CASE ASSESSMENT & TREATMENT PLANNING

Competency Assessment

IMPLANTOLOGY YEAR COURSE

This form is to be completed by the case supervisor

Dentist's Name _____

Patient Name: _____

Date of Birth: _____

INDICATORS	TICK IF COMPETENCY MET
Understanding treatment goals	
Risk factors correctly identified	
Clinical record keeping satisfactory	
Consent process satisfactory	
Assessment process performed correctly	
Significance of anatomical structures understood	
Effective treatment plan proposed	
Complexity correctly classified	

Supervisor's comments:-

Overall competency assessment –

Acceptable ❑

Unacceptable ❑

Supervisor's name: _____

Supervisor's signature: _____

Date: _____