



## **THE AMERICAN BOARD OF OPERATIVE DENTISTRY, INC.**

Application for Eligibility July

2017

### **Eligibility Requirements**

The qualifications required by candidates to obtain certification by the American Board of Operative Dentistry Inc. include:

1. All candidates must have successfully completed an acceptable (+), formal (#), postgraduate education program in operative or restorative dentistry.
2. Candidates may apply for board eligibility while enrolled in postgraduate operative dentistry programs. All candidates currently enrolled in postgraduate programs must include a letter of good standing from the program director with their applications.
3. All candidates must conform to the acceptable moral and ethical standards delineated by the American Dental Association.
4. All candidates must be members of the Academy of Operative Dentistry. Academy membership is required for board eligibility and must be maintained throughout all phases of the certification process.

(+) “Acceptable” refers to those formal programs in Operative or Restorative Dentistry offered by educational institutions accredited by the ADA Commission on Dental Accreditation. Programs must be two (2) or more years in duration.

(#) The term “formal” refers to a course or program with a minimum of two (2) full-time academic years or its equivalent. The major emphasis of the academic course or program must be on operative-restorative procedures and supporting disciplines.

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<b>ABOD OFFICERS 2016 – 2018</b>		<b>ABOD EXECUTIVE COUNCIL 2016 - 2018</b>			
<b>President:</b>	David W. Jones	Richard S. Adcock	Jeanette M. Gorthy	N. Blaine Cook	
<b>Vice-President:</b>	Michael Meharry	David W. Jones	Michael Meharry	Marcela Hernandez	
<b>Secretary:</b>	Jeanette M. Gorthy	Scott Kooistra	Jeffery S. Nordin	So Ran Kwon	
<b>Treasurer:</b>	Kim E. Diefenderfer		Kim E. Diefenderfer		

*I hereby apply to the American Board of Operative Dentistry, Inc. for Board Eligibility status and acceptance into the examination process towards Board Certification.*

1. **Name** \_\_\_\_\_  
Last First Middle
2. **Date and Place of Birth** \_\_\_\_\_ **Citizenship** \_\_\_\_\_
3. **Office/Program Address** \_\_\_\_\_  
Street Suite #  
 \_\_\_\_\_ ( ) \_\_\_\_\_  
City State ZIP Phone
4. **Home Address** \_\_\_\_\_  
Street Apt #  
 \_\_\_\_\_ ( ) \_\_\_\_\_  
City State ZIP Phone
- E-mail address(es) \_\_\_\_\_

**\*NOTE:** We need an address that will be active for **at least 5 years**. Please notify the ABOD Secretary of any address changes.

**5. Education:**

a. Pre-professional Education \_\_\_\_\_  
College / University  
 \_\_\_\_\_ Degree \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_  
City, State

b. Doctoral Education \_\_\_\_\_  
Dental School  
 \_\_\_\_\_ Degree \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_  
City, State

c. Post-doctoral Education \_\_\_\_\_  
(Other than Operative or Restorative residency) Dental School  
 \_\_\_\_\_ Degree \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_  
City, State

d. Advanced training in Operative or Restorative Dentistry. Include a copy of your Certificate or Diploma, or your anticipated graduation date with a letter from your program director.

\_\_\_\_\_ Degree \_\_\_\_\_  
Dental School / Institution  
 Dates \_\_\_\_\_ to \_\_\_\_\_ Dean or Director \_\_\_\_\_

e. List any other Fellowships or Masterships you have received (i.e. AGD Fellowship).

\_\_\_\_\_

\_\_\_\_\_

6. **Federal Dental Service:** Branch of Service \_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

7. **Study Club** experience. Please list any study clubs with which you have been affiliated.

\_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Dates \_\_\_\_\_ to \_\_\_\_\_

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**ABOD EXECUTIVE COUNCIL 2016 - 2018**

**8. Teaching Experience:**

Institution	Department
Dates _____ to _____	
Chairman	
Institution	Department
Dates _____ to _____	
Chairman	

9. On a separate page, list all dental **continuing education credits** earned in the past five years.

10. I have included a copy of my current Academy of Operative Dentistry membership verification: \_\_\_\_\_  
(Initials/Date)

11. List all **dental licenses** that you have ever held and the dates that they were obtained (required for all applications for eligibility based on clinical experience, use extra sheets if necessary):

State or Province and Country	Dates _____ to _____
State or Province and Country	Dates _____ to _____

12. Has any **disciplinary action** ever been taken against you by any dental licensing board? Yes / No  
(Circle one)

If yes, please explain on a separate sheet of paper.

**I agree that prior to or subsequent to the examination the Board may investigate my standing and reputation as a practicing dentist. I also state that I am responsible for the truth of the information herein recorded.**

Date \_\_\_\_\_ Signed \_\_\_\_\_  
Applicant's Signature

**IMPORTANT: This application MUST be notarized by a Notary Public!**

Notary Seal \_\_\_\_\_

[Attach recent small photograph here with tape or glue, no staples please]

Notary Signature \_\_\_\_\_

Commission Expires \_\_\_\_\_

**Return this application and all supporting documents (listed above) to the both of the following addresses** (sending a hard copy of your application and a digital copy may expedite the application process):

La Jolla Dental  
Attn: ABOD Application  
8950 Villa La Jolla Drive Suite C210  
La Jolla, CA 92037  
[ABOD\\_Sec@comcast.net](mailto:ABOD_Sec@comcast.net)

**Application Fee: The fee for application for ABOD eligibility is \$100.00 and is non-refundable.**

Payment must be made online by credit card via PayPal. **Personal checks cannot be accepted by ABOD.** Applicants will be invoiced via e-mail after receipt of their applications.

**Submission of incomplete application packages may result in additional processing fees.**

**NOTE:** Applications are reviewed only 3-4 times per year. Therefore, payment invoices may not be sent immediately after application submission. Please do **NOT** contact ABOD about the status of your application until at least 3 months after your submission.

**Stop!** Package must include the following:

- Completed application
- Verification of Academy of Operative Dentistry Membership
- Copy of Completed Program Certificate, letter from Program Director, and United States Dental Board license as appropriate.
- A photo taken within the last 6 months attached to the application

**All incomplete packages will be returned without consideration.**  
**Digital applications will not be considered without a hard copy sent to the Secretary at the address above.**

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