REMOVABLE PARTIAL DENTURES

STANDARDS OF CARE EVALUATION FORM

Resident: _____ Procedure: _____

Patient's Name: _____

Month: _____

	Acceptable	Needs Impr.	Unacceptable
1. Patient's History & Treatment Plan			
2. Diagnostic Casts			
3. RPD Design			
4. Rest Preparations			
5. Final Impressions			
6. Master Casts			
7. Framework Try-In			
8. Corrected Cast			
9. CJR			
10. Tooth Selection			
11. Wax Try-In			
12. Insertion			
13. Post Operative Tx			
14. Patient Management			
15. Resident Time Management			
16. Laboratory Reline, RPD			
17. Lab Procedures			
a. Impression Trays			
b. Record Base			
c. Tooth Set-up Anatomic			
d. Tooth Set-up Zero Degrees			
e. Processed Prosthesis			
f. Finished Prosthesis			

REMOVABLE PROSTHODONTICS (Cont'd)

Acceptable Needs Impr. Unacceptable

Monthly Assessment

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

Performance Standard Assessment

Reviewed: _____

Resident: _____

Mentor: _____

Date: _____

COMMENTS: