

Royal College of Dentists of Canada Oral and Maxillofacial Surgery Case List Report

I, Dr. _____ submit the following list of cases as partial requirement for the Oral and Maxillofacial Surgery examination of the Royal College of Dentists of Canada and do hereby state that I performed or held responsibility at the senior resident level for these cases.

Date: _____ Signature: _____
(Candidate)

This is to certify that Dr. _____ either performed or held responsibility at the senior resident level for the cases detailed on the five following pages of the Case List Report Form, as initialled:

(Please PRINT)			
Name:			
Position:			
Hospital:			
Address:			
Telephone:		Fax:	

Date: _____ Signature: _____
(Hospital Administrator/Authorized Signature)

- Please ensure each page of the six (6) page Case List Report Form has been certified. The candidate's initials should also appear on each page.
- If multiple institutions/hospitals are represented, please submit contact information (copy this page) for each facility and have each hospital administrator countersign/initial the other five pages of this form.

Group I

Ten (10) cases of fractures involving the maxillofacial complex, including five (5) open procedures. Case selection must demonstrate a variety of mandibular and midface injuries.

Date	ID	Procedure	Hospital Administration Initial

Certified (Please Initial): _____ Candidate Initials: _____

Group II

Ten (10) surgical procedures for significant lesions of the maxillofacial complex arising from congenital, developmental, traumatic, inflammatory, neoplastic or metabolic disturbances.

Date	ID	Procedure	Hospital Administration Initial

Certified (Please Initial): _____ Candidate Initials: _____

Group IV

Ten (10) cases of dentoalveolar surgery.

Date	ID	Procedure	Hospital Administration Initial

Certified (Please Initial): _____ Candidate Initials: _____

Group V

Ten (10) cases where the candidate has administered the general anesthetic or neuroleptanesthesia either as an inpatient or as an outpatient.

Date	ID	Procedure	Hospital Administration Initial

Certified (Please Initial): _____ Candidate Initials: _____