



**PORTFOLIO EXAMINATION  
CERTIFICATION OF CLINICAL EXPERIENCE COMPLETION**

Candidate Name: \_\_\_\_\_

Dental College: \_\_\_\_\_

<b>Competency Examination</b>	<b>Minimum Required Experiences</b>	<b>Date Completed</b>
Oral Diagnosis and Treatment Planning (ODTP)	20	
Direct Restorations (DR)	60	
Indirect Restorations (IR)	14	
Removable Prosthodontics (RP)	5	
Endodontics (E)	5	
Periodontics (P)	25	

I, \_\_\_\_\_, hereby certify that the information provided is true and correct.

Signature of Clinic Director \_\_\_\_\_

Date \_\_\_\_\_