Application for American Board of Oral Implantology/Implant Dentistry Certification
211 East Chicago Avenue, Suite 750-B
Chicago, Illinois 60611-2616
Phone: 312-335-879h
Fax: 312-335-9045

Part I Application

_____

First **MI** **Last** **Degree**

Last 4 digits of SS#_____ or 4 Digits _____
(This will be your candidate number)

Preferred Mailing Address:

Address: _____

City_____State _____Zip _____

Phone _____ Fax _____

E-Mail _____ @ _____

Undergraduate Dental Education:

Name of Institution: _____

Location: _____Degree _____

Date graduated _____

Routes:

☐ Route 1: Dental Implantology Program | **Please complete box A**

- You are a graduate of a Full Time post-doctoral program in Oral Implantology
- The program must have been a minimum of 2 years in length
- The program is sponsored by an institution accredited or approved by either the Commission on Dental Accreditation of the American Dental Association or JCAHO in the United States or Canada

(You must fulfill each of the above requirements to qualify under this route)

☐ Route 2: Board Certified Specialist | **Please complete box B**

- You are a board certified graduate of a full time advanced education program accredited by the ADA Commission on Dental Accreditation in the United States or Canada in one of the following specialties:
  - Oral and Maxillofacial Surgery
  - Periodontics
  - Prosthodontics

(You must fulfill each of the above requirements to qualify under this route)

☐ Route 3: Dental Specialist| Non-Board Certified | **Please complete box A**

- You have completed a full time advanced education program minimum of two (2) years in:
  - Oral and Maxillofacial Surgery
  - Periodontics
  - Prosthodontics

  (If you are board certified in any of these specialties, you will apply under route 2)

(You must fulfill each of the above requirements to qualify under this route)

☐ Route 4: General Practitioner **| Please complete box C**

- You are a general dentist, or dental specialist not listed in Routes 1, 2 or 3, you are licensed to practice dentistry where you reside
- Have a minimum of seven (7) years of clinical practice experience in Implant Dentistry
- You have completed 75 cases of implant treatment and the implants have been fully restored and functional for a minimum of 1 year
- Possess a minimum of 670 hours of Continuing Dental Education hours or Continuing Medical education hours that are specific to implant dentistry

☐ Route 5: General Practitioner (AAID Fellow or Associate Fellow) **| Please complete box C**

- You are a general dentist, or dental specialist not listed in Routes 1, 2 or 3, you are licensed to practice dentistry where you reside
- Have a minimum of seven (7) years of clinical practice experience in Implant Dentistry
- You have completed 75 cases of implant treatment and the implants have been fully restored and functional for a minimum of 1 year
- Possess a minimum of 570 hours of Continuing Dental Education hours or Continuing Medical education hours that are specific to implant dentistry
- **You are an Associate Fellow or Fellow of the American Academy of Implant Dentistry**

General Practitioner Requirements: 300 hours continuum education
370 hours of implant dentistry related continuum education

AAID Associate Fellow and Fellow Requirements: 300 hours of implant dentistry related continuum education
270 hours continuum education

Explanation for continuing education hours

For purposes of this application, the ABOI defines a continuum as a series of implant specific CE courses given by the same sponsor which are in aggregate a minimum of 60 hours or more.

The continuing education programs submitted must be recognized by the continuing education provider that is recognized in the country in which you reside for example, in the United States and Canada, it would be AGD or the ADA.

Continuing education that's required to be implant related in nature is including but not limited to the following examples:

Implant Surgery	Conscious Sedation	Pharmacology
Periodontology	Occlusion	Medical Emergencies
Computer Diagnostics	Treatment planning	Bone/Soft Tissue Grafting

Please submit your continuing education hours on the ABOI CDE/ CME Documentation form which can be found on our website at: www.aboi.org

All examinations are administered in English, the ABOI/ID does not provide interpreters.

If you are a Fellow of the American Academy of Implant Dentistry you are exempt from taking the written examination.

Box A: Please complete if you qualify under Route 1 or Route 3.

What Institution did you attend and receive your postgraduate dental specialty education?

Name of institution and location: _____

_____

Dates attended: _____

Program director:_____Phone number:_____

Degree awarded: _____ Discipline: _____

If you are able to fulfill the requirements for route 1, you are exempt from taking the Part I written examination

Licensure:

What state(s) or Canadian province(s) do you maintain a dental or an educational license:
Please list all:

License #_____ Expiration _____

License #_____ Expiration _____

For ABOI Use Only:

License Confirmed: Status of License:

Initials:

Box B: Please fill out if you qualify under Route 2.

If you are able to fulfill the requirements for this route, you are exempt from taking the Part I written examination

What institution did you attend and receive your postgraduate dental specialty education?

Name of institution and location: _____
_____

Dates attended: _____

Degree awarded: _____ Discipline: _____

Board Certifications:

Name of board: _____Date issued: _____

Certificate # _____Expiration:_____

Licensure:

What state(s) or Canadian province(s) do you maintain a dental or an educational license:
Please list all:
License #_____ Expiration _____
License #_____ Expiration _____

For ABOI Use Only:

License Confirmed: Status of License:

Initials:

Box C: Please fill out if you qualify under Route 4 or Route 5.

If you are a Fellow of the American Academy of Implant Dentistry you are exempt from taking the written examination.

Licensure:
Where do you maintain a dental or dental educational license:

Please list all:
Country and License #_____Expiration _____

Country and License #_____Expiration _____

For ABOI Use Only:

License Confirmed: Status of License:

Initials:

Certification and Release

I, _____, hereby certify that the foregoing information is true and correct to the best of my knowledge, and I understand that my electronic signature submitted with my application shall serve as my verification of the information I submitted to ABOI and as confirmation of my identity.

I hereby agree to advise ABOI immediately in writing of any changes in my status that would amend or alter the information I have provided in my application. If the American Board of Implantology / Implant Dentistry ("ABOI") awards me a Diplomate certification, I agree to uphold the principles and the objectives of ABOI and to abide by its bylaws.

I hereby agree to waive and relinquish any and all claims I may have arising out of, or in connection with, this application, the grade or grades given to me with respect to the oral and/or written examinations administered to me by ABOI, or the decision of ABOI to issue me a Diplomate certification, or any other certification.

I hereby fully release, discharge, and exonerate ABOI, its directors, officers, members, examiners, representatives, and agents from any actions, suits, obligations, damages, claims, or demands arising out of, or in connection with, this application, the grade or grades given to me with respect to the oral and/or written examinations administered to me by ABOI, or the decision of ABOI to issue me a Diplomate certification, or any other certification.

I hereby acknowledge and understand that the ABOI's decision(s) whether my oral and/or written examinations qualify me for a Diplomate certification or any other certification, vest solely and exclusively in ABOI. I understand that, in the event of any dispute between ABOI and me, ABOI's decision(s), including any decision after the completion of the appeal process set forth by ABOI, is/are final and binding.

Dated: _____, 20___

_____
Applicant's Signature

SUBSCRIBED AND SWORN to
before me this ___ day of
_____, 20____.

_____

Notary Public

Application Policies, Fees and Deadlines

Part I application fee	$400.00
Part I examination fee (Part I examination fee waived for Route 1,2, and Fellows of AAID)	$500.00
Part II examination fee (oral exam/case presentations)	$900.00

A cancellation of $400.00 will apply for any candidate requesting to cancel any portion of the certification exam within 45 days of the date of the scheduled examination.

The Re-Examination fee is $400.00

Part II must be successfully completed within four years of receipt of the Part I application.

Applicable fees must accompany your application(s). Fees are non-refundable and must be in U.S. dollars drawn from a U.S. bank. Please make checks payable to ABOI/ID.

Applications for each examination are due by December 1st of each year.

Case submission is required **at the same time** of application for the oral examination. Please await confirmation from the ABOI/ID Headquarter office before scheduling travel arrangements for examination.

Examination dates vary from year to year and will be posted on the ABOI website as soon as they are available; Check www.aboi.org for current testing dates.

American Board of Oral Implantology/ Implant Dentistry
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Chicago, IL 60611
312-335-8793 Fax: 312-335-9045

Credit Card Payment Submission

Name as if appears on credit card: _____

VISA _____ MASTERCARD _____ AMERICAN EXPRESS_____

Card Number: _____

Expiration Date: _____

Security Code on back of card:_____Billing Zip code: _____

Amount:_____

I authorize the American Board of Oral Implantology to charge the above amount to my credit card,

Signature: _____

Date: _____

Authorization to Release Academic Information Form

Notice: By signing below you are authorizing the ABOI a one-time release of private school record information from the following institution: _____

I _____ hereby authorize the release of my private transcript and professional training / academic information and records to the American Board of Oral Implantology/ Implant Dentistry and its agents. I authorize the release of the following information:

_____ Grade reports from all classes attended

☐ Confirmation of completion status

Should you need to contact me regarding this authorization, I can be reached at the following phone number:

Name: _____

Phone: _____

Years attended: _____

Signature: _____

Date: _____

American Board of Oral Implantology/Implant Dentistry
211 E. Chicago Avenue, Suite 750-B
Chicago, Il 60611

American Board of Oral Implantology/Implant Dentistry

Confidentiality Agreement

I hereby attest that I will not divulge the nature or content of any question or answer on the ABOI/ID Certification examination to any individual or entity, and I will report to the ABOI/ID Board of Examiners any solicitations and disclosures of which I become aware.

I will not remove, or attempt to remove, any ABOI/ID Examination materials, notes, or other unauthorized materials from the examination room.

I understand that failure to comply with this attestation may result in invalidation of my grades, disqualification from future examinations, and possible civil penalties and liability.

Candidate Signature: _____

Print Name: _____

Date: _____

For ABOI Use only:

_____ Application Complete

List missing items if any:

_____CME Form complete

_____Affidavits/ Release of Academic Information Form signed

_____ Confidentiality Statement Signed

_____Yes _____No

Comments: