College of Denturists of British Columbia

Confirmation of Patient Suitability

I , _____ and _____ have examined the patient,
Registrant's Name (print) *Candidate's Name (print)*
_____, and it is our position that this patient is suitable to act as a patient
Patient's Name (print)
for the Complete Denture Examination to be held in Vancouver on July 13 - 16, 2015 (inclusive). We also confirm compliance with the following information and that the patient is aware of their requirements with respect to the examination.

Each patient for the examination is provided by the Candidate and must be one that the Candidate themselves would be prepared to work on in an examination situation. The Candidates, along with a Registrant, must verify the following information in the selection of a patient for the examination.

1. The Examiners are aware that there is no such thing as a perfect patient. However, the patient **must** present **without** any medical or physical impairment/abnormality, which would require "unusual" treatment requirements or hinder normal timely provision of treatment. In addition, please verify, by marking the box, that the patient does not present with any of the following:
   - ☐ i. No severe unusable oral anatomical undercut(s);
   - ☐ ii. No bulbous and/or excessively mobile tuberosity(ies);
   - ☐ iii. No excessively resorbed residual ridge(s) - (less than 2 mm of crestal bone height);
   - ☐ iv. No excessively mobile residual ridge(s);
   - ☐ v. No TMJ dysfunction which limits jaw mobility or function;
   - ☐ vi. No tissue anomalies - (e.g. lesions, trauma, hyperplasia, recent extraction(s), recent unhealed surgical corrections, tumor);
   - ☐ vii. No other medical conditions or infectious diseases - (e.g. extreme fatigue, mobility impairment, mental instability, physical impairments such as Parkinson's disease with tremors, fibromyalgia, respiratory disease requiring oxygen therapy, HIV/AIDS, Hepatitis);
   - ☐ viii. No gross abnormality(ies);
   - ☐ ix. No dental implantology or remaining natural teeth, residual roots and/or retained roots;
   - ☐ x. No existing dentures with more than Eight (8) mm of interocclusal distance/freeway space;
   - ☐ xi. No existing dentures which require any repair or modifications prior to proceeding with replacement dentures; and
   - ☐ xii. No denture(s) with tissue conditioning in place.

2. Please verify, by marking the box, that the patient meets each of the following requirements:
   - ☐ i. Be consistently (and comfortably) wearing and functioning with a maxillary and mandibular complete denture, on a daily basis, and the dentures must be in excess of Six (6) months of age;
   - ☐ ii. Be able to fluently communicate in English, both verbal and written; and
   - ☐ iii. Be a skeletal Class I jaw relationship (Orthognathic).

3. Please verify, by marking the box, that the patient is aware of the following commitments to this examination:
   - ☐ i. The four day requirement;
   - ☐ ii. The daily time requirement;
   - ☐ iii. That they will be treated by an Examination Candidate other than yourself;
   - ☐ iv. That they are expected to follow the directions and requests of the Candidate who is treating them;
   - ☐ v. That they will be undergoing procedures which may be different than what they have previously encountered;
   - ☐ vi. That they are expected to take all steps to ensure that they are healthy and able to be worked on without undue duress to the Candidate;
   - ☐ vii. That they comply with the times to be in attendance at the facility as indicated by the Candidate;
   - ☐ viii. That upon completion of the examination on the fourth day, they will be required to remain at the examination facility until the Examiners have examined the dentures and they have been released by the Registrar or designate;
   - ☐ ix. That failing to attend as required and/or failing to remain until released by the Registrar or designate, will result in your failure and immediate dismissal from the examination as well as the disqualification of the Candidate who is treating them in the examination;
   - ☐ x. That they will **NOT** receive the new dentures made by the Candidate; and
   - ☐ xi. That the patients **agree** to these commitments and procedures, by signing appropriate CDBC issued consent form(s).

☐ 4. Please verify, by marking the box, that the patient is not a Denturist, Dentist or any other oral health professional.

5. Please verify your understanding, by marking the box, that Candidates are required to bring the following examination supplies:
   - ☐ i. **TWO** sets, each of a different brand, of appropriately sized anterior teeth and 20 degree anatomical posterior teeth for the patient;
   - ☐ ii. **THREE** sets of different sized impression trays for the patient;
   - ☐ iii. Additional appropriately sized anterior teeth, 20 degree anatomical posterior teeth and/or impression trays that the Candidate may need for their own examination.

☐ 6. Please verify your understanding, by marking the box, that Candidates with incorrect or incomplete forms will not be permitted to challenge the Complete Denture Examination.

Certification/Affirmation

I hereby certify/affirm that the information given on this form is correct and complete to the best of my knowledge and belief, and I sign this in the presence of a witness at the City/Town of _____, British Columbia, on this _____ day of _____, 2015

_____ Registrant's Name (print)

_____ Candidate's Name (print)

_____ Registrant's Signature

_____ Candidate's Signature

THIS FORM MUST BE COMPLETED AND RETURNED TO THE COLLEGE OFFICE BY JULY 10, 2015.