**Pilot Voluntary Continuing Professional Development Programme for New Registrants 2020-21**

**Clinical Experience Log**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Category/Sub-category of Clinical Procedures** | **Operative Dentistry**  (*Total number not less than 12*) | | | **Oral Surgery & Oral Medicine**  (*Total number not less than 12*) | | | | **Paediatric Dentistry** (*Total number not less than 5*) | |
| **Extracoronal –**  **Cast Metal / Ceramic** (Onlay, Full Crown, CMC and All-ceramic)  *(Not less than 6)* | **Any Other Procedures** (Please Specify) | **Trans-alvcolar (MOS) for**  **Non-Impacted Tooth** | | **MOS for Impacted Tooth** | **Any Other Procedures** (Please Specify) | **Pulpotomy and Pulpectomy**  *(Not less than 3)* | | **Any Other Procedures** (Please Specify) |
| *(Not less than 3)* | | *(Not less than 3)* |
| **Number of Clinical Procedures Performed** |  |  |  | |  |  |  | |  |

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| **Category/Sub-category of Clinical Procedures** | **Prosthodontics**  (*Total number not less than 15*) | | | **Orthodontics**  (*Total number not less than 5*) | |
| **Fixed Bridges /  Resin-bond Retained**  *(Not less than 6)* | **Removable Partial Denture /  Complete Denture**  (No. of Arches)  *(Not less than 6)* | **Any Other Procedures** (e.g. Implant Supported Crown/Bridge) | **Orthodontic Diagnosis**  *(Not less than 3)* | **Any Other Procedures**  (e.g. Interceptive Orthodontics, Retainers) |
| **Number of Clinical Procedures Performed** |  |  |  |  |  |

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| **Category/Sub-category of Clinical Procedures** | **Root Canal Treatment**  (*Total number not less than 12*) | | | **Other Clinical Scenarios/Cases**  (*Total number not less than 18*) | | | | |
| **Anterior /  Premolar**    *(Not less than 6)* | **Molar**  *(Not less than 3)* | **Any Other Procedures** (Please Specify) | **Treatment of Medically Compromised Patients**  *(Not less than 3)* | **Case with Disability** (e.g. Special Care / Special Needs)  *(Not less than 3)* | **Management of Dental Emergency**  *(Not less*  *than 3)* | **Referral for**  **Advice / Treatment**  *(Not less*  *than 3)* | **Management of Patients with Periodontal Diseases**  *(Not less*  *than 3)* |
| **Number of Clinical**  **Procedures Performed** |  |  |  |  |  |  |  |  |

**Name of Mentee:** **Signature**: **Date**:

**Registration No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Mentor:**  **Signature**: **Date**:

**Remarks**

1. Please take note of the minimum number of clinical procedures required for performance in each category/sub-category.
2. In selection of the clinical cases, please choose those with learning value.
3. Please complete and keep a self-appraisal form for **EACH** of the clinical procedures performed for verification.