COMPLETE DENTURES

STANDARDS OF CARE EVALUATION FORM

Resident: _____
Procedure: _____
Patient's Name: _____
Month: _____

	Acceptable	Needs Impr.	Unacceptable
1. Patient's History & Treatment Plan	_____	_____	_____
2. Preliminary Impressions	_____	_____	_____
3. Border molding	_____	_____	_____
4. Final Impressions	_____	_____	_____
5. Master Casts	_____	_____	_____
6. Location of vibrating line	_____	_____	_____
7. CJR	_____	_____	_____
8. Tooth Selection	_____	_____	_____
9. Wax Try-In	_____	_____	_____
10. Insertion	_____	_____	_____
11. Clinical Remount	_____	_____	_____
12. Post Operative Tx	_____	_____	_____
13. Patient Management	_____	_____	_____
14. Resident Time Management	_____	_____	_____
15. Lab Procedures			

	Acceptable	Needs Impr.	Unacceptable
a. Impression Trays	_____	_____	_____
b. Record Base	_____	_____	_____
c. Tooth Set-up Anatomic	_____	_____	_____
d. Tooth Set-up Zero Degrees	_____	_____	_____
e. Processed Prosthesis	_____	_____	_____
f. Finished Prosthesis	_____	_____	_____

Monthly Assessment

1. Acceptable: _____
2. Needs Improvement: _____
3. Unacceptable: _____

Performance Standard Assessment

Reviewed: _____

Resident: _____

Mentor: _____

Date: _____

COMMENTS: