Dental Office SOLUTIONS

Continuing Education Questionnaire

NAME: ____

WORK PHONE NUMBER: ____

CELL PHONE NUMBER: ____

WORK FAX NUMBER: ____

E-MAIL ADDRESS: ____

What courses are of interest to you and what courses dates would you like to participate?

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What are your short (1 – 2 years) and long (3 – 5 years) term career goals?

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SKILLS, EXPERIENCES AND KNOWLEDGE

Please check all skills and knowledge areas in which you have experience:

____ Implant Placement
____ Suturing
____Periodontal Surgery
    ____Connective Tissue Grafting
    ____Bone Grafting
    ____Periodontal Plastic Surgery
____Oral Surgery
    ____Atraumatic Extraction
    ____Use of Osteotomes
____Oral Anatomy
____Implant Prosthetics
    ____Occlusion
    ____Prosthetic Design
____Cone Beam CT
    ____Interpretation
    ____Planning
____Staff Training and Motivation

Please return your completed questionnaire to: Stephanie Laverde, CE Coordinator
E-mail: www.kellycourses@dentalofficesolutions.com Fax: (336) 778 – 1570

Please list skills, experiences and knowledge areas in which you would like to receive training.

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What do you hope to learn, understand, or be able to do better as a result of your experience as a course participant?

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MISCELLANEOUS

Have you attended a Dental Office Solutions course in the past? If so when? Please describe your experience.

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What are your expectations of the DOS Mentoring Program? Why do you want to participate in the program as a mentee?

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What steps, if any, have you taken to enhance your implant placement and surgical skills over the past 2 to 3 years?

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