familiar with the equipment prior to the exam and follow all directions carefully. WREB cannot be responsible and will not compensate for time lost due to the malfunction of your personal equipment or rental equipment.

Scoring Criteria and Patient Welfare

Because WREB serves as a testing agency, not a teaching agency, performance that fails to meet examination standards does not always require immediate corrective action and may not present an immediate health concern for the patient.

Patients participating in WREB exams may be released from the exam with restorations or treatments that received a failing score without Examiners requiring immediate correction of the condition. A failing score is an indication of not meeting exam criteria even though the restoration might still be serviceable. Only the most severe conditions, which could constitute an immediate threat to the patient’s health, are identified by the Examiners with a Postoperative Care (PO) form. A Postoperative Care form is completed for the following situations:

- Soft tissue laceration or mutilation or major iatrogenic tissue trauma
- Pulp exposure
- Fractured direct restorations
- Margins of restorations so defective that the tooth would be endangered if not treated prior to the next regular recall exam
- Contacts (interproximal) so defective that the tooth or periodontium would be endangered if not treated prior to the next regular recall exam
An *Instructions to Candidate (IC)* form may be completed by the Grading Examiners to request removal of caries, affected dentin, unsound demineralized enamel, or any remaining restorative material. This form may also be used to request additional radiographs, adjustment of occlusion, or for any other communication that an Examiner deems appropriate.

Although the conditions that initiate a *Postoperative Care or Instructions to Candidate* form also may result in a low score in one or more of the scored categories, scoring is an independent event and is based only on the established criteria. Receiving either form is not an indication of procedure or exam failure. Absence of these forms does not assure satisfactory completion of any procedures. For example, it is possible that a score of “2” is appropriate in a category because of elements in the criteria, but there is no immediate threat to the patient’s health and no need for immediate exam site correction. No forms would be issued, even though the procedure score would be failing.

A *Follow-Up Care Agreement* form (sample form pg. 26) must be completed for each patient. If a patient is used for more than one procedure by the same Candidate, only one form needs to be completed with all procedures indicated on the form for that patient. If a patient is shared by one or more Candidates, each Candidate must complete a *Follow-Up Care Agreement* for that patient. Prior to arriving at the exam, have a dentist accessible to the patient (licensed in the state in which the patient resides) who acknowledges the responsibility of providing any necessary postoperative care, sign the form on either the "A" or "B" Section of the form. Give the yellow copy of the form to the patient after they sign the form. The white copy is turned in at the end of the exam in the *Candidate Packet*. If you are unable to have a licensed dentist sign the *Follow-Up Care Agreement* in advance (patient is obtained during the exam), the form may be completed after the exam and either emailed or mailed to the WREB office. Final exam scores will not be released to the Candidate or any State Boards until the form is received.

**Patient Selection**

The following criteria apply to all patients for the clinical exam:

- There is no minimum age for Operative procedures.
- The minimum patient age for the Periodontal Treatment procedure is 18 years.
- Patients cannot have completed more than two years of dental school.

Patient selection is an important factor in the clinical exam. You must provide a patient or patients for the Operative and the Periodontal Treatment procedures.

Patient selection is your responsibility. WREB staff, the Boards of Dentistry of participating states, and dental schools are not able to supply patients. You are graded on your ability to accurately determine and effectively interpret patient qualification criteria. This is an integral part of the examination. Therefore, other professionals should not “prequalify” your patient for the examination.

WREB strongly discourages the use of patient procurement services. Patient procurement services are not allowed in the school during the examination. Use of such services is absolutely not necessary for success on the exam. Patient acceptance criteria are designed to standardize
the exam, not as an obstacle to patient procurement. Reading the criteria and understanding the broad range of patients acceptable for the Operative procedure(s) and the Periodontal Treatment procedure will enable you to evaluate your own patients’ qualifications. The patients accepted by WREB are patients you routinely treat in a school dental clinic or a dental office. To increase the likelihood of success, WREB encourages you to procure patients for the exam whom you routinely treat in dental school or your dental office.

One patient may be used for all patient procedures if the criteria are met. Candidates may share a patient if the criteria are met. Patients with a need for antibiotic prophylaxis may not be shared with other Candidates at the exam. You bear all risks and benefits associated with using the same patient for more than one procedure or sharing a patient with another Candidate.

If you share a patient with another Candidate, each Candidate must submit the procedures separately for approval to start and for the preparation and finish grading.

If using more than one patient, you may work on one patient at your own operatory while another patient is in the grading area. If a patient is approved by the Grading Examiners, no appellate procedure may be based on the difficulty of the procedure submitted.

Incomplete procedures cannot be evaluated. Therefore, an additional consideration in your patient selection is the cooperative attitude of the patient. A patient should not be selected who is apprehensive, hypersensitive, or is unable to remain until the examination is completed. If your patient is unable to be examined by three Grading Examiners, you will fail that procedure.

**Patient Medical History (sample form pg. 27)**

- WREB accepts patients with a blood pressure reading of 159/99 or below. A patient with blood pressure readings between 160/100 and 180/110 is accepted only with written consent of the patient’s physician. WREB does not allow treatment of any patient with a blood pressure reading greater than 180/110. Preoperative blood pressure and pulse must be taken on each patient prior to acceptance and recorded on the Patient Medical History form.

- Obtain written clearance and/or antibiotic prophylaxis from a physician or dentist in the case of any significant medical problem. The medical clearance must indicate the specific medical concern. WREB adheres to the current American Heart Association Guidelines regarding required premedication. Patients with a need for antibiotic prophylaxis may not be shared with other Candidates at the exam.

- Any patient who has received intravenous bisphosphonates for bone cancer or severe osteoporosis is not acceptable for the exam.

- Any patient with diabetes controlled by insulin injection(s) or an insulin infusion device is not acceptable for the exam.

- Any patient who has had a heart attack, stroke, or cardiac surgery within the past six (6) months is not acceptable for the exam.

- Any patient who has clinical symptoms of active tuberculosis (clinical symptoms would include a productive cough or chest pain) is not acceptable for the exam.

- Any patient with a known latex allergy is not acceptable for the exam.
• Any patient who has been diagnosed as HIV positive must present a medical consult with permission to sit for the exam.
• Any patient who is known to be pregnant is not acceptable, except with the written consent of the patient’s health care provider.
• Any patient with problems which might be aggravated by the length or nature of the exam may be rejected at the discretion of the Examiners.

A legal consent is provided on the back of the Patient Medical History form and must be signed by the patient. If a patient is under the age of legal consent for the state in which the exam is given, the Consent Form must be signed by the parent or legal guardian of the underage patient.

If you are using the same patient for more than one procedure you may submit one Patient Medical History and Consent Form for that patient with all procedures indicated. Candidates who share a patient must submit separate Patient Medical History and Consent Forms for the procedure(s) performed on the patient. The patient must sign Patient Medical History and Consent Forms for each Candidate who performs procedures on them.

Your patient is essential to your success on the exam. Treat all patients with care and compassion. Patients should receive nourishment during the exam. Special care must be taken when sharing patients or using one patient for multiple procedures to ensure the patient receives adequate breaks and nourishment. Patients who are unable to be graded due to hypoglycemia or severe dehydration may result in a failing grade.

Patients should be given directions to the school, parking information, directions to the clinic and should be aware of the time commitment due to the nature of the exam and your exam schedule.

Patients should be prepared for temperature extremes in the clinic. Headphones, newspapers, books, and magazines are permissible outside of the grading area. Electronic devices, including cell phones and smart watches, are not allowed in the grading area.

Patient comfort should be considered and proper local anesthetic utilized as needed.

Any form of inhalation, parenteral or enteral sedation cannot be used during the exam. Patients must be ambulatory.

Radiographs

Preoperative radiographs are required for the Operative and Periodontal Treatment procedures. Specific radiograph requirements for each procedure are outlined in each section of this Guide.

WREB accepts the use of conventional film and digital radiographic images as long as they are of diagnostic quality. Because schools differ in their radiographic facilities, please refer to the "Site Information" for the site where you plan to take the exam to determine what is available (found on the website at wreb.org). Some exam sites will have only conventional facilities available, some will have only digital, and others will have both. It is important that you are prepared for what is available at the exam site you have selected.
You should also read the Site Information carefully to determine if a digital site is equipped for
secure transmission of images between different exam sites, or from your school to the exam
site. It may be necessary to submit printed digital images. Depending on the facilities available,
different portions of the following information will apply.

A. Digital Radiographs

All digital radiographs must be diagnostic. Examiners will view all images, printed or on
monitors, as though they are mounted “button out.” Format your submissions accordingly.

Endodontic images, printed or on monitors, must include a 2.0 mm sphere for measuring.

- Digital Images on Monitors
  Only the radiographs being submitted for approval should be saved in the folder
  accessed by Examiners. All images submitted for a procedure must fit on one screen
  without overlap. The individual images should be no larger than three times the size
  of a conventional #2 film radiograph.

- Printed Digital Images
  Printed digital images must include a label in legible print that includes Candidate ID
  Number, patient's first name, procedure, tooth number and surface.

Printed digital images must be printed on high quality photographic paper. One
printed image is required for each submission. All printed images for each procedure
must fit on one 8 ½” by 11” page without overlap and individual images should be no
larger than three times the size of a conventional #2 film radiograph (3½ x 2½ inches).

B. Conventional Radiographs

- WREB accepts the use of conventional #2 film radiographs at all examination sites, as
  long as they are of diagnostic quality.

- Conventional films may be interpreted by Examiners using loupes with 2.5 X
  magnification or greater and backlighting (i.e., view box).
The use of image analysis tools, such as zoom and magnifier, will not be a part of an Examiner’s evaluation of digital images.

Perform all enhancement or edge sharpening prior to submitting images for patient acceptance. It is your prerogative to use these feature(s) in digital or scanned conventional #2 film format to provide the best radiographic images for Examiner assessment.

**Authentication/Security**

All digital radiographs must be of diagnostic quality. Image capture stations are specified by the site. After capture transfer to the server, select images for uploading and enhance them as desired. The host site will provide specific radiographic personnel during Candidate screening and testing times. No individual other than the Candidate will be allowed to assist in image selection or editing for submission. A final archival disc will be provided to WREB by the host site for all digitally stored Candidate radiographs at completion of the exam.

You may submit digital radiographs from another dental school or dental office other than your exam site using equipment and information systems that conform to the DICOM Standard. Electronic transmission of digital radiographic images will be considered secure and authentic if they are received by designated exam personnel and never leave the DICOM secure format. If digital radiographs do not conform to DICOM Standard format, you may choose to take digital radiographs at the exam site, submit conventional films, or provide printed digital images.

**Alteration of Radiographs**

An altered radiograph is defined as a change to the proprietary tag of the format file. Intentionally performing any alteration, including but not limited to, cropping, compressing or “doctoring the image” as in a Photoshop*-type program is prohibited. Enhancement or edge sharpening is acceptable.

When you applied for your exam online, you electronically signed an affidavit that the radiographs submitted are original, unaltered films. (Periodontal films may be duplicates.)

Should analysis by WREB detect radiographic alteration of submitted digital images or conventional films, failure of the examination for unethical conduct will occur. If there is a question, you will be required to retake the radiographs with an observer present at the exam site.

**Exam Preparation Materials**

With this **Candidate Guide**, you received the following items:

- Two (2) **Follow-Up Care Agreement** forms to be signed in advance by a dental care provider and your patients
- Two (2) **Patient Medical History and Consent** forms

Refer to Pages 19, 20 and 21 for details on these forms.
It is highly recommended that you watch the Candidate preparation tutorials available on wreb.org.

Candidate Orientation is held the first day listed on the exam schedule. Following Candidate Orientation, you will receive your Candidate Packet containing:

- (9) Candidate ID badges
- (5) Assistant ID badges
- (2) Worksheets for the Direct Posterior Composite procedure
- (1) Worksheet for the Periodontal Treatment procedure
- (1) A Dental Assistant Verification form
- (10) Patient bib labels
- (3) Patient Information and Questionnaires

Other worksheets are available upon request: Direct Amalgam, Direct Anterior Composite, and Indirect Posterior Class II (Cast Gold). Please see a WREB staff member or Floor Examiner.

Keep the packet envelope to submit required exam materials to WREB personnel when you complete the exam. Candidate Packs will be collected throughout the exam at the patient check-in desk outside the grading area.

If the items are missing and/or not returned, final results will be held by the WREB office until all items are received.
ILLUSTRATION OF INSTRUMENTS

Mirror-metal #4 or #5 Front Surface

“Pigtail” Operative Explorer - comparable to the Starlight #2 or Suter #2, Brasseler 2/6 or Hu-Friedy #2R/2L

“Shepherd’s Hook” Operative Explorer - comparable to the Thompson #5, Hu-Friedy EXD #5

Perio Explorer - ODU 11/12

Perio Probe - color coded in 3-6-9-12 mm increments

Miller-Type Articulating Paper Forcep
FOLLOW-UP CARE AGREEMENT

The WREB Dental Exam is the process for determining if a Candidate has the clinical skills necessary to obtain a license to practice dentistry. Therefore, no guarantee can be made that the treatment performed during this exam will be adequate. If you need additional follow-up care related to the treatment received during the exam, you must visit a licensed dentist of your choice or you may use the referral below. Your candidate will provide you with a signed copy of this “Follow-Up Care Agreement” form.

I. PROVIDER’S ACCEPTANCE OF RESPONSIBILITY - Provider must be accessible to patient and licensed in the state in which the patient resides (option A or option B must be completed).

A. This is to acknowledge that I agree to provide any follow-up care required related to treatment rendered during the WREB Dental Exam. It is understood that this agreement expires sixty (60) days following the exam.

Name of Licensed Provider

Address

City/State/Zip

Telephone No.

Signature of Provider

Date

OR

B. The patient is a “patient of record” at the __________________________, Dental School and will be provided follow-up care as necessary according to the guidelines of the School of Dentistry.

Signature of Authorized School Official

Date

II. PATIENT ACCEPTANCE

I have read the above, and understand and accept that additional treatment related to services rendered during this exam may be required. I understand that any necessary follow-up care is the responsibility of the licensed dentist (part A above) who signs this form. No school or exam location is responsible for providing follow-up care, unless that school or exam location has signed this “Follow-Up Care Agreement” (part B above), and acknowledges responsibility for follow-up care. I understand that there may be a fee involved in the follow-up care and that I will be responsible for that fee unless other arrangements have been made with the candidate. It is further understood that the provider listed above (part A or part B) has no obligation to provide care if not initiated within sixty (60) days after the exam.

Patient Signature (or Parent/Guardian if patient is a minor)

Date

White Copy: Candidate File

Yellow Copy: Patient File

Use Ink
Western Regional Examining Board ("WREB") is a national dental and dental hygiene testing agency required to test candidates’ clinical skills for the states that accept the results of WREB examinations. This involves doing certain types of dental procedures for volunteer patients.

The WREB examinations are typically administered at various dental schools and universities ("Schools") or "Schools" around the country. You have agreed to volunteer as a patient for a candidate (the "Candidate") that is taking a WREB examination. Other than at administering an examination at a School, WREB has no relationship or affiliation with any of the Schools.

The Candidate has met the educational requirements necessary to take the exam, but WREB and the Schools have no knowledge regarding the Candidate’s skill or competency. The Candidate, who is treating you, may not be licensed in any of the member states of WREB. The Candidate will be performing a dental examination on you, including one or more procedures (collectively the "Procedures") as a part of the examination to determine if the Candidate is qualified to be licensed as a dentist or dental hygienist in WREB state.

WREB and the Schools do not assume any responsibility for the treatment or procedures you receive from the Candidate. If an injury occurs during the examination, neither WREB (including its examiners) nor the School (including anyone acting on its behalf) assumes any responsibility to provide you with further dental treatment. WREB and the Schools assume no responsibility for notifying you of any error, substandard, or negligent work rendered by the Candidate. If you have any concerns regarding the quality of care administered by the Candidate, then you should see a licensed dentist.

By volunteering to be a patient for the Candidate during the WREB examination, you expressly acknowledge and agree that you are not and will not become a patient of record of the School solely due to the treatment or procedures that you receive from the WREB Candidate during the examination. The School is merely a hosting site and is in no way responsible for supervising or overseeing the examination.

You hereby expressly agree to assume the risk for injuries of any kind that occur before, during, or after the WREB examination. You agree to indemnify WREB (including its examiners) and the School (including anyone acting on its behalf) against any losses, claims, demands, damages, assessments, costs and expenses (including any reasonable attorney’s fees) of any kind, nature or description resulting from, arising out of, or relating to your participation in the examination.

I hereby state that I have read and understood this Patient Consent Form and Assumption of Risk. I confirm that I have not completed more than two years of dental school, foreign or domestic. I consent to having radiographs and a dental examination made for me. I hereby consent to the Procedures. I realize that local anesthetics may have to be administered and I consent to the use of local anesthetics by the Candidate. I consent to having the WREB examiners take intraoral photographs of my teeth and gums for use in future examiner calibrations, provided my name is not associated with the photographs in any way. I understand that my medical history on the reverse side will be shared with examiners as required to determine eligibility for the exam and for reference in case of medical emergency.

I authorize the Candidate ID: __________, and his or her assistant, to perform a dental examination (including the procedures), upon me.

Dental Procedure(s): __________

Printed Name: ______________________

Date: ______________________

Patient Blood Pressure: __________

Patient Pulse: __________

Floor Examiner Initials: __________

Patient’s Initials: __________

Front
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)
- Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)

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)
- Indirect Posterior Class II Cast Gold (inlay/onlay up to and including a ¾ Crown)
- A 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, 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. 50-53 and 61-62) accommodate 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. A 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 pg. 33.
• 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 approved 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 surfaces approved 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.

**Indirect Posterior Class II (Cast Gold)**

A. The restoration must be a Class II restoration (minimally an inlay up to and including a ¾ crown) on any permanent posterior tooth except the mesial of a lower first premolar. An MOD restoration on a lower first premolar is acceptable with a qualifying distal lesion.

B. Caries on an unrestored proximal surface is required unless there is an existing direct restoration showing sufficient breakdown to warrant a new restoration. The caries must have clearly reached or penetrated the DEJ on at least one of the two required radiographs.

• All caries on the occlusal surface must be restored. You may do one preparation to include all caries, or separate preparations if there is adequate, sound tooth structure between the carious lesions. Separate preparations must be restored with the same restorative material. Cusp tips are considered part of the occlusal surface.

• If there are qualifying 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 approved tooth that reaches or penetrates the DEJ must be restored. If the tooth has a lesion that reaches or penetrates the DEJ on one 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 veneer, orthodontic bracket or engager, is not acceptable. A tooth with an existing indirect restoration is also not acceptable (except as specified in item B, bullet four above).

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 the 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 opposing the planned restoration 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.

**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 approval 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 pg. 36.

You may use the same patient for two (2) restorative procedures. Both procedures may be submitted for approval 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 approved. The second tooth may be 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 approval at the same time. You may also submit both preparations and both finished restorations at the same time.
No electronic devices, including cell phones and smart watches, are allowed in the grading area. Patients with electronic devices will be required to return the device to the Candidate clinic.

To receive approval 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 III Composite-Violet, Class II Amalgam-Blue, Cast Gold-Gold). 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 pgs. 21-23.
Minimally Qualifying Lesion
Caries has clearly reached the DEJ radiographically.

Qualifying Lesion
Caries has clearly penetrated the DEJ radiographically.

Does Not Qualify
Caries has not clearly reached the DEJ radiographically.
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.

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 approval 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/Consent Form**: A **Patient Medical History** (including current blood pressure and pulse) and **Consent Form** must be completed for each patient. Refer to the sample form on pg. 27. If you use the same patient for more than one procedure, only one **Patient Medical History** is necessary. Mark the box on the upper right corner of the form for each procedure being submitted. Note that each procedure also must be listed on the **Consent Form** on the reverse side. **Make sure your patient signs the Patient Consent Form.**

The **Patient Medical History** form must be initialed by a Floor Examiner before administering local anesthetic or sending your patient to the grading area for approval. You should take both the **Medical History** and the worksheet to a Floor Examiner; 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 and Consent Form** will be retained at the patient check-in desk; Grading Examiners will not see it.

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

- New/uncratched #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 paperwork (items A-D) on top of 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 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 approved, 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 approved 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 pg. 45.
If your patient is not approved, he/she will return with your instruments and the following:

- Pink copy of an “Unacceptable for Treatment” form indicating the reason the patient was not approved.
- New Patient Medical History and Consent Form.
- 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 approved 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 approved.

**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 pg. 39.

Provisional acceptance, for the Operative Section only, is available only to matriculating students at participating sites. For a complete list of participating sites, please visit our website at wreb.org. If your site is not listed, you will submit your patient at the exam as instructed under Patient Acceptance, pg. 31.

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.

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) in the traditional manner 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 in the traditional manner at the exam. You will be notified of results approximately within one (1) week after the submission window closes.

You may upload two (2) submissions. Once a procedure is submitted, no changes will be allowed. 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 name, 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 WREB office 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 end of this section. You will receive an email approximately one (1) week after the 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 traditional acceptance process at the exam and will be subject to the patient submission rejection penalty.
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.

At the Exam
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 in the provisionally accepted patient name, tooth number, and surfaces on the line provided. Failure to provide this information will result in a longer wait time for your patient while WREB staff obtains this information from you.

Starting at 7:30 a.m., Floor Examiners will be available to review Patient Medical History 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
  - The occlusal surface of the tooth must have some contact with the opposing dentition.
  - The lesion must be on a permanent posterior tooth and not only on the mesial of a lower first premolar.
- Class III
  - 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 as would be completed for traditional acceptance.
- Radiographs that were submitted for provisional acceptance should be up on the screen for Floor Examiner reference.
• Completed *Patient Medical History* 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 gets in line for preparation grading (or a modification request).

• Patient Tray: Include all items listed on back of worksheet for provisional 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 traditional acceptance process and if found to be unacceptable, you will incur the patient submission rejection penalty as outlined on pg. 48.

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 on your worksheet on the “Accepted by” line and you may proceed with your preparation (provided it is at least 8:00 a.m.).

**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 pgs. 42-44.

**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 examination. If you wish to place a sealant, you may do so after the finish is graded.

**Indirect Pulp Cap Caries**: 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 Notes 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 tactilely different from the adjacent unaffected enamel and should be removed.

**Cavity Preparation**

WREB Examiners are calibrated to WREB Preparation Scoring Criteria (see pgs. 50-52 and 61). 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.

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 enter and initial a note on the worksheet, and 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 pg. 39. 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 pg. 39), 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.

Preparing a tooth without initial approval or preparing the wrong tooth results in failure of the entire Operative Section. Preparing a surface that has not been approved, without modification approval (e.g., including a lingual groove on a maxillary molar approved for Class II restoration), results in loss of all points for outline and extension and internal form. Restoring an operative procedure with a material other than what has been approved at acceptance (e.g., tooth approved for an amalgam and restored with composite or vice versa), results in failure of the Operative Section. If for any reason a Candidate submits a different procedure in lieu of a previously approved procedure, a point deduction will result.

**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. 50-52 and 61). 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. 51) 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/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

   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 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.

No electronic devices, including cell phones and smart watches, are allowed in the grading area. Patients with electronic devices will be required to return the devices to the Candidate clinic.
After the preparation is graded, your patient will return with the worksheet initialed by one Grading Examiner indicating that the preparation has been graded. At least three 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).

For the Indirect (cast gold) preparation:
You may take impressions only until 4:30 p.m. All Candidates and patients must be out of the clinic by 5:00 p.m.

You may use laboratory facilities available at the school for casting the indirect restoration, or you may have a commercial laboratory fabricate the casting. You are responsible for the final indirect restoration whether it is done by you or a commercial laboratory.

Prior to cementation of the indirect restoration, you must have a Floor Examiner initial “Review of Tooth” on the Cast Gold Worksheet. The review may be done at any stage of finish (from casting on the sprue to polished casting ready to cement) and is done without a rubber dam. You may proceed with finishing the casting in the mouth while waiting for a Floor Examiner to review the tooth. However, the casting must be removed from the mouth for a Floor Examiner to review. After reviewing the tooth, the Floor Examiner will initial “Review of Tooth” on the worksheet.

“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 mounted radiographs) with the “Finish Restoration Grade” box marked on the worksheet.

B. **Patient Tray** with:
   - New/uncratched #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 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 indicating that the finish has been graded. At least three 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 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 examination” 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.**

**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, 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 Scale on pgs. 50-53 and 61-62. 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.

**PREPARATION WEIGHTING**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</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>
</tbody>
</table>

**FINISH WEIGHTING**

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<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>

<table>
<thead>
<tr>
<th>Score Deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Submission Rejection</strong></td>
</tr>
<tr>
<td>(Validated by two or more Grading Examiners.)</td>
</tr>
</tbody>
</table>

| Pulp Exposure                              |
| (Recognized by a Candidate or Floor Examiner or found during grading and validated by the Grading Examiners.) | = 0.5 deducted from the applicable preparation score. |

| Modification Request Not Appropriate       |
| (Validated by two or more Grading Examiners.) | = 0.5 deducted for each modification request validated not appropriate. No maximum. |

| Caries Remaining*                          |
| (Validated by two or more Grading Examiners.) | = Failure of the Operative Section. |

*This is a critical error that immediately terminates the Operative Section for the Candidate. The Candidate cannot proceed to a second procedure.*
**OPERATIVE SCORING (CONTINUED)**

<table>
<thead>
<tr>
<th>Late Penalties</th>
<th></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></td>
</tr>
<tr>
<td></td>
<td>The applicable preparation or finish will not be graded. No points earned.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unusual Situations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing a tooth without approval*</td>
<td>Failure of the Operative Section</td>
</tr>
<tr>
<td>Preparing the wrong tooth*</td>
<td>Failure of the Operative Section</td>
</tr>
<tr>
<td>Restoring an operative procedure with a material other than what has been approved at acceptance (e.g., tooth approved for an amalgam and restored with composite or vice versa).*</td>
<td>Failure of the Operative Section</td>
</tr>
<tr>
<td>Preparing the wrong surface or surface that has not been approved. (If the wrong surface is prepared, the original approved lesion must be included in the preparation.)</td>
<td>Loss of all points for Outline and Extension and Internal Form</td>
</tr>
<tr>
<td>After patient submission is approved, (by Grading Examiners, or by a Floor Examiner if provisionally accepted), Candidate fails to complete the approved treatment on the tooth.</td>
<td>0.3 deduction from the applicable preparation score</td>
</tr>
<tr>
<td>Failing to submit a patient to the grading area for review of a modification request after instructed to do so by a Floor Examiner.</td>
<td>Loss of all points for the preparation</td>
</tr>
</tbody>
</table>

*This is a critical error that immediately terminates the Operative Section for the Candidate. The Candidate cannot proceed to a second procedure.*
<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTLINE &amp; EXTENSION</strong></td>
<td></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. 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.</td>
<td>Lack of treatment of fissures will seriously compromise the tooth and restoration.</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>Unsound demineralized enamel penetrates the DEJ. Cavosurface has multiple major areas of roughness and/or sharp angles that will lead to restoration failure.</td>
<td></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.</td>
<td>Walls 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><strong>INTERNAL FORM</strong></td>
<td></td>
<td></td>
<td></td>
<td></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><strong>OPERATIVE ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></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 inadequate, 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 definitly require restoration.</td>
</tr>
</tbody>
</table>
# DIRECT ANTERIOR CLASS III - COMPOSITE PREPARATION

## SCORING CRITERIA RATING SCALE

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTLINE &amp; EXTENSION</strong></td>
<td></td>
<td></td>
<td></td>
<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. Outline is slightly irregular but does not weaken the tooth.</td>
<td>Outline is moderately over or under extended. Outline is moderately irregular but does not weaken the tooth.</td>
<td>Outline is severely over or under extended. Gingival wall is in contact or obviously overextended. Incisal extension has broken contact. 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. Gingival wall is grossly overextended. Tactilely unsound demineralized enamel penetrates the DEJ. Caries remains in the enamel or is not completely accessed. Unapproved surface prepared.</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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incisal contact is not broken.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cavosurface forms a smooth continuous curve with no sharp angles.</td>
<td>Cavosurface is slightly irregular and rough; no sharp angles are present.</td>
<td>Cavosurface is moderately irregular and rough. A few sharp angles are present.</td>
<td>Cavosurface is severely irregular and/or with sharp angles.</td>
<td>Cavosurface has multiple gross irregularities and/or enamel weaknesses that will cause the restoration to fail.</td>
</tr>
<tr>
<td>There are no acute cavosurface angles.</td>
<td>Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration.</td>
<td>Cavosurface angles possibly compromise the integrity of the tooth or restoration.</td>
<td>Cavosurface angles will lead to enamel fracture or fracture of the restoration.</td>
<td>Cavosurface angles are grossly inappropriate for the situation and will lead to fracture of the restoration.</td>
</tr>
<tr>
<td>Axial wall follows external contour of tooth. Depth does not exceed 1.0 mm beyond the DEJ.</td>
<td>Axial wall generally follows external contour of tooth. Depth does not exceed 1.5 mm beyond the DEJ.</td>
<td>Axial wall does not follow contour of tooth. Depth does not exceed 2.0 mm beyond the DEJ.</td>
<td>Axial wall depth exceeds 2.0 mm beyond the DEJ. Affected dentin remains. Indirect pulp cap declared when no caries or affected dentin remains.</td>
<td>Gross removal of tooth structure jeopardizes the health of the tooth. Caries remains in the dentin or is not completely accessed. Unapproved surface prepared.</td>
</tr>
<tr>
<td>Internal line angles are rounded and smooth. Internal walls are well defined.</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. Moderately sharp line angles are present.</td>
<td>Internal walls are severely irregular and not defined. Angle of walls undermines enamel, jeopardizes incisal angle, or encroaches on the pulp.</td>
<td>Grossly irregular and sharp line angles show total disregard for the health of the tooth.</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>Score</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Outline is generally smooth and flowing, and does not weaken tooth in any manner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Outline is slightly irregular but does not weaken tooth. Isthmus is slightly wider than required for lesion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Outline moderately weakens marginal ridge or a cusp. Isthmus is too wide or too narrow for lesion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Outline severely weakens marginal ridge or a cusp. Outline is misshapen and/or forces improper angle of exit. Uneven demineralized enamel that is tactilely different from the adjacent unaffected enamel is present.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</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>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Outline & Extension

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Proximal and gingival extensions are visually open and break contact up to 1.0 mm.</td>
</tr>
<tr>
<td>4</td>
<td>Proximal and/or gingival extensions are slightly overextended.</td>
</tr>
<tr>
<td>3</td>
<td>Proximal and/or gingival extensions are moderately overextended.</td>
</tr>
<tr>
<td>2</td>
<td>Proximal and/or gingival extensions are in contact or obviously overextended.</td>
</tr>
<tr>
<td>1</td>
<td>Proximal and/or gingival extensions are grossly overextended.</td>
</tr>
</tbody>
</table>

### Optimal treatment of fissures

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Adequate treatment of fissures. Neither the tooth nor restoration is compromised.</td>
</tr>
<tr>
<td>4</td>
<td>Adequate treatment of fissures are near optimal. Axial wall contour is near optimal.</td>
</tr>
<tr>
<td>3</td>
<td>Adequate treatment of fissures. Axial wall contour is near optimal.</td>
</tr>
<tr>
<td>2</td>
<td>Adequate treatment of fissures. Axial wall contour is questionable. Axial wall contour is not optimal.</td>
</tr>
<tr>
<td>1</td>
<td>Adequate treatment of fissures. Axial wall contour is not optimal.</td>
</tr>
</tbody>
</table>

### Proximal cavosurface angles are approximately 90°. The integrity of both tooth and restoration is maintained.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Proximal and/or gingival extensions are slightly overextended. Axial wall contour is near optimal. Retentive grooves are minimal and extend up to and including the occlusal surface.</td>
</tr>
<tr>
<td>4</td>
<td>Proximal and/or gingival extensions are moderately overextended. Axial wall contour is questionable. Axial wall contour is not optimal. Retentive grooves are too deep or too shallow and/or placed in an incorrect position.</td>
</tr>
<tr>
<td>3</td>
<td>Proximal and/or gingival extensions are in contact or obviously overextended. Axial wall contour is not optimal. Retentive grooves are too deep or too shallow and/or placed in an incorrect position.</td>
</tr>
<tr>
<td>2</td>
<td>Proximal and/or gingival extensions are grossly overextended. Axial wall contour is not optimal. Retentive grooves are too deep or too shallow and/or placed in an incorrect position.</td>
</tr>
<tr>
<td>1</td>
<td>Proximal and/or gingival extensions are grossly overextended. Axial wall contour is not optimal.</td>
</tr>
</tbody>
</table>

### Pulpal floor is 1.5 mm-2.0 mm from the cavosurface and provides adequate bulk for strength of restorative material. Axial wall depth at the gingival floor is 1.0 mm-1.5 mm.

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>5</td>
<td>Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.</td>
</tr>
<tr>
<td>4</td>
<td>Axial wall contour is near optimal. Retentive grooves are minimal and extend up to and including the occlusal surface.</td>
</tr>
<tr>
<td>3</td>
<td>Axial wall contour is questionable. Axial wall contour is not optimal.</td>
</tr>
<tr>
<td>2</td>
<td>Axial wall contour is not optimal.</td>
</tr>
<tr>
<td>1</td>
<td>Axial wall contour is not optimal.</td>
</tr>
</tbody>
</table>

### 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 follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ. |

### Slot design: Proximal box is present. Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Internal Form

<table>
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<tr>
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<tr>
<td>5</td>
<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 follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.</td>
</tr>
<tr>
<td>4</td>
<td>Conventional design: Internal form is mostly smooth, but some minor roughness and/or sharp angles are present. 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>
</tr>
<tr>
<td>3</td>
<td>Conventional design: Internal form is generally smooth, but some moderate roughness and/or sharp angles are present. Retentive grooves, if placed, are too deep or too shallow, or placed in an incorrect location. Axial wall contour is not optimal. Slot design: Proximal box is present. Axial wall contour is not optimal. Retentive grooves are too deep or too shallow and/or placed in an incorrect position.</td>
</tr>
<tr>
<td>2</td>
<td>Conventional design: Internal form is rough and unfinished with major areas of roughness or sharp angles that will lead to restoration failure. Retentive grooves, if placed, are too deep or too shallow, or placed in an incorrect location, and will compromise the tooth or restoration. Slot design: Preparation has scooped appearance with excessive rounding of all line angles. Retentive grooves are too deep, too shallow, and/or placed in an incorrect location, and will compromise the tooth or restoration.</td>
</tr>
<tr>
<td>1</td>
<td>Conventional design: Internal form is grossly rough and/or has gross sharp angles that will lead to restoration failure. Gross disregard for proper placement of retentive features will compromise the tooth and restoration. Slot design: There is gross lack of internal form. Retentive grooves are absent.</td>
</tr>
</tbody>
</table>

### 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 follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ. |

### Slot design: Proximal box is present. Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Internal Form

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</tr>
<tr>
<td>4</td>
<td>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>
</tr>
<tr>
<td>3</td>
<td>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>
</tr>
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<td>2</td>
<td>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>
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### 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 follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ. |

### Slot design: Proximal box is present. Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Axial wall follows external contour of the tooth. Retentive grooves extend from gingival floor up to and/or including occlusal surface, are no more than 0.5 mm deep, and parallel to the DEJ.

### Operative Environment

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<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<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>
</tr>
<tr>
<td>4</td>
<td>Rubber dam isolation is not optimal, but the preparation is clean and dry.</td>
</tr>
<tr>
<td>3</td>
<td>Rubber dam isolation is adequate, but the wrong teeth are isolated. The preparation can be cleaned and dried.</td>
</tr>
<tr>
<td>2</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>
</tr>
<tr>
<td>1</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>
</tbody>
</table>

### No damage to the adjacent tooth.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>No damage to the adjacent tooth.</td>
</tr>
<tr>
<td>4</td>
<td>Minor damage to the adjacent tooth can be removed by polishing without changing the shape of the contact.</td>
</tr>
<tr>
<td>3</td>
<td>Damage to the adjacent tooth can be removed by polishing, but the shape of the contact will be changed.</td>
</tr>
<tr>
<td>2</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>
</tr>
<tr>
<td>1</td>
<td>Damage to the adjacent tooth will definitely require restoration.</td>
</tr>
</tbody>
</table>
### DIRECT FINISH
**SCORING CRITERIA RATING SCALE**

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</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. Marginal ridge is improperly shaped.</td>
<td>Anatomical form is improper. Marginal ridge is poorly shaped.</td>
</tr>
<tr>
<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. Embrasures are severely over or under contoured.</td>
<td>Grossly improper proximal contour or shape.</td>
</tr>
<tr>
<td>Normal proximal contact area and position are restored. Contact is visually closed and resists the passage of lightly waxed floss.</td>
<td>There is slight variation of normal contact area and position. Contact is visually closed and resists the passage of lightly waxed floss.</td>
<td>There is moderate variation of normal contact area and position. Lightly waxed floss will pass through the contact with slight resistance.</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><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>
</tr>
<tr>
<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>Occlusion is restored to proper centric with no lateral interferences.</td>
<td>There is severe hyperocclusion in centric or lateral excursions. Occlusal contact marks appear only on the restoration.</td>
<td>Occlusion is grossly inadequate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FINISH, FUNCTION &amp; DAMAGE</strong></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>
</tr>
</tbody>
</table>
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Posterior Composite 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.

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

Indicate:

<table>
<thead>
<tr>
<th>Type (outline or internal)</th>
<th>Location</th>
<th>Extent</th>
<th>Reason</th>
<th>Floor Examiner Initials</th>
<th>Grading Examiner Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
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<td></td>
</tr>
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<td></td>
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<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

 Radiographs submitted on computer

Acceptance

Note to Examiners (if necessary)  Accepted by:__________________________  Accepting Examiners Initials

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

Indicate:

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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

 Preparation Grade

Note to Examiners (if necessary)  Preparation Graded:___________  Grading Examiners 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: __________________  Clinic Day 2: __________________

Floor Examiner  Floor Examiner

Finish Restoration Grade □ Slot Design

Note to Examiners (if necessary)  Finish Graded:___________  Grading Examiners Initials

Patient may be released from the examination:  Floor Examiner

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

2019 - Revised
### Medications Taken By Patient Today

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Drug Name and Concentration</th>
<th># of Tabs/Capsules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Local Anesthetic Administered for this Procedure

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Type and Concentration of Local Anesthetic and Vasoconstrictor</th>
<th>Cartridges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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/Consent Form
  - Including pulse & blood pressure
  - Floor Examiner initials
  - Patient Procedure(s)
  - Patient address and signature
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- 40-micron Articulating Paper on Miller Type Forceps (if Provisionally Accepted)
- Floss Singles (if Provisionally Accepted)

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

#### Submitting Patient for Finish Grade
(no rubber dam)
- Worksheet with radiographs
  - Box checked for “Finish Restoration Grade”
  - Medication taken, # cartridges local anesthetic administered
  - Notes to Examiner, if needed
- 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 Mirror
  - New Pigtail Explorer
  - New Shepherd’s Hook Explorer
  - Three 2 x 2 Gauze
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray

### Instruments
- New #4 or #5 Metal Front Surface Mirror
- New Pigtail Explorer
- New Shepherd’s Hook Explorer
- Three 2 x 2 Gauze
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray
Composite Worksheet
Direct Anterior Class III

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

Referred for Clinical Review By: __________

Acceptance
Note to Examiners (if necessary)

Accepted By: __________
Accepting Examiners Initials

Modification Request - (Floor Examiner may instruct you to proceed or may send your patient to the grading area)
Indicate:
Type (outline or internal) Location Extent Reason
Floor Examiner Initials Grading Examiner Initials
1. 
2. 
3. 
4. 
5. 
6. 

☐ Preparation Grade
Note to Examiners (if necessary)

Preparation Graded: __________
Grading Examiners 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
Note to Examiners (if necessary)

Finish Graded: __________
Grading Examiners Initials

Patient may be released from the examination: __________
Floor Examiner

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

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  - Medication taken, # cartridges local anesthetic administered
- Completed Patient Medical History/Consent Form
  - Including pulse & blood pressure
  - Floor Examiner initials
  - Patient Procedure(s)
  - Patient address and signature
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- Rubber dam in place
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- Completed Patient Medical History/Consent Form (if Provisionally Accepted)

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

**Submitting Patient for Finish Grade**
(no rubber dam)
- Worksheet with radiographs
  - Box checked for “Finish Restoration Grade”
  - Notes to Examiner, if needed
- 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 Mirror
  - New Pigtail Explorer
  - New Shepherd’s Hook Explorer
  - Three 2 x 2 Gauze
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray

**Instruments**
- New #4 or #5 Metal Front Surface Mirror
- New Pigtail Explorer
- New Shepherd’s Hook Explorer
- Three 2 x 2 Gauze
## Sample Amalgam Worksheet
### Direct Posterior Class II

- **Candidate ID #:** _______

- **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** □

**Note to Examiners** (if necessary)

**Accepted by:** _______

**Accepting Examiners Initials**

**Modification Request** - (Floor Examiner may instruct you to proceed or may send your patient to the grading area)

<table>
<thead>
<tr>
<th>Type (outline or internal)</th>
<th>Location</th>
<th>Extent</th>
<th>Reason</th>
<th>Floor Examiner Initials</th>
<th>Grading Examiner Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</tbody>
</table>

**PREPARATION GRADE**

**Note to Examiners** (if necessary)

**Preparation Graded:** _______

**Grading Examiners 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:** _______
- **Clinic Day 2:** _______

**FINISH RESTORATION GRADE** □

**Slot Design** □

**Note to Examiners** (if necessary)

**Finish Graded:** _______

**Grading Examiners Initials**

**Patient may be released from the examination:** _______

**Floor Examiner**

---

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

---

2019 - Revised
## Medications Taken By Patient Today

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Drug Name and Concentration</th>
<th># of Tabs/Capsules</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

## Local Anesthetic Administered for this Procedure

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Type and Concentration of Local Anesthetic and Vasoconstrictor</th>
<th>Cartridges</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

## 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/Consent Form
  - Including pulse & blood pressure
  - Floor Examiner initials
  - Patient Procedure(s)
  - Patient address and signature
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- Rubber dam in place
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- Completed Patient Medical History/Consent Form (if Provisionally Accepted)

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

### Submitting Patient for Finish Grade (no rubber dam)
- Worksheet with radiographs
  - Box checked for “Finish Restoration Grade”
  - Medication taken, # cartridges local anesthetic administered
  - Notes to Examiner, if needed
- Patient Tray
  - Add Miller-type Articulating Paper Forceps
- Candidate ID label on patient bib
- Patient Eye Protection
- Completed Patient Medical History/Consent Form (if Provisionally Accepted)

### Patient Tray for All Procedures
- Instruments
  - New #4 or #5 Metal Front Surface Mirror
  - New Pigtail Explorer
  - New Shepherd’s Hook Explorer
  - Three 2 x 2 Gauze
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray
### INDIRECT POSTERIOR CLASS II PREPARATION

#### SCORING CRITERIA RATING SCALE

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTLINE &amp; EXTENSION</strong></td>
<td></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. Limestone is slightly wider than required for lesion.</td>
<td>Outline moderately weakens marginal ridge or a cusp. Limestone is too wide or too narrow for lesion.</td>
<td>Outline severely weakens marginal ridge or a cusp. Unsound demineralized enamel that is tactically different from the adjacent unaffected enamel is present.</td>
<td>Outline is grossly improper and/or lacks any definite form. Tactically unsound demineralized enamel penetrates the DEJ. Caries remains in the enamel or is not completely accessed. Unapproved surface prepared.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximal and gingival extensions are visually open and break contact 0.75 mm-1.25 mm. The gingival margin has a discernible bevel (at least 0.5 mm). All margins and bevels are smooth and well defined.</td>
<td>Proximal and/or gingival extensions are slightly overextended. Margins are slightly irregular. Bevels are less than 0.5 mm or greater than 1.0 mm.</td>
<td>Proximal and/or gingival extensions are moderately overextended. Margins are moderately irregular. Bevels are moderately shallow or deep.</td>
<td>Proximal and/or gingival extensions are in contact or obviously overextended. Margins are critically irregular or not defined. Bevels are critically shallow or deep, or on large areas of unsupported enamel.</td>
<td>Proximal and/or gingival extensions are grossly overextended. Margins exhibit gross lack of definition. Bevels are absent.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<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.</td>
<td>Lack of treatment of fissures will seriously compromise the tooth and restoration.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximal cavosurface angles are approximately 90°.</td>
<td>Cavosurface angles are not optimal but do not compromise the integrity of the tooth or restoration.</td>
<td>Cavosurface angles possibly compromise the integrity of the tooth or restoration.</td>
<td>Improper cavosurface angles will cause the final restoration to fail.</td>
<td>Cavosurface angles are grossly improper.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
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<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal resistance and retention form. Parallelism of walls is ideal; there are no undercuts present.</td>
<td>Resistance and retention form is adequate. Walls are slightly over-tapered. No undercuts are present.</td>
<td>Resistance and retention form is minimally present. Walls are moderately over-tapered, or a small undercut on one wall compromises draw.</td>
<td>Resistance and retention form is inadequate. Walls are excessively over-tapered, or moderate undercuts are present. Complete seating or retention of the restoration is compromised.</td>
<td>Resistance and/or retention form is completely absent. Walls are grossly over-tapered or gross undercuts present. Seating or retention of the restoration is not possible. Unapproved surface prepared.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal depth/reduction of walls conserves tooth structure and allows for adequate bulk of restorative material.</td>
<td>Slight over-reduction or under-reduction of walls and/or floor is present.</td>
<td>Moderate over-reduction or under-reduction of walls and/or floor is present.</td>
<td>Critical over-reduction or under-reduction of walls and/or floor is present. Excessive depth will damage the pulp. Affected dentin remains. Indirect pulp cap declared when no caries or affected dentin remains.</td>
<td>Gross over-reduction or under-reduction of walls and/or floor is present. Pulp is definitely compromised. Caries remains in the dentin or is not completely accessed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>4</th>
<th>3</th>
<th>2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>All walls are smooth. Line angles are clearly defined.</td>
<td>Walls and/or line angles are slightly irregular.</td>
<td>Walls and/or line angles are moderately irregular.</td>
<td>Walls and/or line angles are rough and poorly defined.</td>
<td>There is gross lack of internal definition throughout preparation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
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</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

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<thead>
<tr>
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<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<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>INDIRECT RESTORATION FINISH SCORING CRITERIA RATING SCALE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>ANATOMICAL FORM</strong></td>
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<td></td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<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. Marginal ridge is improperly shaped.</td>
<td>Anatomical form is improper. Marginal ridge is poorly shaped.</td>
<td>There is gross lack of anatomical form.</td>
</tr>
<tr>
<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. Embrasures are severely over or under contoured.</td>
<td>Grossly improper proximal contour or shape.</td>
</tr>
<tr>
<td>Normal proximal contact area and position are restored.</td>
<td>There is slight variation of normal contact area and position. Contact is visually closed and resists the passage of lightly waxed floss.</td>
<td>There is moderate variation of normal contact area and position. Lightly waxed floss will pass through the contact with slight resistance.</td>
<td>Contact is visually open, or floss will not pass through the contact.</td>
<td>Contact is grossly open.</td>
</tr>
<tr>
<td>Restoration is fully seated with no excesses or deficiencies anywhere along the margins.</td>
<td>Restoration is seated. Margins are closed, but slight marginal excesses or deficiencies are detectable with an explorer.</td>
<td>Restoration is seated. Moderate marginal excesses or deficiencies are detectable with an explorer.</td>
<td>Restoration is not seated. There are multiple areas of exposed cement, open margins, and/or marginal excesses.</td>
<td>Restoration is not seated. There are grossly evident areas of exposed cement, open margins, and/or marginal excesses.</td>
</tr>
<tr>
<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. Surface has minor casting irregularities.</td>
<td>Severe surface irregularities, pitting, or voids are present.</td>
<td>Gross surface defects are present.</td>
</tr>
<tr>
<td>Occlusion is restored to proper centric with no lateral interferences.</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>
Patient’s First Name: ____________________

Cast Gold Worksheet
Indirect Posterior Class II

Tooth #:___________   □ DO Inlay  □ MO Inlay  □ MOD Inlay  □ MOD Onlay  
□ 3/4 Crown  □ DO Inlay & MO Inlay  □ Other

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

□ 2nd Submission  □ 3rd Submission  Candidate ID #:___________

Floor Examiner may instruct you to proceed or may send your patient to the grading area

Indicate:

Patient may be released from the examination:

Floor Examiner

Referred for Clinical Review By:

Acceptance

Note to Examiners (if necessary)

Preparation Graded:

Preparation Graded by:

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

Indicate:

Type (outline or internal)   Location   Extent   Reason

Floor Examiner Initials   Grading Examiner Initials

1.________________________

2.________________________

3.________________________

4.________________________

5.________________________

6.________________________

□ PREPARATION GRADE

Preparation Graded by:

Grading Examiners Initials

□ FINISH RESTORATION GRADE

Finish Graded by:

Grading Examiners Initials

Patient may be released from the examination:

Floor Examiner

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

Clinic Day 1:  ____________________    Clinic Day 2:  ____________________

Floor Examiner  Floor Examiner

Review of Tooth without casting in place, prior to cementation

Floor Examiner

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

2019 - Revised
Medications Taken By Patient Today

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Drug Name and Concentration</th>
<th># of Tabs/Capsules</th>
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Local Anesthetic Administered for this Procedure

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<th>Date and Time</th>
<th>Type and Concentration of Local Anesthetic and Vasoconstrictor</th>
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</table>

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/Consent Form
  - Including pulse & blood pressure
  - Floor Examiner initials
  - Patient Procedure(s)
  - Patient address and signature
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- 40-micron Articulating Paper on Miller Type Forceps
  (if Provisionally Accepted)
- Floss Singles (if Provisionally Accepted)

**Submitting Patient for Preparation Grade**

- Worksheet with radiographs
  - Box checked for "Preparation Grade"
  - Notes to Examiners, if needed
  - Medication taken, # cartridges local anesthetic administered
- Rubber dam in place
- Patient Tray
- Candidate ID label on patient bib
- Patient Eye Protection
- Completed Patient Medical History/Consent Form
  (if Provisionally Accepted)

**Submitting Patient for Finish Grade**

(no rubber dam)

- Worksheet with radiographs
  - Box checked for "Finish Restoration Grade"
  - Medication taken, # cartridges local anesthetic administered
  - Notes to Examiner, if needed
- 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 Mirror
  - New Pigtail Explorer
  - New Shepherd’s Hook Explorer
  - Three 2 x 2 Gauze
- Instruments must be in an open autoclave bag
- Place paperwork on top of the tray

**Instruments**

- New #4 or #5 Metal Front Surface Mirror
- New Pigtail Explorer
- New Shepherd’s Hook Explorer
- Three 2 x 2 Gauze

**Checklist of Required Items**

**Submitting Patient for a Modification Request**

- Worksheet with radiographs
  - Medication taken, # cartridges local anesthetic administered
- Notes to Examiners on the Worksheet
  - Type of modification
  - Location of modification
  - Exact extent of modification
  - Why the modification is needed
- Rubber dam in place
- Patient Tray
- Candidate ID label on patient bib
- Call a Floor Examiner
- Completed Patient Medical History/Consent Form
  (if Provisionally Accepted)
ENDODONTICS

Endodontic Section Overview

The Endodontic Section is a three (3) hour exam consisting of two (2) procedures:

1. **Anterior Tooth Procedure**: Treat one maxillary central incisor simulated tooth, including access, instrumentation, and obturation.

2. **Posterior Tooth Procedure**: Access one mandibular first molar simulated tooth. Access on the posterior tooth must allow Grading Examiners to identify all canal orifices.

You will be given three (3) hours to complete the exam and will be allowed in the Simulation Lab an additional 30 minutes before the exam to set up. The Endodontic Section is a scheduled time block to which Candidates are randomly assigned. Approximately four (4) weeks prior to the exam, you will receive your schedule with your assigned time block.

WREB examines Candidates with varying educational backgrounds and schools may teach different endodontic procedures. WREB does not look for one standard procedure and scores performance according to the *Endodontic Scoring Criteria Rating Scale* at the end of this section.

**Supplies**

Acadental materials will be used for the Endodontic Section. The teeth to be used on the exam are X2 Endo™ teeth. These teeth are similar to but not exactly the same as teeth available from Acadental for practice.

In the Simulation Lab, you will receive in a ziplock bag:

1. Your assigned teeth, (one maxillary central incisor and one mandibular first molar), mounted with Apex Putty™ and Fixing Gel™ in the appropriate sextants. There will be a secure number printed on the sextants, which will be pre-assigned to your WREB Candidate ID Number.

2. Two preoperative radiographic views for your assigned teeth (one buccal-lingual view and one proximal view).


You will need to provide:

1. The maxillary ModuPRO® Endo arch with magnetic Carrier Tray™ and three removable sextants.

2. The mandibular ModuPRO® Endo arch with magnetic Carrier Tray™ and three removable sextants.

3. Articulator, required at some sites (check your exam site’s information).

You must bring the upper and lower carrier trays with all necessary sextants to complete the arches. No extracted teeth should be in any of the sextants. Only the supplies listed in the “Site Information” will be provided by the school. You must provide all other supplies and equipment, including special equipment or mechanical files. Before entering the Simulation Lab, make sure you have all necessary equipment and supplies.
The “Site Information” (available at wreb.org) will have details on compatible equipment and whether you may purchase the arches through the school. Arches may be purchased directly from Acadental at acadental.com/WREB. Acadental carries segmented sextants approved for this exam. Please refer to the “Site Information” (available at wreb.org) for your exam site prior to arrival to be sure your particular typodont is compatible with their manikin setup. All six (6) sextants must be mounted in the arches during treatment.

Exam Procedure

There will be an assigned time for the Endodontic Section. If enrolled in the Prosthodontic Section, it will be scheduled on the opposite day of your Endodontic Section. Specific time assignments may vary due to logistical limitations. You should review your exam schedule carefully when you receive notification that group assignments have been made (approximately four (4) weeks prior to the exam).

You will report to the designated Simulation Lab at the appointed time. You must bring your personal handpieces and burs or anything else needed to complete preparations on simulated teeth in a simulation environment. When entering the lab, make sure you are wearing your Candidate ID Badge and it is visible. As a reminder, electronic devices, including cell phones, are prohibited in the Simulation Lab.

Stations have been pre-assigned and will be marked by a green numbered card. When you enter the lab, see the Proctor who will give you your station number. You must sit at the unit assigned to you and may begin setting up your unit. Once you are at your assigned unit, then you may pick up your sextants from the Proctor. It is recommended you do this after you have confirmed that you have all required instruments and materials and will not need to leave the lab. After receiving the sextants, you may not leave the lab without notifying the Floor Examiner. The Floor Examiner must check that the correct sextants are in the arch and mounted in the manikin prior to your leaving the lab. Leaving the lab without notifying the Floor Examiner will result in failure of the Endodontic Section. Do not start treatment until you have setup check approval from the Floor Examiner and you hear the start of the examination announced.

The type of radiographic equipment (conventional and/or digital) may vary site to site. The Lab Maintenance Auxiliary is available to answer any questions you have on how to use the equipment and should be notified of any equipment problems.

Please remember to place all syringes, files and other sharps in the Sharps containers.

You will be allowed to enter the lab at your assigned setup time. Again, you must wear your Candidate ID Badge in a visible location or you will not be allowed to enter. You are allowed a thirty (30) minute setup period prior to the start of the Endodontic Section. Use this time to make additional preoperative radiographs (if needed), to arrange materials and become familiar with the manikin setup procedure. Being prepared with all of the necessary materials will allow you to be ready to begin on time.
Remember that after you receive your sextants, if you need to leave the lab, you must notify the Floor Examiner and the two (2) sextants must be mounted in the manikin. Before you leave the lab, check out with the Proctor. If there are mechanical problems with your unit, you must notify the Floor Examiner immediately. Leaving the room with sextant(s) will result in an automatic failure of the Endodontic Section.

Once you receive your sextants, write with permanent black marker your WREB Candidate ID Number on the lingual of each sextant, making sure not to interfere with the manufacturer’s preprinted code. Place the sextants in the carrier tray to complete your arches and mount in the manikin. Complete your Endodontic Worksheet. The Floor Examiner will perform a setup check and initial your Endodontic Worksheet. The following should be ready for the Floor Examiner:

1. Endo arches/articulator properly mounted in the manikin
2. Sextants with WREB Candidate ID Number written on the lingual with permanent black marker
3. Manikin in correct patient treatment position with correct vertical dimension
4. Light on and mirror on tray
5. Completed Endodontic Worksheet on tray

Once these items are ready, notify the Floor Examiner you are ready for a setup check. The rubber dam need not be in place for setup check. Both anterior and posterior teeth will receive a setup check at the same time.

Do not start treatment until you have setup check approval from the Floor Examiner and the Floor Examiner has announced the start of the exam.

If access is started without a setup check or prior to the announced start time, all access points for the tooth are lost.

If the pulp chamber has been entered without a setup check or prior to the announced start time, all points for the tooth are lost.

Rubber dam placement must simulate proper placement on a patient and is required before any treatment of the tooth is begun. It must remain in place throughout the procedure. Rubber dams may be removed only for making radiographs. It is recommended that the rubber dam clamp not be placed on the tooth being treated.

Performing the access opening or filing/preparation, or condensation of a canal without a rubber dam properly placed, is reason for dismissal from the Endodontic Section with loss of all points for both teeth for the Endodontic procedures.

Single or multi-tooth isolation is acceptable. Placing the rubber dam clamp on an adjacent tooth is recommended. If a tooth loosens, notify the Floor Examiner immediately.
You are expected to:

1. Follow universal precautions including radiation safety.
2. Work with arches mounted in proper patient head simulation.

Violation of any of the above is grounds for dismissal and the loss of all points for the Endodontic Section.

Working on the tooth or sextant in your hand and not properly mounted, at any time during the exam, is reason for dismissal from the Endodontic Section with loss of all points for both teeth for the endodontic procedures.

You are allowed to bring this Candidate Guide into the lab and refer to it during the exam. Textbooks or other informational material must not be brought into the lab. No magnification other than loupes is allowed. Candidates may not assist each other; this includes critiquing another Candidate’s radiographs and/or discussion of treatment. Assistants are not permitted for this procedure.

**Anterior Tooth Procedure**

You will perform Endodontic treatment of one maxillary central incisor including access, instrumentation, and obturation.

Instrumentation technique, either mechanical or manual, is at your discretion.

If a root fractures during treatment, Grading Examiners will score no higher than a 3.00 for condensation.

Any form of gutta-percha filling technique may be used; including any warm gutta-percha or carrier based thermoplasticized gutta-percha techniques, as well as thermoplastic synthetic polymer filling material. Because the X2 Endo™ teeth use 3D printing, warm vertical obturation techniques work best at 175 degrees as opposed to 200+ degrees with natural teeth. There should be no fill coronal to the cemento-enamel junction (CEJ) in the proximal view.

You may make notes concerning treatment on the Endodontic Worksheet, which you feel would be beneficial to the Grading Examiners; however, the Floor Examiner will not sign any note about treatment which he/she has not personally observed.

When making radiographs, the sextants should be removed from the arches as necessary. Only the preop and postop radiographs will be turned in. Taking excessive radiographs during the three-hour block consumes time and may result in late penalties. Plan accordingly.
**Posterior Tooth Procedure**

You will perform endodontic access on a mandibular first molar, provided in your Endodontic ziplock bag. Be sure that the Grading Examiners can identify the orifices of all canals. **You are not required to instrument or obturate any posterior canals.** Please refer to the *Endodontic Scoring Criteria Rating Scale*, which describes all of the criteria that will be used by Grading Examiners to score the Access.

**Preoperative Radiographs**

A sphere, measuring 2.0 mm, has been embedded in the tooth sextant by the manufacturer for the exam. This sphere will be visible on the preoperative radiographs provided to you with your sextants. The sphere may be used to assist in determining/measuring the estimated working length and/or final treatment working length. The sphere can also be used to estimate the various dimensions of the pulp chamber.

**Postoperative Radiographs**

When making radiographs, the sextants should be removed from the arches. Place the sextant so the tooth to be radiographed faces the center of the radiograph head. Place the film or sensor under the sextant. If the film does not stay in place, use soft wax to secure the film or the sextant or use the OPTI-X. Further instructions on taking radiographs with either conventional film or digital may be found at acadental.com/MPEMounting.

The plastic sextant is less dense than bone; therefore, exposure times may need to be reduced. Postoperative radiographs of the final treatment should be taken with rubber dam and clamp removed. The radiographs should be from the same projection as the preoperative radiographs supplied: one from a buccal projection and one from a proximal projection.

The 2.0 mm sphere must be visible on all digital radiographic images.

Your postoperative digital radiographs may be printed or submitted by saving to a specific folder in the computer, depending on the site. If you are submitting your digital radiographs by computer, the images must be stored to the appropriate template at the capture station so that all required views of each tooth fit on the monitor screen at the same time. Both postoperative images for the anterior tooth should appear on one screen and both images for the posterior tooth should appear on another. The individual images must not exceed three times the size of a conventional #2 film radiograph.

The file name for each tooth should include your Candidate ID Number, tooth number, and either “Anterior” or “Posterior.” A sample file name for an anterior tooth would be: **B160 #8 Anterior.**
You are responsible for submitting high-quality radiographs/images.

Postoperative radiographs validated undiagnostic by the Grading Examiners will result in a deduction from the Endodontic score. (See pg. 73 for “Endodontic Scoring.”) Radiographs are undiagnostic when they must be retaken to determine adequacy of treatment. If final radiographs are not submitted, there will be a deduction for each tooth.

Be familiar with the Site Information provided at wreb.org to determine the type of radiographic equipment that will be available in the Simulation Lab. Some schools will have only digital facilities, and some will have only conventional. If conventional, schools will provide either automatic or hand developers. Be prepared to use either method of developing film. You must use the developing and fixing machines provided by the school in the lab. You may not leave the lab to develop films or provide your own developing equipment. You may provide your own self-developing film. Neither the school nor WREB can be held responsible for the quality of radiographs. There are often lines for the radiograph machines at the end of the three-hour exam. **It is important that you schedule carefully or be prepared with self-developing film.**
Completing the Section

When turning in your ziplock bag after treatment, be sure it includes:

1. The two sextants with the treated teeth.
2. Candidate ID Number written on the lingual with permanent black marker.
4. Preoperative radiographs provided by WREB.
5. Postoperative radiographs:
   - If digital site with computer submission, the images must be saved in Candidate folder.
   - If digital site with printed radiographs, the printed images must be included in the ziplock bag.
   - If conventional site, the films, in a two-hole film mount, must be included in the ziplock bag.

It is your responsibility to ensure that all of the materials listed above are turned in. The Proctor will note your checkout time, but is not responsible for checking your materials. Once you have left the lab, you will be subject to failure of the Endodontic Section for items not turned in.

Late penalties will be assessed to Candidates who exceed the three (3) hours allotted for the exam. You must have your endodontic sextants and radiographs turned in on time to avoid a late penalty. A deduction to the Endodontic score will be assessed for each five (5) minutes beyond the end of the time allowed. After 15 minutes, all points for the Endodontic Section will be lost. (See pg. 74 for “Late Penalties.”)

A random selection of teeth may be evaluated at the end of each exam. Any alteration or replacement of a tooth will result in failure of the entire exam and appropriate disciplinary action will be taken. Examiners may remove the teeth from the sextants to look for irregularities.

Definitions

The following definitions are provided to assist you in more fully understanding scoring criteria and communications with Examiners:

**Apical Perforation**: Creating a new apical foramen.

**Ledging**: An irregularity created in the canal wall during filing.

**Major Tissue Trauma**: Major tissue trauma is defined as gross iatrogenic damage to the simulated gingiva, adjacent teeth, or surrounding tissue resulting in significant injury to the simulated patient. This includes gross perforation that would result in loss of the tooth.

**Strip Perforation**: A perforation on the lateral side of the root caused by transporting.

**Transporting**: Changing the position of the canal by straightening the walls during filing.
**Unroofed Pulp Chamber**: The dentin that covers the chamber incisally or occlusally, in which no ledges or overhangs are visible.

**Zipping**: Transporting the apical foramen.

**Reference Material**

WREB uses the basic endodontic access criteria from Stephen Cohen. Pathways of the Pulp, (11th ed.), Elsevier, Inc. St. Louis.

Other references are:


American Association of Endodontics. (Spring 2010). Access Opening and Canal Location Endodontics - Colleagues for Excellence. (Available online at AAE.org)
The Endodontic Section consists of two (2) procedures:

1. **Anterior Tooth Procedure**: Treat one maxillary central incisor simulated tooth, including access, instrumentation, and obturation.

2. **Posterior Tooth Procedure**: Access one mandibular first molar simulated tooth. Access on the posterior tooth must allow Grading Examiners to identify all canal orifices.

**Weighting**
Anterior Access is weighted 27%
Anterior Condensation is weighted 46%
Posterior Access is weighted 27%

The Endodontic Section is scored by three independent Grading Examiners. Grading Examiners score according to the *Endodontic Scoring Criteria Rating Scale* on pg. 75. The recorded score for each category is based on median (middle) score of the three (3) scores assigned by the Grading Examiners. The median grades are then weighted and summed.

A score of 3.00 or higher is required to pass the Endodontic Section.

**Endodontic Onsite Retakes**
Candidates with a failing result in Endodontics may have the opportunity to retake the section at the same exam site on Clinic Day 3. This will be dependent on each Candidate’s scheduled sections and individual time constraints. Onsite retakes for Endodontics are not available on Clinic Days 1 or 2. Three (3) hours will be allotted for Endodontic retakes on Clinic Day 3. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, Candidates may retake the Endodontic Section at a different site (retake fees will apply).

**Score Deductions**

| Undiagnostic Radiographs (postoperative) | = 0.2 deducted per tooth
| Radiographs are undiagnostic when they must be retaken to determine adequacy of treatment. | Maximum 0.4 deduction
| Validated by two or more Grading Examiners |
| Missing Radiographs (postoperative) | = 0.3 deducted per tooth
| Validated by two or more Grading Examiners | Maximum 0.6 deduction

73
### Late Penalties

Time is determined by the official WREB clock displayed in the Simulation Lab.

<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>Loss of all points for the Section</td>
</tr>
</tbody>
</table>

### Unusual Situations

<table>
<thead>
<tr>
<th>Unusual Situation</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessed the wrong tooth*</td>
<td>Failure of the Endodontic Section</td>
</tr>
<tr>
<td>Started without a setup check or before start time announced</td>
<td>Failure of the Endodontic Section</td>
</tr>
<tr>
<td>Repeated failure to use universal precautions</td>
<td>Failure of the Endodontic Section</td>
</tr>
<tr>
<td>Repeated violation of simulation protocol</td>
<td>Failure of the Endodontic Section</td>
</tr>
<tr>
<td>Major Tissue Trauma*</td>
<td>Failure of the Endodontic Section</td>
</tr>
<tr>
<td>Left Simulation Lab with sextant(s)</td>
<td>Failure of the Endodontic Section</td>
</tr>
</tbody>
</table>

*This is a critical error that precludes an onsite retake.*
# Endodontic Scoring Criteria Rating Scale

<table>
<thead>
<tr>
<th>ACCESS OPENING</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outline</td>
<td>Near ideal shape, size and location. For anterior esthetics are not affected. If crown is fractured, access is intact or outline and shape can be determined by putting pieces back together.</td>
<td>Some variation in shape, size and/or location. May be slightly over or under extended. For incisors, minor encroachment on incisal edge, but is acceptable for apical instrumentation. If crown is fractured, outline and shape can mostly be determined.</td>
<td>Shape, size and/or location are functional. May be moderately over or under extended. For anterior, encroachment on incisal edge is more than necessary for apical instrumentation. If crown is fractured, outline and shape can mostly be determined.</td>
<td>Improper shape, size and/or location (prevents proper instrumentation); or too large (crown is compromised by excessive extension). For anterior, severe encroachment on the incisal edge inappropriate for apical instrumentation. If crown is fractured, outline and shape can partially be determined.</td>
<td>Grossly improper shape, size or location; crown severely compromised by gross extension. For anterior, incisal edge is grossly violated, not necessary for apical instrumentation. If crown is fractured, outline and shape cannot be determined.</td>
</tr>
<tr>
<td>Access</td>
<td>No obstructions to canals.</td>
<td>Slight over or under removal of tooth structure. Slight obstruction present.</td>
<td>Moderate over or under removal of tooth structure. Moderate obstruction present.</td>
<td>Excessive over or under removal of tooth structure (prevents proper instrumentation). Filled with gutta percha or other material preventing proper visualization of access.</td>
<td>External crown shape altered. Occusal surface reduced. Coronal or furcal perforation.</td>
</tr>
<tr>
<td>Fill</td>
<td>Gutta-percha fully within root, less than or equal to 1.0 mm from apical foramen. Less than or equal to 1.0 mm of sealer extruded beyond apical foramen. May have more than 1.0 mm but less than or equal to 3.0 mm of sealer extruded beyond apical foramen.</td>
<td>Gutta-percha fully within root, less than or equal to 1.5 mm from apical foramen. Gutta-percha less than or equal to 2.0 mm from apical foramen, short or long. Sealer extruded more than 3.0 mm beyond the apical foramen.</td>
<td>Gutta-percha less than or equal to 2.0 mm from apical foramen.</td>
<td>Gutta-percha less than or equal to 3.0 mm from apical foramen or none present; or an unacceptable material used.</td>
<td>Gutta-percha more than 3.0 mm short or long from apical foramen or none present; or an unacceptable material used.</td>
</tr>
<tr>
<td>Shape</td>
<td>Smooth and tapered from CEJ to apical foramen. Smooth and tapered, minor irregularities. Minor under or over instrumentation. Tapered with moderate irregularities. Moderate under or over instrumentation. Apex transported but less than or equal to 1.0 mm.</td>
<td>Tapered with moderate irregularities. Moderate under or over instrumentation. Apex transported greater than 1.0 mm or less than or equal to 3.0 mm, creating an artificial canal.</td>
<td>Tapered with significant irregularities. Excessive over or under instrumentation. Apex transported greater than 3.0 mm or less than or equal to 3.0 mm, creating an artificial canal.</td>
<td>Root perforation due to stripping. Apex transported greater than 3.0 mm creating an artificial canal.</td>
<td></td>
</tr>
</tbody>
</table>

A separated file in the canal will be scored based on established WREB criteria. A root fracture can score no higher than a 3.00 for condensation.
Endodontic Worksheet

Anterior Tooth #: ____________
Candidate ID #: ____________

Posterior Tooth #: ____________
Date: ____________

Setup Check

☐ Endo arches/articulator properly mounted in manikin
☐ Sextants with WREB Candidate ID written on the lingual with Sharpie permanent marker
☐ Manikin in correct patient treatment position with correct vertical dimension
☐ Light on and mirror on tray
☐ Endodontic Worksheet on tray

Floor Examiner

<table>
<thead>
<tr>
<th>Treatment - Note to Grading Examiners</th>
<th>Grading Examiner Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Checklist of required items after treatment (in ziplock bag):

☐ The two sextants with treated teeth
☐ Candidate ID written on lingual with Sharpie permanent marker
☐ Endodontic Worksheet
☐ Preoperative radiographs provided by WREB
☐ Postoperative radiographs: One buccal and one proximal for each tooth:
  • If digital site with computer submission, must be saved in Candidate folder.
  • If digital site with printed radiographs, include in the bag.
  • If conventional site, submit in two-hole film mounts in the bag.

This worksheet must be turned in at the end of the exam.

2018 - Revised
PERIODONTAL TREATMENT

Periodontal Treatment Section Overview

You are responsible for providing a patient for the Periodontal Treatment Section of the exam and will perform scaling and root planing on one or two (2) quadrants of the mouth.

Only one quadrant is required if the criteria listed below are met. If additional teeth are needed to obtain the required calculus and/or pocket depths, two quadrants may be used.

General Instructions

Periodontal patients may be submitted for approval to treat at any time during the exam. However, periodontal treatment must be completed the same day your patient is approved for treatment.

All teeth in the selected quadrant must be treated. If a second quadrant is used, all teeth in both quadrants must be treated.

The quadrant submitted should not contain teeth with acute (painful) periapical or periodontal conditions. WREB cautions against pre-scaling any surfaces of the teeth as it may reduce the number of qualifying surfaces in the submission and may result in a patient submission rejection.

Patient Criteria

A. Teeth
   There must be a minimum of six (6) teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar.

B. Calculus
   A minimum of eight (8) surfaces of readily demonstrable subgingival calculus must be present in one or two quadrants. Readily demonstrable subgingival calculus is defined as easily explorer detectable, heavy ledges. At least six surfaces of the subgingival calculus must be on posterior teeth. Each tooth has four surfaces: mesial, distal, facial, and lingual for qualifying calculus.

C. Sulcus/Pockets
   At least one sulcus/pocket depth of 5.0 mm or greater must be present on at least two of the teeth.

A single tooth has a maximum of six periodontal pockets.
A partially erupted third molar does not qualify for presence of calculus or pocket depth and will not be graded for treatment. A partially erupted third molar is one that has not fully reached the occlusal plane or has tissue covering part of the occlusal surface. A fully erupted third molar does qualify and will be graded for treatment.

**Patient Acceptance**

Prior to beginning treatment, the quadrant(s) must be approved by the Grading Examiners. You may submit your patient or your patient may be submitted by your assistant if all paperwork is complete and the required instruments are present.

No electronic devices, including cell phones and smart watches, are allowed in the grading area. Patients with electronic devices will be required to return the device to the Candidate clinic.

To facilitate Grading Examiner evaluation and for patient comfort, anesthetize the quadrant(s) you are submitting for approval. Send your patient to the grading area with:

A. **Worksheet**: (sample, pgs. 85-86) Use only blue or black ink (not pencil). Complete the original worksheet (not a copy).
   - Write your patient’s first name only.
   - Write your Candidate ID Number in the upper right corner.
   - Check the quadrant(s) you are submitting.
   - List all teeth for the quadrant(s) you are submitting.
   - Indicate missing teeth with an "X" through the entire column.
   - Indicate the location of subgingival calculus by marking an “X” in the appropriate boxes for all teeth in the quadrant(s).
   - Using a periodontal probe, measure the sulcus/pocket depths. Measurements should be taken at the greatest depth for each area. For each tooth, record the pocket depths of 3.0 mm or greater in the spaces provided.
   - Check the “Acceptance” box.
   - All medications your patient has taken today, including type, concentration and amount should be listed on the back of the worksheet. Cartridges of local anesthetic, as they are administered for the procedure, also should be listed. If no medications are taken, write none.

B. **Radiographs**: Full mouth periapical radiographs including bitewings.
   Your patient must have full-mouth periapical radiographs including bitewings. Posterior periapical radiographs should include root apices of any third molars when practical. A "Note to Examiners" on the worksheet, at acceptance, indicating patient intolerance in capturing the entire tooth on the radiograph(s) is acceptable. The radiographs must have been taken within the past three (3) years and they must be dated. Original radiographs are preferred, however, duplicated or printed copies will be accepted if they are of diagnostic quality. Panographic films are not acceptable. Radiographs should be paper clipped to the back of the worksheet; please do not staple.
Radiographs must have your Candidate ID Number and your patient’s first name only on the film mount, template or print. Do not use film mounts that identify a school name or location. If incorrect, outdated, or poor-quality radiographs are submitted, the radiographs and worksheet will be returned to you for correction. No points will be deducted.

Digital radiographs are accepted if they meet the criteria specified on pg. 22. If submitting radiographs by computer, the file name should include your Candidate ID Number, patient first name and the word “Perio.”

C. **Patient Medical History/Consent Form**: The completed *Patient Medical History and Consent Form* signed (sample, pg. 27).

A Patient Medical History (including current blood pressure and pulse) and Consent Form must be completed for each patient. If you use the same patient for more than one procedure only one Patient Medical History is necessary. Mark the box on the upper right corner of the form for each procedure being submitted. Note that each procedure also must be listed on the Consent Form on the reverse side. **Make sure your patient signs the Consent Form.**

The Patient Medical History form must be reviewed and initialed by a Floor Examiner before your patient is sent to the grading area for approval. Provide both the Periodontal Worksheet and Patient Medical History, including blood pressure and pulse, for a Floor Examiner to review. A Floor Examiner will also verify that your patient has completed the reverse of this document that constitutes the consent form and assumption of risk for you to perform the dental procedure described. When your patient is submitted for acceptance, the Patient Medical History and Consent Form will be retained at the patient check-in desk; Grading Examiners will not see it.

D. **Patient Tray** with:
- New/uncratched #4 or #5 metal front surface mirror
- New/sharp ODU 11/12 explorer
- New/sharp color coded 3-6-9-12 mm periodontal probe
- Three 2" x 2" gauze pads

The instruments must be in an open autoclave bag. The paperwork should be placed on top of the tray.

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

F. **Patient Eye Protection**: Prescription glasses or safety glasses must be worn by all patients.

**Patient Approved** – If your patient is approved, the patient will return with:
- The worksheet initialed by one Grading Examiner next to “Acceptance”
- Radiographs
- Instruments

You may proceed with treatment.
**Patient Not Approved** – If your patient is not approved, the patient will return with:

- A pink *Unacceptable for Treatment Form* indicating the reason the patient was not approved
- Instruments
- Radiographs
- New *Patient Medical History and Consent Form*

**Patient Unaccepted**

If the first periodontal patient submission does not meet the criteria listed on pgs. 77-78, the patient will not be approved by the Grading Examiners. A deduction will be applied to the Periodontal Treatment score. No additional deductions for subsequent rejected submissions will be assessed.

The worksheet for the patient submission rejection will be retained in the grading area.

If your patient was submitted with only one quadrant for acceptance and did not qualify, the same patient may be resubmitted with an additional quadrant.

**Treatment**

Periodontal treatment must be completed the same day your patient is approved.

If a patient is approved, but treatment is not completed the same day, you will be allowed to resubmit the same patient and have the submission re-approved, or submit an alternate submission on a different patient. In either situation, there is a deduction from the Periodontal Treatment score.

You are evaluated on the thoroughness of calculus removal and root planing of all teeth in the quadrant(s) selected. Completely remove calculus and smooth root surfaces of all teeth in the quadrant(s).

Sonic or ultrasonic devices are acceptable, but rotary instruments and/or chemicals for calculus removal are prohibited.

**Major Tissue Trauma**

Major tissue trauma is defined as iatrogenic damage to extra-intraoral tissues resulting in significant injury to the patient, such as lacerations, burns, amputated papillae, or large tissue tags.

Grading Examiners compare the preoperative gingival condition to the postoperative gingival condition. Validated major tissue trauma by two or more Grading Examiners results in loss of all points for the treatment procedure.
**Treatment Grade**

When treatment is completed, send the patient to the grading area with:

A. **Worksheet:** The worksheet with an “X” in the box for “Treatment Grade”

B. **Radiographs:** Full mouth periapical radiographs including bitewings

C. **Patient Tray** with:
   - New/uncratched #4 or #5 metal front surface mirror
   - New/sharp ODU 11/12 explorer
   - New/sharp color coded, 3-6-9-12 mm periodontal probe
   - Three 2” x 2” gauze pads

   The instruments must be in an open autoclave bag. The paperwork should be placed on top of the tray.

D. **Patient Bib:** Your Candidate ID label should be attached to the upper right corner of the patient’s bib (patient’s right side).

E. **Patient Eye Protection:** Prescription glasses or safety glasses must be worn by all patients.

Patients are evaluated by three Grading Examiners and may be in the grading area for more than an hour. Consider patient comfort and re-anesthetize, if necessary, before sending your patient to the grading area.

Your patient will return with the instrument tray, radiographs and the worksheet with “Treatment Grade” initialed by a Grading Examiner.

**Releasing Your Patient**

After the “Treatment Grade,” review the worksheet for all necessary initials. If the Grading Examiner initials are missing from the “Acceptance” or “Treatment Grade” notify a Floor Examiner.

Missing initials which are not brought to the attention of a Floor Examiner cannot be grounds for an appeal.

Give your patient the yellow copy of the completed *Follow-Up Care Agreement* form for any postoperative care which may be necessary. Have your patient fill out the *Patient Questionnaire*. 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.**
References

The complete guidelines for antibiotic coverage in patients having some form of cardiac disease or repair. (2008). *Journal of the American Dental Association* 139(1), Special Supplement: 3S-24S.


AAPD for both anesthetic and antibiotic pediatric doseages.
PERIODONTAL TREATMENT SCORING

A final score of 75.00 or higher is required to pass the Periodontal Treatment Section.

Scoring
Validated calculus remaining is an error which is documented by at least two Grading Examiners and will be scored on the following scale:

<table>
<thead>
<tr>
<th>Calculus Pieces Remaining</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>1</td>
<td>87.50%</td>
</tr>
<tr>
<td>2</td>
<td>75.00%</td>
</tr>
<tr>
<td>3</td>
<td>62.50%</td>
</tr>
<tr>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>5</td>
<td>37.50%</td>
</tr>
<tr>
<td>6</td>
<td>25.00%</td>
</tr>
<tr>
<td>7</td>
<td>12.50%</td>
</tr>
<tr>
<td>8</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Periodontal Treatment Onsite Retakes

Candidates with a failing result in the Periodontal Treatment Section may have the opportunity to retake the section at the same exam site. This will be dependent on each Candidate’s scheduled sections and individual time constraints. A Candidate with a validated finding of major tissue trauma will not be allowed to retake the Periodontal Treatment Section at the same exam site. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, Candidates may retake the Periodontal Treatment Section at a different site (retake fees will apply).

<table>
<thead>
<tr>
<th>Score Deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Rejection</td>
</tr>
<tr>
<td>= Validated by two or more Examiners – a 10% deduction from the total possible of 100% only applied to first patient</td>
</tr>
<tr>
<td>Resubmission of patient or submission of another patient after receiving approval</td>
</tr>
<tr>
<td>= A 10% deduction. If both a patient rejection and a resubmission occur, only one 10% deduction will be taken</td>
</tr>
<tr>
<td>Major Tissue Trauma*</td>
</tr>
<tr>
<td>= Validated by two or more Examiners results in loss of all points for the treatment procedure</td>
</tr>
</tbody>
</table>

*This is a critical error that precludes an onsite retake.
<table>
<thead>
<tr>
<th>Late Penalties</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5 minutes late</td>
<td>= 4% deduction</td>
</tr>
<tr>
<td>6 to 10 minutes late</td>
<td>= 8% deduction</td>
</tr>
<tr>
<td>11 to 15 minutes late</td>
<td>= 12% deduction</td>
</tr>
<tr>
<td>16 or more minutes late</td>
<td>Procedure will not be graded. No points earned.</td>
</tr>
</tbody>
</table>
**Periodontal Treatment Worksheet**

**Patient’s First Name:** ______________________  **Candidate ID #: ____________**

- [ ] Radiographs submitted on computer
- [ ] Upper Right
- [ ] Upper Left
- [ ] Lower Right
- [ ] Lower Left

### TEETH #’S

| CALCULUS | # | # | # | # | # | # | # | # | # | # | # | # | # | # | # | # | # | # | # |
| D        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| F        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| M        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| L        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

<table>
<thead>
<tr>
<th>PROBING DEPTH</th>
<th>DF</th>
<th>F</th>
<th>MF</th>
<th>ML</th>
<th>L</th>
<th>DL</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

- [ ] ACCEPTANCE  **Accepted by:** ____________

**Note to Examiners** (if necessary)

Grading Examiner Initials

- [ ] TREATMENT GRADE  **Treatment Graded:** ____________

**Note to Examiners** (if necessary)

Grading Examiner Initials

**Patient may be released from the examination:** ____________

Floor Examiner

**2019 - Revised**
### Medications Taken By Patient Today

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Drug Name and Concentration</th>
<th># of Tabs/Capsules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Local Anesthetic Administered for this Procedure

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Type and Concentration of Local Anesthetic and Vasoconstrictor</th>
<th>Cartridges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

### Checklist of Required Items

**SUBMIT PATIENT WITH:**

- Periodontal Treatment Worksheet
  - Your patient’s first name
  - Your Candidate ID # in the upper right corner
  - Selected quadrant(s) circled
  - Teeth numbers indicated
  - Calculus indicated with “X” if present
  - Probing depths measured
  - Box checked for “Acceptance” or “Treatment Grade”
  - Medication taken and local anesthetic administered

- Full Mouth Periapical Radiographs including Bitewings
  - If radiographs submitted digitally, mark box on worksheet

- Patient Medical History/Consent Form - Approval Only
  - Completed, including pulse and blood pressure
  - Patient address and signature
  - Floor Examiner initials

- A Tray Containing the Following
  - New metal #4 or #5 front surface mirror
  - New ODU #11/12mm perio explorer
  - New 3-6-9-12mm perio probe
  - Three 2 X 2 gauze pads

- Place instruments in an open autoclave bag, with paperwork on top
- Patient bib with appropriate Candidate ID Number label on upper right-hand corner
- Patient eye protection
PROSTHODONTICS

Prosthodontic Section Overview

The Prosthodontic Section is a three and one-half hour (3.5) hour exam consisting of two (2) procedures:

1. Preparation of an anterior tooth for a full-coverage crown.
2. Simulated preparation of two abutments to support a posterior three-unit fixed partial denture prosthesis.

The preparations are performed on simulated teeth in a mounted articulator and manikin that is positioned to simulate working on a patient.

You will be given three and one-half (3.5) hours to complete the exam and will be allowed in the Simulation Lab an additional 30 minutes before the exam to set up. The Prosthodontic Section is a scheduled time block to which Candidates are randomly assigned. Approximately four (4) weeks prior to the exam, you will receive your schedule with your assigned time block.

WREB examines Candidates with varying educational backgrounds and schools may teach different prosthodontic procedures. WREB does not look for one standard procedure and scores performance according to the Prosthodontic Scoring Criteria Rating Scale at the end of this section.

Supplies

Acadental materials will be used for the Prosthodontic Section. In the Simulation Lab, you will receive in a ziplock bag:

1. The maxillary ModuPRO® One arch to be treated.
2. A CheckMate One™ - You will use the CheckMate One™ during the exam to make PVS putty matrices for examiner grading.
3. A Prosthodontic Worksheet.

You will need to provide:

1. A ModuPRO® One model (an articulator is required at some sites, please check the "Site information" provided for each site at wreb.org)
2. The mandibular ModuPRO® One arch.

The “Site Information” (available at wreb.org) will have details on compatible equipment and whether you may purchase supplies through the school. Arches may be purchased directly from Acadental at acadental.com/WREB. Only the supplies listed in the "Site Information" will be provided by the school. This will include a PVS (or PVS-like) regular set putty material for making the putty matrices. It should not be light body, but regular or heavy body. Schools have been asked to provide the PVS material, but some may not. You must check the "Site Information" for your exam site to verify. If the school is not providing, it is your responsibility to provide the PVS material. You must provide all other supplies and equipment, including a knife to section the PVS putty matrices, such as an X-Acto knife, or a Bard-Parker handle with a #11 or #25 blade.
You are allowed to bring the Dental Exam Candidate Guide into the Simulation Lab and refer to it during the exam. Notes, textbooks or other informational material must not be brought into the lab. No magnification other than loupes is allowed.

Exam Procedure

You will prepare a maxillary central incisor for an All Ceramic Crown (ACC) restoration:

Tooth #9

The teeth to be prepared as abutments for the posterior three-unit fixed partial denture prosthesis to replace missing Tooth #4 will be:

Teeth #3 and #5

For each posterior abutment, you will select and circle on the Prosthodontic Worksheet your preferred restorative material for the simulated situation. Preparation characteristics should reflect requirements of the restorative material selected. Restorative material choices are verified by a Floor Examiner during a setup check before you begin preparation of the abutments.

Restorative material for the maxillary central incisor will be:

ACC: All Ceramic Crown (porcelain) restoration, (including lithium disilicate)

Restorative material choices for the three-unit fixed partial denture are:

FCC: Full Coverage Crown - Cast metal (gold) or monolithic zirconia
PFM: Porcelain Fused to Metal (or to a zirconia substructure)

There will be an assigned time for the Prosthodontic Section. If enrolled in the Endodontic Section, it will be scheduled on the opposite day of your Prosthodontic Section. Specific time assignments may vary due to logistical limitations. You should review your clinical exam schedule carefully when you receive notification that group assignments have been made (approximately four (4) weeks prior to the exam).

You will report to the designated Simulation Lab at the appointed time. You must bring your personal handpieces and burs or anything else needed to complete preparations on simulated teeth in a simulation environment. When entering the lab, make sure you are wearing your Candidate ID Badge and it is visible. As a reminder, electronic devices, including cell phones, are prohibited in the Simulation Lab.

Stations have been pre-assigned and will be marked by a yellow numbered card. When you enter the lab, see the Proctor, who will give you your assigned work station number. You must sit at the unit assigned to you. Find your assigned unit, then pick up your model from the Proctor. It is recommended you do this after you have confirmed that you have all required instruments and materials and will not need to leave the lab. Once you have received the model, you may not leave the lab without notifying the Floor Examiner. The Floor Examiner must check that the
correct arch is mounted in the manikin prior to your leaving the lab. A Candidate who leaves the Simulation Lab or removes the arches at any time during the examination is subject to failure if permission was not received from the Floor Examiner.

You will have 30 minutes to set up your station, ensure handpieces are working, fabricate matrices, mount articulators, fill out the worksheet, and obtain the required setup check before the Prosthodontic Section officially starts. If there are mechanical problems with your unit, you must notify the Floor Examiner immediately.

Prior to setup check, you will use the CheckMate One™ to fabricate two polyvinyl siloxane (PVS) putty matrices capturing preoperative tooth form. The matrices will be used by Grading Examiners to evaluate aspects of tooth reduction according to Prosthodontic Scoring Criteria Rating Scale. Two putty matrices are required: one maxillary anterior matrix and one maxillary posterior matrix covering the abutment teeth to be prepared. The matrices should be fabricated on the benchtop before mounting the arches.

An instructional video that demonstrates proper fabrication and sectioning of the putty matrices is available for review at acadental.com/checkmateone.

Section the matrices facial-lingually through the center of each tooth to be prepared. A properly sectioned anterior matrix yields two (2) pieces; a properly sectioned posterior matrix yields three (3) pieces. Write your Candidate ID Number with a Sharpie permanent marker on each piece of the matrix and, from anterior to posterior, number each piece 1-5. The resulting five marked matrix pieces will be checked by the Floor Examiner as part of the setup check required before start of the examination. The five marked matrix pieces must be submitted to the Proctor along with the treated arch containing the completed preparations at conclusion of the examination.

acadental.com/checkmateone
When ready, inform the Floor Examiner that you are ready for the setup check. The Floor Examiner will check and verify that:

- The Worksheet (sample pg. 98) is properly completed. Candidate ID Number and the date must be legible in the spaces provided on the Worksheet. The Worksheet designation has been circled for the intended restorative material.
- The maxillary arch has Candidate ID Number written on palatal with Sharpie permanent marker.
- The matrices are fabricated, sectioned, numbered 1-5 and marked with the Candidate ID Number.
- The articulator with arches containing teeth to be prepared and with matrices in place is mounted on the manikin, in a normal patient head position, open at a normal vertical dimension, and not overextended.

If anything needs to be corrected, the Floor Examiner will ask you to make the necessary correction and return to recheck things before initialing your Worksheet. If everything is in order, the Floor Examiner will initial the Floor Examiner line on the Worksheet. Do not start treatment until you have setup check approval from the Floor Examiner and you hear the start of the examination announced.

Once a setup check has been received, arches are not to be removed from the manikin head. If you need to leave the Simulation Lab for any reason after receiving your arches, **you must notify the Floor Examiner.** Once a setup check is received, the maxillary arch can only be removed when the exam is completed, or with permission from the Floor Examiner. A Candidate who leaves the Simulation Lab or removes the arches at any time during the examination is subject to failure if permission was not received from the Floor Examiner.

Do not begin your preparations until you hear the start of the examination announced. The Floor Examiner’s announcement will be similar to “You may now begin your preparations.” Starting to prepare teeth before being authorized to begin will result in loss of all points for the Prosthodontic Section. Once the announcement is made, you will have three and one half (3.5) hours to complete the section.

The Floor Examiner will be available throughout the session to answer questions relative to administration of the Examination and proper completion of forms. The Floor Examiner is also responsible for monitoring examination security and will circulate through the Simulation Lab and observe Candidates while the examination is underway. The Floor Examiner will monitor Candidates to ensure that:

- Proper patient head position and normal vertical dimension are appropriately simulated throughout the examination.
- None of the simulated dental arches or teeth are removed from any articulator until they are ready to be submitted.
- Universal precautions are followed.
- Candidates work independently.
You should inform the Floor Examiner immediately if a problem arises. For example, you should notify a Floor Examiner if there is clinic equipment malfunction/failure. Lost time due to school equipment failure may be compensated if it is more than fifteen (15) minutes from the time it is reported to the Floor Examiner. There is no compensation if time lost is less than 15 minutes or if the problem is your own equipment failure.

Similarly, if a tooth loosens in the arch or any other problem arises, stop treatment and inform the Floor Examiner immediately.

Assistants are not permitted for this procedure. Candidates may not assist each other. This includes critiquing of another Candidate’s work or discussion of treatment.

You are to work independently, observe universal precautions, and work in a manner that simulates performing procedures on a patient. Any unprofessional, unethical or inappropriate behavior could result in immediate dismissal and failure of the Prosthodontic Section.

If, after receiving notice of a violation, a Candidate repeatedly violates universal precautions, then he or she will be dismissed from the session and will fail the Prosthodontic Section.

**Completing the Section**

When turning in your ziplock bag after treatment, be sure it includes:

1. The treated maxillary arch with Candidate ID Number written on it (not obstructing the pre-printed manufacturer code)

2. A completed *Prosthodontic Worksheet*

3. Putty matrices (five pieces) with:
   - Candidate ID Number written on each piece
   - Each piece numbered 1-5, Anterior to Posterior
   - Pieces placed over corresponding teeth

4. Do not include the CheckMate One™ in the ziplock bag

It is your responsibility to ensure that all materials listed above are turned in. The proctor will note your checkout time, but is not responsible for checking your materials. **Once you have left the Simulation Lab, you will be subject to failure of the Prosthodontic Section for items not turned in.**

The finish deadline for each examination session is fixed. Candidates who report late to their assigned Prosthodontic session will have less than three and one-half (3.5) hours to complete their preparations. WREB cannot extend the time for individual Candidates. Candidates who complete their preparations early may submit their arch, matrices, and worksheet to the Proctor and leave.
The WREB Floor Examiner will announce and remind Candidates still working of remaining time at intervals of 30 minutes, 15 minutes, 5 minutes, and 1 minute before the deadline; however, completing the examination and appropriately submitting everything required to the Proctor on time remains wholly the Candidate’s responsibility. Any Candidate who exceeds the time allotted for the examination will be considered late and assessed a late penalty. (See pg. 94 for “Late Penalties.”)

**Definitions**

The following definitions are provided to assist you in more fully understanding scoring criteria and communications with Examiners:

**Abutment:** A tooth that provides support or anchorage for a fixed or removable prosthodontic restoration.

**Cavo-surface angle:** The angle formed by the junction of the cavity wall and surface of the tooth.

**Axial wall:** The internal cavity surface parallel to the long axis of the tooth.

**Bevel:** A plane, or to create a plane, sloping from the horizontal or vertical that creates a cavosurface angle greater than 90°.

**Bridge:** A fixed restoration that replaces one or more missing natural teeth.

**Cavo-surface margin or cavo-surface line angle:** The junction of the prepared cavity wall or margin and unprepared surface of the tooth. It comprises the entire external outline of the preparation and is (or should be) continuous.

**Chamfer:** A finish line or margin design with a rounded internal axio-gingival line angle in which the gingival floor meets the external cavosurface at approximately 90°.

**Convergence:** The angle of opposing preparation walls which, if projected in a gingival to occlusal direction, would meet at a point some distance from the tooth.

**Divergence:** The angle of opposing preparation walls which, if projected in an occlusal to gingival direction, would meet at a point some distance from the tooth.

**Finish line:** The terminal portion of the preparation adjacent to any unprepared portion of the tooth.

**J Margin:** A term used to describe a margin that at or near its cavosurface is more coronal than elsewhere between the cavosurface and the axial wall of the preparation.

**Line of Draw:** The path or direction of withdrawal or insertion of any fixed or removable restoration that allows full seating of the restoration. For full seating of a multi-abutment fixed or removable restoration the path or direction of withdrawal or insertion for all abutments, together, must be aligned.
**Major Tissue Trauma:** Major tissue trauma is defined as gross iatrogenic damage to the simulated gingiva, adjacent teeth, or surrounding tissue resulting in significant injury to the simulated patient. Examples include lacerations, burns, amputated papillae, large tissue tags, or adjacent teeth requiring immediate care had the treatment been on a patient.

**Occluso-axial line angle:** The angle formed by the junction of the prepared occlusal and axial surfaces.

**Resistance form:** Features of a tooth preparation that enhance stability of a restoration and resist dislodgement along an axis other than the path of insertion.

**Retention form:** Features of a tooth preparation that resist dislodgement of a restoration in a vertical direction or along the path of insertion.

**Shoulder:** A finish line or margin design in which the gingival floor meets the external cavosurface at approximately 90°.

**Taper:** Taper is to gradually become increasingly narrow in one direction.

**Reference Material**


PROSTHODONTIC SCORING

The Prosthodontic Section consists of two (2) procedures:

1. Preparation of an anterior tooth for a full-coverage crown.
2. Simulated preparation of two abutments to support a posterior three-unit fixed partial denture prosthesis.

Preparation Weighting

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occlusal Reduction</td>
<td>30%</td>
</tr>
<tr>
<td>Axial Reduction</td>
<td>25%</td>
</tr>
<tr>
<td>Margins and Finish Line</td>
<td>35%</td>
</tr>
<tr>
<td>Operative Environment</td>
<td>10%</td>
</tr>
</tbody>
</table>

The Prosthodontic Section is graded by three independent Grading Examiners. Grading Examiners grade according to the Prosthodontic Scoring Criteria Rating Scale on pg. 96. Each preparation is evaluated on the four (4) criteria listed above. For each evaluated criterion, the score is determined by multiplying the median (middle) score by the designated weight factor. The sum of the resulting products is the score for the preparation. The average score for all three preparations, minus any applicable score deductions, is the overall score for the Prosthodontic Section. A score of 3.00 or higher is required to pass the Prosthodontic Section.

Prosthodontic Onsite Retakes

Candidates with a failing result in Prosthodontics may have the opportunity to retake the section at the same exam site on Clinic Day 3. This will be dependent on each Candidate’s scheduled sections and individual time constraints. Onsite retakes for Prosthodontics are not available on Clinic Days 1 or 2. Three and one-half (3.5) hours will be allotted for Prosthodontic retakes on Clinic Day 3. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, Candidates may retake the Prosthodontic Section at a different site (retake fees will apply).

<table>
<thead>
<tr>
<th>Score Deductions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge Preparation</td>
<td>0.5 deduction from each abutment score. Validated by two or more Grading Examiners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Late Penalties</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time is determined by the official WREB clock displayed in the Simulation Lab.</td>
<td></td>
</tr>
<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>Loss of all points for the Section</td>
</tr>
</tbody>
</table>
### Unusual Situations

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th><strong>Result</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Started without a setup check or before start time announced</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
<tr>
<td>Preparing the wrong tooth*</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
<tr>
<td>Major tissue trauma*</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
<tr>
<td>Repeated failure to use universal precautions</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
<tr>
<td>Repeated violation of simulation protocol</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
<tr>
<td>Left Simulation Lab with either or both arches</td>
<td>Failure of the Prosthodontic Section</td>
</tr>
</tbody>
</table>

*This is a critical error that precludes an onsite retake.*
## PROSTHODONTIC SCORING CRITERIA RATING SCALE

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occlusal/Incisal Reduction</strong></td>
<td>Optimal (FCC 1.5 mm, PFM &amp; ACC 2.0 mm). Occlusal planes are well defined and accurately reproduce occlusal contours.</td>
<td>Slightly deviates from optimal. Occlusal reduction is sufficient. Occlusal planes are slightly flat or deep.</td>
<td>Deviates (up to 1.0 mm) from optimal. Occlusal planes moderately flat or deep. Sharp angle(s) may affect the restoration.</td>
<td>Deviates &gt; 1.0 mm from optimal. Occlusal planes are severely flat or deep. Sharp angles will affect crown fabrication or prognosis.</td>
</tr>
</tbody>
</table>

| **Axial Reduction & Taper (Resistance & Retention)** | Optimal (FCC 0.5 - 1.0 mm, PFM & ACC 1.0 - 1.5 mm). Follows natural contour of the tooth. Axial walls are smooth and well defined. Optimum taper. (5 – 10°) No undercut. | Slightly deep, shallow or irregular. Walls are slightly rough. Taper is appropriate. (10 – 15°) No undercut. | Moderately deep (FCC up to 2.0 mm, PFM or ACC up to 2.5 mm) shallow, rough or irregular. May impact contour or appearance of the restoration. Taper is acceptable. (15 - 20°) or <5° A small area of undercut easily can be blocked out. | Severely deep or shallow. Excessively short, rough, or irregular. Will impact appearance or function of the restoration. Taper is excessive. (20 – 30°) Undercut will result in an open margin or interfere with seating. | Grossly deep or shallow. Misshapen, short, rough, or irregular. Adjacent tooth remains in contact or pulp could be compromised. Taper is gross. (>30°) Gross undercut. No path of insertion (cannot be seated.) |

| **Margins & Finish Line** | Gingival margin is at least 1.0 mm from the adjacent tooth. Margin design is optimal (FCC 0.5 mm, PFM & ACC 1.0 - 1.5 mm). Margins are smooth and of uniform width. Finish line is continuous, flowing, well defined, coronal to and within 0.5 mm of the gingival margin. | Gingival margin is ~ 1.0 mm from the adjacent tooth. Margin design is appropriate, but slightly varies in width. There is no “J” margin. Finish line is continuous but slightly irregular, coronal to and 0.5 – 0.9 mm from the gingival margin. | Gingival margin is 0.5 mm-0.9 mm from the adjacent tooth. Margin design is acceptable, but is moderately uneven (deep or shallow), or moderately rough. There is a mild “J” margin. Finish line is questionably continuous or moderately irregular, or ~ 1.0 mm coronal to the gingiva. | Gingival margin location compromises die fabrication. Margin design is severely deep/shallow or rough. Width is very uneven. There is a severe “J” margin. Finish line is discontinuous, is severely irregular, uneven, poorly defined, 1.1 – 2.0 mm above the gingival margin or is subgingival. | Gingival margin is in contact with the adjacent tooth. Margins are not evident, grossly inappropriate, uneven or wide. There is a gross “J” margin. Finish line is non-existent, indistinct, grossly irregular or more than 2.0 mm from the gingival margin. |

| **Operative Environment** | No damage to the gingiva. No damage to adjacent or opposing teeth. | Slight damage to the gingiva. Minor damage to an adjacent tooth (can be polished without changing the contact). | Moderate damage to the gingiva. Moderate damage to an adjacent tooth (can be polished but may alter contact shape). | Severe damage to the gingiva. Biologic width may be violated. Severe damage to adjacent tooth (may require restoration to create acceptable contact.) | Gross damage to the gingiva. Biologic width is violated. Gross damage to adjacent tooth. Adjacent tooth requires restoration. |

**FCC:** Full Coverage Crown - Cast metal (gold) or monolithic zirconia  
**PFM:** Porcelain Fused to Metal (or to a zirconia substructure)  
**ACC:** All Ceramic Crown (porcelain) restoration, (including lithium disilicate)
Taper Determination Cone

Examiners will reference this diagram to determine the degree of taper on the crown’s preparations.
# Prosthodontic Worksheet

**Candidate ID #:**

**Date:**

## Anterior Crown Preparation

<table>
<thead>
<tr>
<th>Anterior Tooth</th>
<th>Restorative Material</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>ACC</td>
</tr>
</tbody>
</table>

## Bridge Abutment Preparations

<table>
<thead>
<tr>
<th>Anterior Abutment</th>
<th>Restorative Material</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>ACC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Posterior Abutment</th>
<th>Restorative Material</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>FCC, PFM</td>
</tr>
</tbody>
</table>

## Setup Check

- Maxillary arch has Candidate ID written on palatal with Sharpie permanent marker.
- Arches/articulator properly mounted in manikin.
- Manikin in correct patient treatment position with correct vertical dimension.
- Putty matrices (five pieces) are fabricated and sectioned:
  - Candidate ID Number written on each piece
  - Each piece numbered 1-5, Anterior to Posterior
- Completed Prosthodontic Worksheet on tray.

## Checklist of required items after treatment (in ziplock bag):

- Treated maxillary arch with Candidate ID Number
- Prosthodontic Worksheet
- Putty matrices (five pieces) with:
  - Candidate ID Number written on each piece
  - Each piece numbered 1-5, Anterior to Posterior
  - Pieces placed over corresponding teeth
  - Do not include the CheckMate One™ in the ziplock bag
- Deliver bag to the WREB Proctor before leaving the Simulation Lab.

Restorative material choices:

- **FCC** Full Coverage Crown - Cast metal (gold) or monolithic zirconia
- **PFM** Porcelain Fused to Metal (or to a zirconia substructure)
- **ACC** All Ceramic Crown (porcelain) restoration (including lithium disilicate)

This worksheet must be turned in at the end of the exam.

---

2019 - Revised
END OF CLINICAL EXAM

After all procedures have been completed, make sure:

- All paperwork for each procedure has the required signatures.
- A Floor Examiner has initialed all Operative and Periodontal Treatment worksheets as required.

If any signatures are missing, notify a Floor Examiner.

Be sure you have given your patient(s) the yellow copy of the Follow-Up Care Agreement form. Make sure that the Follow-Up Care Agreement is completely filled out and signed and dated by the patient, follow-up school of record and/or follow-up care provider.

Place the items listed below in your white Candidate Packet. If any of these items are missing, your results will be held until received by the WREB office.

- One (1) or Two (2) Restorative Worksheets - Tan, Orchid, Blue, and/or Gold (Film or printed radiographs should be stapled to the worksheet, if applicable.)
- Periodontal Treatment Worksheet - White
  If Perio Section was taken.
- One (1) Dental Assistant Verification form
  This form must be completed and signed by the Candidate even if an Assistant was not used. If an Assistant was used, his/her signature is also required.
- Follow-Up Care Agreements
  White original copy for each patient treated. This form must have Section A or B filled out completely and signed and dated by the patient, follow-up school of record and/or follow-up care physician.
- Pink Copies of Paperwork
  If applicable, i.e., Instructions to Candidate, Floor Examiner Check Sheet, Patient Unaccepted for Treatment, Late Penalty, Modification Request forms.
- Patient Questionnaires - Please provide us with your questionnaires filled out by your patient(s). Results will not be held if the questionnaires are not turned in with your packet.

Extras - Candidate/Assistant Badges and Bib Labels do NOT need to be returned. Please return any BLANK worksheets, Forms, and/or Patient Questionnaires.

After completion of the exam, collect all the items listed on the front side of your Candidate Packet and return to the patient check-in desk. Items are dependent on all sections taken. Please do not seal your Candidate Packet envelope. Return your Packet only if you have completed all your sections.

WREB will email a link to the Candidate Survey. We ask that you complete the Survey after the clinical exam.
It is WREB policy to notify Candidates of final exam results as soon as possible after the conclusion of an exam. Results will be posted online and can be accessed with your Candidate login and password. You will receive an email notice once your results are available.

Do not call the WREB office for exam results. Exam results are confidential and will not be given over the telephone, fax, or by email. They will only be posted to your secure WREB login online.
FREQUENTLY ASKED QUESTIONS

1. May I use a foreign trained dentist as my Dental Assistant?
Operative Assistants may not be dentists (including graduates of foreign dental schools) or be in their final year of dental school. Operative Assistants may be Dental Assistants or Dental Hygienists, if they do not hold a permit to place and finish restorative materials.

2. What is the minimum age a patient can be? If my patient is under 18, does the parent or guardian need to stay during the procedure?
The minimum patient age for the Periodontal Treatment procedure is 18 years. There is no minimum age for Operative procedures. A parent or guardian does not have to remain during the procedure. The parent or guardian will need to sign the Consent Agreement on the back of the Patient Medical History form.

3. When are my Assistant and my patient allowed on the clinic floor to start the exam? When can I put my patient in line for acceptance or grading?
Assistants and patients may enter the clinic with you at 7:00 a.m. on Clinic Days 1, 2 and 3. For patient comfort, patients should not be sent to the grading area any earlier than 7:45 a.m. The exam officially begins at 8:00 a.m.
The patient line will not move until 8:00 a.m. Candidates who are assigned Endodontics/Prosthodontics the first morning of the exam may not submit patients until 10:00 a.m. (See details under “General Information-Schedule and Clinic Hours.”)

4. Do I have to have my patient in line for grading by 10:30 a.m. on the last day of the exam?
You have until 11:00 a.m. to have your patient in line for grading on the last day. The first two days of the exam, your patient must be in line for grading by 4:00 p.m. (See details under “General Information-Schedule and Clinic Hours.”)

5. Are translators allowed on the clinic floor?
Translators will be allowed on the clinic floor or in the grading area only as needed. Translators will be asked to remain in the patient waiting area until, or if, their services are required.

6. What are Floor Examiners?
Floor Examiners assist Candidates on the clinic floor:
• Answer questions, clarify exam procedures
• Act as liaisons between Candidates and Grading Examiners
• Have extra forms for Candidates such as Patient Medical History and Follow-Up Care Agreements
• Sign Patient Medical History forms
• Distribute forms from Examiners that affect Candidates and procedures
• Check on modifications (see “Operative-Modification Procedure”)

• Manage pulp exposures
• Check and initial steps in the processes involved on worksheets. (See “Operative-Patient Acceptance” or “General Information-Exam Personnel and Anonymity.”)

7. **May I anesthetize my patient before I send him/her to the grading area for approval to start?**
   
   For Periodontal Treatment patients, you should anesthetize the quadrant(s) submitted for approval to facilitate Examiner evaluation and for patient comfort. For Operative patient check-in for acceptance, you may anesthetize patients at your discretion.

8. **May I submit two Operative restorations for approval at the same time?**
   
   If the procedures are on the same patient but not on adjacent teeth and accepting both would not cause the loss of occlusal contact, they may be submitted for approval at the same time. You may not submit patients with adjacent teeth (consecutive tooth numbers for acceptance. (See details under “Operative-Patient Acceptance.”)

9. **If I have two Operative restorations approved to start, do I have to do both preparations that day?**
   
   You may do only one preparation if you choose. For the procedure that has been approved but not started, bring your worksheet to a Floor Examiner for the proper paperwork. (See details under “Operative-Dismissal for the Day Approval.”)

10. **Do I have to work with a rubber dam?**
    
    You do not have to work with a rubber dam, but a rubber dam is required when submitting a patient for the preparation grade or when requesting a modification request for your patient on the Candidate clinic floor. (See details under “Operative-Preparation Grade.”)

11. **When do I call a Floor Examiner to check for a modification of outline or internal form?**
    
    When removal of caries, affected dentin, unsound demineralized enamel, or remaining restorative material will extend the outline and/or internal form of the preparation beyond the criteria for a “5”. (See details under “Operative-Modification Procedure.”)

12. **How do I write a modification request?**
    
    Write the type, location, extent, and reason (i.e., caries, affected dentin, unsound demineralized enamel, or remaining restorative material) for the “Modification Request(s)” in the spaces provided on the procedure worksheet. The space on the worksheet is limited, therefore, you are encouraged to write the total extent required to remove the lesion on your initial modification request(s) in 0.5 mm increments (i.e., 0.5 mm, 1.0 mm, 1.5 mm). A Floor Examiner will be available to answer any questions you may have.
13. **When do I need original radiographs? And, when do I not?**

Operative procedures require original radiographs of the tooth taken within the prior six (6) months. The radiographs must show the current condition of the tooth. Duplicates are not acceptable. Separate radiographs or images are needed for each procedure. (See details under “Operative-Patient Acceptance.”)

The Periodontal Treatment procedure requires complete mouth periapical radiographs, including bitewings. The radiographs must have been taken within the past three (3) years. Original radiographs are preferred, but duplicates are acceptable if they are of diagnostic quality. (See details under “Periodontal Treatment-Patient Acceptance.”)

14. **If WREB considers all exposures avoidable, how do I deal with an exposure or near exposure?**

The preferred procedure is to leave a small amount of caries or affected dentin (0.5 mm) over the pulp to avoid an exposure. Write in the “Note to Examiners” on the worksheet your intentions. All other caries in the preparation must be removed. If an exposure does occur, write in the “Note to Examiners” on the worksheet your intentions regarding the exposure and how it will be managed, place a rubber dam (if not already in place) and call a Floor Examiner. Upon verification of the exposure, a Floor Examiner will instruct you to place a pulp capping material over the exposure as soon as possible. (See details under “Operative-Cavity Preparation.”)

15. **Can my assistant dismiss my patient while I am in the Endodontic Section?**

Yes, if there is no follow up required when your patient returns from the grading area. Remember, a Floor Examiner’s initials are required on worksheets for patient release from the exam.

16. **How many initials from Examiners do I need on my worksheet?**

It depends on what portion of the restoration you are doing. One initial is required at Acceptance, at least two initials if you have sent a note with a modification procedure and three initials are required if you have sent a patient for grading. (See details and sample worksheet under “Operative.”)

17. **When do I have to go to the Simulation Lab to do my Endodontics/Prosthodontics section?**

All Candidates will be assigned a specific time block for the Endodontics Section and a separate time block for the Prosthodontics Section, (if enrolled in Prosthodontics). Your specific schedule will be posted to your wreb.org Candidate profile approximately four weeks prior to the exam. You may go to the simulation lab any time during your assigned block for each exam, however, it is recommended you be in the lab in the first 30 minutes to avoid any delay getting your “Setup Check.” Candidates arriving later will be admitted, but will not receive time extensions. You must turn in all required materials at the end of the time block or you will receive a late penalty. There are no exceptions.
18. **My patient was provisionally accepted for my Operative procedure. Can I begin treatment at 8:00 a.m.?**

Yes, provided that ALL of the following have been completed:

1. The patient’s *Patient Medical History* form has been reviewed and initialed by a Floor Examiner.
2. Your provisionally accepted patient has been clinically examined by a Floor Examiner for acceptance criteria (starting a preparation without Floor Examiner approval results in failure of the Operative Section).
3. The operative worksheet has been initialed for acceptance by the Floor Examiner.

19. **If I have a patient that was provisionally accepted but am not using, can my friend use this same patient?**

Yes, but your friend must submit patient for acceptance. Provisional Acceptance does not transfer between candidates.

20. **When do I take the Comprehensive Treatment Planning (CTP) computerized Section?**

The CTP computer-based section can be taken at a Prometric Testing Center. Once you are enrolled in an exam, information will be emailed to you. This will include the time frame to take the exam, Prometric’s contact information to schedule your appointment, and your eligibility number.

21. **Can I change my assigned time for the Endodontic/Prosthodontic Sections?**

No. Once schedules are posted, they cannot be changed. Schedules are arranged in advance and in the best interest of all Candidates, taking into consideration space availability, supplies and exam materials. Schedules are made to give Candidates the optimum open block time and to maintain patient flow in the grading area.

22. **What identification do I need to provide at the exam?**

Candidates MUST present acceptable and valid identification in order to be admitted to the WREB Dental Exam. On Orientation Day, you shall appear in person and provide two (2) valid, non-expired forms of identification. (See WREB Exam Security and Identification Verification under “General Information.”) You will not receive your Exam Packet without proper identification.

23. **Do I need to complete two operative preparations?**

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, 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.
24. I have passed all required sections of the WREB Exam but I may need to take the Prosthodontics Section for licensure. Can I take it at a future exam site?

Yes. If you have completed core sections of the WREB Exam (CTP, Operative, and Endodontics) and then want to take the Prosthodontics Section you can do this anytime in the same calendar year simply by applying for the section online.

If you are returning the following year or beyond, then the state board where you are seeking licensure must send a letter to the WREB Office stating that the Prosthodontics Section is required for licensure. Once the letter is received by WREB, we will assist in enrolling you for the Section.

25. I am taking the WREB Exam, however, I am not a student at the school where I am testing. Am I allowed to participate in Provisional Acceptance?

You will need to review the Site information available at wreb.org. If you are allowed to participate, you will need to communicate with the site contact or coordinating person at the school to determine the school’s requirements for submission of images.

26. If I finish my Endo Section early, can I begin work on Operative or Periodontal procedures?

Yes. Operative and Periodontal Treatment procedures may be performed any time during the Exam that you are not working in your assigned Endodontic or Prosthodontic Sections.
USEFUL PREPARATION TERMS WHEN COMMUNICATING WITH EXAMINERS

Class III

Diagrams not to scale.
USEFUL PREPARATION TERMS WHEN COMMUNICATING WITH EXAMINERS

Class II

- Pulpal Floor
- Axial-Pulpal Line Angle
- Distal Wall
- Axial Wall
- Gingival Floor
- Axial-Gingival Line Angle
- Finger Extension

Diagrams not to scale.