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

**Clinical Experience Log**

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| **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.