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Schedule of the 2009 ADEA House of Delegates

Opening of the ADEA House of Delegates

Saturday, March 14, 2009, 4:00 to 5:00 p.m., Phoenix Convention Center, 301 West A/B

Voting for ADEA President-elect

Sunday, March 15, ballots may be cast between the hours of 8:00 a.m. and 5:00 p.m., at the ADEA House of Delegates booth in the registration area in the Phoenix Convention Center.

Monday, March 16, ballots may be cast between the hours of 8:00 a.m. and 4:30 p.m., at the ADEA House of Delegates booth in the registration area in the Phoenix Convention Center.

Tuesday, March 17, ballots may be cast between the hours of 8:00 a.m. and 4:30 p.m., at the ADEA House of Delegates booth in the registration area in the Phoenix Convention Center.

ADEA Reference Committee Hearings

ADEA Reference Committee on Association Policy
   Monday, March 16, 3:00 to 4:00 p.m., Phoenix Convention Center, 221 B

ADEA Reference Committee on Association Administrative Affairs
   Tuesday, March 17, 1:00 to 2:00 p.m., Phoenix Convention Center, 222 A/B

Closing of the ADEA House of Delegates

Wednesday, March 18, noon to 1:00 p.m., Phoenix Convention Center, 301 West A/B

For the order of business of each session of the House, please see the section on “Order of Business of the ADEA House of Delegates” on page 25. For the names of the members of the Reference Committees and the resolutions assigned to them, please see page 24.
Members of the 2009 ADEA House of Delegates

ADEA Board of Directors

Dr. Charles N. Bertolami, President, New York University
Dr. James Q. Swift, Immediate Past President, University of Minnesota
Dr. Ronald J. Hunt, President-elect, Virginia Commonwealth University
Prof. Cheryl Westphal, Vice President for Allied Dental Program Directors, New York University
Dr. Diane C. Hoelscher, Vice President for Faculties, University of Detroit Mercy
Dr. Lily T. Garcia, Vice President for Sections, University of Texas Health Science Center at San Antonio
Dr. Rishi Popat, Vice President for Students, Harvard School of Dental Medicine
Dr. Todd E. Thierer, Vice President for Hospitals and Advanced Educational Programs, University of Rochester
Dr. John N. Williams, Vice President for Deans, University of North Carolina at Chapel Hill
Ms. Barbara Nordquist, Vice President for the Corporate Council, KaVo/DEXIS/Gendex/Pelton & Crane/ISI
Dr. Richard W. Valachovic, Executive Director, American Dental Education Association

ADEA Council of Allied Dental Program Directors

Administrative Board
Dr. Susan Kass, Chair, Miami-Dade College
Prof. Tami Grzesikowski, Chair-elect, St. Petersburg College
Prof. Ethel G. Campbell, Secretary, University of North Carolina at Chapel Hill
Dr. Susan Duley, Member-at-Large, Clayton State University
Prof. Cheryl Westphal, Vice President, New York University

Additional Delegates, Dental Assisting
Prof. Donna Estes, Texas State Technical College
Prof. Jeannie Martinez-Welles, University of New Mexico
Prof. Pamela Wood, Texas State Technical College

Additional Delegates, Dental Hygiene
Dr. Shirley Beaver, Kennedy-King College
Prof. Michele Carr, The Ohio State University
Dr. Susan Crim, University of Tennessee
Dr. Ellen Grimes, Vermont Technical College
Prof. Anne E. Gwozdek, University of Michigan
Prof. Gwen L. Hlava, University of Nebraska
Dr. Laura Joseph, Farmingdale State College of New York
Prof. M. Elizabeth Kaz, Rio Salado College
Dr. Sally M. Mauriello, University of North Carolina at Chapel Hill
Prof. Trisha Nunn, Utah College of Dental Hygiene
Prof. Martha H. Roberson, Virginia Western Community College
Prof. Donna Wittmayer, Clark College
Additional Delegate, Special/Advanced Programs
Dr. Linda Boyd, University of Idaho

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ADEA Council of Deans

Administrative Board
Dr. Teresa A. Dolan, Chair, University of Florida
Dr. Leo E. Rouse, Chair-elect, Howard University
Dr. Huw F. Thomas, Secretary, University of Alabama at Birmingham
Dr. Denise K. Kassebaum, Member-at-Large, University of Colorado at Denver
Dr. John N. Williams, Vice President, University of North Carolina at Chapel Hill

Additional Delegates, Deans
Dr. Sigmund H. Abelson, University of Southern California
Dr. Mert N. Aksu, University of Detroit Mercy
Dr. Carole A. Anderson, The Ohio State University
Dr. Ann M. Boyle, Southern Illinois University
Dr. Thomas W. Braun, University of Pittsburgh
Dr. Richard N. Buchanan, University at Buffalo
Dr. William B. Butler, Meharry Medical College
Dr. Jack Clinton, Oregon Health & Science University
Dr. James S. Cole, Baylor College of Dentistry
Dr. Jack Dillenberg, Arizona School of Dentistry and Oral Health
Dr. R. Bruce Donoff, Harvard School of Dental Medicine
Dr. Connie L. Drisko, Medical College of Georgia
Dr. John D.B. Featherstone, University of California at San Francisco
Dr. Cecile A. Feldman, University of Medicine and Dentistry of New Jersey
Dr. Patrick J. Ferrillo Jr., University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Catherine M. Flaitz, University of Texas Health Science Center at Houston
Dr. Steven W. Friedrichsen, Creighton University
Dr. Buford O. Gilbert, University of Mississippi
Dr. Jerold S. Goldberg, Case School of Dental Medicine
Dr. Lawrence I. Goldblatt, Indiana University
Dr. Charles J. Goodacre, Loma Linda University
Dr. Bruce S. Graham, University of Illinois at Chicago
Dr. Henry A. Gremillion, Louisiana State University
Dr. Timothy L. Hotell, University of Tennessee
Dr. Jeffrey W. Hutter, Boston University
Dr. Amid I. Ismail, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. David C. Johnsen, University of Iowa
Dr. Kenneth L. Kalkwarf, University of Texas Health Science Center at San Antonio
Dr. James J. Koebl, Western University of Health Sciences
Dr. Ira B. Lamster, Columbia University
Dr. Patrick M Lloyd, University of Minnesota
Dr. William K. Lobb, Marquette University
Dr. R. Lamont MacNeil, University of Connecticut
Dr. Nancy M. Mills, University of Missouri-Kansas City
Dr. Lonnie H. Norris, Tufts University
Dr. No-Hee Park, University of California, Los Angeles
Dr. Peter J. Polverini, University of Michigan

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Dr. John W. Reinhardt, University of Nebraska
Dr. Yilda Rivera, University of Puerto Rico
Dr. John J. Sanders, Medical University of South Carolina
Dr. John J. Sauk, University of Louisville
Dr. Richard J. Simonsen, Midwestern University
Dr. Thomas P. Sollecito, University of Pennsylvania
Dr. Martha J. Somerman, University of Washington
Dr. Christian S. Stohler, University of Maryland
Dr. Sharon P. Turner, University of Kentucky
Dr. Robert A. Uchin, Nova Southeastern University
Dr. Louise T. Veselicky, West Virginia University
Dr. Karen P. West, University of Nevada, Las Vegas
Dr. Ray C. Williams, Stony Brook University
Dr. Robert A. Uchin, Nova Southeastern University
Dr. Louise T. Veselicky, West Virginia University
Dr. Karen P. West, University of Nevada, Las Vegas
Dr. Ray C. Williams, Stony Brook University
Dr. Stephen K. Young, University of Oklahoma

Additional Delegates, Non-Hospital Based Advanced Dental Education Programs
Dr. Rolf G. Behrents, Saint Louis University
Dr. C. Lynn Hurst, University of Southern Nevada
Dr. Cyril Meyerowitz, University of Rochester
Dr. Steven R. Sewall, Medical College of Wisconsin
Dr. Philip Stashenko, The Forsyth Institute
Dr. Mark A. Warner, Mayo School of Graduate Medical Education

Additional Delegates, Federal Dental Service Programs
Major General Russell J. Czerw, United States Army Dental Corps
Rear Admiral Christopher G. Halliday, United States Public Health Service
Colonel Robert Manga, United States Army Graduate Dental Education
Colonel Thomas R. Schneid, United States Air Force Dental Service
Captain Robert Michael Taft, United States Navy Dental Corps
Dr. Timothy O. Ward, United States Department of Veterans Affairs

Additional Delegate, Association of Canadian Faculties of Dentistry
Dr. Lex MacNeil, The University of British Columbia

ADEA Council of Faculties

Administrative Board
Dr. Nadeem Karimbux, Chair, Harvard School of Dental Medicine
Dr. Michael A. Siegel, Chair-elect, Nova Southeastern University
Dr. Kenneth R. Etzel, Secretary, University of Pittsburgh
Dr. Karen F. Novak, Member-at-Large, University of Kentucky
Dr. Diane C. Hoelscher, Vice President, University of Detroit Mercy

Additional Delegates
Dr. Elizabeth Andrews, Western University of Health Sciences
Dr. Laura Caroline Barritt, Creighton University
Dr. Carol A. Bibb, University of California, Los Angeles
Dr. Susan Chialastri, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Nereyda P. Clark, University of Florida
Dr. Madelyn Coar, University of Alabama at Birmingham
Dr. Paula L. Collins, University of Louisville
Prof. Marsha A. Cunningham-Ford, University of Iowa
Dr. Joseph A. D'Ambrosio, University of Connecticut
Dr. Debra A. Dixon, Southern Illinois University
Dr. Victoria Evangelidis-Sakellson, Columbia University
Dr. Kim E. Fenesy, University of Medicine and Dentistry of New Jersey
Dr. Riki Gottlieb, Virginia Commonwealth University
Dr. John F. Guarente, Boston University
Dr. Kevin M. Gureckis, University of Texas Health Science at San Antonio
Dr. Arnaldo J. Guzman-Garcia, University of Puerto Rico
Dr. Wayne W. Herman, Medical College of Georgia
Dr. Edwin H. Hines, Meharry Medical College
Dr. Andrea D. Jackson, Howard University
Dr. Nancy L. Jacobsen, University of Oklahoma
Dr. T. Roma Jasinevicius, Case School of Dental Medicine
Dr. Bernard A. Karshmer, University of Colorado
Dr. Gordon G. Keyes, West Virginia University
Dr. Allan J. Kucine, Stony Brook University
Dr. Peter M. Loomer, University of California, San Francisco
Dr. William P. Lundergan, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Michael D. McCunniff, University of Missouri-Kansas City
Prof. Melinda L. Meadows, Indiana University
Dr. Lisa M. Mruz, University at Buffalo
Dr. Valerie A. Murrah, University of North Carolina at Chapel Hill
Dr. Ivy D. Peltz, New York University
Dr. Elizabeth S. Pilcher, Medical University of South Carolina
Dr. David L. Pitts, University of Washington
Dr. Judith A. Porter, University of Maryland
Dr. Robert G. Rashid, The Ohio State University
Dr. Nelson Rhodus, University of Minnesota
Dr. Sandra K. Rich, University of Southern California
Dr. Larry B. Salzmann, University of Illinois at Chicago
Dr. Mark Scarbecz, University of Tennessee
Dr. John D. Seeberg, Nova Southeastern University
Dr. Francis G. Serio, University of Mississippi
Dr. Yolanda Annetta Slaughter, University of Pennsylvania
Dr. Chet A. Smith, Louisiana State University
Dr. Woosong Sohn, University of Michigan
Dr. Robert D. Spears, Baylor College of Dentistry
Dr. Jeffery C.B. Stewart, Oregon Health & Science University
Dr. Henry St. Germain, University of Nebraska
Dr. Lane C. Thomsen, Loma Linda University
Dr. Paul L. Trombly, Tufts University
Prof. Donna P. Warren-Morris, University of Texas Health Science Center at Houston
Dr. Linda M. Wells, Marquette University
Dr. Michelle Wheater, University of Detroit Mercy
Dr. Janet Woldt, Arizona School of Dentistry and Oral Health
Dr. Wendy Sue Woodall, University of Nevada, Las Vegas
ADEA Council of Sections

**Administrative Board**
Dr. William Davenport Jr., Chair, University of Nevada, Las Vegas
Dr. Allen Otsuka, Chair-elect, Southern Illinois University
Dr. Michael A. Landers, Secretary, Case School of Dental Medicine
Dr. Judith Skelton, Member-at-Large, University of Kentucky
Dr. Lily T. Garcia, Vice President, University of Texas Health Science Center at San Antonio

**Academic Affairs**
Dr. Marilyn S. Lantz, Councilor, University of Michigan
Dr. Pamela R. Overman, Chair, University of Missouri-Kansas City

**Anatomical Sciences**
Dr. H. Wayne Lambert, Chair, West Virginia University
Dr. Douglas Gould, Chair-elect, The Ohio State University

**Behavioral Sciences**
Dr. Elaine L. Davis, Councilor, University at Buffalo
Prof. Kimberly Werth, Chair, University of Detroit Mercy

**Biochemistry, Nutrition, and Microbiology**
Dr. Alan E. Levine, Councilor, University of Texas Health Science Center at Houston
Prof. Lisa F. Harper Mallonee, Chair, Baylor College of Dentistry

**Business and Financial Administration**
Mr. John W. Barch, Councilor, University of Texas Health Science Center at San Antonio
Ms. Juana S. Moore, Chair, Baylor College of Dentistry

**Clinic Administration**
Dr. Wilbert Milligan III, Chair, University of Pittsburgh
Dr. Lex MacNeil, Councilor, University of British Columbia

**Clinical Simulation**
Dr. Frank W. Licari, Councilor, University of Illinois at Chicago
Dr. Kenneth L. Allen, Chair, New York University

**Community and Preventive Dentistry**
Dr. Vladimir W. Spolsky, Councilor, University of California, Los Angeles
Dr. Sena Narendran, Chair, Case School of Dental Medicine

**Comprehensive Care and General Dentistry**
Dr. Fred J. Fendler, Councilor, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Susan M. Lee, Chair, University of California, San Francisco
Continuing Education
Dr. William O. Butler, Councilor, University of Texas Health Science Center at San Antonio
Ms. Carol E. Trecek, Chair, Marquette University

Dental Anatomy and Occlusion
Dr. Stanley J. Nelson, Councilor, University of Nevada, Las Vegas
Dr. Charles K. Hill, Chair, University of Nevada, Las Vegas

Dental Assisting Education
Prof. Linda S. Stewart, Councilor, University of North Carolina at Chapel Hill
Dr. Carolyn K. Breen, Chair, University of Medicine and Dentistry of New Jersey

Dental Hygiene Education
Prof. Joyce C. Hudson, Councilor, Indiana University
Prof. Christine M. Blue, Chair, University of Minnesota

Dental Informatics
Dr. Elise S. Eisenberg, Councilor, New York University
Ms. Athena Tsembelis, Chair, University at Buffalo

Dental School Admissions Officers
Dr. Joseph M. McManus Jr., Councilor, Columbia University
Dr. Venita J. Sposetti, Chair, University of Florida

Development, Alumni Affairs, and Public Relations
Ms. Rita A. Startup, Chair, New York University
Ms. Ashley T. Sharp, Chair-elect, New York University

Educational Research/Development and Curriculum
Dr. Andrew I. Spielman, Chair, New York University
Ms. Gail S. Mitchell, Councilor, University of Florida

Endodontics
Dr. Roberta Pileggi, Councilor, University of Florida
Dr. Leandro R. Britto, Chair, University of Florida

Gay-Straight Alliance
Dr. Frederick G. More, Councilor, New York University
Dr. John L. Zimmerman, Chair, Columbia University

Gerontology and Geriatrics Education
Dr. Katherine F. Schrubbe, Councilor, Marquette University
Dr. Georgia Dounis, Chair, University of Nevada, Las Vegas

Graduate and Postgraduate Education
Dr. Solon Kao, Chair, Medical College of Georgia
Dr. Kathy L. Marshall, Secretary, Howard University

Minority Affairs
Dr. Keith A. Mays, Councilor, University of Maryland
Dr. Cornell C. Thomas, Chair, Southern Illinois University

**Operative Dentistry and Biomaterials**  
Dr. Kevin B. Frazier, Councilor, Medical College of Georgia  
Dr. Juan A. Agosto, Chair, University of Puerto Rico

**Oral and Maxillofacial Pathology**  
Dr. Alice E. Curran, Councilor, University of North Carolina at Chapel Hill  
Dr. Jerry E. Bouquot, Chair, University of Texas Health Science Center at Houston

**Oral and Maxillofacial Radiology**  
Dr. Margot L. Van Dis, Councilor, Indiana University  
Dr. Jahanzeb Chaudhry, Chair-elect, Indiana University

**Oral and Maxillofacial Surgery/Anesthesiology/Hospital Dentistry**  
Dr. Jeffrey D. Bennett, Councilor, Indiana University  
Dr. Paul S. Tiwana, University of Louisville

**Oral Biology**  
Dr. L. Jack Windsor, Chair-elect, Indiana University  
Dr. Mark S. Wolff, Chair, New York University

**Oral Diagnosis/Oral Medicine**  
Dr. Thomas P. Shopper, Councilor, Louisiana State University  
Dr. Janet E. Leigh, Chair, Louisiana State University

**Orthodontics**  
Dr. David A. Covell Jr., Councilor, Oregon Health & Science University  
Dr. Jaleh Pourhamidi, Chair, University of Southern Nevada

**Pediatric Dentistry**  
Dr. Joan E. Kowolik, Councilor, Indiana University  
Dr. Lubna Fawad, Chair, University of Mississippi

**Periodontics**  
Dr. Grishondra Branch-Mays, Councilor, University of Maryland  
Dr. Peter M. Loomer, University of California, San Francisco

**Physiology, Pharmacology, and Therapeutics**  
Dr. Gary E. Jeffers, Councilor, University of Detroit Mercy  
Dr. David H. Shaw, Chair, University of Nebraska

**Postdoctoral General Dentistry**  
Dr. Heidi C. Crow, Councilor, University at Buffalo  
Dr. Russell S. Bergman, Chair, Lehigh Valley Hospital Health Network

**Practice Management**  
Dr. David G. Dunning, Councilor, University of Nebraska  
Dr. Dunn H. Cumby, Chair, University of Oklahoma
**Prosthodontics**  
Dr. Lisa A. Lang, Councilor, University of Texas Health Science Center at San Antonio  
Dr. Sharon Siegel, Chair, Nova Southeastern University  

**Student Affairs and Financial Aid**  
Dr. Carolyn L. Booker, Councilor, Virginia Commonwealth University  
Ms. Cheryl W. White, Chair, University of Medicine and Dentistry of New Jersey

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**ADEA Council of Hospitals and Advanced Education Programs**

**Administrative Board**  
Dr. John R. Agar, Chair, University of Connecticut  
Dr. Vincent J. Iacono, Chair-elect, Stony Brook University  
Dr. Gerald N. Glickman, Secretary, Baylor College of Dentistry  
Dr. Pamela J. Hughes, Member-at-Large, University of Minnesota  
Dr. Todd E. Thierer, Vice President, University of Rochester  

**Additional Delegates**  
Dr. G. Frans Currier, University of Oklahoma, Pediatric Dentistry/Orthodontics  
Dr. Tracy M. Dellinger, University of Mississippi, Academy of General Dentistry/Advanced Education in General Dentistry  
Dr. Carla A. Evans, University of Illinois at Chicago, American Association of Orthodontists  
Dr. Robert J. Flinton, University of Medicine and Dentistry of New Jersey, American College of Prosthodontists  
Dr. George T. Gallagher, Boston University, American Academy of Oral and Maxillofacial Pathology  
Dr. James D. Johnson, University of Washington, American Association of Endodontists  
Dr. Paula S. Jones, Academy of General Dentistry  
Dr. Sheila H. Koh, University of Texas Health Science Center at Houston, Advanced Education in General Dentistry  
Dr. Judith K. Messura, Wake Forest University, Special Care Dentistry  
Dr. David W. Paquette, University of North Carolina at Chapel Hill, American Academy of Periodontology  
Dr. N. Sue Seale, Baylor College of Dentistry, American Academy of Pediatric Dentistry  
Dr. David M. Shafer, University of Connecticut, American Association of Oral and Maxillofacial Surgeons  
Dr. Raymond K. Simmons, University of Texas Health Science Center at Houston, General Practice Residency  
Dr. Jane A. Weintraub, University of California, San Francisco, American Association of Public Health Dentistry

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**ADEA Council of Students**

**Administrative Board**  
Mr. Nathan J. Hawley, Chair, University of Nevada, Las Vegas  
Mr. Jason Tanguay, Vice Chair, University of Washington  
Mr. James K. Han, Secretary, University of California, San Francisco  
Dr. Erik M. Unger, Member-at-Large, University of Alabama at Birmingham  
Dr. Rishi Popat, Vice President, Harvard School of Dental Medicine

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2009 ADEA House of Delegates Manual
Predoctoral Dental Students – Northeast
Ms. Lorrelei A. Paires, Columbia University
Mr. Burton L. Rankie, University at Buffalo

Predoctoral Dental Students – Southeast
Mr. Milin R. Parikh, Medical College of Georgia
Mr. Drew D. Whitford, University of Florida

Predoctoral Dental Students – South Central
Mr. Michael Syamken, University of Texas Health Science Center at Houston
Ms. Elise M. Trahant, Louisiana State University

Predoctoral Dental Students – Midwest
Ms. Shaheda G. Govani, Marquette University
Mr. Nathan Robinson, University of Minnesota

Predoctoral Dental Students – Pacific
Mr. Zachary A. Carnow, University of the Pacific Arthur A. Dugoni School of Dentistry
Ms. Phi D. Luong, University of California, San Francisco

Predoctoral Dental Students – Ohio Valley
Mr. Daniel B. Claman, The Ohio State University
Ms. Sana Pasha, Howard University

Postdoctoral Dental Students – Hospital Programs
Dr. Kai-Chiao Joe Chang, University of Detroit Mercy
Dr. Justin J. Seaman, New York University
Dr. Summer Totonchi, Southern Illinois University

Postdoctoral Dental Students – Non-Hospital Programs
To be determined
To be determined

Allied Dental Students – Dental Hygiene
Ms. Eryn C. Fletcher, University of Detroit Mercy
Ms. Jennifer K. Lansing, University of Minnesota
Ms. Joan Ong, University of Southern California

Allied Dental Students – Dental Assisting
To be determined
To be determined

Allied Dental Students – Dental Laboratory Technology
To be determined
To be determined
ADEA Corporate Council

Delegates
Mr. Harold S. (Buddy) Auten, Chair, Sirona Dental Systems, LLC
Mr. Daniel W. Perkins, Chair-elect, AEGIS Communications
Ms. Barbara Nordquist, Vice President, KaVo/DEXIS/Gendex/Pelton& Crane/ISI
Introduction to the ADEA Governing Process

Introduction

The American Dental Education Association is a democratic organization and thus has a governmental structure that at first appears complex. It really isn’t. Nevertheless, members—especially new ones—would have difficulty trying to understand the Association by studying its Bylaws. This section of the House of Delegates Manual is therefore designed to summarize and clarify the Association’s structure and its policy-making procedures so you will know how to participate in those procedures. If you want further information, you should refer to the Bylaws, pages 125-150. This section describes (1) how ADEA is organized, (2) how resolutions are introduced, and what happens to them, and (3) how Reference Committees function.

How ADEA is Organized

You first must know how ADEA is organized in order to understand the Association’s policy-making procedures. Illustration 1 at the end of this section shows that ADEA is organized into four basic components: (1) the House of Delegates, (2) the Board of Directors, (3) councils and their administrative boards, and (4) sections.

ADEA House of Delegates

The ADEA House of Delegates is the Association’s legislative (policy-making) body. It convenes twice at each ADEA Annual Session. The House of Delegates consists of the Board of Directors (see below) and all or some members of the Association’s seven councils. All members of the ADEA Councils of Deans and Faculties are delegates. The numbers of delegates from the ADEA Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, and Students are based on percentages of those councils’ members. The number of section delegates depends on the number of sections. The councilor and chair of each section serve as delegates.

ADEA Board of Directors

The Board of Directors is ADEA’s administrative body and is responsible for running the Association’s affairs between ADEA Annual Sessions. It has 11 members—President, President-elect, Immediate Past President, the Vice President for each of the seven Councils, and the Executive Director.

The Board of Directors can establish interim Association policies that are consistent with existing policies if it apprises the House of its actions at the next ADEA Annual Session.

ADEA Councils

Six of the Association’s seven councils represent different constituencies at Member Institutions. The seventh consists of the councilor and chair of each ADEA section (see below). Councils represent their constituencies in the Association and at its Member Institutions. They identify, initiate, and oversee projects and reports of value to their members and other Association members. Councils may also participate in the Association’s policy-making process. When requested, they identify potential consultants to the Board of Directors and other groups.
All councils meet at the ADEA Annual Sessions, and some hold additional meetings between Annual Sessions.

The ADEA Council of Allied Dental Program Directors consists of the directors of dental hygiene, assisting, and laboratory technology education programs conducted by Member Institutions. In addition, the council includes directors of special allied dental education programs at the post-entry level that lead to a baccalaureate or advanced degree.

The ADEA Council of Deans consists of the dean of each U.S. dental school; the chief dental administrative officer of each affiliate (nondental school) member institution conducting non-hospital-based postdoctoral dental education programs; the chief dental officer of the U.S. Air Force, Army, Navy, Public Health Service, and Veterans Administration; and the President of the Association of Canadian Faculties of Dentistry.

The ADEA Council of Faculties consists of one faculty representative from each U.S. dental school.

The ADEA Council of Hospitals and Advanced Education Programs consists of the chief of dental service and directors of general practice and specialty residency programs that conduct postdoctoral dental education programs at Member Institutions.

The ADEA Council of Sections consists of the councilor and chair of each of the Association's sections.

The ADEA Council of Students consists of one student representative for each of the following types of programs conducted by all Member Institutions: (1) programs leading to the D.D.S. or D.M.D. degree, (2) postdoctoral dental education programs, (3) dental hygiene education programs, (4) dental assisting education programs, and (5) dental laboratory technology education programs.

The ADEA Corporate Council consists of the official representative of each ADEA Corporate Member.

Council Administrative Boards
Each council has a five-member administrative board, consisting of a Vice President (who is an Association officer who serves on the ADEA Board of Directors), a Chair, a Chair-elect, a Secretary, and a Member-at-Large. Each administrative board meets at least once between Annual Sessions and is responsible for planning its council's ADEA Annual Session program and for managing the council's affairs. Administrative boards relate to their councils much as the Board of Directors relates to the House of Delegates.

Sections
Each ADEA Individual, Student, Honorary, or Retired Member may join any of the Association's sections. Each section is concerned with a particular academic or administrative area.

Individual members may attend the meetings of any sections but can participate in the business affairs of only those to which they belong. Each section has a councilor, chair, chair-elect, and secretary. The section officers function much as the council administrative boards do, in that they plan their section’s ADEA Annual Session meetings and manage the section’s affairs between Annual Sessions.
Standing and Special Committees

From time to time, the ADEA Board of Directors appoints standing and special committees to assist it in its operations.

Organizational Structure of the American Dental Education Association
How Resolutions are Introduced and What Happens to Them

Resolutions are the vehicles by which the Association’s policies and administrative procedures are established, amended, or deleted. Resolutions may be introduced either between ADEA Annual Sessions or at an Annual Session during the Opening Session of the House of Delegates. Each year, the ADEA Board of Directors presents several resolutions to the House, and any individual member may also present resolutions.

How to Introduce a Resolution at an ADEA Annual Session

Only delegates may introduce resolutions at an ADEA Annual Session and only at the Opening Session of the House (See Illustration 2). The ADEA councils meet before the Opening Session of the House. During those meetings, they have an opportunity to develop resolutions that can then be presented by one of their delegates at the Opening Session.

If a council develops a resolution after the Opening Session, the resolution cannot be considered by the House until the following year. However, the resolution can be sent immediately after the Annual Session to the ADEA Executive Director who then presents it to the ADEA Board of Directors for consideration before the next Annual Session.

How to Introduce a Resolution between ADEA Annual Sessions

Any individual member may submit a resolution between ADEA Annual Sessions (See Illustration 3). Resolutions should be sent to the ADEA Executive Director who forwards them to the other members of the ADEA Board of Directors.

The Board of Directors often refers resolutions to appropriate councils, sections, or standing and special committees for their recommendations. The Board of Directors, however, takes action on all resolutions prior to the Annual Session and sends them on to the ADEA House of Delegates. The Board of Directors may recommend approval, postponement, or rejection of a resolution, or may simply forward a resolution without comment.

All individual members must present resolutions to the Executive Director in writing before November 1 preceding the ADEA Annual Session in order for the Board of Directors to review the resolution prior to the Annual Session. Nondelegates who fail to meet that deadline may still ask a delegate to introduce a resolution for them at the Opening Session of the House.

Format of Resolution

Resolutions must follow a specific format. They should not be numbered because staff assigns numbers.

“Whereas” clauses should not be used. Instead, when necessary, a succinct background statement should precede the resolution.

Resolutions proposing expenditure of Association funds must be accompanied by a cost impact statement estimating the total amount of funds required and the period of expenditure. Such resolutions presented without cost impact statements will be declared deficient. Staff will assist resolution drafters in estimating expenditures.

Any resolution whose approval would change the ADEA Policy Statements and Position Papers must specify exactly how those documents would be affected. Likewise, any resolution whose approval would change the ADEA Bylaws must specify exactly how those documents would be affected. Staff will assist members in drafting these resolutions.
The following fictitious statement and resolution exemplifies the format of an ADEA resolution.

<table>
<thead>
<tr>
<th>Sample ADEA Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Directors Quorum</td>
</tr>
</tbody>
</table>

The present Bylaws of the American Dental Education Association provide that a majority of the members of the Board of Directors constitutes a quorum for the transaction of business. It is believed that the quorum requirements should be increased because it is presently possible for only six individuals to make important decisions affecting the Association. The following resolution is therefore presented for consideration.

Resolved, that the quorum requirement for the Board of Directors be increased from a majority of the members to two thirds of the members; and be it further

Resolved, that Bylaws Chapter IV (Board of Directors), Section E (Quorum), which reads:

Section E. Quorum, A majority of the members constitutes a quorum for the transaction of business at regular or special sessions.

Be amended to read:

Section E. Quorum. Two thirds of the members constitute a quorum for the transaction of business at regular or special sessions.
2. What Happens to Resolutions Introduced at Annual Session

Reference Committee on Association Administrative Affairs

House of Delegates

Reference Committee on Association Policy

Delegates

3. What Can Happen to a Resolution Introduced Between Annual Sessions

Reference Committee on Association Administrative Affairs

House of Delegates

Reference Committee on Association Policy

Executive Director

Board of Directors

Individual Member

Council/s

Section/s
How ADEA Reference Committees Function

Purpose
Before each ADEA Annual Session, the ADEA Board of Directors appoints two Reference Committees, the ADEA Reference Committee on Association Administrative Affairs and the ADEA Reference Committee on Association Policy. Most resolutions to be considered by the ADEA House of Delegates are referred to one of these committees. Resolutions dealing with administrative, procedural, and business affairs of the Association are referred to the Reference Committee on Association Administrative Affairs. Resolutions dealing with the policies and public positions of ADEA are referred to the Reference Committee on Association Policy.

The Reference Committees hold hearings at the Annual Session, at which all individual members have an opportunity to discuss and debate the resolutions before they are considered by delegates at the Closing Session of the House. After their hearings, the Reference Committees write reports recommending specific actions on each resolution, and the reports are presented at the Closing Session.

Hearings
Hearings are open to all individual members and other ADEA Annual Session participants. Reference Committee chairs have the authority to determine whether a nonmember may speak.

At their hearings, each Reference Committee provides an opportunity for discussion on each resolution referred to it. A Reference Committee must recommend action to the House on each resolution, even if there is no discussion at the hearing. However, if there is no discussion, a Reference Committee need not necessarily recommend approval of a resolution; it can recommend another action. Reference Committees have considerable authority; they may propose the adoption of a resolution, or they may recommend amendment, postponement, or rejection. Each Reference Committee prepares a report at the end of its hearing, which will be given at the Closing of the House. Each committee must, in its report, explain its recommendations briefly, noting the reasons for agreement or disagreement with the original recommendations.

A Reference Committee chair cannot permit motions or votes at hearings because Reference Committees are intended only to receive information and opinions. Further, a chair may not debate points, either at the hearing or the Closing Session of the House.

More
There is more on Reference Committees specific to the 2009 ADEA Annual Session in the next section.

Conclusion
We hope this information has given you a basic understanding of how ADEA works and has encouraged you to participate actively in the Association’s affairs. Please contact ADEA staff members Ms. Sue Sandmeyer, Associate Executive Director for Knowledge Management, or Ms. Susan Krug, Associate Executive Director for Member Services, at 202-289-7201 or at sandmeyers@adea.org or krugs@adea.org for any further information you need.
ADEA Reference Committees

ADEA Reference Committee on Association Administrative Affairs

Dr. Linda D. Boyd, Idaho State University, Council of Allied Dental Program Directors
Dr. Teresa A. Dolan, University of Florida, Council of Deans
Mr. James K. Han, University of California, San Francisco, Council of Students
Dr. Vincent J. Iacono, Stony Brook University, Council of Hospitals and Advanced Education Programs
Dr. Lisa A. Lang, University of Texas Health Science Center at San Antonio, Council of Sections, Chair
Ms. Lisa Nascimento, Carl Zeiss Meditec, Inc., Corporate Council
Dr. Frank G. Serio, University of Mississippi, Council of Faculties

ADEA Reference Committee on Association Policy

Dr. Keith A. Mays, University of Maryland, Council of Sections, Chair
Dr. Susan I. Duley, Clayton State University, Council of Allied Dental Program Directors
Dr. Gerald N. Glickman, Baylor College of Dentistry, Council of Hospitals and Advanced Education Programs
Dr. Henry St. Germain Jr., University of Nebraska, Council of Faculties
Mr. Jason Tanguay, University of Washington, Council of Students
Dr. John N. Williams, University of North Carolina at Chapel Hill, Council of Deans
Ms. Noel Paschke, Philips Oral Healthcare, Inc., Corporate Council

ADEA Reference Committees Meeting Times and Locations of Hearings

ADEA Reference Committee on Association Policy
Monday, March 16, 3:00 to 4:00 p.m., Phoenix Convention Center, 221 B

ADEA Reference Committee on Association Administrative Affairs
Tuesday, March 17, 1:00 to 2:00 p.m., Phoenix Convention Center, 222 A/B
Resolutions to be Considered by
the ADEA House of Delegates

While there are five Resolutions (1H-2009 through 5H-2009) that will be acted upon by the House at its Opening Session on Saturday, March 14, from 4:00 to 5:00 p.m. (Phoenix Convention Center, Room 301 West A/B), there are eight resolutions (6H-2009 through 13H-2009) that the Board of Directors has referred to hearings of Reference Committees. In addition, any resolutions introduced at the Opening Session of the House will also be referred to the appropriate Reference Committee.

After the Reference Committees have met on March 16 and 17, these eight resolutions (and any that are presented from the floor) will be considered by the House at its Closing Session on Wednesday, March 18, noon to 1:00 p.m., Phoenix Convention Center, Room 301 West A/B. At the Closing Session the Reference Committees’ chairs will read the resolutions that their committees have heard, and their reports will be submitted to the House (but not read aloud).

Resolutions to be Heard by the ADEA Reference Committee on Association Policy

The Reference Committee on Association Policy will hold a hearing on resolutions 6H-2009 through 9H-2009 at its hearing, which will be Monday, March 16, from 3:00 to 4:00 p.m. in the Phoenix Convention Center, Room 221 B. Additional resolutions introduced at the Opening Session of the House may be referred to this committee.

Resolutions to be Heard by the ADEA Reference Committee on Association Administrative Affairs

The Reference Committee on Association Administrative Affairs will hear resolutions 10H-2009 through 13H-2009 on Tuesday, March 17, from 1:00 to 2:00 p.m. in the Phoenix Convention Center, Room 222 A/B. Additional resolutions introduced at the Opening Session of the House may also be referred to this committee.

Order of Business of the ADEA House of Delegates

Opening Session
Saturday, March 14, 2009, 4:00 – 5:00 p.m., Phoenix Convention Center, Room 301 West A/B

Call to Order—ADEA President Dr. Charles N. Bertolami
Report of Quorum
Approval of the Minutes of the Previous Session
Reports
  President-elect’s Address—Dr. Ronald J. Hunt
  Executive Director’s Report—Dr. Richard W. Valachovic

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- 25 -
Report of the Nominating Committee—Dr. James Q. Swift
Referrals of Reports and Resolutions
—Recess, until March 18, 2009, noon

Closing Session
Wednesday, March 18, noon to 1:00 p.m., Phoenix Convention Center, Room 301 West A/B

Call to Order—ADEA President Dr. Charles N. Bertolami
Report of Quorum
Consideration of Reference Committee Reports and Action on Resolutions
Unfinished Business
New Business
President’s Address—Dr. Charles N. Bertolami
Announcement of New Officers and Recognition of Retiring Officers
Adjournment

Procedures for the Conduct of Business in the ADEA House of Delegates

Designates
A delegate unable to attend a House session or who serves in the House in two or more positions (e.g., as a member of the Council of Faculties and Council of Sections) may appoint a designate to represent him or her. A delegate from the Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, or Students must appoint a designate who is a member of the same council. A delegate from the Council of Sections must appoint the secretary or Chair-elect of his/her section. A delegate from the Councils of Deans and Faculties must appoint a designate from his/her institution. A delegate representing two or more councils must decide which council to represent and then appoint a designate for the other position according to the foregoing guidelines. A delegate must notify ADEA of the name of the designate. This can be done by emailing ADEA prior to the ADEA Annual Session or when picking up voting cards at the ADEA House of Delegates booth in the registration area at the ADEA Annual Session.

Admission Cards
At registration, each delegate and designate will receive three cards: (1) one for admission to the Opening Session of the House, (2) one for admission to the Closing Session, and (3) one for balloting for President-elect. Each delegate and designate must surrender the signed, appropriate card when entering the floor for the Opening and Closing Sessions. Any delegates or designates who misplace their admission or voting cards should immediately report the loss to staff in the Association’s registration area.

Seating of Delegates
Delegates are seated by council affiliation, and each delegate is required to sit with his or her council. The council seating areas will be marked by signs.

Visitors
All registered ADEA Annual Session participants are not only invited but also encouraged to attend the ADEA House of Delegates sessions as well as meetings of the
Reference Committees. There will be visitors’ seating sections at both the Opening and Closing Sessions.

Presiding Officer
The Association’s President—Dr. Charles N. Bertolami—is the presiding officer of the House. In the absence of the President, the President-elect is the presiding officer. The President casts the deciding vote in case of a tie, appoints judges and tellers to assist in determining the result of any action taken by ballot, and performs any other duties required by the rules of order.

Recording Officer
The ADEA Executive Director is the recording officer of the ADEA House of Delegates and the custodian of its records. The Executive Director may appoint a public stenographer to record the verbatim proceedings of the Opening and Closing Sessions of the House.

Rules of Order
The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the deliberations of the House in all cases where they are applicable and not in conflict with the Association’s Bylaws.

Parliamentarian
A parliamentarian will be present during the sessions of the House of Delegates.

Explanation of Motions
To avoid confusion, each type of motion is assigned a definite rank as shown in the table on pages 29-31.

The rank is based on the urgency of each motion. When a motion is before the House, any motion is in order if it has a higher precedence or rank than the immediately pending motion, but no motion having a lower precedence is in order. Motions are considered and decided in a reverse order to that of their proposal. For example, a motion to amend the main motion is dispensed with before the main motion, and a motion to amend an amendment is voted on before the original motion to amend.

After a motion to approve is made and seconded, the resolution is before the House for debate, amendment, and final action. A motion to approve is a main motion, and a vote by the House disposes of the resolution.

A motion to postpone definitely may be used to defer consideration of a resolution until some definite future time, usually the next ADEA Annual Session. Such resolutions are often referred to the ADEA Board of Directors, councils, or sections for their recommendations.

There is no motion to postpone indefinitely available to delegates. The motion to postpone indefinitely was often confused with the motion to lay on the table, because they both set aside the pending main motion without bringing it to a direct vote. Unlike a motion to lay on the table, however, the motion to postpone indefinitely was debatable, and also opened the main question to debate. Because theoretically it was a new motion, it provided a loophole for those who had exhausted their right of debate, enabling them to get around the limitation and continue debating the main motion. This practice has been criticized because it prolongs debate, and because it violates the principle of majority rule, providing a means of thwarting the will of the assembly, as expressed in the motion limiting debate. It also confuses those who are not familiar with the motion, and who assume that it...
would merely “postpone” the pending question, as the name might seem to indicate, instead of killing it.

The motion to lay on the table accomplishes the main purpose of the motion to postpone indefinitely—that is, it suppresses the main motion without bringing it to a vote—but without the unintended result of prolonging discussion without the assembly’s permission.

Legislative bodies have traditionally killed motions by tabling them, and this is the most common method of “postponing indefinitely” in American organizations of all kinds. It is recommended that when a motion is made to postpone indefinitely, the chair handle it as a motion to lay on the table.

If an amended or substitute resolution is approved, the issue is resolved. However, if an amended or substitute resolution is not approved, the House returns to discussion of, and a vote on, the original version.

Amendments to the ADEA Bylaws

A proposed amendment to the Bylaws must be presented in writing at the Opening Session, and is then voted on at the Closing Session. A Bylaws amendment is enacted if it receives an affirmative vote of at least two thirds of the delegates present and voting.

Voting Procedures during ADEA House of Delegates Sessions

The presiding officer usually determines the method of voting during sessions of the House. He or she may choose a voice vote, a show of hands, a standing vote, or a secret ballot, depending on the closeness of the vote and the presiding officer’s sense of the House.
## Principal Rules Governing Motions in the ADEA House of Delegates

<table>
<thead>
<tr>
<th>Order of Precedence¹</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>No²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend²</td>
</tr>
<tr>
<td>3. Question of Privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Postpone temporarily (table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority³</td>
<td>Main Motion</td>
<td>None</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>None</td>
</tr>
<tr>
<td>6. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>Amend²</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, close debate, limit debate</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, close debate, limit debate</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Rewardable Motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
</tbody>
</table>

¹ Motions are in order only if no motion higher on the list is pending. Thus, if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

² Debatable if no other motion is pending

³ Requires two-thirds vote when it would suppress a motion without debate
## Principal Rules Governing Motions in the ADEA House of Delegates

<table>
<thead>
<tr>
<th>Order of Precedence</th>
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<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. a. The main motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Restorative, Subsidiary</td>
</tr>
<tr>
<td>10. b. Restorative main motions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Main motion</td>
<td>Subsidiary, Restorative</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>Previous action</td>
<td>Subsidiary</td>
</tr>
<tr>
<td><strong>No order of Precedence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes(^2)</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

\(^1\) When used out of order of precedence.

\(^2\) Usual practice is to amend a motion that has been rejected.
## Principal Rules Governing Motions in the ADEA House of Delegates

<table>
<thead>
<tr>
<th>No order of Precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>What other motion can be applied to it?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Decision of Chair</td>
<td>Close debate, limit debate</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td><strong>Requests</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Any error</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>All motions</td>
<td>None</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Main motion</td>
<td>None</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Main motion</td>
<td>None</td>
</tr>
</tbody>
</table>

Voting for ADEA President-elect

The members of the ADEA House of Delegates will cast ballots for ADEA President-elect during the ADEA Annual Session. Delegates may cast their ballots for President-elect between the hours of 8:00 a.m. and 5:00 p.m. on Sunday, March 15; between 8:00 a.m. and 4:30 p.m. on Monday, March 16; and between 8:00 a.m. and 4:30 p.m. on Tuesday, March 17. Voting will be at the ADEA House of Delegates booth in the registration area in the Phoenix Convention Center. These are the only times when a delegate or designate may cast a ballot for President-elect. Only a delegate (or official designate) may vote, and he/she must surrender his/her voter registration card to receive a ballot.

The 2009 Nomination Process for ADEA President-elect

The Board of Directors placed several calls for nominations in the Bulletin of Dental Education Online and Journal of Dental Education.

All members were invited to nominate as many individuals as they wished, including themselves.

The Council Administrative Boards were also invited to nominate candidates; however, the Boards were not informed of the identity of the other candidates. In order to maintain confidentiality, only the Nominating Committee and the ADEA Executive Director knew the identity of all nominees.

The deadline for submitting nominations was November 1, 2008.

The Nominating Committee voted to select the candidates to stand for election.

Upon the recommendation of the Nominating Committee, the Board of Directors presents two candidates for 2009-10 ADEA President-elect. (The office leads in successive years to the offices of President and Immediate Past President.) The candidates are:

Dr. Sandra Carlin Andrieu, Associate Dean, Louisiana State University School of Dentistry

Dr. John N. Williams, Dean, University of North Carolina at Chapel Hill School of Dentistry

A brief biographical sketch of each candidate follows.
Nominees for ADEA President-elect

Sandra Carlin Andrieu, Ph.D.

Dr. Andrieu has served as Associate Dean of Academic Affairs at Louisiana State University (LSU) Health Sciences Center School of Dentistry for the past 15 years. She began her career in dental education as a dental hygiene faculty member and later served as Director of the Program in Dental Hygiene. As an academic dean, she serves on numerous school and Health Sciences Center committees at LSU and works with a regional accrediting agency.

Dr. Andrieu’s desire to gain more knowledge about academic issues nationwide led her to become active in the ADEA Section on Academic Affairs, where she served in each of the officer positions of that Section and was subsequently elected ADEA Vice President for Sections and served on the ADEA Board of Directors.

Her continued service on the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI) Oversight Committee allowed her to work directly with the various external agencies that influence curricula, including representatives from the American Dental Association (ADA) Board of Trustees, Division of Education, and Council on Dental Education and Licensure; the Joint Commission on National Dental Examinations; and the Commission on Dental Accreditation.

In Dr. Andrieu’s words: “My engagement in dental education began as a dental hygiene faculty member and became further grounded over the past 30 years as both my faculty and administrative responsibilities became more broad-based. I have been fortunate to have had a diverse set of experiences and ever-increasing responsibility. I believe that I have the critical personal qualities and the professional experience that reflects our members. I appreciate your consideration of my interest in serving as President-elect of ADEA.”

John N. Williams, D.M.D., M.B.A.

Dr. Williams has been Dean of the University of North Carolina School of Dentistry since 2005. Prior to this, he served for six and a half years as Dean of the University of Louisville School of Dentistry, where he began his academic career as Associate Dean of Educational Programs and (concurrently) Assistant University Provost.

For more than 20 years, Dr. Williams has been active in ADEA and its predecessor organization. He served as ADEA Vice President for Sections and on the ADEA Legislative Advisory Committee. Currently, he holds the position of ADEA Vice President for Deans. He has been faculty advisor for three years for the ADEA Leadership Institute, served on the ADEA Women’s
Affairs Advisory Committee, and currently serves as Board liaison to the ADEA Minority Affairs Advisory Committee.

In addition to his service to ADEA, Dr. Williams has been an active site visitor for the Commission on Dental Accreditation, having chaired eight comprehensive site visits. His previous professional positions have provided him with experience raising money; directing curriculum for D.D.S./D.M.D., allied, and advanced education programs; and directing complex academic dental organizations.

Dr. Williams states, “I have had extensive involvement in organized dentistry at the state and national level as well as with previous positions with ADEA. I believe my knowledge, experience, and insights into dentistry and dental education—both challenges and opportunities—have prepared me well to assume this national leadership position. I would welcome the opportunity to serve as your ADEA President-elect.”
Report of the ADEA Board of Directors on Resolutions for Consideration by the 2009 ADEA House of Delegates

The ADEA House of Delegates will consider the 13 resolutions in this report, plus any additional ones introduced at the Opening Session. The House will act on Resolutions 1H-2009 through 5H-2009 at its Opening Session on Saturday, March 14, 2009, from 4:00 to 5:00 p.m. The House will act on all others at its Closing Session on Wednesday, March 18, 2009, from noon to 1:00 p.m. Both sessions will be held in the Phoenix Convention Center, 301 West A/B. The resolutions from the Board of Directors in the report are sequenced as follows:

Resolutions to be Acted on at the Opening Session

1H-2009 Commission on Dental Accreditation Commissioner
2H-2009 ADA Council on Dental Education and Licensure (CDEL) Member
3H-2009 Joint Commission on National Dental Examinations Member
4H-2009 ADEAGies Foundation Appointment
5H-2009 Appreciations

Resolutions to be Acted on at the Closing Session

6H-2009 ADEA Policy Statement on Health Care Reform
7H-2009 ADEA Competencies for Entry into the Allied Dental Professions
8H-2009 ADEA Statement on Professionalism in Dental Education
9H-2009 Support of a Voluntary PGY-1 Experience
10H-2009 ADEA Council of Students Name Change
11H-2009 ADEA Bylaws Technical Changes
12H-2009 Provisional Membership of East Carolina University School of Dentistry
13H-2009 Approval of the Fiscal Year 2010 Budget

All of the resolutions in this report that require House action are printed in **boldface** for delegates’ ease of identification.
Actions at the Opening Session of the ADEA House of Delegates

Resolution 1H-2009
Commission on Dental Accreditation Commissioner

The current ADEA representatives to the Commission and their termination dates (in the fall of the years shown) are:

- Dr. James J. Koelbl, Western University of Health Sciences College of Dental Medicine (2009)
- Dr. Michael J. Reed, University of Missouri-Kansas City School of Dentistry (2010)
- Dr. Sharon P. Turner, University of Kentucky College of Dentistry (2011)
- Dr. Richard N. Buchanan, University at Buffalo School of Dental Medicine (2012)

Dr. Koelbl will complete his term on the Commission on Dental Accreditation (CODA) this fall at the 2009 ADA Annual Session. He is not eligible for an additional term. Thus, the 2009 ADEA House will have to elect a new Commission member. To replace Dr. Koelbl on the Commission, the ADEA Board of Directors is recommending that the House elect Dr. Leo E. Rouse, Dean, Howard University College of Dentistry, to a four-year term to expire in 2013.

The ADEA bylaws allow delegates to nominate additional candidates for CODA membership at the Opening Session of the House. (Please note: ADEA appointees to CODA must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run, and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA registration area.

The ADEA Board of Directors asks the House approve the following resolution:

1H-2009. Resolved, that the ADEA House of Delegates elect Dr. Leo E. Rouse to a four-year term on the Commission on Dental Accreditation with the term to begin at the conclusion of the 2009 ADA Annual Session and end at the conclusion of the 2013 ADA Annual Session.
Resolution 2H-2009
ADA Council on Dental Education and Licensure Member

The current ADEA members to the ADA Council on Dental Education and Licensure (CDEL) and their termination dates (in the fall of the years shown) are:

- Dr. William K. Lobb, Marquette University (2009)
- Dr. James R. Hupp, East Carolina University (2010)
- Dr. Cyril Meyerowitz, University of Rochester (2011)
- Dr. Patrick M. Lloyd, University of Minnesota (2012)

Dr. Lobb will complete his term on CDEL this fall at the 2009 ADA Annual Session. He is not eligible for an additional term. Thus, the 2009 ADEA House will have to elect a new CDEL member. To replace Dr. Lobb on the Council, the ADEA Board of Directors is recommending that the House elect Dr. Tariq Javed, Medical University of South Carolina, to a four-year term to expire 2013.

The ADEA bylaws allow delegates to nominate additional candidates for ADA CDEL membership at the Opening Session of the House. (Please note: ADA CDEL members must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA Registration Area.

The ADEA Board of Directors asks the House approve the following resolution:

2H-2009. Resolved, that the ADEA House of Delegates elect Dr. Tariq Javed to a four-year term on the ADA Council on Dental Education and Licensure with the term to begin at the conclusion of the 2009 ADA Annual Session and end at the conclusion of the 2013 ADA Annual Session.
Resolution 3H-2009
Joint Commission on National Dental Examinations Member

The Joint Commission on National Dental Examinations (JCNDE) consists of three representatives each from the ADA and ADEA, six from the American Association of Dental Examiners, and one each from the American Dental Hygienists’ Association, the American Student Dental Association, and the public sector. The JCNDE members appointed by the ADEA House of Delegates and their termination dates (in the fall of the years shown) are:

- Dr. Marsha A. Pyle, Case School of Dental Medicine (2009)
- Dr. Andrew I. Spielman, New York University (2010)
- Dr. Ellen B. Byrne, Virginia Commonwealth University (2012)

Dr. Pyle will complete her term this fall at the 2009 ADA Annual Session. To represent ADEA, the Board of Directors is recommending that Dr. Birgit J. Glass, University of Texas Health Science Center at San Antonio, be appointed for a four-year term beginning in 2009 and ending in 2013.

The ADEA bylaws allow delegates to nominate additional candidates for ADA JCNDE membership at the Opening Session of the House. (Please note: ADA JCNDE members must be active members of the ADA.) Any delegate presenting a nominee must obtain the candidate’s consent to run and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review in the ADEA Registration Area.

The ADEA Board of Directors asks the House approve the following resolution:

3H-2009. Resolved, that the ADEA House of Delegates elect Dr. Birgit J. Glass to a four-year term on the Joint Commission on National Dental Examinations with the term to begin at the conclusion of the 2009 ADA Annual Session and end at the conclusion of the 2013 ADA Annual Session.
Resolution 4H-2009
ADEAGies Foundation Appointment

In order to enhance their ability to manage the challenges facing dental and allied dental education and research, the William J. Gies Foundation for the Advancement of Dentistry joined with ADEA in 2002 to create the William J. Gies Foundation for the Advancement of Dentistry of the American Dental Education Association (ADEAGies Foundation). The mission of the ADEAGies Foundation is to enhance the oral health of the public through programs that support dental education, research, leadership, and recognition.

According to the bylaws, the Board of Trustees of the ADEAGies Foundation consists of four or more ADEA appointed members, including the Past President, the Executive Director, one member appointed by the ADEA Board of Directors (but who cannot be a Board member), and a member appointed by the ADEA House of Delegates. The appointment by the ADEA House of Delegates is for a two-year term, beginning in July 2009 and ending in July 2011 with the appointment of a new member at the ADEA Annual Session.

The ADEA Board of Directors asks the House to approve the following resolution:

4H-2009. Resolved, that the ADEA House of Delegates appoint Mr. George Rhodes to a two-year term to expire in 2011, as a member of the Board of Trustees of the William J. Gies Foundation for the Advancement of Dentistry of the American Dental Education Association.
ADEA relies significantly on outside support for a number of its activities, and numerous organizations provided much-needed assistance since last year’s ADEA Annual Session. The ADEA Board of Directors expresses its sincere appreciation to the following companies, organizations, institutions, and individuals for their generous support. Those who have supported ADEA activities and events over the past year—from last year’s ADEA Annual Session until the start of this year’s Annual Session—are listed alphabetically. Most of the companies listed are also Corporate Members of ADEA, and we are especially grateful to them.

_ADA Insurance Plans_ cosponsored the meeting of the ADEA sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2008 Meetings.

_ADEA AADSAS_ cosponsored the meeting of the ADEA sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2008 Meetings.

The _ADEA Corporate Council_ sponsored the Opening Plenary at the 2008 ADEA Annual Session.

The _ADEA Council of Students_ cosponsored the 2008 ADEA/ADEA Council of Students/Colgate Palmolive Junior Faculty Award.

The _ADEAGies Foundation_ funded the ADEA/William J. Gies Foundation Education Fellowship and the ADEA/William J. Gies Foundation Research Scholarship. The Foundation cosponsored the 2008 ADEA Leadership Institute.

_A-dec_ was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. A-dec sponsored lunch at the 50th Annual ADEA Deans’ Conference and cosponsored dinner and a reception at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. The company also sponsored a reception at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and Exhibit Hall raffle items at the 2008 ADEA Annual Session.

_AEGIS Communications_ cosponsored the welcoming reception at the 50th Annual ADEA Deans’ Conference.

The _American Academy of Oral and Maxillofacial Pathology_ supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.

The _American Academy of Pediatric Dentistry_ supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.

The _American Academy of Periodontology_ supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.
The American Association for Dental Research sponsored the 2008 AADR/ADEA Academic Dental Careers Fellowship Program.

The American Association of Endodontists supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.

The American Association of Oral and Maxillofacial Surgeons cosponsored the 2008 ADEA/ASDA National Dental Student Lobby Day.

The American Dental Association provided travel stipends for the RWJF/AAMC/ADEA Summer Medical and Dental Education Program.

American Eagle Instruments, Inc. sponsored Exhibit Hall raffle items at the ADEA 2008 Annual Session.

Arizona School of Dentistry and Oral Health was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

The Association of American Medical Colleges provided travel stipends for the RWJF/AAMC/ADEA Summer Medical and Dental Education Program.

axiUm Software provided a break for the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. The company also sponsored an Exhibit Hall raffle item at the ADEA 2008 Annual Session.

Baylor College of Dentistry was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

BIOMET 3i was a general sponsor of the ADEA Fall 2008 Meetings.

Boston University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Brasseler USA sponsored the golf tournament reception and prizes at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference. The company also sponsored an Exhibit Hall raffle item at the ADEA 2008 Annual Session.

The California Endowment provided a grant to conduct a three-year evaluation of the California Dental Pipeline Program Phase II, a program designed to increase access to dental care for underserved populations.

Carl Zeiss Meditec, Inc. sponsored the Mentor/Mentee Program at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and a break at the 50th Annual ADEA Deans’ Conference.

Case School of Dental Medicine was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.
Certiphi Screening, Inc. cosponsored the meeting of the ADEA sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2008 Meetings.

Colgate-Palmolive Co. was a Diamond Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company again provided generous support for the ADEA/Colgate-Palmolive Co. Allied Dental Educators’ Fellowship and for the Allied Dental Leadership Development Program. Colgate-Palmolive Co. was a founding and continuing supporter of ADEA’s online Journal of Dental Education. The company sponsored the ADEA/Colgate-Palmolive Oral Systemic Link curriculum guideline development project. The company sponsored a networking lunch at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and sponsored conference tote bags at the Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. Colgate-Palmolive Co. sponsored educational sessions and a break at the 50th Annual ADEA Deans’ Conference and also sponsored the New Deans’ Workshop at this meeting. Colgate-Palmolive Co. supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.

Creighton University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

The DentalEZ Group was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

DENTSPLY International, Inc. was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company hosted a reception at the 50th Annual ADEA Deans’ Conference and was a general sponsor of the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. DENTSPLY International, Inc. provided the conference tote bags for the 41st Annual National ADEA Allied Dental Program Directors’ Conference and cosponsored the Third ADEA Summit on Advanced Education at the 2008 ADEA Fall Meetings.

DEXIS, LLC/Gendex Imaging/ISI sponsored a break at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

Discus Dental, Inc. sponsored the keynote address at the 50th Annual ADEA Deans’ Conference and the golf tournament beverage cart for the Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

Epocrates, Inc. sponsored Exhibit Hall raffle items at the ADEA 2008 Annual Session.

Fortress Insurance Company sponsored the ADEA President’s Reception at the 2008 ADEA Annual Session.

The Forsyth Institute was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

GC America, Inc. sponsored the golf tournament beverage cart at the 50th Annual ADEA Deans’ Conference.
G. Hartzell and Son cosponsored the welcome reception at the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

GlaxoSmithKline was a Diamond Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored three awards presented to dental educators to enhance their teaching efforts: the ADEA/GlaxoSmithKline/National Dental Association Dr. Jeanne C. Sinkford Scholar, the ADEA/GlaxoSmithKline Excellence in Teaching Award, and ADEA/GlaxoSmithKline Dental Hygiene Teaching Fellowship Program. GlaxoSmithKline was a founding and continuing supporter of ADEA’s online Journal of Dental Education. The company cosponsored the 50th Annual ADEA Deans’ Conference and the ADEA Fall 2008 Meetings. At the 2008 ADEA Annual Session, GlaxoSmithKline sponsored Faculty Development Workshops. The company continued support for the GlaxoSmithKline Prosthodontics Endowment in the ADEAGies Foundation to support ADEA’s Section on Prosthodontics. The company cosponsored the 2008 ADEA/ASDA National Dental Student Lobby Day and the 2008 ADEA Allied Dental Faculty Leadership Development Program. GlaxoSmithKline sponsored an educational session at the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

Harvard School of Dental Medicine was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Henry Schein, Inc. sponsored a break at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and a breakfast at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

Howard University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Hu-Friedy Mfg. Co., Inc. was a Platinum Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored a breakfast session at the 50th Annual ADEA Deans’ Conference and cosponsored a reception and dinner for the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. Hu-Friedy Mfg. Co., Inc. sponsored a reception and dinner at the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

Indiana University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Johnson & Johnson Healthcare Products, Division of McNeil-PPC, Inc. was a Premier Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored the ADEA/Johnson & Johnson Healthcare Products Preventive Dentistry Scholarships and the ADEA/Johnson & Johnson Healthcare Products/Enid A. Neidle Scholar-in-Residence Program for Women. The company sponsored the keynote address at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and an education program at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration. The company cosponsored the 50th Annual ADEA Deans’ Conference, the 2008 ADEA Allied Dental Faculty Leadership Development Program, and the 2008 ADEA Leadership Institute.
The Josiah Macy, Jr. Foundation provided a grant to support the Bridging the Gap Program, designed to develop a flexible seven-year dental curriculum as a way to increase the number of underrepresented minority and low-income students going into dentistry.

Kahler Slater sponsored lunches for golfers at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference.

KaVo Dental Corporation/Pelton & Crane was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored the welcome reception at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and breakfast at the 50th Annual ADEA Deans’ Conference.

Kilgore International sponsored a break at the 2008 ADEA Annual Session.

Liaison International, Inc. was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement and cosponsored the meeting of the ADEA Sections on Dental School Admissions Officers and Student Affairs and Financial Aid at the ADEA Fall 2008 Meetings.

Loma Linda University was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Louisiana State University was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

The Maurice H. Kornberg School of Dentistry, Temple University, was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Medical University of South Carolina was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Midwestern University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

The National Dental Association cosponsored the ADEA/GlaxoSmithKline/National Dental Association Dr. Jeanne C. Sinkford Scholar in the 2008 ADEA Leadership Institute.

National Dentex Corporation was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

New York University was a Diamond Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Nobel Biocare AB was a general sponsor of the 50th Annual ADEA Deans’ Conference and supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.
OMNI Preventive Care, a 3M ESPE Company, co-sponsored ADEAassist t-shirts and hats at the 2008 ADEA Annual Session.

OralCDx was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Oral Health America, the Beauchamp Funds, the George H. Whiteley Memorial Foundation and DENTSPLY International, Inc. supported the ADEAGies Foundation for the ADEA Leadership Institute.

OraPharma, Inc. was a Premier Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company cosponsored the 50th Annual ADEA Deans’ Conference and sponsored an education program at the 41st Annual National ADEA Allied Dental Program Directors’ Conference. OraPharma, Inc. provided support for general programming and activities for the ADEA Council of Sections and for the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings. The company supported the online Journal of Dental Education and the 2008 ADEA/ASDA National Dental Student Lobby Day.

Pacific Dental Services, Inc. sponsored the official 2008 ADEA Annual Session poster and was a general sponsor of the 50th Annual ADEA Deans’ Conference.

Patterson Dental sponsored an educational session at the 50th Annual ADEA Deans’ Conference.

Pentron Clinical Technologies sponsored educational sessions at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference.

Philips Oral Healthcare, Inc. was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored the conference lanyards at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and cosponsored ADEAassist t-shirts and hats at the 2008 ADEA Annual Session.

Premier Dental Products Company supported lunches for nongolfers at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration, and a break at the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

The Procter & Gamble Company was a Diamond Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored a breakfast and the meeting portfolios at the 50th Annual ADEA Deans’ Conference. The Procter & Gamble Company sponsored the ADEA Allied Dental Hygiene Clinic Coordinators’ lunch, the ADEA Predental Advisor’s workshop, the ADEA Dental Hygiene Graduate Program Directors meeting, and the meeting portfolios at the 2008 ADEA Annual Session. The company sponsored a lunch at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and a breakfast at the 41st Annual National ADEA Allied Dental Program Directors’ Conference. The company is a continuing supporter of ADEA’s online Journal of Dental Education. The Procter & Gamble Company was a cosponsor of the 2008 ADEA Allied Dental Faculty Leadership Development Program and of the 2008 ADEA Leadership Institute. The
company cosponsored the Eighth ADEA Diversity and Access to Dental Careers Conference at the ADEA Fall 2008 Meetings and the ADEA/Crest Oral-B Laboratories Scholarship for Dental Hygiene Students Pursuing Academic Careers. The Procter & Gamble Company sponsored the Caries Process and Prevention Strategy curriculum and online education program development.

*The Robert Wood Johnson Foundation* provided grants to support the AAMC/ADEA Summer Medical and Dental Education Program and the ExploreHealthCareers.org website. The Foundation also provided support through the RWJF Dental Pipeline II NPO for Admission Committee Workshops and activities to support efforts to address diversity in the predoctoral accreditation standards.

*SDI (North America) Inc.* sponsored a breakfast at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

*Secure Innovations, Inc.* sponsored a breakfast at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

*Sigma Phi Alpha,* the dental hygiene honor society, sponsored the 2008 ADEA/Sigma Phi Alpha Linda E. DeVore Scholarship.

*Sirona Dental Systems, LLC* was a Gold Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored educational sessions at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference. Sirona Dental Systems, LLC also cosponsored the TechExpo at the 2008 ADEA Annual Session.

*Stage Front Presentation Systems* sponsored an educational session at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration.

*Sunstar Americas, Inc.* sponsored the ADEA/Sunstar Americas, Inc. Harry W. Bruce, Jr. Legislative Fellowship and the ADEA Legislative Leadership dinner, the Meeting-at-a–Glance, and an Exhibit Hall raffle item at the 2008 ADEA Annual Session. The company sponsored an educational program at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and cosponsored the ADEA Allied Dental Faculty Leadership Development Program. Sunstar Americas, Inc. provided conference flash drives at the 50th Annual ADEA Deans’ Conference.

*Dr. James and Lori Swift* were Gold Level sponsors of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

*3M ESPE* was a general sponsor of the 50th Annual ADEA Deans’ Conference and sponsored an educational session at the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

*Tom’s of Maine* was a founding and continuing supporter of the online *Journal of Dental Education*. The company continued support for an endowment in the ADEAGies Foundation for ADEA’s Gay-Straight Alliance Section and was a general sponsor of the ADEA Allied Dental Faculty Leadership Development Program. At the 2008 ADEA Annual
Session, Tom’s of Maine sponsored an education program by the Gay Straight Alliance Section, a break for the ADEA Section program for Community and Preventive Dentistry, and Exhibit Hall raffle items.

_Tufts University_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_Ultradent Products, Inc._ sponsored golf shirts and a break at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference. The company also supported the Third ADEA Summit on Advanced Dental Education at the ADEA Fall 2008 Meetings.

_University at Buffalo_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Alabama at Birmingham_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of California, Los Angeles_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Connecticut_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Detroit Mercy_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Kentucky_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Louisville_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Maryland_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Michigan_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Minnesota_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Mississippi_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Missouri-Kansas City_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

_University of Nebraska Medical Center_ was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.
University of Nevada Las Vegas Medicine was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of North Carolina at Chapel Hill was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Oklahoma was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Rochester was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Tennessee was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of Texas Health Science Center at San Antonio was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

University of the Pacific Arthur A. Dugoni School of Dentistry was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Virginia Commonwealth University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

VitalSource Technologies, Inc. sponsored the 2008 ADEA Council of Students/Vital Source Technologies, Inc. Junior Faculty Award. The company was a general sponsor of the 50th Annual ADEA Deans’ Conference and cosponsored the TechExpo at the 2008 ADEA Annual Session.

Water Pik, Inc. cosponsored the Welcome Reception at the 41st Annual National ADEA Allied Dental Program Directors’ Conference and Exhibit Hall raffle items at the 2008 ADEA Annual Session.

West Virginia University was a Deans’ List Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement.

Whip Mix Corporation sponsored a Section education program at the 2008 ADEA Annual Session.

Wolters Kluwer sponsored an Exhibit Hall raffle item at the ADEA 2008 Annual Session.

Zimmer Dental was a Diamond Level sponsor of the 2008 William J. Gies Awards for Vision, Innovation, and Achievement. The company sponsored educational sessions at the 2008 Mid Year Meeting of the ADEA Sections on Business and Financial Administration and Clinic Administration and at the 50th Annual ADEA Deans’ Conference. Zimmer Dental supported the ADEA Council of Hospitals and Advanced Education Programs at the ADEA 2008 Annual Session and also sponsored the conference pens and keycards. The company supported the Third ADEA Summit on Advanced Dental
Education at the ADEA Fall 2008 Meetings. Zimmer Dental cosponsored the 41st Annual National ADEA Allied Dental Program Directors’ Conference.

The ADEA Board of Directors asks the House to approve the following resolution:

5H-2009. Resolved, that the American Dental Education Association expresses its sincere appreciation to the following organizations and individuals for their generous support of the Association’s activities and programs between the start of the 2008 ADEA Annual Session and the start of the 2009 ADEA Annual Session:

- ADA Insurance Plans
- ADEA AADSAS
- The ADEA Corporate Council
- The ADEA Council of Students
- The ADEAGies Foundation
- A-dec
- AEGIS Communications
- The American Academy of Oral and Maxillofacial Pathology
- The American Academy of Pediatric Dentistry
- The American Academy of Periodontology
- The American Association for Dental Research
- The American Association of Endodontists
- The American Association of Oral and Maxillofacial Surgeons
- The American Dental Association
- American Eagle Instruments, Inc.
- Arizona School of Dentistry and Oral Health
- The Association of American Medical Colleges
- axiUm Software
- Baylor College of Dentistry
- BIOMET 3i
- Boston University
- Brasseler USA
- The California Endowment
- Carl Zeiss Meditec, Inc.
- Case School of Dental Medicine
- Certiphi Screening, Inc.
- Colgate-Palmolive Co.
- Creighton University
- DentalEZ Group
- DENTSPLY International, Inc.
- DEXIS, LCC/Gendex Imaging/ISI
- Discus Dental, Inc.
- Epocrates, Inc.
- Fortress Insurance Company
- The Forsyth Institute
- GC America, Inc.
- G. Hartzell and Son
- GlaxoSmithKline
- Harvard School of Dental Medicine
- Henry Schein, Inc.
- Howard University

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• Hu-Friedy Mfg. Co., Inc.
• Indiana University
• Johnson & Johnson Healthcare Products, Division of McNeil-PPC, Inc.
• The Josiah Macy Jr. Foundation
• Kahler Slater
• KaVo Dental Corporation/Pelton & Crane
• Kilgore International
• Liaison International, Inc.
• Loma Linda University
• Louisiana State University
• The Maurice H. Kornberg School of Dentistry, Temple University
• Medical University of South Carolina
• Midwestern University
• National Dental Association
• National Dentex Corporation
• New York University
• Nobel Biocare AB
• OMNI Preventive Care, a 3M ESPE Company
• OralCDx
• Oral Health America, the Beauchamp Funds, the George H. Whiteley Memorial Foundation and DENTSPLY International, Inc.
• OraPharma, Inc.
• Pacific Dental Services, Inc.
• Patterson Dental
• Pentron Clinical Technologies
• Philips Oral Healthcare, Inc.
• Premier Dental Products Company
• The Procter & Gamble Company
• The Robert Wood Johnson Foundation
• SDI (North America) Inc.
• Secure Innovations, Inc.
• Sigma Phi Alpha
• Sirona Dental Systems, LLC
• Stage Front Presentations
• Sunstar Americas, Inc.
• Dr. James and Lori Swift
• 3M ESPE
• Tom’s of Maine
• Tufts University
• Ultradent Products, Inc.
• University at Buffalo
• University of Alabama at Birmingham
• University of California, Los Angeles
• University of Connecticut
• University of Detroit Mercy
• University of Kentucky
• University of Louisville
• University of Maryland
• University of Michigan
• University of Minnesota
• University of Mississippi
• University of Missouri-Kansas City
• University of Nebraska Medical Center
• University of Nevada Las Vegas
• University of North Carolina at Chapel Hill
• University of Oklahoma
• University of Rochester
• University of Tennessee
• University of Texas Health Science Center at San Antonio
• University of the Pacific Arthur A. Dugoni School of Dentistry
• Virginia Commonwealth University
• VitalSource Technologies, Inc.
• Water Pik, Inc.
• West Virginia University
• Whip Mix Corporation
• Wolters Kluwer
• Zimmer Dental
Actions at the Closing Session
of the ADEA House of Delegates

Resolution 6H-2009
ADEA Policy Statement on Health Care Reform

Background

Health care reform is again on the national policy agenda. After more than a decade of
tinkering with the health care system, making incremental changes to it, there is a growing
consensus among a majority of stakeholders (i.e., businesses, consumers, providers,
government, insurers, etc) that a systemic approach is needed to transform the American health
care system.

The health care crisis, as many are describing the current situation, is not primarily about
the moral issue of millions of Americans lacking health insurance, though that is a major
consideration in seeking system-wide changes. Rather, the crisis should be viewed as
essentially an economic problem facing our nation, perhaps THE central economic problem that
adversely affects living standards, job creation and retention, wage growth, and U.S.
competitiveness in global markets.

When garnering facts and data to support a movement toward systemic health care
reform, cold realities need to be taken into consideration. A few of these are:

- The costs of health care are surging at extraordinary rates. The United States spends
over two trillion dollars annually on health care, more than any other nation in the
world.2

- Over the past five years, health insurance premiums have increased more than four
and a half times faster than inflation. Estimates from a variety of sources, including the
Kaiser Family Foundation, put the average annual premium for employer-sponsored
family coverage at $12,973.3

- Health care costs add an average of $1,525 per vehicle to the price of every care
produced by the Big Three auto makers in 2007.4 The CEO of General Motors said:

1 Poisal JA, Truffer C, Smith S, Sisko A, Cowan C, Keenan S, Dickensheets B. Health Spending
Projections Through 2016: Modest Changes Obscure Part D’s Impact. Health Affairs, 21 February

2 The Organization for Economic Co-operation and Development. Health Data Updates: Data, Sources

3 DiJulio B, Employer Sponsored Health Insurance – A Comparison of the Availability and Cost of
Coverage for Workers in Small Firms and Larger Firms, Kaiser Family Foundation’s Health Care
Marketplace Project, November 2008, Available at

4 Dalmia S, Health Care Costs Imperil Big Three, The UAW’s health care dreams. Wall Street Journal,
“The cost of health care in the U.S. is making American business extremely uncompetitive versus our global counterparts.”

- The rapid rates of increase in health care costs erode not only the living standards of those who receive retirement funds from their former employer, but also the profitability of the company whose benefits they enjoy. For many businesses health care costs are the largest category of uncontrollable costs.

- Escalating health care costs are putting enormous pressures on the budgets of state and local governments, making it difficult for them to maintain current levels of health care benefits to their citizens. These costs are eroding the capacity of state, local and Federal governments to adequately fund other critical programs, such as higher education, which in turn produces the educated and skilled workforce needed to compete in the international economy of the twenty first century.

- Currently, nearly 47 million individuals, 9 million of which are children, are without medical insurance, up 6.8 percent since 2000. In addition, more than 130 million adults have no dental insurance, including nearly 23 million children.

- An epidemic of sub-standard care exists. There is a wide gulf - what the Institute of Medicine (IOM) calls a “quality chasm” - between the care that patients should receive and the care that is actually delivered. A new RAND study found that participants in the study received only 54.9 percent of recommended care - a proportion that varied little across the categories of preventive, acute, and chronic care.

The recent tragic deaths of two young boys, Deamonte Driver from Maryland, and Alexander Callender from Mississippi, of complications caused by infections that began with abscessed teeth, caused a firestorm on Capitol Hill with regard to the value and importance of oral health care. Consequently, oral health has a higher profile than it had previously and should rightly be included in the debate on health care reform.

Until the recent economic downturn, nearly all public opinion polls ranked affordable health care as the #1 domestic issue. On a national level it ranks, along with the economy, second after the war in Iraq. During the 2008 presidential campaign President-Elect Barack Obama made reform a core commitment of his campaign promising to enact universal health care by the end of his first presidential term.

The American Dental Education Association (ADEA) has determined that if the oral health community is not at the health care reform table, the likelihood of oral health being included is minimal. Without our participation in the debate, we also lose opportunities to create new and evolving roles for dental and allied dental education within the broader health care environment.

Consequently, in March 2008, the ADEA Legislative Advisory Committee (LAC) crafted “Oral Health Care: Essential to Health Care Reform,” a policy statement and set of guiding principles.

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principles with regard to health care reform. In June 2008, the ADEA Board of Directors unanimously approved the document as “ad hoc interim policy” until the ADEA House of Delegates could consider the document.

A survey to determine our members’ level of support for the Association’s participation in the national debate and for the ADEA health care reform policy statement was conducted at the ADEA Fall Meetings in Philadelphia in October 2008 and at the November 2008 Deans’ Conference in Tempe, Arizona using the Automated Response System. All ADEA members were notified that the same survey would be posted on ADEA’s webpage for their feedback, which was accepted from November 1 through December 31, 2008. Five hundred and nine responses from ADEA members were received indicating overwhelming support for ADEA’s active involvement in the debate. A large majority of members also supported ADEA’s policy statement. Survey results are attached to this resolution.

The ADEA Board of Directors asks the House to approve the following resolution:

**6H-2009. Resolved, that the ADEA House of Delegates approves, accepts and endorses “Oral Health Care: Essential to Health Care Reform” as the official policy of the Association with regard to the current national debate on health care reform.**

Attachments:

1) Oral Health Care: Essential to Health Care Reform

2) Summary of ADEA Member Survey Results
As the voice of dental education, the American Dental Education Association (ADEA)\(^7\), whose members serve as providers of care for thousands of uninsured, underserved low-income patients, believes that dental and allied dental educators have an ethical obligation to promote access to oral health care. **To that end, ADEA believes that any comprehensive reform of the U.S. health care system should provide universal coverage to all Americans and access to high-quality, cost-effective oral health care services.** Health care reform must also include investments in dental public health that improve our nation’s capacity to meet the health care needs of patients, communities, and other stakeholders.

**Millions Lack Dental Insurance**

Ensuring oral health is a shared responsibility of individuals and families, the private sector, and federal, state, and local governments. The United States spends over two trillion dollars annually on health care,\(^8\) more than any other nation in the world.\(^9\) Nevertheless, access to health care is still beyond the reach of more than 47 million Americans.\(^10\) In 2003, the U.S. Surgeon General reported that the number of Americans without dental insurance was more than 2.5 times the number lacking medical insurance.\(^11\) Approximately 130 million adults and children are without dental coverage.\(^12\) Many individuals, particularly those who are uninsured, often delay dental treatment until serious or acute dental emergencies occur. The cost of caring for Americans without health insurance in emergency rooms adds approximately $922 to the average cost of annual premiums for employer-sponsored family coverage.\(^13\) And the cost of

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7. The American Dental Education Association (ADEA) represents all 57 dental schools in the United States in addition to 714 dental residency training programs and 577 allied dental programs, as well as more than 12,000 faculty who educate and train the nearly 50,000 students and residents attending these institutions. It is at these academic dental institutions that future practitioners and researchers gain their knowledge, where the majority of dental research is conducted, and where significant dental care is provided.


providing preventive dental treatment is estimated to be 10 times less than the cost of managing symptoms of dental disease in a hospital emergency room.\textsuperscript{14}

Grave Oral Health Disparities Exist

According to the U.S. Surgeon General,\textsuperscript{15} dental disease is disproportionately found among individuals with special health care needs, with low incomes, and from underrepresented minorities and among those who live in underserved rural, urban, and frontier communities. Special care patients have more dental disease, missing teeth, and difficulty in obtaining dental care than the rest of the population. These inequities challenge us to make adequate investments in a strong dental public health infrastructure that extends beyond the traditional, economically driven model of care. The current model may well serve a majority of U.S. citizens, but it is not achieving universal coverage and equitable access to oral health for everyone.

Enhancing Productivity and Preserving Employer-Sponsored Coverage

Dental disease significantly impacts the nation’s domestic productivity and global competitiveness. More than 51 million school hours and 164 million hours of work are lost each year due to dental-related absences.\textsuperscript{16} More generally, uncompensated care adversely affects American businesses as costs are shifted to private payers. Health care costs added $1,525 to the price of every car produced by the Big Three auto makers in 2007.\textsuperscript{17} Most workers and families receive health insurance through employer-sponsored coverage. Changes to the health care system should bolster rather erode businesses' capacity to purchase health and dental coverage for their employees. Any proposal to reform the U.S. health care system should ensure that the economic viability of American businesses is maintained and that they are able to compete in the global marketplace.

PRINCIPLES FOR HEALTH CARE REFORM

Academic dental institutions are vital public trusts and national resources. They educate the future dental workforce, conduct dental research, inform communities of the importance and value of good oral health, and provide oral health care services and serve as dental homes to thousands of patients. It is within the broad range of oral health expertise and the interests represented by our membership that the American Dental Education Association offers the


following principles for providing access to and coverage of affordable oral health care services in health care reform:

1. The availability of health care, including oral health care, fulfills a fundamental human need and is necessary for the attainment of general health. Every American should have access to affordable diagnostic, preventive, restorative, and primary oral health care services so as to eliminate pain, suffering, and infection. Coverage must ensure that individuals are able to obtain needed oral health care and provide them with protection during a catastrophic health crisis. Oral health care services are proven to be effective in preventing and controlling tooth decay, gum infections, and pain, and can ameliorate the outcomes of trauma. Oral health services should have parity with other medical services within a reformed U.S. health care system. The equitable provision of oral health care services demands a commitment to the promotion of dental public health, prevention, public advocacy, and the exploration and implementation of new models of oral health care that provide care within an integrated health care system.

2. The needs of vulnerable populations have a unique priority. Health professionals, including those providing oral health care services, must individually and collectively work to improve access to care by reducing barriers that low-income families, minorities, remote rural populations, medically compromised individuals, and persons with special health care needs experience when trying to obtain needed services. New integrated models of care that expand roles for allied dental professionals as well as other health professionals, (including family physicians, pediatricians, geriatricians, and other primary care providers) as team members may be needed to address the complex needs of some patients. Statutory language may be needed to clarify and expand coverage of “medically necessary” dental care provided under Medicare to beneficiaries with serious medical conditions in order to prevent complications and death associated with their health condition and treatment.

3. Prevention is the foundation for ensuring general and oral health. Prevention and wellness hold the promise of stemming escalating costs and treating diseases at early stages before expensive emergencies occur. Most dental diseases are preventable, and early dental treatment is cost effective. Preventing and controlling dental diseases includes adequate financing of organized activities to promote and ensure dental public health through education, applied dental research, and the administration of programs such as water fluoridation and dental sealants. Improving oral health by multiple preventive approaches (including periodontal disease management) has saved more than $4 billion per year in treatment costs. Prevention of dental diseases ranks above HIV screening and

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influenza immunization in cost savings.\textsuperscript{21} Children who receive preventive dental care early in life have lifetime dental costs that are 40 percent lower than children who do not receive care.\textsuperscript{22} Oral cancer treatment costs in the earliest stages of the disease are estimated to be 60 percent lower than those at an advanced stage of disease.\textsuperscript{23} Every dollar invested in community water fluoridation yields approximately $38 in savings on dental treatment costs.\textsuperscript{24}

4. **The financial burden of ensuring coverage for health care, including oral health care coverage, should be equitably shared by all stakeholders.** Access to affordable health care services requires a strong financial commitment that is a responsibility shared by all major stakeholders, including individuals and families, as well as providers, employers, private insurers, and federal, state, and local governments. To ensure health, oral health care services must be an integral component of financing and delivery systems regardless of whether the care is provided by a public or private insurance program or in a community or an individual setting. The burden of uncompensated care and the cost shifting that occurs adversely impacts U.S. businesses, limits governments’ capacity to address other pressing economic and social concerns, and strains the health care safety net to the breaking point.

5. **A diverse and culturally competent workforce is necessary to meet the general and oral health needs of our demographically changing nation.** Racial and ethnic diversity of health professionals contributes to improved access to care, greater patient choice and satisfaction, and enriched educational experiences for students.\textsuperscript{25} Proposals to reform the U.S. health care system should include adequate funding for programs that are designed to increase the number of underrepresented minorities in the health professions. This would ensure a workforce that is prepared to meet the needs of a diverse population that continues to expand. Academic dental institutions, which educate and train oral health care professionals, have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society. This responsibility includes preparing oral health care providers to care for a racially and ethnically diverse population, an aging population, and individuals with special needs.


6. Reducing administrative costs and realigning spending can increase quality, improve health, and create savings for additional reforms. Approximately $700 billion (about a third) of U.S. health care spending is used for administrative and operating costs or to benefit third party payers and does not directly impact health outcomes. Reducing these administrative burdens in the delivery of health care and creating new payment incentives that reward providers for delivering quality care will improve health care. It also has the potential to enhance provider participation and lower health care costs over time. More dollars would then be available for reforms such as strengthening primary care and chronic care management, increasing the supply and availability of primary care practitioners, and reinvesting in the training of a twenty-first century health care workforce. Targeted tax changes might also be used to improve efficiencies, ensure the even distribution of health care, and promote efficient use of consumers' health care dollars.

Summary of ADEA Member Survey Results

1. How important, if at all, is it for policymakers to address any or all of the following challenges in the U.S. health care system: escalating costs, increasing numbers of uninsured individuals, and a decline in the quality of services?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Valid</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>397</td>
<td>80</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>63</td>
<td>13</td>
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<td>Neither important or unimportant</td>
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<tr>
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<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Very unimportant</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>494</td>
<td>100</td>
</tr>
</tbody>
</table>

2. How important, if at all, is it that oral health care be included in the national debate about reforming the U.S. health care system?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Valid</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very important</td>
<td>399</td>
<td>80</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>61</td>
<td>12</td>
</tr>
<tr>
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<td>10</td>
<td>2</td>
</tr>
<tr>
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<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Very unimportant</td>
<td>21</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>501</td>
<td>100</td>
</tr>
</tbody>
</table>

3. Would you support a national health care reform plan that did not include insurance coverage for basic oral health care services?

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>Yes</td>
<td>145</td>
<td>29</td>
</tr>
<tr>
<td>No</td>
<td>239</td>
<td>49</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>108</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td>492</td>
<td>100</td>
</tr>
</tbody>
</table>

4. How important, if at all, is it to include oral health care promotion and education, dental disease prevention and early detection and treatment in any proposal to reform the U.S. health care system?

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
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<td>79</td>
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<tr>
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<tr>
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<td>2</td>
</tr>
<tr>
<td>Somewhat unimportant</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Very unimportant</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>498</td>
<td>100</td>
</tr>
</tbody>
</table>

5. To what extent do you agree or disagree with the statement that every American should have access to affordable diagnostic, preventive, and primary oral health care services?

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
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<td>69</td>
</tr>
<tr>
<td>Agree</td>
<td>105</td>
<td>21</td>
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<tr>
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<td>29</td>
<td>6</td>
</tr>
<tr>
<td>Disagree</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>493</td>
<td>100</td>
</tr>
</tbody>
</table>

6. To what extent do you agree with the statement that American businesses are less competitive in a global market because of the increasing costs of health care and the growing number of Americans without health care?

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
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<td>29</td>
</tr>
<tr>
<td>Agree</td>
<td>160</td>
<td>32</td>
</tr>
<tr>
<td>Neither agree or disagree</td>
<td>110</td>
<td>22</td>
</tr>
<tr>
<td>Disagree</td>
<td>63</td>
<td>12</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>27</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>506</td>
<td>100</td>
</tr>
</tbody>
</table>
7. To what extent do you support ADEA’s participation in the national debate on health care reform?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly support</td>
<td>399</td>
</tr>
<tr>
<td>Somewhat support</td>
<td>54</td>
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<tr>
<td>Neutral</td>
<td>26</td>
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<tr>
<td>Somewhat do not support</td>
<td>6</td>
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<tr>
<td>Strongly do not support</td>
<td>24</td>
</tr>
<tr>
<td>Total</td>
<td>509</td>
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</tbody>
</table>

8. To what extent do you support the ADEA Board of Directors’ policy statement and principles on health care reform?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly support</td>
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<tr>
<td>Somewhat support</td>
<td>112</td>
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<tr>
<td>Neutral</td>
<td>49</td>
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<tr>
<td>Somewhat do not support</td>
<td>10</td>
</tr>
<tr>
<td>Strongly do not support</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>491</td>
</tr>
</tbody>
</table>

9. To what extent do you agree or disagree with the following statement from the ADEA Board of Directors’ policy statement? "Dental educators have a moral obligation to promote access to oral health care."

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>322</td>
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<tr>
<td>Somewhat agree</td>
<td>110</td>
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<tr>
<td>Neither agree or disagree</td>
<td>28</td>
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<tr>
<td>Somewhat disagree</td>
<td>23</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>498</td>
</tr>
</tbody>
</table>
10. To what extent do you agree or disagree with the following statement from the ADEA Board of Directors’ policy statement? "The financial burden of ensuring health insurance coverage, including oral health care coverage, is a shared responsibility among all major stakeholders, such as employers, individuals, federal and state governments, private insurers, and other payers."

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Valid</th>
<th>Percent</th>
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<tbody>
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<td>57</td>
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<tr>
<td>Agree</td>
<td>126</td>
<td>25</td>
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</tr>
<tr>
<td>Disagree</td>
<td>41</td>
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<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>499</td>
<td>100</td>
</tr>
</tbody>
</table>

11. To what extent do you agree or disagree with the following statement from the ADEA Board of Directors’ policy statement? "Academic dental institutions which educate and train oral health care professionals have a distinct responsibility to educate dental and allied dental health professionals who are competent to care for the changing needs of society."

<table>
<thead>
<tr>
<th>Frequency</th>
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<th>Percent</th>
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<tr>
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<tr>
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<td>59</td>
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<tr>
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<tr>
<td>Disagree</td>
<td>8</td>
<td>1</td>
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<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>1</td>
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<tr>
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12. What is your status?

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Student Predoctoral</td>
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</tr>
<tr>
<td>Student Postdoctoral</td>
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<tr>
<td>Student Allied Professions</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Part-Time/Adjunct Faculty Member</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Full-Time Faculty Member</td>
<td>137</td>
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<tr>
<td>Administrator/Staff</td>
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<td>14</td>
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<tr>
<td>Retired</td>
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<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>7</td>
</tr>
</tbody>
</table>
Resolution 7H-2009
ADEA Competencies for Entry into the Allied Dental Professions

Background

Under the direction of the ADEA Board of Directors, the ADEA Council of Allied Dental Program Directors engaged a special ADEA Council Task Force (Task Force on Collaboration, Innovation and Differentiation – CID) to review the former Competency document for Dental Hygiene and consider developing additional Competencies for Dental Assisting and Dental Laboratory Technology. The existing Competencies for Entry into the Dental Hygiene Profession were first approved in 1999 and revised and approved again in 2003. Part of the Task Force focus was to create a new document reflecting current and emerging allied dental practice and education.

The ADEA Council of Allied Dental Program Directors began their process of assessing the roles of the allied dental professions with an ADEA sponsored Focus Group in January 2005, followed by an Allied Dental Education Summit in June 2006. The Task Force was formed in June 2007 to respond to some of the recommendations that came from the June 2006 Summit.

The revised Competencies document can be found on the pages following this resolution. While the ADEA Board of Directors and the ADEA Council of Allied Dental Program Directors recognize that each accredited allied dental program has its own set of competencies that correspond to each institution’s and program’s unique mission, Competencies for Entry into the Allied Dental Professions is intended as a reference for programs as they undergo curricular change. It is the consensus of the ADEA Board of Directors that the document should be considered as a final draft as is for consideration by the ADEA House of Delegates and not be subject to further wordsmithing. The Introduction that precedes the Competencies for Entry into the Allied Dental Professions addresses in detail the goals of the document and how it is intended to be used.

If accepted, this version of Competencies for Entry into the Allied Dental Professions will replace the 2003 ADEA House approved Competencies for Entry into the Dental Hygiene Profession.

The ADEA Board of Directors asks the House to approve the following resolution:

7H-2009. Resolved, that the ADEA House of Delegates approves the revised Competencies for Entry into the Allied Dental Professions.
Competencies for Entry into the Allied Dental Professions

Introduction

In 1998-99, the Dental Hygiene Section of the American Association of Dental Schools, now the American Dental Education Association (ADEA), developed and presented Competencies for Entry into the Profession of Dental Hygiene. These were widely used by the majority of accredited dental hygiene programs in defining specific program competencies.

Following the June 2006 Allied Dental Education Summit, a special Task Force of the ADEA Council of Allied Dental Program Directors was formed to advance the recommendations from the 2006 Summit. One recommendation was to develop similar competency statements for the dental assisting and dental laboratory technology disciplines. Given that charge, the ADEA Task Force on Collaboration, Innovation, and Differentiation (ADEA CID) undertook a comparative review of the draft Competencies for the New General Dentist and the Competencies for Entry into the Profession of Dental Hygiene. Both documents were analyzed from the perspective of where the allied dental professions should be headed to support an overall health care team concept and a professional model of education and practice and, at the same time, address curriculum innovation and change and better address access to care issues in the spirit of collaboration with multiple health care partners. The Task Force decided to focus its energy on updating and revising the Dental Hygiene Competencies (DHC) document. The final revised document is inclusive of both the dental assisting and dental laboratory technology disciplines and also serves as a companion to the documents produced by the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI).

The purpose of this document is to:

- Define the competencies necessary for entry into the respective allied dental professions
- Serve as a resource for accredited allied dental education programs to promote change and innovation within their respective programs
- Support existing and future curriculum guidelines
- Serve as a resource for new and developing accredited programs in the allied dental professions
- Serve as a mechanism to inform other health disciplines about curricular priorities in allied dental education
- Enhance opportunities for intra- and inter-professional collaboration in understanding professional roles of oral health team members and other health care providers
- Support developing new education models for accredited allied dental education programs.

The competencies describe the abilities expected of allied dental health professionals entering their respective professions. These competency statements are meant to serve as guidelines. It is important for individual programs to further define the competencies they want their graduates to possess, describing (1) the desired combination of foundational knowledge, psychomotor skills, communication skills, and professional behaviors and attitudes required, (2) the standards used to measure the students' independent performance in each area, and (3) the evaluation mechanisms by which competence is determined. Since there is a great deal of variability in the structure, length, pre-requisite course requirements, recognition given program graduates, and state defined scopes of practice and levels of supervision, program faculty should adapt this document to meet the needs of their individual programs and institutions.
Given the dynamic nature of science, technology, and the health professions, these competencies should be reviewed and updated periodically.

This document is not intended to be a stand alone document and should be used in conjunction with other professional documents developed by the professional agencies that support the respective disciplines. These could include but are not limited to: the Commission on Dental Accreditation Standards for Dental Hygiene, Dental Assisting and Dental Laboratory Technology programs, the Joint Commission on National Boards, the American Dental Hygienists’ Association Standards for Clinical Dental Hygiene Practice, the Dental Assisting National Board, the Dental Assisting National Board Task Analysis, 9th edition, National Association of Dental Laboratories and the National Board for Certification of DLTs Standards for Certification, and other state and regional licensing examinations. This document is not intended to standardize educational programs in allied dental education but rather to allow for future program innovation, growth and expansion. This document is also not intended to serve as a validation for program content within allied dental education or for written or clinical licensing examinations.

The five general domains described in this document should be viewed as themes or broad categories of professional focus that transcend specific courses and learning activities. They are intended to encourage consistency, professional emphasis, and focus throughout the respective discipline-specific curriculum. Within each domain, major competencies expected of the program graduate are identified. Each major competency reflects the ability to perform or provide a particular complex professional activity, which is intellectual, affective, psychomotor, or all of these in nature.

Supporting competencies and specific course objectives delineating foundational knowledge, skills, and attitudes should be further developed by each program faculty, and these should reflect the overall mission and goals of the particular college and program(s). Mastery of supporting competencies related to a specific service or task is needed in order to demonstrate mastery of a major competency.

The competencies delineated in this document are written for the three primary allied dental professions and apply to formal, accredited programs in higher education institutions. While many competencies are common to all three disciplines, the level of mastery and application would differ based on the allied discipline, type of program, length of the program, graduate credentialing options, and institutional mission and goals for the program. Program faculty should define actual competencies, the level of mastery and how competence is measured for their program(s). While the majority of allied dental professionals work within an oral health care team supporting private practice dentistry, other models have or will evolve. Accredited allied dental education programs have a responsibility to prepare their graduates for practice in all jurisdictions.
Domains

1. **Core Competencies (C)** reflect the ethics, values, skills, and knowledge integral to all aspects of the allied dental professions. These core competencies are foundational to all the roles of the allied dental professional.

2. **Health Promotion and Disease Prevention (HP)** is a key component of health care. Changes within the health care environment require the allied dental professional to have a general knowledge of wellness, health determinants, and characteristics of various patient or client communities.

3. **Community (CM)**: Allied dental professionals must appreciate their roles as health professionals at the local, state, and national levels. While the scope of these roles will vary depending on the discipline, the allied dental professional must be prepared to influence others to facilitate access to care and services.

4. **Patient/Client Care (PC)**: The three primary allied dental professionals have different roles regarding patient or client care. These are reflected in the competencies presented for each discipline. The roles of the allied dental disciplines in patient or client care are ever changing, yet central to the maintenance of health. Allied dental graduates must use their skills to assess, diagnose (DH), plan, implement, and evaluate treatment or services provided. Allied dental personnel must be appropriately educated in an accredited program and credentialed for the patient or client care services they provide, and these requirements vary by individual jurisdictions.

5. **Professional Growth and Development (PGD)** reflect opportunities that may increase patients’ or clients’ access to the oral health care system or may offer ways to influence the profession and the changing health care environment. The allied dental professional must possess transferable skills (e.g., in communication, problem solving, and critical thinking) to take advantage of these opportunities.
Competencies for Dental Assisting

Entry-level dental assistants work within a private practice or other clinical setting and assist the dentist in providing patient or client care. They may be certified but have no licensing requirements. These competencies assume a supervisory relationship.

Core Competencies (C)

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of oral health care.
C.3 Use critical thinking skills and comprehensive problem solving to identify oral health care strategies that promote patient or client health and wellness.
C.4 Use evidence based decision-making to evaluate emerging technologies and treatment modalities that can be applied to achieve high quality cost effective patient or client care.
C.5 Assume responsibility for professional actions and care based on accepted scientific theories and research as well as the accepted standard of care.
C.6 Continuously perform self-assessment for lifelong learning and professional growth.
C.7 Integrate accepted scientific theories and research into educational, preventive, and therapeutic oral health services.
C.8 Promote the values of the profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.9 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.11 Provide accurate, consistent, and complete documentation for assessment, planning, implementation, and evaluation of oral health services.
C.12 Initiate a collaborative approach with all patients or clients when developing individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning.
C.13 Initiate consultations and collaborations with all relevant health care providers to facilitate optimal treatments.
C.14 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

Health Promotion and Disease Prevention (HP)

HP.1 Promote positive values of overall health and wellness to the public and organizations within and outside the profession.
HP.2 Respect the goals, values, beliefs, and preferences of all patients or clients.
HP.3 Identify individual and population risk factors and develop strategies that promote health related quality of life.
HP.4 Evaluate factors that can be used to promote patient or client adherence to disease prevention or health maintenance strategies.
HP.5 Utilize methods that ensure the health and safety of the patient or client and the oral health professional in the delivery of care.

Community Involvement (CM)

CM.1 Assess the oral health needs and services of the community to determine action plans and availability of resources to meet the health care needs.
CM.2 Provide educational services that allow patients or clients to access the resources of the health care system.
CM.3 Provide community oral health services in a variety of settings.
CM.4 Facilitate patient or client access to oral health services by influencing individuals or organizations for the provision of oral health care.
CM.5 Evaluate reimbursement mechanisms and their impact on the patient or client’s access to oral health care.
CM.6 Evaluate the outcomes of community based programs and plan for future activities.
CM.7 Advocate for effective oral health care for underserved populations.

**Patient/Client Care (PC) Assessment**

PC.1 Systematically collect, analyze, and record diagnostic data on the general, oral, and psychosocial health status of a variety of patients and clients, using methods consistent with medico-legal principles.
PC.2 Recognize predisposing and etiologic risk factors that require intervention to prevent disease.
PC.3 Recognize the relationship between systemic disease, medications, and oral health that impact overall patient or client care and treatment outcomes.
PC.4 Identify patients or clients at risk for a medical emergency and manage the patient/client care in a manner that prevents an emergency.

**Planning**

PC.5 Select and assemble the appropriate materials and armamentarium for general and specialized patient or client care.
PC.6 Collaborate with the patient or client, and other health professionals as required, to formulate a comprehensive care plan that is patient or client-centered and based on the best scientific evidence and professional judgment.

**Implementation**

PC.7 Utilize universal infection control guidelines for all clinical procedures.
PC.8 Collaboratively manage restorative procedures that preserve tooth structure, replace missing or defective tooth structure, maintain function, are esthetic, and promote soft and hard tissue health.
PC.9 Provide clinical supportive and intra-oral treatments within the parameters of general and specialized patient or client care.
PC.10 Prevent, identify, and manage medical and dental emergencies.

**Evaluation**

PC.11 Evaluate the effectiveness of the provided services and modify as needed.
PC.12 Compare actual outcomes to expected outcomes, reevaluating goals, diagnoses, and services when expected outcomes are not achieved.

**Professional Growth and Development**

PGD.1 Pursue career opportunities within health care, industry, education, research and other roles as they evolve for the dental assistant.
PGD.2 Develop practice management and marketing strategies to be used in the delivery of oral health care.
PGD.3 Access professional and social networks to pursue professional goals.
Competencies for Dental Hygiene

Dental hygienists must complete an accredited educational program and qualify for licensure in any state or jurisdiction. They practice in collaboration with dental and other health care professionals in a variety of settings.

Core Competencies (C)

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of oral health care.
C.3 Use critical thinking skills and comprehensive problem solving to identify oral health care strategies that promote patient or client health and wellness.
C.4 Use evidence based decision-making to evaluate emerging technology and treatment modalities to integrate into patient or client dental hygiene care plans to achieve high-quality, cost-effective care.
C.5 Assume responsibility for professional actions and care based on accepted scientific theories and research as well as the accepted standard of care.
C.6 Continuously perform self-assessment for lifelong learning and professional growth.
C.7 Integrate accepted scientific theories and research into educational, preventive, and therapeutic oral health services.
C.8 Promote the values of the profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.9 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.11 Provide accurate, consistent, and complete documentation for assessment, diagnosis, planning, implementation, and evaluation of oral health services.
C.12 Initiate a collaborative approach with all patients or clients when developing individualized care plans that are specialized, comprehensive, culturally sensitive, and acceptable to all parties involved in care planning.
C.13 Initiate consultations and collaborations with all relevant health care providers to facilitate optimal treatments.
C.14 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

Health Promotion and Disease Prevention (HP)

HP.1 Promote positive values of overall health and wellness to the public and organizations within and outside the profession.
HP.2 Respect the goals, values, beliefs, and preferences of all patients or clients.
HP.3 Refer patients or clients who may have physiologic, psychological, or social problems for comprehensive evaluation.
HP.4 Identify individual and population risk factors and develop strategies that promote health related quality of life.
HP.5 Evaluate factors that can be used to promote patient or client adherence to disease prevention or health maintenance strategies.
HP.6 Utilize methods that ensure the health and safety of the patient or client and the oral health professional in the delivery of care.
Community Involvement (CM)

CM.1 Assess the oral health needs and services of the community to determine action plans and availability of resources to meet the health care needs.

CM.2 Provide screening, referral, and educational services that allow patients or clients to access the resources of the health care system.

CM.3 Provide community oral health services in a variety of settings.

CM.4 Facilitate patient or client access to oral health services by influencing individuals or organizations for the provision of oral health care.

CM.5 Evaluate reimbursement mechanisms and their impact on the patient or client's access to oral health care.

CM.6 Evaluate the outcomes of community based programs and plan for future activities.

CM.7 Advocate for effective oral health care for underserved populations.

Patient/Client Care (PC) Assessment

PC.1 Systematically collect, analyze, and record diagnostic data on the general, oral, and psychosocial health status of a variety of patients or clients using methods consistent with medico-legal principles.

PC.2 Recognize predisposing and etiologic risk factors that require intervention to prevent disease.

PC.3 Recognize the relationship between systemic disease, medications, and oral health that impact overall patient/client care and treatment outcomes.

PC.4 Identify patients or clients at risk for a medical emergency and manage the patient/client care in a manner that prevents an emergency.

Dental Hygiene Diagnosis

PC.5 Use patient or client assessment data, diagnostic technologies and critical decision-making skills to determine a dental hygiene diagnosis and reach conclusions about the patient or client's dental hygiene care needs.

Planning

PC.6 Utilize reflective judgment in developing a comprehensive patient or client dental hygiene care plan.

PC.7 Collaborate with the patient or client, and other health professionals as indicated, to formulate a comprehensive dental hygiene care plan that is patient or client-centered and based on the best scientific evidence and professional judgment.

PC.8 Make referrals to professional colleagues and other health care professionals as indicated in the patient or client care plan.

PC.9 Obtain the patient or client’s informed consent based on a thorough case presentation.

Implementation

PC.10 Provide specialized treatment that includes educational, preventive and therapeutic services designed to achieve and maintain oral health. Partner with the patient or client in achieving oral health goals.

Evaluation

PC.11 Evaluate the effectiveness of the provided services and modify care plans as needed.
PC.12 Determine the outcomes of dental hygiene interventions using indices, instruments, examination techniques, and patient or client self-reports as specified in patient/client goals.

PC.13 Compare actual outcomes to expected outcomes, re-evaluating goals, diagnoses, and services when expected outcomes are not achieved.

**Professional Growth and Development**

PGD.1 Pursue career opportunities within health care, industry, education, research, and other roles as they evolve for the dental hygienist.

PGD.2 Develop practice management and marketing strategies to be used in the delivery of oral health care.

PGD.3 Access professional and social networks to pursue professional goals.
Dental laboratory technicians provide laboratory services as prescribed by a dentist within a laboratory setting. These competencies assume this prescriptive authority of the dentist. Dental laboratory technicians may be certified but have no licensing requirements.

Core Competencies (C)

C.1 Apply a professional code of ethics in all endeavors.
C.2 Adhere to state and federal laws, recommendations, and regulations in the provision of oral health care.
C.3 Use critical thinking skills and comprehensive problem solving to identify oral health care strategies that promote patient or client health and wellness.
C.4 Use evidence based decision-making to evaluate emerging technology and treatment modalities that can be applied to achieve high-quality, cost-effective patient or client care.
C.5 Assume responsibility for professional actions and care based on accepted scientific theories and research as well as the accepted standard of care.
C.6 Continuously perform self-assessment for lifelong learning and professional growth.
C.7 Integrate accepted scientific theories and research into educational, preventive, and therapeutic oral health services.
C.8 Promote the values of the profession through service-based activities, positive community affiliations, and active involvement in local organizations.
C.9 Apply quality assurance mechanisms to ensure continuous commitment to accepted standards of care.
C.10 Communicate effectively with diverse individuals and groups, serving all persons without discrimination by acknowledging and appreciating diversity.
C.11 Provide accurate, consistent, and complete documentation for prosthetic laboratory services.
C.12 Manage medical emergencies by using professional judgment, providing life support, and utilizing required CPR and any specialized training or knowledge.

Health Promotion and Disease Prevention (HP)

HP.1 Respect the goals, values, beliefs, and preferences of all patients or clients.
HP.2 Evaluate factors that can be used to promote patient or client adherence to disease prevention or health maintenance strategies.
HP.3 Utilize methods that ensure the health and safety of the patient or client and the oral health professional in the delivery of care.

Community Involvement (CM)

CM.1 Provide community oral health services in a variety of settings.
CM.2 Facilitate patient or client access to oral health services by influencing individuals or organizations for the provision of oral health care.
CM.3 Evaluate the outcomes of community based programs and plan for future activities.
CM.4 Advocate for effective oral health care for underserved populations.
Patient/Client Care (PC) Assessment

PC.1 Ensure that adequate information has been supplied by the dentist for the manufacture of custom made prosthetic dental devices.

PC.2 Determine treatment options based on the evaluation of relevant data.

PC.3 Collaborate and advise on the advantages, limitations, and appropriateness of various designs of custom made dental devices relevant to proposed treatment plans.

Planning

PC.4 Design or facilitate in the design of custom made dental devices.

PC.5 Recognize the application of radiological imaging methods to support prognosis and the planning of treatment.

PC.6 Select appropriate materials for manufacture of custom made dental devices.

PC.7 Demonstrate an understanding of the manufacturing requirements for the dental device.

Implementation

PC.8 Use effective infection control procedures.

PC.9 Manufacture dental devices in a broad range of areas to a clinically acceptable standard adhering to the standards of appropriate regulatory agencies.

PC.10 Recognize and institute procedures to minimize hazards related to practice of dental laboratory technology.

Evaluation

PC.11 Identify appropriate form of custom made dental devices.

PC.12 Determine functionality of manufactured dental devices according to established industry standards.

PC.13 Recognize the importance of quality assurance systems and standards in the manufacturing processes.

PC.14 Demonstrate efficient handling, storage, and distribution of dental devices.

Professional Growth and Development

PGD.1 Pursue career opportunities within health care, industry, education, research and other roles as they evolve for the dental laboratory technician.

PGD.2 Develop practice management and marketing strategies to be used in the delivery of oral health care.

PGD.3 Access professional and social networks to pursue professional goals.
**Glossary**

**Access.** Mechanism or means of approach into the health care environment or system.

**Assessment.** Systematic collection, analysis, and documentation of the oral and general health status and patient/client needs through a variety of methods, including radiographs, diagnostic tools, and instruments.

**Client.** Potential or actual recipients of health care, including oral health care, and including persons, families, groups, and communities of all ages, genders, sociocultural, and economic states.

**Client-centered.** Approaching services from the perspective that the patient or client is the main focus of attention, interest, and activity and the patient or client’s values, beliefs, and needs are of utmost importance in providing care.

**Critical thinking.** The disciplined process of actively conceptualizing, analyzing, and applying information as a guide to action; ability to demonstrate clinical reasoning, diagnostic thinking, or clinical judgment.

**Community.** Group of two or more individuals with a variety of oral health needs including the physical, psychological, cognitive, economic, cultural, and educational and compromised or impaired people. The community also includes consumers and health professional groups, businesses, and government agencies.

**Cultural sensitivity.** A quality demonstrated by individuals who have systematically learned and tested awareness of the values and behavior of a specific community and have developed an ability to carry out professional activities consistent with that awareness.

**Dental Assistant (DA).** An allied dental health professional who assists the dentist in practice and may choose to specialize in any of the following areas of dentistry: chairside general dentistry, expanded functions dental assisting (restorative) in general or pediatric dentistry, orthodontics, oral surgery, periodontics, assisting in dental surgery at area hospitals, endodontics, public health dentistry, dental sales, dental insurance, dental research, business assisting, office management, or clinical supervision.

**Dental hygiene care plan.** An organized presentation or list of interventions to promote health or prevent disease of the patient or client’s oral condition; plan is designed by the dental hygienist based on assessment data and consists of services that the dental hygienist is educated and licensed to provide.

**Dental hygiene diagnosis.** The dental hygiene diagnosis is a component of the overall dental diagnosis. It is the identification of an existing or potential oral health problem that a dental hygienist is educationally qualified and licensed to treat. The dental hygiene diagnosis utilizes critical decision-making skills to reach conclusions about the patient or client’s dental hygiene needs based on all available assessment data.

**Dental hygiene process of care.** There are five components to the dental hygiene process of care: assessment, dental hygiene diagnosis, planning, implementation, and evaluation. The purpose of the dental hygiene process of care is to provide a framework within which individualized needs of the patient or client can be met and to identify the causative or
influencing factors of a condition that can be reduced, eliminated, or prevented by the dental hygienist.

**Dental Hygienist (DH).** A preventive oral health professional who has graduated from an accredited dental hygiene program in an institution of higher education, licensed in dental hygiene to provide educational, clinical, research, administrative, and therapeutic services supporting total health through the promotion of optimum oral health.

**Dental Laboratory Technician (DLT).** An allied dental professional who manufactures custom made dental devices according to written authorization from licensed dentists using a variety of materials, equipment, and manufacturing techniques in the specialty areas of complete dentures, removable partial dentures, orthodontics, crown and bridge, and ceramics.

**Evaluate.** The process of reviewing and documenting the outcomes of treatment and interventions provided for patients or clients.

**Evidence-based care.** Provision of patient or client care based on the integration of best research evidence with clinical expertise and patient/client values.

**Intervention.** Oral health services rendered to patients or clients as identified in the care plan. These services may be clinical, educational, or health promotion related.

**Medico-legal.** Pertains to both medicine and law; considerations, decisions, definitions, and policies provide the framework for many aspects of current practice in the health care field.

**Occupational model.** Suggests technical training for a trade or occupation.

**Outcome.** Result derived from a specific intervention or treatment.

**Patient.** See client.

**Practice.** To engage in patient or client care activities.

**Professional model.** Requires formal academic education and qualification for entry into a profession through prolonged education, licensure, or regulation, and adherence to an ethical code of practice.

**Refer.** Through assessment, diagnosis, or treatment, it is determined that services are needed beyond the practitioner's competence or area of expertise. It assumes that the patient or client understands and consents to the referral and that some form of evaluation will be accomplished through cooperation with professionals to whom the patient or client has been referred.

**Reflective judgment.** A construct that merges the mental capabilities of critical thinking and problem solving and represents a higher level clinical decision-making skill.

**Risk assessment.** Qualitative and quantitative evaluation gathered from the assessment process to identify the risks to general and oral health. The data provides the clinician with the information to develop and design strategies for preventing or limiting disease and promoting health.
Risk factors. Attributes, aspects of behavior, or environmental exposures that increase the probability of the occurrence of disease.

References
1. ADHA Standards for Clinical Dental Hygiene Practice, ADHA, March 2008.
7. Competencies for Entry into the Profession of Dental Hygiene, ADEA, March 1999.
8. Competencies for the Baccalaureate Degree in Dental Hygiene Program. Old Dominion University, College of Health Sciences, School of Dental Hygiene, accessed 8-6-07, http://hs.odu.edu/dental/academics/bs/competencies.shtml.
Resolution 8H-2009
ADEA Statement of Professionalism in Dental Education

The American Dental Education Association policy statements are the official statements on policy of the Association on issues related to dental education. The following ADEA Statement on Professionalism in Dental Education is brought before the House of Delegates for approval.

The American Dental Education Association is committed to a culture of academic integrity and professionalism in dental education as exemplified by the six values of competence, fairness, integrity, responsibility, respect and service-mindedness within the allied, predoctoral and advanced dental education community.

Background

The American Dental Education Association (ADEA) is committed to developing and sustaining institutional environments within the allied, predoctoral, and postdoctoral dental education community that foster academic integrity and professionalism.

The ADEA Task Force on Professionalism in Dental Education was charged by the ADEA Board of Directors with the development of an ADEA Statement on Professionalism in Dental Education for the dental education community. All seven ADEA Councils endorsed this effort and were represented on the Task Force. Through its work, the Task Force sought to identify and clarify those personal and institutional values and behaviors that support academic integrity and professionalism in dental education and that are aligned with the existing values and codes of the dental, allied dental, and higher education professions.

The Task Force intends for this ADEA Statement on Professionalism in Dental Education to help define the expectations for professional behavior in dental education institutions, including the values and behaviors that should guide students as they enter the dental and allied dental professions, and faculty and administrators as they continuously improve their educational programs.

The Task Force acknowledges and respects that each academic dental education institution has its own unique culture, institutional values, principles and processes, and in some cases, codes of conduct for institutional members. The ADEA Statement on Professionalism in Dental Education is not intended to replace or supersede these codes. Rather, it is intended to serve as a touchstone upon which the entire dental education community can build a shared understanding and definition of professionalism. We invite our colleagues, individual and institutional, to use this statement to develop their own codes of professionalism.

The Task Force also recommends that advisory opinions be developed to provide “real-life applications” of these values and that best practices in developing and advancing a culture of professionalism within dental education be documented and disseminated. It is our belief that through these illustrative stories, the concept of professionalism will be more easily understood and applied by individuals and institutions.
The Task Force hopes that this ADEA Statement on Professionalism in Dental Education stimulates broad discussions about professional behavior in dental education, provides guidance for individual and institutional behavior within dental education, and in so doing supports professionalism across the continuum of dental education and practice.

The ADEA Board of Directors asks the House to approve the following resolution:

8H-2009. Resolved, that the ADEA House of Delegates approves, accepts, and endorses the ADEA Statement on Professionalism in Dental Education.
Values Defining Professionalism in Dental Education

The Task Force identified and developed the following six values-based statements defining professionalism in dental education:

**Competence**
Acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.

**Fairness**
Demonstrating consistency and even-handedness in dealings with others.

**Integrity**
Being honest and demonstrating congruence between one’s values, words, and actions.

**Responsibility**
Being accountable for one’s actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

**Respect**
Honoring the worth of others.

**Service-mindedness**
Acting for the benefit of the patients and the public we serve, and approaching those served with compassion.

A discussion of each of these values follows and includes a more full definition of each value and a description of the behaviors that enactment of the value requires and to which all members of the dental education community can aspire.

In developing the ADEA Statement on Professionalism in Dental Education, the Task Force sought to align the Statement with existing codes of ethics and conduct within the allied, predoctoral, and postdoctoral dental communities. To illustrate the continuity of these values between the dental education community and the practicing community, the discussion of each value includes a reference to the ethical principles espoused by the American Dental Association (ADA Principles of Ethics and Code of Professional Conduct) and the American Student Dental Association (ASDA Student Code of Ethics), and the values expressed in the American Dental Hygienists’ Association’s Code of Ethics for Dental Hygienists.

Finally, examples of how the value applies to different constituencies within the dental education community are provided.
Detailed Definitions of the Six Values

**Competence: acquiring and maintaining the high level of special knowledge, technical ability, and professional behavior necessary for the provision of clinical care to patients and for effective functioning in the dental education environment.**

Expanded Definition: Encompasses knowledge of oral health care (having acquired the unique knowledge, skills, and abilities required for effective provision of clinical care to patients); knowledge about how people learn and skills for effective pedagogy (including developing curriculum and assessments); knowledge of ethical principles and professional values; lifelong commitment to maintain skills and knowledge; modeling appropriate values as both an educator and a dental professional; developing ability to communicate effectively with patients, peers, colleagues, and other professionals; recognizing the limits of one's own knowledge and skills (knowing when to refer); and recognizing and acting upon the need for collaboration with peers, colleagues, allied professionals, and other health professionals. Includes recognizing the need for new knowledge (supporting biomedical, behavioral, clinical, and educational research) and engaging in evidence-based practice.

Alignment with:
- ADA Principles of Ethics: beneficence and nonmaleficence
- ADHA Code for Dental Hygienists: beneficence and nonmaleficence
- ASDA Student Code of Ethics: nonmaleficence and beneficence

Examples:
1. For students: Learning oral health care is a top priority. Develop the habits and practices of lifelong learning, including self-assessment skills. Accept and respond to fair negative feedback about your performance (recognize when you need to learn). Learn and practice effective communication skills. Know the limits of your knowledge and skills and practice within them; learn when and how to refer.

2. For faculty: Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development in oral health care and pedagogy. Ensure curricular materials are current and relevant. Model effective interactions with patients, colleagues, and students; accept and respond to constructive criticism about your performance (recognize when you need to learn). Know the limits of your skills and practice within them; model how and when to refer; acknowledge and act on the need for collaboration.

3. For researchers: Generate new knowledge. Engage in lifelong learning and evaluate and enhance your abilities in this area; model continuous professional development. Model effective interactions with patients, colleagues, and students; accept and respond to fair negative feedback about your performance (recognize when you need to learn).

4. For administrators and institutions: Set high standards. Learn and practice effective self-assessment skills; accept and respond to fair negative feedback (recognize the need for institutional learning and address it); acknowledge and act on the need for collaboration. Support the learning needs of all members of the institution and encourage them to pursue lifelong learning.
**Fairness: demonstrating consistency and even-handedness in dealings with others.**

Expanded Definition: Encompasses consideration of how to best distribute benefits and burdens (to each an equal share, to each according to need, to each according to effort, to each according to contribution, to each according to merit⁴ are some of the possible considerations); encompasses evenhandedness and consistency; includes setting process standards, striving for just consideration for all parties, ensuring consistency in application of process (following the rules) while recognizing that different outcomes are possible, transparency of process, and calibration; consistent, reliable, and unbiased evaluation systems; commitment to work for access to oral health care services for underserved populations.

Alignment with:
- ADA Principles of Ethics: justice, beneficence, nonmaleficence
- ADHA Code for Dental Hygienists: justice and fairness, beneficence, nonmaleficence
- ASDA Student Code of Ethics: justice, nonmaleficence and beneficence

Examples:
1. For students: Follow institutional rules and regulations. Promote equal access to learning materials for all students and equal access to care for the public.

2. For faculty: Use appropriate assessment and evaluation methods for students; view situations from multiple perspectives, especially those that require evaluation; provide balanced feedback to students, colleagues, and the institution. Use evidence-based practices. Promote equal access to oral health care.

3. For researchers: Set high standards for the conduct of research and use unbiased processes to assess research outcomes. Generate data to support evidence-based practice and education.

4. For administrators and institutions: Set high standards and ensure fair, unbiased assessment and evaluation processes for all members of the institution, including applicants to educational programs. Ensure that institutional policies and procedures are unbiased and applied consistently; ensure transparency of process. Provide leadership in promoting equal access to care for the public.
Integrity: being honest and demonstrating congruence between one’s values, words, and actions.

Expanded definition: Encompasses concept of wholeness and unity; congruence between word and deed; representing one’s knowledge, skills, abilities, and accomplishments honestly and truthfully; devotion to honesty and truthfulness, keeping one’s word, meeting commitments; dedication to finding truth, including honesty with oneself; willingness to lead an examined life; willingness to engage in self-assessment and self-reflection; willingness to acknowledge mistakes; commitment to developing moral insight and moral reasoning skills; recognizing when words, actions, or intentions are in conflict with one’s values and conscience and the willingness to take corrective action; dedication and commitment to excellence (requires more than just meeting minimum standards), making a continual conscientious effort to exceed ordinary expectations; encompasses fortitude, the willingness to suffer personal discomfort, inconvenience, or harm for the sake of a moral good.

Alignment with:
ADA Principles of Ethics: beneficence, nonmaleficence, and veracity
ADHA Code for Dental Hygienists: beneficence, nonmaleficence, and veracity
ASDA Student Code of Ethics: nonmaleficence and beneficence, dental student conduct

Examples:
1. For students: Strive for personal and professional excellence. Take examinations honestly; make entries in patients’ records honestly.
2. For faculty: Strive for personal and professional excellence in teaching, practice, research, or all of these. Represent your knowledge honestly.
4. For administrators and institutions: Strive for personal, professional, and institutional excellence. Use appropriate outcomes measures and acknowledge openly when improvements need to be made. Ensure institutional systems and structures are honest, open, and respectful and do not create undue conflicts.
Responsibility: being accountable for one’s actions and recognizing and acting upon the special obligations to others that one assumes in joining a profession.

Expanded Definition: Encompasses the concepts of obligation, duty, and accountability; requires an appreciation of the fiduciary relationship (a special relationship of trust) between oral health professionals and patients, and the profession and society. Accountability requires fulfilling the implied contract governing the patient-provider relationship as well as the profession’s relationship to society; includes standard setting and management of conflicts of interest or commitment as well as meeting one’s commitments and being dependable. It requires striking a morally defensible balance between self-interest and the interest of those who place their trust in us, our patients and society; keeping one’s skills and knowledge current and a commitment to lifelong learning; and embracing and engaging in self-regulation of the profession, including peer review and protecting from harm those who place their trust in us.

Alignment with:
ADA Principles of Ethics: beneficence and nonmaleficence
ADHA Code for Dental Hygienists: beneficence and nonmaleficence
ASDA Student Code of Ethics: nonmaleficence and beneficence

Examples:
1. For students: Meet commitments; complete assignments on time; make your learning a top priority. Acknowledge and correct errors; report misconduct and participate in peer review.

2. For faculty: Continuously improve as a teacher; stay current; set high standards. Respect time commitments to others; be available to students when assigned to teach; meet commitments. Acknowledge and correct errors; report and manage conflicts of interest or commitment. Ensure that all patient care provided is in the best interest of the patient; ensure that patient care provided is appropriate and complete; protect students, patients, and society from harm. Report misconduct and participate in peer review.

3. For researchers: Know and practice the rules and regulations for the responsible conduct of research; stay current. Meet commitments; report and manage conflicts of interest or commitment; report scientific misconduct and participate in peer review.

4. For administrators and institutions: Continuously improve as administrators. Use appropriate institutional outcomes assessments and continuously improve institutional systems and processes; acknowledge and correct errors. Report misconduct and support institutional peer review systems.
Respect: honoring the worth of others.

Expanded Definition: Encompasses acknowledgment of the autonomy and worth of the individual human being and his/her belief and value system; sensitivity and responsiveness to diversity in patients’ culture, age, gender, race, religion, disabilities, and sexual orientation; personal commitment to honor the rights and choices of patients regarding themselves and their oral health care, including obtaining informed consent for care and maintaining patient confidentiality and privacy (derives from our fiduciary relationship with patients); and according the same to colleagues in oral health care and other health professions, students and other learners, institutions, systems, and processes. Includes valuing the contributions of others, interprofessional respect (other health care providers), and intraprofessional respect (allied health care providers); acknowledging the different ways students learn and appreciating developmental levels and differences among learners; includes temperance (maintaining vigilance about protecting persons from inappropriate over- or undertreatment, abandonment, or both) and tolerance.

Alignment with:
- ADA Principles of Ethics: autonomy, beneficence and nonmaleficence
- ADHA Code for Dental Hygienists: individual autonomy and respect for human beings, beneficence and nonmaleficence
- ASDA Student Code of Ethics: patient autonomy and nonmaleficence and beneficence

Examples:
1. For students: Develop a nuanced understanding of the rights and values of patients; protect patients from harm; support patient autonomy; be mindful of patients’ time and ensure timeliness in the continuity of patient care. Keep confidences; accept and embrace cultural diversity; learn cross-cultural communication skills; accept and embrace differences. Acknowledge and support the contributions of peers and faculty.

2. For faculty: Model valuing others and their rights, particularly those of patients; protect patients from harm; support patient autonomy. Accept and embrace diversity and difference; model effective cross-cultural communication skills. Acknowledge and support the work and contribution of colleagues; accept, understand, and address the developmental needs of learners. Maintain confidentiality of student records; maintain confidentiality of feedback to students, especially in the presence of patients and peers.

3. For researchers: Protect human research subjects from harm; protect patient autonomy. Accept, understand, and address the developmental needs of learners. Acknowledge and support the work and contributions of colleagues.

4. For administrators and institutions: Recognize and support the rights and values of all members of the institution; acknowledge the value of all members of the institution; accept and embrace cultural diversity and individual difference; model effective cross-cultural communication skills. Support patient autonomy, protect patients from harm, and safeguard privacy; protect vulnerable populations. Create and sustain healthy learning environments; ensure fair institutional processes.
Service-mindedness: acting for the benefit of the patients and the public we serve, and approaching those served with compassion.

Expanded Definition: Encompasses beneficence (the obligation to benefit others or to seek their good as well as the primacy of the needs of the patient or the public, those who place their trust in us); the patient’s welfare, not self-interest, should guide the actions of oral health care providers. Also includes compassion and empathy; providing compassionate care requires a sincere concern for and interest in humanity and a strong desire to relieve the suffering of others; empathic care requires the ability to understand and appreciate another person’s perspectives without losing sight of one’s professional role and responsibilities; extends to one’s peers and co-workers. The expectation that oral health care providers serve patients and society is based on the autonomy granted to the profession by society. The orientation to service also extends to one’s peers and to the profession. Commitment of oral health care providers to serve the profession is required in order for the profession to maintain its autonomy. The orientation to service also extends to encouraging and helping others learn, including patients, peers, and students. Dental education institutions are also expected to serve the oral health needs of society not only by educating oral health care providers, but also by being collaborators in solutions to problems of access to care.

Alignment with:
- ADA Principles of Ethics: beneficence and justice
- ADHA Code for Dental Hygienists: beneficence, justice and fairness
- ASDA Student Code of Ethics: nonmaleficence and beneficence and justice

Examples:
1. For students: Contribute to and support the learning needs of peers and the dental profession. Recognize and act on the primacy of the well-being and the oral health needs of patients and society in all actions; provide compassionate care; support the values of the profession. Volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public.

2. For faculty: Model a sincere concern for students, patients, peers, and humanity in your interactions with all; volunteer to work for the benefit of patients, society, colleagues, and the profession to improve the oral health of the public. Model recognition of the primacy of the needs of the patients and society in the oral health care setting and, at the same time, support the learning needs of students. Contribute to and support the knowledge base of the profession to improve the oral health of the public.

3. For researchers: Generate new knowledge to improve the oral health of the public; contribute to and support the learning needs of students, colleagues, and the dental profession. Model the values of and service to the dental profession and to relevant scientific and research associations; volunteer to serve the public and the profession; engage in peer review.

4. Administrators and institutions: Recognize and act on opportunities to provide oral health care for underserved populations. Encourage and support all members of the institution in their service activities; provide leadership in modeling service to the profession and the public.
Appendix One
ADEA Statement of Professionalism in Dental Education
Task Force Membership

Task Force Chair
Dr. Richard N. Buchanan, Dean, University at Buffalo School of Dental Medicine

Representing the Council of Allied Program Directors
Dr. Susan I. Duley, Associate Professor of Dental Hygiene, Clayton State University

Representing the Corporate Council
Mr. Daniel W. Perkins, President, AEGIS Communications

Representing the Council of Deans
Dr. Cecile A. Feldman, Dean, University of Medicine and Dentistry of New Jersey New Jersey Dental School

Representing the Council of Faculties
Dr. Kenneth R. Etzel, Associate Dean, University of Pittsburgh School of Dental Medicine

Representing the Council of Hospitals and Advanced Education Programs
Dr. Todd E. Thierer, University of Rochester Eastman Dental Center

Representing the Council of Sections
Dr. Judith Skelton, Associate Professor, University of Kentucky

Representing the Council of Students
Mr. Matthew MacGinnis, dental student, University of Southern California

ADA’s Council on Dental Education and Licensure
Dr. Frank A. Maggio, American Dental Association

Representing the ADA’s Council on Ethics, Bylaws and Judicial Affairs
Dr. David Boden, American Dental Association

Representing the Commission on Dental Accreditation
Dr. James R. Cole II

Representing the American Student Dental Association
Mr. Michael C. Meru, dental student, University of Southern California

At-Large Representatives
Dr. Marilyn S. Lantz, Associate Dean, University of Michigan School of Dentistry
Dr. Kathleen Roth, ADA Immediate Past President

References


4. Ibid.


9. Ibid.


14. Ibid.


18. Ibid.
Resolution 9H-2009
Support of a Voluntary PGY-1 Experience

Background

In its capacity as the voice of dental education, the American Dental Education Association’s House of Delegates approved Competencies for the New General Dentist in 2008. This document's intent is to define the areas in which a dental graduate must be competent in order to successfully practice independently and unsupervised. It delineates six domain areas of competence: critical thinking, professionalism, communication and interpersonal skills, health promotion, patient management and informatics, and patient care. The premise of the document is that if dental graduates are able to demonstrate competence in these areas, they are prepared for dental practice.

Educational reform (such as implementing a mandatory PGY-1) should be a product of either resolving inadequacies in the current system or implementation of more effective methods. It has not been demonstrated that recent dental graduates are not competent in the areas defined by ADEA or that a PGY-1 is a more effective way of gaining competence. Additionally, all ADEA member institutions are accredited by the Commission on Dental Accreditation (CODA) which ensures that all U.S. dental schools provide a level of training that prepares students to achieve competence.

The didactic and clinical experiences in the current predoctoral curriculum meet the needs of most recent dental graduates to fulfill ADEA’s Competencies for the New General Dentist. As such, ADEA recognizes the value of advanced educational programs and supports dental students seeking additional experience through voluntary PGY-1 experiences, but a mandatory PGY-1 should not be required of all dental graduates.

Therefore, the ADEA Council of Students recommends changing the current ADEA Policy Statement I. Education, J. Advanced Education 5. Promoting the Goal of Advanced Education which currently reads:

5. Promoting the Goal of Advanced Education. Coordinate the educational goals, objectives, and competencies of predoctoral and advanced education to effect a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage all dental graduates to pursue postdoctoral dental education in an advanced general dentistry or other advanced dental education program and continue to monitor the feasibility of providing an opportunity for a year of advanced education for all dental graduates. If feasible, advocate that all dental graduates participate in a year of service and learning in an accredited PGY-1 program.

...to read in the following manner:

5. Promoting the Goal of Advanced Education. Coordinate the educational goals, objectives, and competencies of predoctoral and advanced education to effect a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage all dental graduates to pursue postdoctoral dental education in an advanced general dentistry or other advanced dental education program, if the dental student desires to do so, and continue to monitor the feasibility of providing an opportunity for a year of advanced education for all dental graduates.
education for all dental graduates. If feasible, advocate that all dental graduates participate in a year of service and learning in an accredited PGY-1 program.

The ADEA Board of Directors asks the House to approve the following resolution:

9H-2009. Resolved, that the ADEA House of Delegates approves an amendment to the ADEA Policy Statement on Advanced Education so that ADEA Policy Statement I. Education, J. Advanced Education 5. Promoting the Goal of Advanced Education, reads, “Coordinate the educational goals, objectives, and competencies of predoctoral and advanced education to effect a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage all dental graduates to pursue postdoctoral dental education in an advanced general dentistry or other advanced dental education program, if the dental student desires to do so.”
Resolution 10H-2009
ADEA Council of Students Name Change

The ADEA Council of Students (COS) was first established and recognized at the Annual Session meeting of the American Association of Dental Schools (AADS) in Washington, DC, in April 1973. Since that time, significant changes have occurred in the climate of dental education. Students in predoctoral education dental programs and those pursuing allied dental careers have been and continue to remain a vital component of the ADEA membership, comprising more than 11,000 students as of November 2008, of which nearly 10% are students in allied dental education programs, 6% are residents and fellows in advanced education programs, and 67% are dental students. These percentages reflect self-reported data as individuals join ADEA through the ADEA Membership Portal.

Moreover, recent graduates from dental schools continue their support and involvement with the Council of Students as residents in advanced dental educational programs. However, the current council name, ADEA Council of Students, does not accurately reflect the composition of the council or the level of participation from members at the post-doctoral education level.

In attempt to acknowledge the participation of all aforementioned groups and to promote increased involvement of our colleagues at the post-doctoral level, all of whom will likely be future leaders in dental education, the Council of Students respectfully recommends a name change from "ADEA Council of Students" to "ADEA Council of Students, Residents and Fellows." Modifying the Council name will revitalize and expand Council membership, cultivate active participation from residents and fellows from various specialties and disciplines, and provide leverage for a unified voice for the American Dental Education Association as a whole.

The ADEA Board of Directors asks the House to approve the following resolution:

10H-2009. Resolved, that the ADEA House of Delegates approve changing the name of the ADEA Council of Students to the ADEA Council of Students, Residents and Fellows,

and be it further resolved that the Council’s name change be reflected throughout the ADEA Bylaws.
Resolution 11H-2009
ADEA Bylaws Technical Changes

Three technical changes are needed to the ADEA Bylaws to bring them in line with current practices and to enhance their clarity.

The first two changes further clarify term limits for ADEA Council Vice Presidents. *Underscoring* denotes the changes.

1. Chapter III: Elected Association Officers, Section H. Terms of Office, which currently reads:

   *Section H. Terms of Office.* The president-elect, president, and immediate past president serve one-year terms. Individuals who have served a full term as president, president-elect, and / or immediate past president may not succeed themselves in any of those offices. Vice presidents serve three-year terms.

   should be changed to read:

   *Section H. Terms of Office.* The president-elect, president, and immediate past president serve one-year terms. Individuals who have served a full term as president, president-elect, and/or immediate past president may not succeed themselves in any of those offices. Each vice president serves for a single three-year term and may not succeed him- or herself. Not withstanding the foregoing, the vice president for students shall serve for a term of office as set forth in Chapter VIII, Section C(8) of these Bylaws.

2. Chapter VIII: Councils, Section C. Administrative Boards, 8. Terms of Office, which currently reads:

   *8. Terms of Office.* All council officers, except vice presidents, serve one-year terms. Vice presidents serve three-year terms, except for the vice president for students, who may serve up to three consecutive one-year terms if the individual qualifies for membership on the Council of Students during that entire period. An individual who has served a full term as a vice president (three consecutive one-year terms as a vice president for students), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

   should be changed to read:

   *8. Terms of Office.* All council officers, except vice presidents, serve one-year terms. Vice presidents serve three-year terms, except for the vice president for students, who may serve up to three consecutive one-year terms if the individual qualifies for membership on the Council of Students during that entire period. An individual who has served a full term as a vice president (or three consecutive one-year terms as a vice president for students), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.
The ADEA Board of Directors supports a proposal for the third change from the ADEA Corporate Council to change the term of the Council’s Vice President to be parallel with the ADEA Councils of Deans, Faculties, Allied Dental Program Directors, Sections, and Hospitals and Advanced Education Programs. The Vice Presidents of these Councils all serve 3-year terms. As currently stated in the Bylaws, the Vice President for the Corporate Council serves “up to three consecutive one-year terms.”

3. Chapter IX: Corporate Council, Section D. Officers, 8. Terms of Office, which currently reads:

8. Terms of Office. All Corporate Council officers except vice presidents serve one-year terms. Vice presidents may serve up to three consecutive one-year terms,

should be changed to read:

8. Terms of Office. All Corporate Council officers except vice presidents serve one-year terms.

The final sentence in 8 above can be deleted because preceding language in ADEA Bylaws Chapter VIII: Councils, Section C. Administrative Boards. 8. (see directly below) already defines the length of term for each vice president and it is not necessary to repeat it in Chapter IX: Corporate Council, Section D. Officers, 8. Terms of Office.

Chapter VIII: Councils, Section C. Administrative Boards 8. Terms of Office. All council officers, except vice presidents, serve for one-year terms. Vice presidents serve for three-year terms, except for the vice president for students, who may serve up to three consecutive one-year terms if the individual otherwise qualifies for membership on the Council of Students during that entire period. An individual who has served a full term as a vice president (or three consecutive one-year terms as a vice president for students), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

The ADEA Board of Directors asks the House to approve the following technical changes to the Bylaws:

11H-2009. Resolved, that the ADEA House of Delegates approves three changes to the ADEA Bylaws so that they read as follows:

1. Chapter III: Elected Association Officers, Section H. Terms of Office
The president-elect, president, and immediate past president serve one-year terms. Individuals who have served a full term as president, president-elect, and/or immediate past president may not succeed themselves in any of those offices. Each vice president serves for a single three-year term and may not succeed him- or herself. Not withstanding the foregoing, the vice president for students shall serve for a term of office as set forth in Chapter VIII, Section C(8) of these Bylaws.

2. Chapter VIII: Councils, Section C. Administrative Boards 8. Terms of Office.
All council officers, except vice presidents, serve one-year terms. Vice presidents serve three-year terms, except for the vice president for students, who may serve up to three consecutive one-year terms if the individual qualifies for membership on the Council of Students during that entire period. An individual who has served a full term as a vice president (or three consecutive
one-year terms as a vice president for students), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

3. Chapter IX: Corporate Council, Section D. Officers, 8. Terms of Office. All Corporate Council officers except vice presidents serve one-year terms.
Resolution 12H-2009
Provisional Membership of East Carolina University School of Dentistry

The ADEA Bylaws provide that a developing dental school planning to grant a D.D.S. or D.M.D. degree as part of an accredited college or university in the United States, Puerto Rico, or Canada is eligible to apply for Provisional Membership. Applications for Active and Provisional Membership are to be presented in writing at least 60 days before an Annual Session. An institution is elected to membership by a majority affirmative vote of the House of Delegates. Membership becomes effective on July 1 following House approval.

East Carolina University School of Dentistry has made a timely application for ADEA Provisional membership in writing and does meet the criteria for Provisional Membership. Its first dental school class is expected to begin in the fall of 2011.

The ADEA Board of Directors asks the House to approve the following resolution:

12H-2009. Resolved, that the ADEA House of Delegates accepts East Carolina University School of Dentistry’s application for Provisional Membership in ADEA.
In addition to the following overview, delegates should refer to Exhibits 1-2009 and 2-2009 below. Exhibit 1-2009 shows revenue for fiscal years 2006 through 2010 and Exhibit 2-2009 shows expenses for the same years. The ADEA fiscal year runs from July 1 though June 30.

The ADEA Board of Directors asks the House to approve the following resolution:

OVERVIEW OF THE PROPOSED FISCAL YEAR 2010 BUDGET

ADEA has experienced significant growth in programming and services over the last several years fueled by a robust applicant pipeline and growth in nearly every revenue stream. ADEA has increased staffing and other expenses appropriately over the years in order to meet the increasing programmatic and membership demands. With the worsening economy, revenue trends which were on a sharp upwards trajectory beginning in 2003 began to change course in 2008, primarily ADEA’s investment returns and advertising revenue. This negative impact has been mitigated by ADEA’s diversification strategy particularly in grant income, very positive results in institutional membership acquisition and a solid foundation of application fee income. Application fee revenue is now leveling off after five years of double digit growth.

The 2010 budget planning process focused on moving towards zero based budgeting so that the Association can prioritize existing programming while simultaneously reducing expenses. To be prudent and conservative, we assumed our revenues in 2010 will remain largely consistent with our recent history in FY08 and that the financial markets will not recover during 2010. One of the guidelines to Senior Staff in constructing their FY 2010 budget proposals was to assume a baseline of expenses of our history in FY08 less a 7.5% reduction in departmental expenses.

The proposed FY 2010 (July 1, 2009 - June 30, 2010) Association budget was developed over the last four months through a collaborative process involving staff, the Association’s outside accountants, the Finance Committee, and the Board of Directors. Based on these discussions among staff, accountants and leadership, the proposed FY 2010 budget reflects the current level of programming and services with a focus on the Association’s strategic directions as well overall cost reduction. The contribution to reserves is estimated at $500,000 as scheduled by the Board of Directors in September 2002. As much as possible, budget projections are based on historical information from FY 2008 and FY 2009 (note that we were only through less than half of FY 2009 when the proposed FY 2010 budget was being prepared).

DOCUMENTS ATTACHED

The table accompanying this narrative includes the following comparative data:

- The House approved budget for fiscal year ‘09; and
- The ADEA Board of Directors proposed budget for fiscal year ‘10.

REVENUE

The proposed total budgeted revenue for the Association in FY 2010 is $16,802,032. This represents a 2% increase from the FY 2009 budget and an 8% increase from the actual FY2008 revenue. The growth is primarily driven by an increase in projected application fee revenue.

Membership Dues

Modest changes in total dollars by category are driven by changes in number of members based on staff estimates. There is no proposed change to the Association’s membership dues.
Active
Based on 59 U.S. dental schools and 10 Canadian dental schools, the increase from the FY09 budget is driven by the addition of the new dental school at East Carolina University.

Affiliate
The FY 2010 budget in affiliate dues is based on the current affiliate institutional membership and recent recruitment campaign results. The proposed budget is based on 140 allied members at $945, 45 advanced members at $984, 5 non-hospital members at $3,998, and 5 Federal members at $3,922.

Corporate
The proposed budgeted total dues revenue in this category is based on 65 corporate members at $3,400. This budget assumes both consolidation in the dental trade industry and some modest growth in membership.

Individual
Proposed budgeted total dues revenue in this category is based on the current individual member count of 362 individual members at $125 as well as retiree and Leadership Institute Alumni Association dues.

Student
A modest amount of student dues is budgeted for members not affiliated with an ADEA member institution and therefore would pay for their membership. Proposed budgeted total dues revenue in this category is based on 192 student members at $40.

Publications Revenue
The total publications revenue budget for FY 2010 is approximately 35% less than FY 2009 budget revenue in this category. The change is based on FY2009 actual figures which reflect the downward economic trend in advertising revenue in all media. The focus for the FY 2010 advertising budget is to sustain revenue at the FY 2008 level.

Journal of Dental Education and Bulletin of Dental Education Subscriptions Sales
JDE/BDE subscription sales budget is based on a modest increase from actual revenue in FY 2008.

ADEA Opportunities for Minority Students in United States Dental Schools

ADEA Official Guide to Dental Schools
Increased 6% from actual FY 08 revenue.

ADEA Directory of Institutional Members
Publication sales of $1,700 are based on actual FY 2008 revenue.

JDE Advertising
The proposed budget of $156,000 for FY 2010 is based on the FY 2008 actual revenue.

BDE Advertising
The proposed FY 2010 budget is $45,400 is based on FY 2008 actual revenue.
Other Publications/Reprints

Other publications such as the ExploreHealthCareers directory, JDE reprints, JDE pay per view, and JDE Continuing Education, webinars and Annual Session book sales are budgeted at $187,400 for FY 2010.

Application Fees

AADSAS

Projected revenue for AADSAS is $8,899,980 based on 11,100 applicants, before considering the Fee Reduction Program budget. The proposed budget includes an increase in the initial designation fee from $195 to $217 and an increase in the additional designation fee from $60 to $68. The initial designation fee was last changed in 2003. This increase supports the transformation of the application service from a paper based system to a web based multi-direction portal that is comprehensive, user-friendly and efficiently delivers applicant data to ADEA’s end users; applicants, admissions officers and health professions advisors. In order to consider the needs of applicants with extreme financial constraints, the Fee Reduction Program budget has been increased to $125,000. Revenue is increased 17% from the FY 2009 budget.

PASS

Projected revenue of 2,412,000 is based on 3,600 applicants. The initial designation fee has not been changed. The additional designation fee has been increased from $45 to $53. This secondary fee increase is necessary to meet the current operational costs of the application service. The continued growth in PASS revenue is attributable to the increasing number of applicants and programs participating in PASS as a result of marketing initiatives.

AClient User Fee

Income of $108,400 has been budgeted for FY 2010 and represents a small increase from the FY 2009 actual.

Grants and Contributions

Foundation Support

Budgeted support of $549,120 is based on anticipated continued support for the Robert Wood Johnson/American Association of Medical Colleges/ADEA Summer Medical and Dental Education Program, a grant from the RWJF Dental Pipeline II NPO for Admission Committee Workshops and activities to support efforts to address accreditation and diversity; and support for ADEA’s ExploreHealthCareers.org website.

Fellowships and Scholarships

Budgeted at $200,350 based on ADEA’s portfolio of annual fellowships and scholarships.

Corporate Contributions

This is budgeted at $250,000 and includes contributions for ADEA’s Leadership Institute and the Allied Leadership Program and corporate support for the ExploreHealthCareers.org website.

Other Contributions

This is budgeted at $750 and includes contributions from members.
Meetings Registration Income

Annual Session and Exhibitor Fees
Registration and exhibitor fees for the 2010 Annual Session in Washington, DC are budgeted at $739,454 based on recent exhibitor and registration trends. The Annual Session member pre-registration fee is budgeted at $399 up from $349 in FY 2009. The exhibit fee structure was changed for the 2009 Annual Session in Phoenix and it has not been increased for the FY2010 budget. Presently, the member cost is $3,440, $4,400 for non members and $525 for Educational Exhibitors. The decrease in Annual Session revenue from FY08 actuals is driven by a conservative approach to FY 2010 projections.

Association meetings have been budgeted for FY 2010 based on the ADEA Board of Directors’ goal of financial neutrality while taking into account specific subsidies as approved by the Board of Directors.

Deans’ Conference Fees
Proposed budgeted revenues include a Deans’ Conference Assessment of $750 that is paid by all U.S. and Canadian dental schools. The budget also includes an amount for other registration fees historically collected at this meeting.

Sponsor Fees
Budgeted at $620,023 and includes sponsorship of the Annual Session in the amount of $118,450 and other conferences and programs in the amount of $501,573. These figures are based on prior year actual figures and current expectations and commitments already made for FY 2010.

Other Conferences
ADEA will hold a number of meetings at the ADEA Fall 2009 Meetings in October 2009. The Fall Meetings concept came from a recommendation of the ADEA Board of Directors to promote more interaction among member groups, sections, and committees outside of the Annual Session. The 2009 set of meetings will include at least the following components and other groups as determined:

- ADEA Council of Faculties Interim Meeting
- ADEA Council of Students Interim Meeting
- ADEA Council of Sections Interim Meeting
- ADEA Academic Deans’ Conference
- ADEA AFASA Meeting

The total meeting registration revenue for all other conferences other than the ADEA Annual Session and the ADEA Deans’ Conference is budgeted at $266,435.

Other Income

Other Income has been projected at $3,600 in FY 2010 and is primarily income from the ADEA Marketplace. Given the current economic situation and the uncertainty surrounding investment returns, there is no budget proposed for investment income (or loss) in FY 2010.
EXPENSES

Total expenses recommended in the proposed FY 2010 budget are $16,802,032. This represents a 2% increase from the FY 2009 expense budget and a 3% increase from the actual expenses for FY 2008. Given the downward trend in investment and advertising income and the stabilization of application fee growth, the FY 2010 expense budget was developed conservatively based on existing programming, contractual obligations such as rent, and priorities such as information technology security while reducing non strategic expenses from FY 2008 levels.

Personnel Costs and Fees

Total Personnel Costs and Fees are projected at $7,688,130 in the proposed FY 2010 budget. This is a 1% decrease from the FY 2009 budget and a 4% increase from FY 2008 actual personnel costs. The decrease from the FY09 budget is driven primarily by the reduction in temporary staff expenses resulting from efficiencies in application services processing.

*Full-time Salaries*
A 4% pool is budgeted for salary adjustments in FY 2010. No new staff positions are proposed in the FY 2010 budget.

*Temporary Salaries*
Expenses for temporary staff are budgeted at $79,245 based on projections for FY 2010. This expense category continues to be reduced as ADEA adds features to the online application portal for AADSAS and PASS.

*Benefits*
Employee benefits are conservatively budgeted at 16% of salaries, assuming that all vacant positions will be filled and that employees filling these positions will be eligible for all benefits during FY 2010.

*Legal and Auditing Fees*
The legal and audit fees are based on historical experience and projections of required services in FY 2010.

*Consultants*
Consultant expense is budgeted at $1,830,959 and includes expenses for consulting services, honoraria and stipends. The proposed consultant budget includes services for outsourced accounting, human resources, and editorial and production services as well as consultants for ADEA's ExploreHealthCareers programmatic and website initiatives.

Travel

Travel expenses are budgeted based on an 8% increase from the FY 2009 budget and expectations for FY 2010. This accounts for the industry-wide increase in travel costs.
Other Costs

Bank and Credit Card Charges
The budget is $249,538 for credit card processing fees for FY 2010. The projection is based on FY 2008 actual expense and projected credit card revenue for FY 2010.

Developmental Programming
This is budgeted at $728,996 based on current software vendor agreements and includes ADEA’s contractual obligations related to the MedEdPORTAL. This proposed budget represents a 5% decrease from FY 2009 budget.

Data Processing
Data processing is budgeted based on expenses related to transcript verification service, the electronic letters of recommendation service and additional operational support for application services. While there is a significant increase in data processing related to PASS, expenses related to temporary help were able to be reduced in the budget as a direct result.

Computer Operations
This is proposed at $408,884. This expense includes payments for AClient User Fee, legislative monitoring services, hosting ADEA’s association management system, Association Anywhere, hosting the online Journal of Dental Education and strategic investment in the security and reliability of ADEA’s information technology systems.

Office Supplies
This is budgeted at $84,461 for FY 2010. The reduction from 2008 actual expenses is based mainly on the cost savings associated with the electronic letters of recommendation service.

Rent and Refurbishing Expense
The budget for rent is $621,357 based on the 10 year office lease effective as of September 1, 2004.

Depreciation and Amortization
Depreciation and amortization expense is based on ADEA’s current fixed assets balances as well expected upgrades to computer hardware, ADEA’s phone system and other IT projects.

Equipment Rental
The budget for equipment rental is $36,000, office equipment that is leased and used at ADEA’s office. In FY 2009 equipment rental for meetings was budgeted separately from meeting expenses. However, this is typically budgeted and coded to the same account as meeting expenses.

Insurance
Insurance expense is budgeted at $81,000 based on estimates provided by insurance vendors for the Association’s directors and officers’ insurance and business insurance rates for FY 2010.

Memorials and Contributions
Budgeted at $65,303 based on FY2008 actuals. The proposed budget includes $25,000 for administrative support for the home institution of the ADEA president, stipends for ADEA
Annual Session Faculty Development Workshop presenters and other miscellaneous memorials and contributions typically paid by the Association.

Employee Professional Development
Employee Professional Development is budgeted at a fixed rate per employee.

Meetings Expense
Meeting Expense is budgeted at $2,356,322 which is 8% higher than the FY 2008 actual expense. These costs are related to the on site meeting expenses such as food and beverage, hotel room nights, audio visual, and meeting room expenses. Estimates are based on anticipated local expenses for the relevant meeting locations.

Awards and Fellowships
This is budgeted at $185,350 based on ADEA’s portfolio of annual fellowships and scholarships.

Marketing
This is budgeted at $135,823 for existing advertising sales expense as well as newly proposed expenditures for advertising, marketing and affinity items, new products, services, technology, and attendance marketing.

Contribution to Reserves
$500,000 is the proposed budget for the contribution to reserves for FY 2010.

All other expenses such as: telephone and fax; postage and freight; printing and reproduction; repairs and maintenance; dues, subscriptions, and membership fees; recruitment and retention expenses; and miscellaneous expenses were based on FY 2008 actual expenses, expectations for FY 2010 and the overall budget goal of expense reduction.
### ADEA: Exhibit 1-2009
#### Proposed Revenue Budget
**Fiscal Year 2010**

<table>
<thead>
<tr>
<th></th>
<th>FY 2006 Revenue</th>
<th>FY 2007 Revenue</th>
<th>FY 2008 Revenue</th>
<th>FY 2009 Revenue</th>
<th>FY 2010 Revenue</th>
</tr>
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<tbody>
<tr>
<td><strong>MEMBERSHIP DUES</strong></td>
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<td></td>
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<td>Active</td>
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<td>SIG Dues Administrative Fee</td>
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<td><strong>APPLICATION FEES</strong></td>
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<tr>
<td>AADSAS</td>
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<td>7,795,548</td>
<td>7,555,000</td>
<td>8,774,980</td>
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<td>PASS</td>
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<td>1,790,542</td>
<td>2,103,681</td>
<td>1,972,000</td>
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<td>109,600</td>
<td>105,900</td>
<td>108,400</td>
<td>108,400</td>
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<td><strong>TOTAL APPLICATION FEES</strong></td>
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<td>9,635,400</td>
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<td><strong>GRANTS &amp; CONTRIBUTIONS</strong></td>
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<td>Grants</td>
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<td>Fellowships/Scholarships</td>
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<td>56,600</td>
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<td>155,000</td>
<td>200,350</td>
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<td>Corporate Support</td>
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<td>30,508</td>
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<td>Other Contributions</td>
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<td>-</td>
<td>-</td>
<td>750</td>
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<td><strong>TOTAL GRANTS &amp; CONTRIBS</strong></td>
<td>1,057,012</td>
<td>956,263</td>
<td>1,235,987</td>
<td>982,700</td>
<td>1,000,220</td>
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<td><strong>MTG REG &amp; SPONSORSHIPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Session/Exhibits Fees</td>
<td>583,178</td>
<td>699,895</td>
<td>787,724</td>
<td>995,240</td>
<td>739,454</td>
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<td>Deans' Conference Fees</td>
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<td>69,720</td>
<td>55,164</td>
<td>51,000</td>
<td>51,000</td>
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<td>Sponsor Fees</td>
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<td>861,162</td>
<td>861,143</td>
<td>842,950</td>
<td>620,023</td>
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<td>Other Meetings</td>
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<td>264,859</td>
<td>135,216</td>
<td>350,139</td>
<td>266,435</td>
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<td><strong>TOTAL MTG REG &amp; SPONSORS</strong></td>
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<td>1,895,636</td>
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<td>1,676,912</td>
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<tr>
<td><strong>OTHER INCOME</strong></td>
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<td></td>
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<tr>
<td>Investment &amp; Other Income</td>
<td>343,843</td>
<td>812,513</td>
<td>(47,308)</td>
<td>600,000</td>
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</tr>
<tr>
<td>Donated Services</td>
<td>-</td>
<td>-</td>
<td>91,990</td>
<td>-</td>
<td>94,162</td>
</tr>
<tr>
<td><strong>TOTAL OTHER</strong></td>
<td>343,843</td>
<td>812,513</td>
<td>44,682</td>
<td>600,000</td>
<td>97,762</td>
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<td><strong>TOTAL REVENUES</strong></td>
<td>14,052,992</td>
<td>15,633,767</td>
<td>15,663,566</td>
<td>16,538,742</td>
<td>16,802,032</td>
</tr>
</tbody>
</table>
## ADEA: Exhibit 2-2009
### Proposed Expense Budget
#### Fiscal Year 2010

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time salaries</td>
<td>3,248,180</td>
<td>3,613,513</td>
<td>4,255,710</td>
<td>4,694,739</td>
<td>4,562,916</td>
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<tr>
<td>Temporary salaries</td>
<td>435,727</td>
<td>449,855</td>
<td>605,519</td>
<td>795,847</td>
<td>752,184</td>
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<td>Payroll Taxes</td>
<td>217,027</td>
<td>232,946</td>
<td>282,148</td>
<td>314,475</td>
<td>299,026</td>
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<td>Benefits</td>
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<td>495,096</td>
<td>605,519</td>
<td>795,847</td>
<td>752,184</td>
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<td>Legal Fees</td>
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<td>132,591</td>
<td>123,817</td>
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<td>100,000</td>
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<td>30,000</td>
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<td>Consultants, Honoraria, &amp; Stipends</td>
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<td>1,848,590</td>
<td>1,885,636</td>
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<td>1,830,959</td>
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<td>Investment Fees</td>
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<td>417,374</td>
<td>436,457</td>
<td>479,535</td>
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<td><strong>PERSONNEL COSTS AND FEES, TOTAL</strong></td>
<td>5,995,366</td>
<td>6,827,873</td>
<td>7,417,913</td>
<td>7,783,415</td>
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<td>Staff</td>
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<td>426,916</td>
<td>417,374</td>
<td>436,457</td>
<td>479,535</td>
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<td>Nonstaff</td>
<td>225,137</td>
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<td>273,660</td>
<td>328,645</td>
<td>262,670</td>
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<td><strong>TRAVEL, TOTAL</strong></td>
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<td>811,034</td>
<td>691,034</td>
<td>765,102</td>
<td>742,205</td>
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<td>Bank and Credit Card Charges</td>
<td>236,697</td>
<td>252,212</td>
<td>252,469</td>
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<td>249,538</td>
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<td>207,725</td>
<td>791,578</td>
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<td>Data Processing</td>
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<td>Computer Operations</td>
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<td>187,920</td>
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<td>Office Supplies</td>
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<td>392,732</td>
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<td>Rent &amp; Refurbishing expense</td>
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<td>655,431</td>
<td>710,402</td>
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<td>Capital Expenditures</td>
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<td>1,530</td>
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<td>Depreciation/Amortization</td>
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<td>356,085</td>
<td>413,324</td>
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<td>Equipment Rental</td>
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<td>30,009</td>
<td>26,529</td>
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<td>67,111</td>
<td>85,000</td>
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<td>Memorial/Contributions</td>
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<td>83,364</td>
<td>266,565</td>
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<td>Dues/Subscriptions/Membership Fees</td>
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<td>138,266</td>
<td>98,409</td>
<td>109,641</td>
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<td>Employee Prof. Development</td>
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<td>54,661</td>
<td>52,663</td>
<td>98,500</td>
<td>116,000</td>
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<tr>
<td>Miscellaneous Expense</td>
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<td>Meeting Expense</td>
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<td>Donated Services</td>
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<td>2,000</td>
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<td>Recruitment &amp; Retention</td>
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<td>78,732</td>
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<td>Bad Debt Expense</td>
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<td>35,226</td>
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<td>Contribution to Reserves</td>
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<td>600,000</td>
<td>500,000</td>
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<td><strong>OTHER COSTS, TOTAL</strong></td>
<td>6,505,439</td>
<td>6,762,907</td>
<td>7,719,956</td>
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<td><strong>TOTAL EXPENSES</strong></td>
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<td>14,401,814</td>
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<td>16,538,742</td>
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<td><strong>NET SURPLUS (DEFICIT)</strong></td>
<td>$1,086,471</td>
<td>$1,231,953</td>
<td>$(165,337)</td>
<td>$</td>
<td>$(3)</td>
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</tbody>
</table>

Note: Net Surplus (Deficit) In FY2006 and FY2007 is a result of temporarily restricted revenues (e.g. grant funds), and not from general operations. Net Deficit in 2008 is a result of both temporarily restricted revenues and general operations.
ADEA Board of Directors Report on Open Membership
to the 2009 ADEA House of Delegates
January 15, 2009

In March 2005, the 2005 ADEA House of Delegates launched an Open Membership initiative that eliminated individual dues for faculty, staff, students, residents, and fellows at ADEA member institutions. The goals for Open Membership were to increase the number of institutional, corporate and individual members of ADEA and to engage more of the dental education community in ADEA’s programming, activities, and strategic directions. As part of the enabling resolution for Open Membership, the 2005 ADEA House of Delegates urged that the initiative be evaluated for its effectiveness by the ADEA Board of Directors three years after its implementation. The 2008-09 ADEA Board of Directors submits to the 2009 ADEA House of Delegates this evaluation of the Open Membership initiative.

Open Membership Creates Dramatic Change

The decision to institute Open Membership was considered first by the ADEA Board of Directors early in 2005, after an ADEA Membership Task Force study in 2004 determined that membership dues were an obstacle for individual dental, allied dental, and advanced dental faculty, staff, students, residents, and fellows in joining the Association. ADEA competed for resources for individual membership with numerous other organizations, particularly in allied and advanced dental education programs that are not components of dental schools. Examination of this finding led to the proposal of eliminating individual dues and consideration of whether this might increase ADEA membership in a way that would allow the Association to achieve both growth goals and strategic directions. It was estimated that there were about 60,000 individual dental, allied dental, and advanced dental faculty, staff, students, residents and fellows in North America; in 2004 there were about 2,000 dues-paying ADEA Individual Members.

The seven ADEA Councils were brought into the conversation. Dr. Frank A. Catalanotto, currently Professor of Community Dentistry and Behavioral Science at the University of Florida College of Dentistry and ADEA President at that time, says now:

There was a lively, friendly debate. Ultimately we decided it was worth the gamble to try it. Open Membership was a key strategy for encouraging more institutions to join ADEA, particularly hospital-based residency programs and allied dental education programs.
It was decided that Open Membership would be evaluated after three years. It was also agreed that a different kind of value could come from increasing the number of ADEA member institutions and engaging their faculty, staff, students, residents, and fellows in the Association’s work and goals, which center around preparing academic dental institutions, their current and future leaders, and the individuals they serve for a substantially different future world. According to Dr. Eric J. Hovland of the Louisiana State University School of Dentistry, who was ADEA President when Open Membership launched:

*Open Membership greatly increased the value of ADEA membership to institutions. Immediately after the launch, I witnessed the excitement of dental education leaders. They were able to offer so many more faculty, staff, and students the benefits of ADEA membership. This resulted in increased visibility for academic dentistry throughout their institutions.*

Beginning January 1, 2006, individual dues (which had been $125 annually for faculty members and $40 annually for students, residents, and fellows) were eliminated for those affiliated with ADEA member institutions (dental, allied dental, and advanced dental schools and programs, along with corporations). To take advantage of Open Membership and activate an individual membership, an individual at an ADEA member institution simply visits www.adea.org and completes an online form.

Expanded use of technology made the changes economically viable. The *Bulletin of Dental Education* switched from a printed format to an online format, eliminating mailing costs and dramatically increasing the amount of content provided to members. The member benefit of a printed copy of the *Journal of Dental Education (JDE)* mailed each month was replaced with the availability of JDE content online free to ADEA members. (Those wishing to receive printed copies of the JDE now pay a small charge for an annual subscription.)

At the time, the prospect of non-dues value and revenue substantially strengthening ADEA’s position was a long-range goal, not an expectation for the first three years.

**Open Membership Exceeds All Expectations**

ADEA leaders planned for 5,000 eligible people activating individual membership. But that goal was exceeded within days, and in the first few months of 2006 more than 15,000 activated. As of December 2008, ADEA has more than 17,000 individual members.

In January 2006, ADEA kicked off Open Membership with the “Open … Wider” campaign, designed to support ADEA Institutional Members in signing up their faculty, staff, students, residents, and fellows as ADEA individual members. To empower institutional leaders in this grassroots effort, the Association activated online tools; distributed a tool kit with a planner and posters, flyers, presentations, and FAQs describing Open Membership; and announced a contest among ADEA member institutions to sign up individual members. The campaign was an enormous success, with many schools devising creative ways to attract new ADEA Individual Members. The most successful aspects of the Open Wider campaign have been applied in ongoing campaigns to attract new institutional and individual members.

The dramatic increase in membership numbers has led to growth in other measures, all pointing to successful engagement of stakeholders and greater influence for ADEA as the Voice of Dental Education. Dr. James J. Koelbl, Founding Dean of the Western University of Health Sciences College of Dental Medicine, says:
The Open Membership program has been wildly successful in involving members.

Among the examples of increased member engagement in ADEA are:

- Increased attendance at the ADEA Annual Session and other ADEA meetings, with a record-setting 1,802 participants for the 2008 ADEA Annual Session
- More program submissions for the ADEA Annual Session, jumping more than 40% from 2005 to 2009
- More nominees to ADEA and external boards, task forces, committees, and other appointments
- More JDE readers, with average successful requests per week to the JDE Online more than doubling, increasing from nearly 32,000 in 2006 to more than 73,000 in 2008
- More articles submitted to the JDE, from 200 in 2005 to 233 in the first 11 months of 2008
- More JDE subscribers paying for the print edition of the journal, growing from 822 in 2006 to 1,079 in December 2008
- Greatly expanded membership across the 36 ADEA Sections and the nine ADEA Special Interest Groups (SIGs); for example, membership in the ADEA Section on Oral Biology increased more than 3,000% from 2005 to 2008, and nine sections gained more than 1,000 members each, with the ADEA Section on Dental Hygiene Education gaining nearly 2,000 members from 2005 to 2008; the Implant Dentistry SIG now has more than 3,200 individual members
- More visits to www.adea.org, currently receiving more than 700 successful requests per day
- Rapidly growing awareness of ADEA as an “umbrella” dental education community that encompasses different groups and creates opportunities for them to share resources

Also notable is a new power in ADEA speaking as the Voice of Dental Education in legislative advocacy efforts. Many more ADEA Institutional and Individual Members actively represent the interests of dental education and oral health on Capitol Hill and in state capitals. Programs like AADR-ADEA Advocacy Day and ASDA-ADEA National Dental Student Lobby Day, where members speak to representatives from their home states, are more visible to lawmakers now that ADEA represents diverse groups that make up the dental education community.

ADEA is committed to promoting greater equity and diversity in dental education, and it is joined by a variety of partners in efforts to encourage and fund dental education participation by underrepresented minorities. This is an important example of an area in which non-dues revenue has increased substantially since the institution of Open Membership. ADEA has:
• Embarked on the development of a flexible seven-year dental curriculum that can increase the diversity of the dental workforce, funded by the Josiah Macy, Jr. Foundation

• Created the AADR/ADEA Academic Dental Careers Fellowship Program in collaboration with the American Association for Dental Research (AADR), funded initially by a generous gift from the ADA Foundation

• Taken over the leadership and management of the health careers website ExploreHealthCareers.org, supported by a major grant from the Robert Wood Johnson Foundation

• Addressed dental faculty vacancies through the ADEA Minority Dental Faculty Development Program (ADEA MDFD), funded by the W. K. Kellogg Foundation

• Brought together the W. K. Kellogg Foundation, the Robert Wood Johnson Foundation, and The California Endowment to address our common quest to encourage the entry of underrepresented minorities into dental education in the Access to Dental Careers program

• Increased enrollment in the Summer Medical and Dental Education Program co-sponsored with the Association of American Medical Colleges, supported by a major grant from the Robert Wood Johnson Foundation

• Enhanced recruitment, retention, and advancement of minority dental faculty at 11 dental schools with support from the W.K. Kellogg Foundation

• Received a grant from The California Endowment to identify the best strategies for creating and sustaining financially viable partnerships between dental schools and Federally Qualified Health Centers

Over the last six and a half years, ADEA has received nearly $30 million in direct and collaborative grants. More than $27 million has gone directly to ADEA member institutions for distribution, with most of the rest distributed to individual members.

In carrying out its role as the Voice of Dental Education, ADEA has achieved a critical mass that attracts new opportunities and partnerships for the benefit of all. Dr. Todd Thierer, Director of the General Practice Residency Program and Medical Director (Article 28), Eastman Dental Center at the University of Rochester and current ADEA Vice President for Hospitals and Advanced Education Programs, notes:

Open Membership changed the face of ADEA, and also the membership itself. Now our student members are very involved, and they bring an additional energy to our meetings.

In addition to greater numbers of students, residents, and fellows, greater numbers of faculty are now ADEA members, including adjunct and part-time faculty members who might not have become involved without Open Membership. Prof. Cheryl Westphal, currently Assistant Dean for Allied Health Programs at the New York University College of Dentistry and ADEA Vice President for Allied Dental Program Directors, describes the effect of Open Membership within allied dental education programs:

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Open Membership makes ADEA much more valuable to allied dental education. The extension of ADEA membership benefits to full- and part-time faculty, administration, and students has given program directors concrete selling points for ADEA institutional membership. Allied dental education programs are usually very small with limited budgets within their larger institutional setting, so the Open Membership concept has made it a lot more attainable for these smaller programs. With our increased membership from non-dental school programs, we’re benefitting from a broader range of perspectives among allied dental educators and directors, which can be shared with our colleagues in pre- and postdoctoral dental education.

Of course there have been challenges in meeting the needs of members with extraordinarily diverse interests. New groups that bring together members around cross-cutting common interests have taken root, such as the ADEA Academic Deans group and the highly successful ADEA Scholarship of Teaching and Learning (ADEA SoTL) community of interest. ADEA has an opportunity to extend these real-time and online models to expand programming for members of ADEA Sections and SIGs, increase access to pooled resources, and provide additional professional development opportunities. Open Membership will continue to require the Association to engage in innovative thinking, improve member convergence both face-to-face and virtually, augment its technological skill, and bolster staff support.

Open Membership Realizes Most Important Goal

As originally envisioned, Open Membership has dramatically increased ADEA institutional membership.

Membership among allied dental education programs has more than doubled from 65 in 2005 to 132 in December 2008. At the allied dental institutional level, ADEA membership is increasing at more than 18% annually. Currently more than 33% of all institutions with accredited allied dental education programs, including those based at community colleges and technical schools, are now ADEA institutional members.

Similarly, advanced dental education and hospital program membership has also nearly doubled increasing from 24 in 2005 to 44 in December 2008. The annual growth rate for membership among these institutions exceeds 23%. Currently more than 28% of institutions with advanced dental education and hospital programs are ADEA institutional members.

Retention rates across membership groups are high, because members see the value in ADEA membership. Dr. Thierer points out:

   Advanced dental education programs recognize the value of membership once they see the benefits. Before Open Membership, the University of Rochester Eastman Dental Center was an institutional member, but now all of our faculty and staff can join without an additional cost to them. That’s a huge plus. It’s also great for our residents.

Corporate membership in ADEA has increased significantly as well, with 69 dentally related companies and other organizations that are now corporate members of ADEA.

Open Membership Expands Horizons
Engaging more members does not by itself resolve the strategic challenges facing dental education. But it has created more collaboration and energy than originally envisioned, along with an environment that encourages fresh approaches to and increased interest in shared problems. One example is the institution of ADEA Fall Meetings in 2006, an annual event that brings together disparate groups among membership for separate and joint meetings. Participants characterize the format as “an excellent opportunity” that helps them understand issues through the eyes of “those in different positions who I would otherwise never get to know” and “those who do not share my experiences and are part of different kinds of institutions.”

Open Membership has also created a new kind of influence for ADEA among external groups and organizations. Connections to other health professions and the organizations and foundations that support them have resulted new approaches to long-time issues such as equity and diversity in dental education, described above, as well as professional development and funding opportunities for ADEA members.

Dr. Charles N. Bertolami, currently Herbert Robert Fox Dean of the New York University College of Dentistry and ADEA President, characterizes the success of Open Membership:

> Open Membership has brought more institutions into our community and opened dialogues among people who otherwise never would have met. I think it has sparked broader gains than probably were ever imagined. ADEA’s successful incorporation of diverse interests has made it a stronger and more visible association. Now it truly is the Voice of Dental Education.

Dr. Koelbl concurs:

> As our numbers have grown, Open Membership has given us more credibility. Open Membership has given us an opportunity to reach out to more individuals, get their feedback, and better represent the views of ADEA.

In three years, ADEA’s Open Membership initiative has proven to be an effective and successful structure that creates benefits for the institutions and people of allied, predoctoral, and postdoctoral dental education—in short, all of dental education. The Association is poised to embrace future opportunities.

Based on this evaluation, the ADEA Board of Directors concludes that the Open Membership initiative has been a far-reaching success, exceeding the expectations in 2005 of the ADEA Board of Directors and the ADEA House of Delegates.

Respectfully submitted on behalf of the ADEA Board of Directors,

President
As a nation, we entered the current year considerably sobered by the economic turmoil of 2008. Yet as an association, we can take solace in the fact that ADEA is stronger than ever. Membership continues to grow, and so does the influence we exert in the classroom, in clinics, and on Capitol Hill. ADEA is taking the lead on issues of importance to the dental education community: curriculum reform, educational policy, diversity and access, workforce generation, and health care reform. In all these areas, ADEA delivers value to its members in both traditional and innovative ways.

During these challenging economic times, putting member contributions and foundation dollars to good use is more important than ever. To ensure it fulfills this mission, ADEA measures its progress in terms of its four strategic goals: preparing institutions for the future, generating the workforce of the future, developing leaders for the future, and delivering value to members. In this report, we share our most significant advancements toward those goals, and the ADEA Board of Directors has completed an appraisal of our highly successful Open Membership initiative at the end of three years.

In the area of curriculum reform, the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI) made major strides. *Competencies for the New General Dentist*, formulated to provide benchmarks for future curricula, was passed by the ADEA House of Delegates, paving the way for the creation of comprehensive predoctoral curriculum guidelines. ADEA CCI Liaisons are actively working toward curricular innovation, and 110 of them gathered in Chicago last June for the second annual ADEA CCI Liaisons’ Summer Conference. The need for innovative and reliable assessments took center stage at the meeting, and assessment will be the theme for the 2010 ADEA Annual Session. In related efforts, an ADEA CCI task force fielded a survey on assessment methodologies and created an assessment toolbox for use by ADEA members. ADEA CCI also launched a new electronic newsletter, ADEA CCI Liaison Ledger, to promote communication and resource sharing among Liaisons.

ADEA also led a joint ADEA and Commission on Dental Accreditation (CODA) task force in developing revised Predoctoral Dental Education Accreditation Standards. After revisions by CODA, the revised standards were passed in July 2008 and are under review for one year. The ADEA CCI Oversight Committee published additional ADEA CCI white papers in the *Journal of Dental Education* and established a Public Relations Task Force.

The ADEA Center for Educational Policy and Research (ADEA CEPR) pursued an extensive research agenda in collaboration with the ADEA Division of Educational Pathways, ADEA Office of Information Technology, and ADEA Division of Knowledge Management. ADEA CEPR assisted the ADEA Council of Allied Dental Program Directors (ADEA CADPD) in developing a survey of all allied dental program directors, including non-ADEA members, that will form the basis of policy recommendations by the ADEA CADPD Task Force. ADEA CEPR also streamlined the ADEA Faculty Salary Survey, regarded as an invaluable tool for administrators at ADEA Member Institutions.

ADEA CEPR is also studying trends in bachelor’s degrees awarded in the biological and physical sciences and other factors in student decisions to pursue dental degrees. ADEA’s
involvement in two pipeline initiatives, one sponsored by The Robert Wood Johnson Foundation and the other by The California Endowment, is also furthering our understanding of how to attract individuals, especially underrepresented minority and low-income students, to careers in oral health.

The diversity of the U.S. population increases with each passing year, yet underrepresented minorities (URM) are still less likely to enter the health professions. This affects our ability to provide health care to underserved communities in addition to creating a barrier to hiring minority faculty and developing minority leadership for academic dental institutions. As a result, the work of the ADEA Center for Equity and Diversity (ADEA CED) remains as urgent as ever.

Our latest initiative in this regard resulted in last spring's ADEA Leadership Development Workshop for Diversity Officers at U.S. Dental Schools. Seventy-five percent of U.S. dental schools participated in the event, which was made possible in part by funding from the ADEAGies Foundation and the W.K. Kellogg Foundation. We hope this will be the first of many gatherings that teach leadership, advocacy, and planning skills to diversity officers.

Generous funding from entities that have long supported ADEA’s work in equity and diversity made a range of programs possible in 2008. The Connections Supplement Grant, funded by The Robert Wood Johnson Foundation, strengthens programs for prospective and enrolled URM dental students by providing start-up funds for mentoring programs. Another Robert Wood Johnson Foundation grant supported the Summer Medical and Dental Education Program (SMDEP), run jointly by ADEA and the Association of American Medical Colleges (AAMC). The number of predental students participating in AAMC/ADEA SMDEP in 2008 was 184, up from 154 in 2006. Students who took part in the pilot for this enrichment program have begun entering professional schools, and next year ADEA will begin collecting data on where SMDEP graduates are accepted.

The ADEA/W.K. Kellogg Minority Dental Faculty Development Program provided W.K. Kellogg Foundation funding to 11 dental schools and 55 individuals this past year. The Academic Dental Careers Fellowship Program entered its third year with funding from ADEA and the American Association for Dental Research (AADR). Past AADR/ADEA ADCFP Fellows are now well on their way toward academic careers.

ADEA also partnered with the Health Professionals for Diversity Coalition in 2008, and continued to oversee Moving Forward: Bridging the Gap, a promising effort to increase workforce diversity by creating a curriculum model that connects the undergraduate education experience directly to dental school in a seven-year program. This project is supported by the Josiah Macy, Jr. Foundation.

ADEA made significant progress last year toward its goal of generating the workforce of the future. The accomplishments of the ADEA Division of Educational Pathways (ADEA DEP) were exceptional in this regard. ADEA now offers multidirectional, user friendly, paperless application services for use by applicants and our institutional members. The system also provides transcript verification within ADEA AADSAS and accepts and delivers electronic letters of recommendation for all application services. The new ADEA Centralized Application for Advanced Placement for International Dentists (ADEA CAAPID) will be instituted in 2009 at the request of our member institutions. Likewise, an eagerly awaited collaboration with the postgraduate residency matching service will result in a single online application starting in May...
2009. It is noteworthy that while applications to predental programs are leveling off, dentistry still attracts 2.9 applicants for every opening, compared with 2.38 for medicine.

As dental schools strive to admit students from diverse backgrounds, admissions committees are challenged to identify candidates who possess the backgrounds and skills essential for success. Over the past three years, Dental Pipeline leaders and ADEA staff have designed and presented Admissions Committee Workshops at the invitation of 14 U.S. dental schools. Dental schools that have hosted an Admissions Committee Workshop have made substantial strides in admitting and enrolling more diverse classes. In 2008, ADEA received funding from the Dental Pipeline and The Robert Wood Johnson Foundation to identify dental school admissions and diversity officers to continue to present workshops to dental school admission committees. ADEA will also develop a website of resources for trainers and for admissions committees seeking tools and best practices related to diversity and admissions.

To prime the pipeline even earlier, ADEA also led the development of innovative programming designed to better acquaint health professions advisors with the distinctions between the health professions. Presentations at last year’s meeting of the National Association of Advisors for the Health Professions and the ADEA Predental Advisors Workshop resonated with the audience and underscored the collaborative nature of health care.

ADEA’s efforts to generate a diverse workforce of the future also reached new heights in connection with the free, interactive, and multidisciplinary website that we lead, ExploreHealthCareers.org. We’re proud to report that it now ranks #1 on Google with a variety of keyword searches.

ADEA also prides itself on its growing reputation as the voice of dental education. We are leading the effort to make sure oral health is included in the national debate on health care reform. Last year the ADEA Board of Directors approved as interim ad hoc policy a statement on health care reform. ADEA members’ reaction to and support for the policy statement was measured by online surveys and during two ADEA meetings in the fall. Five hundred nine responses were received. As a result of this feedback, a revised policy statement was approved by the ADEA Board of Directors at its January meeting and forwarded for consideration by the ADEA House of Delegates at the 2009 ADEA Annual Session.

The ADEA Board of Directors also approved a statement supporting the concept of a dental home. “Dental Home” refers to the notion that coordinated, family-centered oral health services should be delivered in an ongoing relationship between a dental team and a patient. The Seventh Annual Report to Congress of the Health Resources and Services Administration (HRSA) Advisory Committee on Training in Primary Care Medicine and Dentistry, dealing with this issue, will be forthcoming soon.

ADEA also went on record in support of dental education partnerships between academic dental institutions and community-based clinics. These may lead to a model of dental education with expanded extramural clinical rotations in the community that helps to improve access to care for rural and urban residents. Legislative efforts under way would further this model and these goals.

In June, ADEA Associate Executive Director and Director of the Center for Public Policy and Advocacy Mr. Jack Bresch testified at a Capitol Hill briefing on dental health sponsored by the Alliance for Health Reform. His remarks focused on the vital role academic dental
institutions play as safety net providers, emerging allied dental workforce models, and the core values articulated in the ADEA interim ad hoc policy statement on health care reform.

Mobilizing ADEA members to advocate for these and other issues of concern to our community remains a vital part of our work. 2008 marked the 10th anniversary of National Dental Student Lobby Day, made possible with funding from GlaxoSmithKline; OraPharma, Inc.; the American Association of Oral and Maxillofacial Surgeons (AAOMS); ADEA; the American Student Dental Association (ASDA); and the American Dental Political Action Committee (ADPAC). Over 300 students representing 52 schools attended this event. ADEA also held four more Field Advocacy Workshops last year to train members to make their voices heard. A total of 14 workshops have been held to date, and at least three more are planned for 2009.

Without strong leadership, none of these activities would be possible, so we fully appreciate the importance of addressing our strategic goal of developing leaders for the future. ADEA sponsors a number of programs to support this work. Chief among these is the ADEA Leadership Institute, a year-long program designed to develop the nation’s most promising faculty at academic dental institutions to assume leadership positions in dental and higher education. The current class brings the total number of ADEA Leadership Institute Fellows to 170. Nearly three quarters of graduates say the program has been important or very important to their career advancement.

Applications to the ADEA Allied Dental Faculty Leadership Development Program (ADEA ADFLDP) rose once again last year. ADEA ADFLDP is currently in its fifth year and continues to produce impressive results. Of the program’s 88 graduates, 35 have moved into significant leadership positions, such as program director or associate executive director of a foundation. Five have been recipients of ADEA/GlaxoSmithKline Dental Hygiene Teaching Fellowships, and two have gone on to participate in the ADEA Leadership Institute.

ADEA also supports several leadership programs geared specifically for women. The ADEA/Johnson & Johnson Healthcare Products/Enid A. Neidle Scholar-in-Residence Program marked its 14th year in 2008. An impressive 64% of Neidle Fellows have been promoted in academic rank, and 71% have remained at the same parent institution. ADEA also collaborates with the Hedwig van Ameringen Leaders in Academic Medicine (ELAM) Program. Thirty-three women dental administrators have completed the program, and four of the 11 women who are U.S. dental school deans are also ELAM Program graduates.

In all the things we do, we remain cognizant that we must deliver value to our members. Three years after instituting our Open Membership policy, ADEA represents 249 member institutions (including all dental schools and growing numbers of allied and postdoctoral dental education programs); more than 17,000 individual members, who are predominately faculty, staff, and students of member institutions; and 70 corporate members.

We continue to find innovative ways to serve our members. At the 2008 ADEA Annual Session, we unveiled ADEA’s participation in MedEdPORTAL, a free online international publication venue where educators in the health professions may publish and share educational resources. Advanced education programs, allied dental programs, corporations, and more than two thirds of dental schools are already using MedEdPORTAL. ADEA’s partnership with the Association of American Medical Colleges in support of this venture has proved rewarding to both parties. In the year ahead we will work with deans to encourage faculty members to increase submissions and survey users in order to enhance content accessibility on the site.
We’ve already achieved this goal for our database *ADEA Trends in Dental Education*. Last year we reorganized the site so that regularly updated information is now categorized and indexed as it might be in a library, making it easier to find.

Member access to all types of information through the ADEA website increased markedly last year. We reorganized the site by member and website user areas of interest, and gave it a new “look and feel.” In addition, our acquisition of Microsoft’s SharePoint Server program allows ADEA staff to make up-to-date information available to members more quickly and with greater ease.

ADEA members also value opportunities for face-to-face encounters where they can exchange knowledge and debate ideas directly. The 2008 ADEA Annual Session in Dallas, Texas, drew a record 1,802 attendees who did just that. They expressed enthusiasm about the meeting’s educational offerings, its inclusiveness, and the focus on innovation.

The ADEA Fall 2008 Meetings also provided evidence of our organizational growth. For the first time, a number of joint sessions were held and collaborative working groups crossed professional and institutional boundaries to tackle a range of issues. June’s 41st Annual National ADEA Allied Dental Program Directors’ Conference brought over 200 participants together in Coeur d’Alene, Idaho, to consider the rapid growth in allied dental programs and transitions under way in the allied dental professions. The 50th Annual ADEA Deans’ Conference in November also engaged our members in vigorous discussions around leadership succession and the challenge of recruiting and retaining faculty during an economic crisis.

ADEA issued nearly 40 press releases and received more than 100 instances of media coverage this past year. The *Journal of Dental Education* (JDE) hit a new benchmark when the average successful requests per day topped 10,000 for the first time. Our flagship publication can also boast of having published “New Models of Dental Education,” proceedings of the Macy Convocation, as a JDE supplement. This document puts forward a vision for the future of our field as it stands at a demographic and technological crossroads. Of equal importance, the journal conducted outreach to place this publication in the hands of our partners in the health professions and higher education as well as in those of dental educators.

ADEA thanks all who support our efforts and partner with us. Among them are many of the world’s finest foundations, specifically The Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, the Josiah Macy, Jr. Foundation, and The California Endowment.

I would thank our President, Dr. Charles Bertolami, and the other dedicated members of the ADEA Board of Directors: Dr. Lily Garcia, Dr. Diane Hoelscher, Dr. Ron Hunt, Ms. Barbara Nordquist, Dr. Rishi Popat, Dr. Jim Swift, Dr. Todd Thierer, Prof. Cheryl Westphal, and Dr. John Williams. Those who have served for several years bring a depth of knowledge and commitment to our governance that sustains us in our mission, while the newer arrivals bring fresh perspectives and welcome energy to our endeavors. I also want to acknowledge the many volunteers who provide leadership on ADEA councils, committees, and commissions, and represent us in other associations and organizations. All these voluntary efforts, so generously proffered, nurture and strengthen the Association.

As we embark on a new year, we will face new challenges and some familiar ones as well, but we will also encounter many exciting opportunities. ADEA is poised to seize those opportunities and tackle whatever challenges lie ahead. With its large, active membership, talented leaders, and clear vision, the Association is prepared to take the lead on the most
pressing issues facing the dental education community. It has been an honor to serve ADEA in 2008, and I am eager to continue our work together in the year ahead.

Respectfully submitted,

[Signature]

Richard W. Valachovic, D.M.D., M.P.H.
Executive Director
New Chief Administrators at Member Institutions

New Dental School Deans

Since the 2008 Annual Session, U.S. and Canadian dental schools have appointed the following new deans whose service began between the end of the 2008 ADEA Annual Session and the beginning of the current ADEA Annual Session. The Board of Directors congratulates these members and wishes them success in their assignments.

Dr. Sigmund H. Abelson, Acting Dean, University of Southern California
Dr. Carole A. Anderson, Dean, The Ohio State University
Dr. Thomas Boran, Dean, Dalhousie University
Dr. John D.B. Featherstone, Dean, University of California, San Francisco
Dr. Buford O. Gilbert, Jr., Interim Dean, University of Mississippi
Dr. Henry A. Gremillion, Dean, Louisiana State University
Dr. Timothy L. Hottel, Dean, University of Tennessee
Dr. James R. Hupp, Dean, East Carolina University
Dr. Jeffrey W. Hutter, Dean, Boston University
Dr. Amid I. Ismail, Dean, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Gilles Lavigne, Dean, University of Montreal
Dr. Nancy M. Mills, Interim Dean, University of Missouri-Kansas City
Dr. Thomas P. Sollecito, Interim Dean, University of Pennsylvania
Dr. Ray C. Williams, Dean, Stony Brook University

Other New Administrators at Member Institutions

ADEA Member Institutions have reported the following appointments since the 2008 ADEA Annual Session. The Board of Directors congratulates these new administrators.

The Forsyth Institute, Dr. Philip P. Stashenko, President and CEO
Louisiana State University, Dr. Likith V. Reddy, Chair, Department of Oral and Maxillofacial Surgery
Medical College of Georgia, Dr. Tara Schafer, Interim Chair, Department of Pediatric Dentistry
Oral Health America, Ms. Beth Truett, President and CEO
United States Air Force Dental Service, Colonel Thomas R. Schneid, Dean
United States Army Graduate Dental Education Program, Colonel Robert Manga, Chief
University of California, San Francisco, Dr. Deborah Greenspan, Chair, Orofacial Sciences Department
University of Iowa, Dr. Daniel J. Caplan, Head of the Department of Preventive and Community Dentistry
University of Illinois at Chicago, Dr. Michael Miloro, Interim Department Head and Director, Department of Oral and Maxillofacial Surgery Postgraduate Residency Training Program
University of North Carolina at Chapel Hill, Dr. Lyndon Cooper, Chair of the Department of Prosthodontics
University of North Carolina at Chapel Hill, Dr. David W. Paquette, Assistant Dean for Graduate/Advanced Dental Education
University of North Carolina at Chapel Hill, Dr. Ronald B. Strauss, Executive Associate Provost
New Affiliate Members

Since February 1, 2008, these programs and schools have become Affiliate Members. The Board of Directors welcomes them to ADEA.

Briarwood College, Ms. Angela Kiernan, Chief Dental Administrator (Southington, Connecticut)
Cedars Sinai Medical Center General Practice Residency Program, Dr. Irving Lebovics, Chief Dental Administrator (Los Angeles, California)
Central Florida Community College Dental Assisting Program, Dr. Mark L. Paugh, Chief Dental Administrator (Ocala, Florida)
Columbus Technical College Dental Hygiene and Dental Assisting Programs, Prof. Jan Z. Jones, Manager (Columbus, Georgia)
Cedars Sinai Medical Center General Practice Residency Program, Dr. Irving Lebovics, Chief Dental Administrator (Los Angeles, California)
Central Florida Community College Dental Assisting Program, Dr. Mark L. Paugh, Chief Dental Administrator (Ocala, Florida)
Columbus Technical College Dental Hygiene and Dental Assisting Programs, Prof. Jan Z. Jones, Manager (Columbus, Georgia)
Dixie State College of Utah Department of Dental Hygiene, Prof. Karmen Aplanalp, Program Director (St. George, Utah)
Hawkeye Community College Dental Assisting and Dental Hygiene Programs, Prof. Sarah A. Turner, Chief Dental Administrator (Waterloo, Iowa)
Mesa Community College Dental Hygiene Program, Prof. Phebe Blitz, Program Director (Mesa, Arizona)
Montgomery County Community College Dental Hygiene Program, Prof. Jenny K. Sheaffer, Program Director (Blue Bell, Pennsylvania)
Northwest Dental Residency, Advanced Education in General Dentistry, Dr. Mark Koday, Program Director (Toppenish, Washington)
Pensacola Junior College Dental Hygiene and Dental Assisting Programs, Prof. Sandra Hartley, Chief Dental Administrator (Pensacola, Florida)
Pima County Community College Dental Hygiene, Dental Assisting, and Dental Laboratory Technology Programs, Prof. Karen Tam, Prof. Joy Gail, Prof. Pamela Truitt, Mr. Max Atwell (Tucson, Arizona)
Raymond Walters College Department of Dental Hygiene, Dr. Janelle Schierling, Program Director (Cincinnati, Ohio)
Virginia Western Community College Dental Hygiene Program, Prof. Martha H. Roberson (Roanoke, Virginia)
Waukesha County Technical College Dental Assisting and Dental Hygiene Programs, Prof. Trish Wittig, Chief Dental Administrator (Pewaukee, Wisconsin)
Western University of Health Sciences School of Dentistry (provisional member), Dr. James J. Koelbl, Dean (Pomona, California)
Yale-New Haven Hospital Department of Dentistry, General Residency Program and Pediatric Dentistry Residency Program, Dr. Brian K. Singletary, Chief Dental Administrator (New Haven, Connecticut)
New Corporate Members

These companies have become Corporate Members since February 1, 2008. The Board of Directors welcomes them to ADEA.
Aspen Dental Management, Inc.
Bien Air USA
BioMeDevice, Ltd.
Carl Zeiss Meditec, Inc.
Certiphi Screening, Inc.
D4D Technologies, LLC
Dental Group Practice Association
Institute for Oral Health
Midmark Corporation
Whip Mix Corporation
In Memoriam

With regret, the ADEA Board of Directors announces these deaths of faculty and staff as reported by ADEA Member Institutions.

Dr. Manuel M. Album, University of Pennsylvania
Dr. Arun Bajpai, University of Tennessee
Dr. Thomas K. Barber, University of Illinois at Chicago
Dr. William U. Blymire, University of Pennsylvania
Ms. Kay Bohmont, University of Nebraska
Dr. Philip Boyne, Loma Linda University
Dr. George Carson, University of Pittsburgh
Dr. Frank V. Celenza, New York University
Dr. Jane Chalmers, University of Iowa
Dr. Lewis Aron Chambless, Baylor College of Dentistry
Dr. Paul C. Copoulus, Marquette University
Dr. Hector P. DiNardo, University of Maryland
Dr. Kenneth R. Elwell, Case School of Dental Medicine
Dr. Jay H. Eshleman, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Earl E. Feldman, University of Texas Health Science Center at San Antonio
Dr. Dudley Ernest Felix, Meharry Medical College
Dr. Uwe Frohberg, Baylor College of Dentistry
Dr. Paul Goldhaber, Harvard School of Dental Medicine
Dr. Charles M. Goldstein, University of Southern California
Dr. Joseph Gould, Case School of Dental Medicine
Dr. Bal Krishna Goyal, University of Pennsylvania
Dr. John Halet, University of Texas Health Science Center at San Antonio
Dr. John Hembree, University of Mississippi
Dr. Peter R. Herdman, Southern Illinois University
Dr. Kenneth Hinkelman, University of Pittsburgh and Marquette University

Dr. Harold Z. Hirsch, University of Alabama
Dr. Martin Horvitz, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. John Hucko, University of Pittsburgh
Ms. Lori Hurley, West Virginia University
Dr. William Clarence Hurt, Baylor College of Dentistry
Dr. Erling Johansen, Tufts University
Dr. Sid Kalachandra, University of North Carolina at Chapel Hill
Dr. Robert P. Kusy, University of North Carolina at Chapel Hill
Dr. J. Michael Leary, University of Iowa
Dr. A.K. Leberknight, Sr., The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Bernard G. Levin, University of Southern California
Dr. Leslie Levine, University of Southern California
Dr. Joseph V. Levy, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Patricia A. Lewis, Stony Brook University
Dr. Harald Loe, University of Connecticut
Dr. Benjamin L. Lynch, Creighton University
Dr. T.C. Lyon, Jr., Baylor College of Dentistry
Dr. Randy Malloy, Louisiana State University
Dr. Arthur Marks, New York University
Dr. F. James Marshall, Oregon Health & Science University
Ms. Joanne Mayne, University of Southern California
Dr. Francis L. Miklos, University of Pittsburgh
Dr. Benjamin Moffett, University of Washington
Dr. Derryl Ogden, University of Nebraska
Dr. Jon Park, University of Maryland
Dr. Madison S. Pace, Baylor College of Dentistry
Dr. Melvin A. Reff, University of Maryland
Prof. Albert Richards, University of Michigan
Dr. Ronald F. Rinne, University of Nebraska
Dr. Paul Rosen, University of Medicine and Dentistry of New Jersey
Dr. Leonard Marvin Sakrais, Nova Southeastern University
Dr. Leon Schertzer, New York University
Dr. Jonathan A. Ship, New York University
Dr. Michael Simko, University of Pittsburgh
Dr. Thomas H. Simpson, University of Washington
Dr. Robert S. Staffanou, Baylor College of Dentistry
Dr. Erwin F. Stier, Marquette University
Dr. Clifford M. Sturdevant, University of North Carolina at Chapel Hill
Prof. Ann Stoegbauer, Northeast Wisconsin Technical College
Dr. Eugene F. Stormberg, Creighton University
Dr. Clifford M. Sturdevant, University of North Carolina at Chapel Hill

Dr. Paul P. Taylor, Baylor College of Dentistry
Dr. John L. Thompson, Baylor College of Dentistry
Dr. Angel Rivera Torres, Meharry Medical College
Dr. John Vanatta, Baylor College of Dentistry
Dr. Robert Verbin, University of Pittsburgh
Dr. Anthony A. Vito, University of Pennsylvania
Dr. Samuel Weinstein, University of Nebraska
Dr. Alan S. Weisberg, University of Maryland
Dr. Robert H. Woolf, Oregon Health & Science University
Dr. James Lowell Worley, University of Louisville
Dr. Seymour Yale, University of Illinois at Chicago
ADEA Staff Attending the Annual Session

Staff wear special name badges so they are easy to recognize. They are always willing to assist you.

Office of the ADEA Executive Director
Dr. Richard Valachovic, Executive Director
Dr. Ronald Rupp, Senior Director, External Relations and Institutional Advancement
Dr. Linda Hanlon, Special Liaison to the ADEA Council of Allied Dental Program Directors

ADEA Division of Knowledge Management
Ms. Sue Sandmeyer, Associate Executive Director
Ms. Maria Hodas, Program Associate
Dr. Laura Siaya, Director of Survey Research
Ms. Henryne Tobias, Project Director, ExploreHealthCareers.org

ADEA Division of Member Services
Ms. Susan Krug, Associate Executive Director
Ms. Colleen Allen, Publications Assistant
Ms. Toni Fanelli, Senior Administrative Assistant
Ms. Lauren Gaffney, Publications Manager
Ms. Merideth Menken, Senior Director of Publications and Communications
Ms. Nicole Fauteux, Consultant

ADEA Division of Member Services, Office of Professional Development
Ms. Michelle Allgauer, Senior Director for Meetings and Professional Development
Ms. Rhonda Buford, Meetings Manager
Ms. Renee Latimer, Meetings Manager
Ms. Monique Morgan, Registration and Awards Event Coordinator
Ms. Simone Smith, Meetings Manager

ADEA Center for Educational Policy and Research
Dr. Eugene Anderson, Associate Executive Director
Ms. Lisa Fanning, Director of Grant Programs
Ms. Faduma Hayir, Program Coordinator

ADEA Center for Equity and Diversity
Dr. Jeanne Sinkford, Associate Executive Director and Center Director
Dr. David Brunson, Associate Director
Ms. Cassandra Allen, Program Assistant
Ms. Sonja Harrison, Director, Program Services

ADEA Division of Educational Pathways
Dr. Anne Wells, Associate Executive Director
Mr. Joshua Hargrove, AADSAS Administrative Service Manager
Ms. Chonté James, Director, AADSAS
Ms. Yolanda Jones, PASS Operations Manager
Ms. Leslie Payne, Senior Administrative Assistant
Mr. Peter Storandt, Director of Marketing and Program Development—PASS
Mr. Drake Washington, PASS Program Coordinator

ADEA Center for Public Policy and Advocacy
Mr. Jack Bresch, Associate Executive Director and Center Director
Ms. Deborah Darcy, Director of Congressional Affairs
Ms. Monette McKinnon, Director of Legislative Policy Development
Ms. Myla Moss, Director of Congressional Relations and Regulatory Affairs
ADEA Division of Finance and Operations
Ms. Abigail Gorman, Chief Operating Officer
Ms. Novella Abrams, Senior Administrative Assistant
Mr. Kevin Hawkins, Mail Services Coordinator
Mr. Sunu Kc, Senior Manager of Network Operations
Mr. Qi Li, Director, Information Technology

Office of the Editor, Journal of Dental Education
Dr. Olav Alvares, Editor
Dr. L. Jackson Brown, Editor designate
Prof. William Hendricson, Associate Editor
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Chapter I: Core Values

Section A. The Association’s core values are:
1. Promoting and Improving Excellence in All Aspects of Dental Education. The Association values the development of faculty, staff, and administrators as the key to improving dental education.
2. Building Partnerships in Support of and Advocating for the Needs of Dental Education. The Association values partnerships with those who share an interest in improving dental education by ensuring a sufficient flow of resources and favorable policy options.
3. Serving the Individual Needs of Members and Institutions. The Association values providing a broad range of services for the benefit of both individuals and institutions.
4. Encouraging Communication and Sharing of Information Among the Association’s Members. The Association values intelligent, candid, and efficient communication among Association members, individual and institutional.
5. Expanding the Diversity of Dental Education. The Association values diversity and believes that those who populate dental education—students, faculty, staff, administrators, and patients—should reflect the diversity of our society.
6. Recognizing the Needs of Those the Association Serves. The Association values responsiveness to the needs of students, alumni, patients, and all other constituents.
7. Promoting Oral Health. The Association values oral health care as being integral to the general health and well-being of individuals and society.

Chapter II: Membership

Section A. Categories. The Association has eight membership categories.
1. Institutional membership
   a. Active
   b. Provisional
   c. Affiliate
   d. Corporate
2. Individual membership
   a. Individual
   b. Student
   c. Retired
   d. Honorary

Section B. Qualifications for Institutional Membership
1. Active. A dental school granting a D.D.S. or D.M.D. degree as a part of an accredited college or university in the United States, Puerto Rico, or Canada, and having begun instruction of its first class of dental students, is eligible to apply for active membership. (Canadian dental schools have the option of selecting active or affiliate membership.)
2. Provisional. A developing dental school planning to grant a D.D.S. or D.M.D. degree as part of an accredited college or university in the United States, Puerto Rico, or Canada is eligible to apply for provisional membership. (Developing Canadian dental schools have the option of selecting provisional or affiliate membership.)
3. Affiliate. The following types of institutions in the United States, Puerto Rico, or Canada are eligible to apply for affiliate membership, provided that they are not eligible for active or
provisional membership and that their dental and/or allied dental education programs are accredited by the Commission on Dental Accreditation:

a. Canadian dental schools (may elect active or affiliate membership or provisional membership if a developing institution).

b. Academic institutions—other than hospitals—conducting postdoctoral dental education programs.

c. Hospitals that conduct postdoctoral dental education programs and that are not under the same governance as an active or provisional member institution. Hospital programs under the same governance as active or provisional member institutions are included in the parent school’s active or provisional membership.

d. The United States Air Force, Army, Navy, Public Health Service, and Department of Veterans Affairs and comparable agencies of the Canadian government.

e. Institutions conducting dental hygiene, dental assisting, and dental laboratory technology education programs. Such programs that are under the administrative control of an active or provisional member institution and that are conducted at the main teaching site of that active or provisional member institution are included in the membership of the active or provisional member institution and are automatically members of the Council of Allied Dental Program Directors. Dental hygiene, assisting, and laboratory technology education programs conducted at the main teaching site of an active or provisional member institution but that are not under the administrative control of that active or provisional member institution and dental hygiene, assisting, and laboratory technology education programs that are under the administrative control of an active or provisional member institution and are conducted away from the main teaching site of that active or provisional member institution must be affiliate institutional members in order to belong to the Council of Allied Dental Program Directors.

f. Institutions conducting other dental or allied dental education programs recognized by the Association.

4. Corporate. A company dealing with products and/or services beneficial to dental education and/or dentistry is eligible to apply for corporate membership.

Section C. Election to Institutional Membership. Applications for active and provisional membership should be presented in writing at least sixty days before an annual session. Institutions are elected to membership by a majority affirmative vote of the House of Delegates. Memberships are effective the July 1 following House approval.

Applications for affiliate institutional membership can be submitted at any time for approval by the executive director. Memberships become effective on January 1, April 1, July 1, or October 1, whichever date first follows approval.

Applications for corporate membership can be submitted at any time for approval by the Board of Directors at its next meeting. Memberships become effective on January 1, April 1, July 1, or October 1, whichever date first follows approval. Corporate memberships are reviewed annually.

Section D. Institutional Membership Dues (effective July 1, 2004)

1. Active and Provisional Members. Effective July 1, 2004, annual dues for active and provisional member institutions are $25,522.

Active and provisional institutional membership dues include one individual membership from each member institution.

2. Affiliate Members. Effective July 1, 2004, annual dues for institutions that conduct allied dental education programs are $945. Effective July 1, 2004, annual dues for Canadian dental schools are $1,815.
Effective July 1, 2000, annual dues for the federal dental services are $3,922.

Effective July 1, 2003, annual dues for hospital-based postdoctoral dental education programs are $984. A portion totaling $76 of each such institutional membership shall be allocated as recommended by the Council of Hospitals and Advanced Education Programs and as approved by the Board of Directors.

Effective July 1, 2003, annual dues for institutions that conduct non-hospital-based postdoctoral dental education programs are $3,998. A portion totaling $76 of each such institutional membership shall be allocated as recommended by the Council of Hospitals and Advanced Education Programs and as approved by the Board of Directors.

Dues are payable by February 1, May 1, August 1, or November 1, whichever date first follows approval. Dues include one individual membership, with the institution to determine the individual member.

3. Corporate Members. Effective January 1, 2006, annual dues are $3,400. Dues include up to ten individual members, with the corporation to determine the individual members. $500 of each member’s dues is designated to support the ADEA Annual Session.

Section E. Forfeiture of Institutional Membership
1. Ceasing to meet the membership qualifications specified in Chapter II, Section B, of these Bylaws results in immediate forfeiture of membership.
2. Active or provisional member institutions in arrears in payment of their dues at an annual session forfeit their memberships. Affiliate or corporate member institutions in arrears in payment of their dues more than six months beyond the dues payment date forfeit their memberships.

Section F. Reinstatement of Institutional Membership After Payment of Dues in Arrears
Institutional memberships forfeited for nonpayment of dues may be reinstated upon payment and approval of the executive director.

Section G. Qualifications for Individual Memberships
1. Individual. Any faculty member or other person employed by a dental, advanced education, hospital, and/or allied dental education ADEA member institution is eligible for individual membership.
2. Student. Any student enrolled in a dental school, a postdoctoral dental education program, and/or an allied dental education ADEA member institution is eligible for individual membership.
3. Retired. Any individual who has completely retired from dental education and dental practice and who has been an ADEA individual member is entitled to individual membership.
4. Honorary. Any individual who has rendered a distinct service to humankind, made outstanding contributions to dentistry, and/or rendered exceptional service to the Association may be nominated by the Board of Directors for honorary membership.
5. Affinity. Any individual with a demonstrable interest in dental, allied, or advanced dental education who is not currently a faculty member, employee, or student in an ADEA member institution.

Section H. Approval of Individual Memberships
1. Individual. An individual membership may be activated at any time during the year. Memberships become effective as soon as the activation is processed and remain in effect for the following twelve months.
2. **Student.** A student membership may be activated at any time during the year. It becomes effective as soon as the activation is processed and remains in effect for as long as the member is enrolled at an ADEA Institutional Member.
3. **Retired.** A retired membership may be activated at any time during the year. Memberships become effective as soon as the activation is processed and remain in effect for the following twelve months.
4. **Honorary.** Individuals are elected to honorary memberships by a majority affirmative vote of the House of Delegates. Honorary members are entitled to all the privileges of individual membership except the right to vote. An honorary membership is effective for the member’s lifetime.
5. **Affinity.** Applications for Affinity Individual Membership may be submitted at any time during the year. Memberships become effective as soon as the application is processed and remain in effect for the following twelve months.

**Section I. Individual Membership Dues**
1. **Individual Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or Special Interest Group(s).
2. **Student Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or SIG(s).
3. **Retired Membership.** Effective January 1, 2006, annual dues are $0, and include membership in any Section(s) or Special Interest Group(s).
4. **Honorary Membership.** Honorary members pay no dues.
5. **Affinity Membership.** Effective January 1, 2006, annual dues are $125 for individuals with a demonstrable interest in dental, allied, or advanced dental education and are not currently a faculty member, employee, or student in a member institution. This fee includes membership in any Section(s) or Special Interest Group(s).
6. **Affinity Student Membership.** Effective January 1, 2007, annual dues are $40 for a student who is not enrolled in an ADEA Institutional Member and who has a demonstrable interest in predoctoral, allied, or advanced dental education.

**Section J. Forfeiture of Student Membership**
1. **Student.** Ceasing to meet the membership qualifications specified in Chapter II, Section G.2., of these Bylaws results in immediate forfeiture of student membership. However, the individual may then apply for regular individual membership.

**Section K. Membership Voting Rights**
1. **Voting.** The House of Delegates shall represent the membership and shall have the right to vote on their behalf. Except as otherwise may be expressly required by statute or by the Association’s Articles of Incorporation, no class or category of member of the Association shall have any right to vote.

**Chapter III: Elected Association Officers**

**Section A. Names.** The Association’s elected officers are:
1. President
2. President-elect
3. Immediate Past President
4. Vice President for Allied Dental Program Directors
5. Vice President for Deans
6. Vice President for Faculties
7. Vice President for Hospitals and Advanced Education Programs
8. Vice President for Sections
9. Vice President for Students
10. Vice President for the Corporate Council

Section B. Qualifications. To be eligible for an elected office, a person must be an individual member of the Association. In addition, a person must be a member of a council to be eligible for the vice presidency of that council, with the exception that past Administrative Board members of the Council of Sections who may no longer be members of the council are eligible for nomination as vice president for sections.

Individuals may not serve simultaneously as a principal officer of ADEA (president, president-elect, or immediate past-president) and as a member of the American Dental Association’s Council on Dental Education and Licensure and the Commission on Dental Accreditation.

Section C. Duties of Officers
1. President
   a. To provide leadership in achieving the Association’s mission, objectives, and ongoing business;
   b. To serve as presiding officer of the House of Delegates and Board of Directors; and
   c. To serve as the Association’s official representative to other organizations.
2. President-elect
   a. To serve in place of the president at the request or in the absence of the president; and
   b. To perform any duties requested by the president.
3. Immediate Past President
   a. To serve in place of the president at the request of the president or president-elect or in the absence of both;
   b. To perform any duties requested by the president;
   c. To chair the Finance Committee of the Board of Directors; and
   d. To chair the nominating committee for president-elect.
4. Vice Presidents. The duties of vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.

Section D. Succession. The offices of president-elect, president, and immediate past president are successive.

Section E. Nominations. By April 1 each year, the Board of Directors invites the general membership to suggest nominees for the office of president-elect. Members should consider women and underrepresented minorities for nomination. Members may nominate as many individuals as they wish, including themselves. The deadline for submitting nominations is November 1. Council administrative boards may also nominate individuals.

Between November 1 and December 31, the immediate past president and the seven vice presidents meet as a nominating committee to consider all nominations and shall recommend one or more candidates to stand for election. If a vice president or councilor is a nominee, the chair from that vice president’s or councilor’s council serves on the nominating committee to ensure representation from the council. Any delegate may present additional nominations to the ADEA Executive Director for president-elect no later than thirty days prior to the Opening of the House of Delegates. Any delegate presenting a nomination must obtain the candidate’s consent to run and a copy of the candidate’s curriculum vita, which will be made available for delegates’ review prior to the annual session.
The methods of nominating council vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.

**Section F. Election.** If there is only one candidate for president-elect, he or she is declared elected at the Opening Session of the House. If there are two or more candidates, delegates cast secret ballots at the annual session during times designated by the Board of Directors. Ballot counting is monitored by two individuals selected by the Board of Directors. A plurality of the votes cast is required for election. The methods of electing council vice presidents are delineated in Chapter VIII (Councils) of these Bylaws.

**Section G. Installation.** Elected Association officers are installed at annual sessions at the Closing Session of the House of Delegates.

**Section H. Terms of Office.** The president-elect, president, and immediate past president serve one-year terms. Individuals who have served a full term as president, president-elect, and/or immediate past president may not succeed themselves in any of those offices. Vice presidents serve three-year terms.

**Section I. Replacement.** If a president or president-elect dies, resigns, or is removed for any reason, the Association’s nominating committee nominates one or more candidates to fill the vacancy relating to such officer position. An election is then held by mail ballot of all delegates to the last House of Delegates. Ballots are accompanied by biographical sketches of the candidates. Space is provided on the ballots for write-in candidates. Ballots must be returned within fifteen days after mailing. Ballot counting is monitored by two individuals selected by the Board of Directors. A plurality of the votes cast is required for election. If an immediate past president dies, resigns, or is removed for any reason, the position remains vacant until the president assumes the office at the next annual session, provided, however, that if the person who most recently served as immediate past president (the “former immediate past president”) prior to the death, resignation, or removal of the individual that created the vacancy in the office of the immediate past president is available and willing to serve as the immediate past president, then the former immediate past president may be appointed by the president to serve as the immediate past president until the next annual session when the president assumes such office. In such a case where a vacancy in the office of immediate past president is not filled, the president serves as chair of the Finance Committee and the nominating committee for president-elect. In the event of the death, resignation, or removal of one or more of the vice presidents, the vacancy created thereby shall be filled in accordance with the procedures set forth at Chapter VIII, Section C.9 of these Bylaws. An individual may not hold two or more elected Association offices simultaneously.

**Chapter IV: House of Delegates**

**Section A. Function.** The House of Delegates is the Association’s governing and legislative body.

**Section B. Composition.** The House of Delegates consists of the following members:
1. Board of Directors
2. The Council of Deans
3. The Council of Faculties
4. Representatives of the Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, Sections, and Students, as specified in Chapter VIII (Councils) of these Bylaws.
5. Representatives of the Corporate Council, as specified in Chapter IX (Corporate Council) of these Bylaws.

Section C. Powers and Duties. The House of Delegates has the following powers and duties:
1. To enact and, where appropriate, enforce policies of the Association;
2. To approve all resolutions, opinions, and memorials in the name of the Association;
3. To elect active, provisional, and honorary members;
4. To approve changes in the Bylaws, Policy Statements, and Position Papers;
5. To approve new sections;
6. To approve the Association’s operating budgets;
7. To establish branch offices of the Association or change the location of the Central Office;
8. To elect the president-elect of the Association;
9. To elect nominees for membership in other organizations when so requested; and
10. To serve as an advocate on behalf of all Association policies and positions.

Section D. Sessions. The House of Delegates normally convenes at the Association’s annual sessions. Special sessions may be called by the president or by request of the membership as specified in the Bylaws.

Section E. Official Call
1. Annual Sessions. The executive director sends each institutional and individual member delegate an official notice of the time and place of each annual session or other House meeting. The notice is sent no fewer than thirty days before the first day of the session or meeting.
2. Special Sessions. The executive director sends each institutional and individual member an official notice of the time and place of each special session along with a statement of the business to be considered. The notice is sent no fewer than thirty days before the first day of the session. No other business except that provided for in the call may be considered unless the members present unanimously agree to consider additional business.

Section F. Quorum. A majority of the delegates constitutes a quorum for the transaction of business at regular or special sessions.

Section G. Presiding Officer. The president is the presiding officer. In the president's absence, the president-elect is the presiding officer. In the absence of both, past presidents, in reverse order of service, are called on to preside.

Section H. Recording Officer. The executive director is the recording officer and custodian of the House records. Staff and/or a professional recorder may be used to obtain a record of the House proceedings. The executive director ensures that a record of the proceedings is published annually in the Association's Proceedings.

Section I. Parliamentarian. The executive director, with the approval of the Board of Directors, appoints the parliamentarian.

Section J. Order of Business, Regular Session. The order of business at a regular session of the House of Delegates is as follows, unless changed by a two-thirds affirmative vote of the delegates present and voting:
1. Call to order,
2. Report of quorum by executive director,
3. Approval of minutes of previous session,
4. Reports of officers,
5. Report of Board of Directors,
6. Referrals of reports and resolutions,
7. Action on resolutions,
8. Unfinished business,
9. New business,
10. Installation of officers, and
11. Adjournment.

**Section K. Order of Business, Special Session.** The order of business at a special session is as follows:
1. Call to order,
2. Report of quorum by executive director,
3. Reading of call for special session,
4. Transaction of business as provided in call, and
5. Adjournment.

**Section L. Rules of Order.** The rules contained in the latest edition of Sturgis’s *Standard Code of Parliamentary Procedure* govern the House’s deliberations when not in conflict with these Bylaws.

**Section M. Presentation of Resolutions.** Resolutions may be presented to the House of Delegates at annual sessions by:
1. The Board of Directors in writing at the Opening Session of the House, and
2. Any delegate in writing at the Opening Session of the House of Delegates.
Between annual sessions, any individual member may submit a resolution to the Board of Directors, which may forward it to the House of Delegates at the next annual session with a recommendation for action. The Board of Directors may submit resolutions to an appropriate Association component group for advice before forwarding the resolution to the House of Delegates.

Resolutions proposing expenditure of Association funds must be accompanied by a cost impact statement estimating the amount of funds required and the period of expenditure. Staff assists resolution drafters in estimating expenditures and periods of expenditure, if requested to do so. Resolutions proposing changes in the ADEA policies and Bylaws must specify how the ADEA Policy Statements and Position Papers and Bylaws would be affected.

**Section N. Reference Committees.** Reference committee members are appointed annually by the Board of Directors. Reference committees hold hearings at the annual sessions on resolutions going to the House of Delegates and make recommendations on those resolutions.

**Chapter V: Board of Directors**

**Section A. Function.** The Board of Directors is the Association’s administrative body.

**Section B. Composition.** The Board of Directors consists of the Association’s elected officers, as specified in Chapter III of these Bylaws, and the executive director (an ex officio member), which comprise a board of eleven members.

**Section C. Alternates.** A vice president who is unable to attend a Board of Directors meeting may designate one of the other elected council officers to attend in his or her place as a voting
member of the Board of Directors for that meeting. The principal officers may not designate
alternates.

Section D. Powers and Duties. The Board of Directors has the following powers and duties:
1. To serve as the Association’s administrative body;
2. When the House of Delegates is not in session, to establish ad hoc interim policies, provided
that such policies are not in conflict with existing Association policy and are presented for review
at the next session of the House;
3. To establish rules and regulations consistent with the Bylaws and to govern the organization,
procedure, and conduct of those rules;
4. To report its actions to the House of Delegates at each annual session;
5. To conduct the Association’s planning, including the development of strategic, operational,
and related plans, and to apprise the House of Delegates of those plans;
6. To nominate 1) a candidate(s) for ADEA president; 2) candidates for honorary membership;
and 3) candidates for membership in other organizations, as well as to appoint representatives
to other organizations;
7. To appoint and evaluate the executive director; and
8. To ensure that all accounts of the Association are audited annually and to prepare for House
approval of an annual operating budget for the following fiscal year.

Section E. Sessions
1. Regular Sessions. The Board of Directors normally meets at least four times a year either in
person or by teleconference.
2. Special Sessions. The president may call a special session at the request of at least three
board members, provided that notice of the special session is sent to each member at least ten
days before the meeting. No other business except that provided for in the call may be
considered unless the members present unanimously agree to consider additional business.

Section F. Quorum. A majority of the board’s members constitutes a quorum for the
transaction of business at regular or special sessions.

Section G. Presiding Officer. The president is the presiding officer, and in the president’s
absence, the president-elect. In the absence of both, the immediate past president is the
presiding officer.

Section H. Recording Officer. The executive director is the recording officer. Staff and/or a
professional recorder may be used to obtain a record of meetings.

Section I. Rules of Order. The rules contained in the latest edition of Sturgis’s Standard Code
of Parliamentary Procedure govern the Board of Directors’ deliberations when not in conflict with
these Bylaws.

Section J. Unanimous Consent Mail Ballots. The Board of Directors is authorized to transact
business by unanimous consent in the form of mail ballot. Mail ballots may be sent and returned
by mail, facsimile transmission (fax), and/or electronic mail (email). The results of mail ballots
are as binding as those obtained at official meetings. The following regulations apply to all mail
ballots:
1. Mail ballots should be initiated by an officer or appropriate staff member;
2. Each mail ballot should set forth the specific actions to be considered by the Board of
Directors and include a line for his or her signature;
3. A unanimous vote of all the directors then in office is required for approval; and
4. Ballots not returned within thirty days will not be counted.

Chapter VI: Finance Committee of the Board of Directors

Section A. Functions. The Finance Committee is responsible for assisting the executive
director in preparing the Association’s budget, monitoring the Association’s finances, and
reporting progress and recommendations to the Board of Directors and House of Delegates.

Section B. Composition. The Finance Committee consists of the immediate past president,
who is chair, and the president and president-elect.

Section C. Sessions. The Finance Committee meets as requested by the Board of Directors
and normally in conjunction with Board meetings.

Section D. Quorum. A majority of the committee’s members constitutes a quorum for the
transaction of business.

Section E. Rules of Order. The rules contained in the latest edition of Sturgis’s *Standard Code
of Parliamentary Procedure* govern the deliberations of the Finance Committee when not in
conflict with these *Bylaws*.

Section F. Fiscal Year. The Association’s fiscal year runs from July 1 through June 30.

Section G. Budget. The Board of Directors at each annual session submits an operating
budget for the following fiscal year to the House of Delegates for approval.

Chapter VII: Other Standing and Special Committees of the Board of Directors

Section A. Authority. The Board of Directors may appoint standing and special committees to
assist it in performing its duties. In all such appointments, the Board of Directors should
consider women and underrepresented minorities to serve on such committees. While
committees of the board must always have two or more directors, and directors must constitute
a majority of committee membership, the board may also appoint advisory committees. Advisory
committees may include any individual member of the association and have no limitations
concerning director membership.

Chapter VIII: Councils

Section A. Functions. All but one of the councils (the Council of Sections) represent
institutions and programs in each of the Association’s institutional membership categories. The
Council of Sections represents the Association’s sections. In addition, each council has the
following functions:
1. To represent its constituency within the Association and at the member institutions;
2. To recommend to the Board of Directors how the interests of the council’s constituency might
be represented through the federal legislative and regulatory processes;
3. To exchange information among its members, with other ADEA component groups, and
among member institutions;
4. To work with other ADEA component groups to encourage coordinated approaches to dental
and allied dental education and health care delivery;
5. To identify and provide consultation on projects, studies, and reports that will benefit the
membership;
6. To introduce resolutions to the Board of Directors and/or House of Delegates; and
7. To meet at annual sessions.

**Section B. Composition.** The Association’s councils consist of the following members. All council members must be individual members of the Association.

1. **The Council of Allied Dental Program Directors** consists of the directors (or their alternates) of dental assisting, dental hygiene, and dental laboratory technology education programs in each active, provisional, and affiliate member institution. In member institutions offering more than one allied dental education program, the person (or an alternate) who is the department/division chair or head is also a member of the council. Council membership may also include the directors (or their alternates) of special allied dental education programs at the post-entry level that lead to a baccalaureate or advanced degree. In addition, a member of the Administrative Board who is no longer in any of the above categories may remain a member of the council for the duration of his or her term(s).

**Representation in the House of Delegates.** The Council of Allied Dental Program Directors is represented in the House by one delegate for every ten of its member programs (or major portion thereof) in each of its four membership categories—dental assisting education, dental hygiene education, dental laboratory technology education, and special allied dental education. Each category is represented by at least two delegates, except for the category of special allied dental education, which is represented by at least one delegate. Administrative Board members are delegates, even if they are additional delegates in their category. The council Administrative Board nominates two candidates for each delegate position that will not be filled by an Administrative Board member. Delegates are then elected by mail balloting of the entire council. Delegates are elected to one-year terms and may be reelected.

2. **The Council of Deans** consists of the dean (or an alternate) of each active and provisional member institution, the chief dental administrator (or an alternate) of each affiliate member institution conducting non-hospital-based postdoctoral dental education programs, the chief dental officer or administrator (or an alternate) of each affiliate-member federal dental service, and the president (or an alternate) of the Association of Canadian Faculties of Dentistry. In addition, the council includes any members of its Administrative Board who are no longer in the above categories.

**Representation in the House of Delegates.** All members of the Council of Deans serve as delegates in the House.

3. **The Council of Faculties** consists of one faculty member (or an alternate) elected by the faculty of each active and provisional member institution, in addition to any members of the Administrative Board who are no longer in the above category. Members are elected to three-year terms, and approximately one-third of the members are replaced or reelected annually according to a schedule maintained in the Central Office. The methods of electing members, removing members for cause, and electing new members to fill unexpired terms are left to the discretion of individual member institutions. Each faculty electing or reelecting a member in a given year is required to notify the Central Office of the name of its representative by January 1 preceding the annual session at which the incumbent faculty member’s term ends.

**Representation in the House of Delegates.** All members of the Council of Faculties serve as delegates in the House.

4. **The Council of Hospitals and Advanced Education Programs** consists of the chief of hospital dental service and directors of each accredited residency program in active or
provisional member institutions (including hospitals under the same governance as a dental school) and in hospitals that are affiliate members, in addition to any members of the council Administrative Board who are no longer in the above categories and one representative of all non-recognized specialty programs at each institution described above. Each ADEA-member federal dental service may appoint a nonvoting representative to attend meetings of the Council of Hospitals and Advanced Education Programs.

**Representation in the House of Delegates.** The Council of Hospitals and Advanced Education Programs is represented in the House by one delegate for every ten of its member programs (or major portion thereof). Regardless of the number of member programs, the Council is represented by at least sixteen delegates (the five members of the Administrative Board and one representative each from the recognized and/or accredited programs by the Commission on Dental Accreditation). All Administrative Board members must serve as delegates. The Council Administrative Board, at its annual interim meeting, nominates at least one candidate for each delegate position beyond the sixteen that will not be filled by an Administrative Board member or a recognized specialty representative. Delegates are elected at the ADEA annual session immediately proceeding the year of service. Delegates are elected to one-year terms and may be reelected.

5. **The Council of Sections** consists of the councilor and chair (or their alternates) of each Association section, in addition to any members of the Council Administrative Board who are no longer councilors or chairs of their section. In addition, the chair-elect and secretary from each section are eligible to participate in council meetings and may vote at those meetings. Section chairs-elect and secretaries are not eligible for election to council office.

**Representation in the House of Delegates.** The Council of Sections is represented in the House by the chair of each section and a councillor elected by each section to a three-year term. Councilors may be reelected to one additional three-year term. Council Administrative Board members who are not section chairs or councilors also serve as delegates. If a section chair and/or councilor is unable to serve as a delegate, the section’s chair-elect and/or secretary serve as delegate alternates. Section chairs-elect and secretaries are not eligible to sit with the council in the House of Delegates unless they have been appointed delegate alternates.

6. **The Council of Students** consists of students representing any of the following types of programs conducted by each active, provisional, and affiliate member institution: 1) one representative for a program leading to the D.D.S. or D.M.D. degree, 2) one representative for all students enrolled in postdoctoral education programs, 3) one representative for each dental hygiene education program, 4) one representative for each dental assisting education program, and 5) one representative for each dental laboratory technology education program. The methods of electing members, removing members for cause, and electing new members to fill unexpired terms are left to the discretion of individual member institutions. Each member institution’s chief administrator is required to notify the Central Office of the name(s) of its representative(s) within sixty days after an annual session. Members are elected to one-year terms and may be reelected.

**Representation in the House of Delegates.** The Council of Students is represented in the House by its Administrative Board, in addition to twelve predoctoral dental students, two each from the six regions recognized by the council; four postdoctoral dental students, two from hospital programs and two from non-hospital-based programs; and six allied dental students, two each from dental hygiene, dental assisting, and dental laboratory technology education programs. Delegates are elected to one-year terms and may be reelected. All delegates are elected by the Council of Students at the annual sessions.
7. Alternates. Council members unable to attend a House of Delegates session or a council meeting, or who serve in the House in two or more positions (e.g., as a member of the Council of Faculties and Council of Sections), may appoint alternates to represent them. Members of the Councils of Allied Dental Program Directors, Hospitals and Advanced Education Programs, and Students must appoint alternates who are members of their council. Members of the Council of Sections must appoint the chair-elect or secretary of their section. Members of the Councils of Deans and Faculties must appoint individuals from their institutions. Delegates representing two or more councils in the House must decide which council they wish to represent and then appoint an alternate(s) for the other council(s) according to the foregoing guidelines. All alternates must be ADEA individual members.

Section C. Administrative Boards
1. Names of Officers. Each council has an administrative board consisting of a chair, chair-elect (vice-chair for the Council of Students), secretary, member-at-large, and vice president (ex officio).
2. Qualifications. A person must be an individual member of the Association and a member of his or her council to be eligible for a council office, with the exception that past Administrative Board members of the Council of Sections who may no longer be members of the council are eligible for nomination as vice president for sections.
3. Duties
   a. Chairs. It is the duty of chairs:
      1) To provide leadership in meeting council goals and objectives;
      2) To chair council meetings; and
      3) To plan programs for council meetings.
   b. Chairs-Elect. It is the duty of chairs-elect:
      1) To chair council meetings in the absence of the chair;
      2) To perform any duties requested by the chair; and
      3) To serve as chair of the nominating committee to select candidates for council office.
   c. Secretaries. It is the duty of secretaries:
      1) To record the minutes of council and administrative board meetings or to see that they are recorded;
      2) To submit the minutes of council annual session meetings to the Central Office within sixty days after the session; and
      3) To perform any duties requested by the chair.
   d. Members-at-Large. It is the duty of members-at-large:
      1) To perform any duties requested by the chair.
   e. Vice Presidents. It is the duty of vice presidents:
      1) To serve as ex officio council officers and Association officers;
      2) To represent the councils’ interests on the Board of Directors;
      3) To serve as consultants from the Board of Directors to the councils in conducting their business and meeting their objectives; and
      4) To report Board of Directors’ actions to the council.
4. Succession. Except for the Council of Students, each year, the member-at-large succeeds to the office of secretary, the secretary to the office of chair-elect, and the chair-elect to the office of chair. For the Council of Students, offices are not automatically successive.
5. Nominations. Before each annual session, the chair-elect and two council members who are not officers nominate one or more individuals for the office of member-at-large (and vice president if the incumbent vice president will complete a term at the end of the annual session). For the Council of Students, the vice-chair and two council members who are not officers nominate one or more individuals for the offices of member-at-large, secretary, vice-chair, chair,
and vice president. Additional nominations may be made from the floor at the councils’ annual session meetings.

6. **Election and Appointment.** Council officers are elected at council annual session meetings. The method of voting is left to the discretion of the council chairs. For the Council of Students, immediately after the annual session, the four members of the new Administrative Board appoint a council member to serve as a member-at-large.

7. **Installation.** All council officers, except vice presidents, are installed at council annual session meetings. Vice presidents are installed at annual sessions at the Closing Session of the House of Delegates.

8. **Terms of Office.** All council officers, except vice presidents, serve one-year terms. Vice presidents serve three-year terms, except for the vice president for students, who may serve up to three consecutive one-year terms if the individual qualifies for membership on the Council of Students during that entire period. An individual who has served a full term as a vice president (three consecutive one-year terms as a vice president for students), chair, chair-elect, secretary, or member-at-large may not succeed him- or herself in any of those offices.

9. **Replacement.** An administrative board member who ceases to qualify for membership on a council may continue as a council officer for the duration of his or her term(s) on the board. A board member who completely ceases to be active in dental and/or allied dental education must resign his or her office on the council. In the event of the death, resignation, or removal of a council officer, the council administrative board appoints a non-board member of the council to complete the unexpired term(s) of office; provided, however, that if the vacancy created by such death, resignation, or removal is for the office of the vice president, then the council administrative board shall appoint a non-board member of the council to serve as the vice president until the next annual session meeting of the council, at which annual session an election (in accordance with this Chapter VIII) shall be held to fill the remainder of the term of the office of the vice president that became vacant by reason of such death, resignation, or removal.

10. **Alternates.** Council officers may not send alternates to attend council administrative board or House of Delegates meetings in their place.

Section D. **Sessions.** All councils meet at annual sessions. Administrative boards plan annual session programs and submit program details to the Central Office for publication in the annual session program. The schedule of council programs is determined by the Board of Directors. Councils able to provide funding may hold additional conferences between annual sessions.

Section E. **Quorum.** A majority of the members of a council constitutes a quorum for the transaction of business.

Section F. **Rules.** The rules for councils are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

**Chapter IX: Corporate Council**

**Section A. Functions.** The Corporate Council has the following functions:
1. To represent the corporate members within the Association;
2. To apprise corporate members of relevant Association activities;
3. To establish criteria for, and advise the Board of Directors on, approval of applications for corporate membership;
4. To exchange information among its members, with other component groups of the Association, and among the Association’s member institutions;
5. To serve in a liaison role between the corporate and academic members of the Association;
6. To impart corporate members’ knowledge to other Association members;
7. To work with other component groups of the Association to encourage coordinated approaches to dental and allied dental education and care delivery;
8. To identify projects, studies, and reports that will benefit the Council’s and/or Association’s membership and to provide consultation on those projects, studies, and reports;
9. To introduce appropriate resolutions to the House of Delegates and/or Board of Directors; and
10. To meet at annual sessions.

Section B. Composition. The Corporate Council consists of the official representative of each corporate member.

Section C. Representation in the House of Delegates. The Corporate Council is represented in the House of Delegates by three of its four elected officers: the 1) chair, 2) chair-elect, and 3) vice president.

Section D. Officers
1. Names. The Corporate Council has five officers: a chair, chair-elect, secretary, member-at-large, and vice president (ex officio).
2. Qualifications. An individual must be a member of the Corporate Council to be eligible for a Corporate Council office.
3. Duties
   a. Chair. It is the duty of the chair:
      1) To provide leadership in meeting Corporate Council goals and objectives;
      2) To chair Corporate Council meetings; and
      3) To plan programs for Corporate Council meetings.
   b. Chair-Elect. It is the duty of the chair-elect:
      1) To chair Corporate Council meetings in the absence of the chair;
      2) To perform any duties requested by the chair; and
      3) To serve as chair of the nominating commit-tee to select candidates for Corporate Council office.
   c. Secretary. It is the duty of the secretary:
      1) To record the minutes of Corporate Council meetings or to see that they are recorded;
      2) To submit the minutes of the Corporate Council’s annual session meetings to the Central Office within sixty days; and
      3) To perform any duties requested by the chair.
   d. Member-at-Large. It is the duty of the member-at-large to perform any duties requested by the chair.
   e. Vice President. It is the duty of the vice president:
      1) To serve as a Corporate Council officer and a voting member of the Board of Directors;
      2) To represent the council’s interests on the Board of Directors;
      3) To serve as a consultant from the Board of Directors to the council in conducting its business and meeting its objectives; and
      4) To report Board of Directors’ actions to the council.
4. Succession. Each year, the member-at-large succeeds to the office of secretary, the secretary succeeds to the office of chair-elect, and the chair-elect to the office of chair.
5. Nominations. Before each annual session, the Corporate Council nominates one or more individuals for the office of member-at-large and vice president. Additional nominations may be made from the floor at the council’s annual session meeting.
6. Election and Appointment. Corporate Council officers are elected at the council’s annual session meetings. The method of voting is left to the discretion of the council chair.
7. **Installation.** All Corporate Council officers are installed at the council’s annual session meetings.

8. **Terms of Office.** All Corporate Council officers except vice presidents serve one-year terms. Vice presidents may serve up to three consecutive one-year terms.

9. **Limitation of Terms.** An individual who has served three consecutive one-year terms as a vice president, or as chair, chair-elect, secretary, or member-at-large, may not succeed him- or herself in any of those offices.

10. **Replacement.** An officer who ceases to be a member of the Corporate Council must resign the office at the time he or she ceases to be a member. In such an instance, or when a council officer resigns for any other reason, the other officers appoint another council member to serve out the unexpired term (or successive terms) of office. An individual may not hold two or more Corporate Council offices simultaneously.

11. **Alternates.** Corporate Council officers may not send alternates to attend meetings in their place, except that council officers unable to attend a House of Delegates session may appoint alternates to represent them. Such alternates must be members of the Corporate Council.

**Section E. Sessions.** The Corporate Council meets at annual sessions and may meet at other times of the year as appropriate. The officers plan annual session programs and submit program details to the Central Office for publication in the annual session program. The scheduling of the Corporate Council’s program is determined by the Board of Directors.

**Section F. Quorum.** A majority of the members of the Corporate Council constitutes a quorum for the transaction of business.

**Section G. Rules.** The rules for the Corporate Council are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws. In addition, the following rule applies to corporate members: they may not cite corporate membership for commercial purposes, e.g., to imply ADEA endorsement of products and services.

**Chapter X: Sections**

**Section A. Functions.** A Section is a programmatic group that provides an opportunity for its members to exchange information on the Section’s specific academic and administrative interests.

1. Both academic and administrative Sections are periodically asked by the House of Delegates, Board of Directors, president, and executive director to undertake assignments and to comment on appropriate materials.

2. A Section is further encouraged to initiate projects and studies of benefit to the Association and its members.

3. A Section may submit resolutions to the House of Delegates.

**Section B. Participation and Membership in a Section.** Each Section consists of any Individual, Student, Retired, and Honorary ADEA member interested in the Section’s particular academic or administrative area. An ADEA member may join any number of Sections and may vote, hold office, participate in the business affairs, and attend any meeting of a Section to which he or she belongs.

**Section C. Sections Listing.** The Association has the following Sections:

- Academic Affairs
- Anatomical Sciences
Behavioral Sciences
Biochemistry, Nutrition, and Microbiology
Business and Financial Administration
Clinic Administration
Clinical Simulation
Community and Preventive Dentistry
Comprehensive Care and General Dentistry
Continuing Education
Dental Anatomy and Occlusion
Dental Assisting Education
Dental Hygiene Education
Dental Informatics
Dental School Admissions Officers
Development, Alumni Affairs, and Public Relations
Educational Research/Development and Curriculum
Endodontics
Gay-Straight Alliance
Gerontology and Geriatrics Education
Graduate and Postgraduate Education
Minority Affairs
Operative Dentistry and Biomaterials
Oral and Maxillofacial Pathology
Oral and Maxillofacial Radiology
Oral and Maxillofacial Surgery, Anesthesia, and Hospital Dentistry
Oral Biology
Oral Diagnosis and Oral Medicine
Orthodontics
Pediatric Dentistry
Periodontics
Physiology, Pharmacology, and Therapeutics
Postdoctoral General Dentistry
Practice Management
Prosthodontics
Student Affairs and Financial Aid
Section D. Formation of a Section
1. To form a new Section, a group must have begun as a Special Interest Group (SIG; see Chapter XI, Section D. Formation of a SIG). When Section status is desired, the SIG must:
a. Notify the chair of the Council of Sections Administrative Board and Council of Sections staff liaison of the intent to propose a new Section.
b. Prepare a proposal to support the case following criteria established by the Council of Sections Administrative Board.
c. Submit the completed proposal to the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison no later than September 1.
2. The Council of Sections Administrative Board considers each proposal to form a new Section at its interim Fall Meeting.
   a. If the proposal is approved, the Council of Sections Administrative Board forwards the recommendation to the ADEA Board of Directors for consideration at its January meeting.
   b. If the recommendation is approved by the ADEA Board of Directors, the Board of Directors forwards a resolution to form the new Section to the House of Delegates for hearing at the subsequent Annual Session.
   c. Only the House has the authority to approve a resolution proposing a new Section. Upon approval by the House of Delegates, a new Section begins operation immediately. If the proposal is not approved, the SIG may resubmit its request in a subsequent year.

Section E. Review. The Council of Sections Administrative Board reviews each Section annually. A review of performance is based on criteria established by the Council of Sections Administrative Board and announced annually in advance of the review.
1. The Administrative Board may impose corrective actions, including probation, for those Sections that fail to submit annual reports or perform prescribed functions.
2. The Council of Sections Administrative Board may recommend that a Section be disbanded or suggest that two or more Sections be merged into one Section based on strong similarities.
   a. The Council of Sections Administrative Board forwards a recommendation that a Section be disbanded or merged to the ADEA Board of Directors.
   b. If the recommendation is approved by the ADEA Board of Directors, the Board of Directors forwards an appropriately worded resolution to the House of Delegates for hearing at the subsequent Annual Session.
   c. Only the House of Delegates has the authority to disband a Section or merge Sections.

Section F. Officers and Term of Office. Each Section has a councilor, who serves a three-year term of office, and a chair, chair-elect, and secretary, who serve one-year terms in each office in succession.
1. Qualifications. A person must be a member of the Association and a member of the Section to be eligible for office in that Section. In the instance of councilor, the person must first have served through the officer positions, including the chair, to be eligible for election to the councilor position.
2. Duties
   a. Councilor. The duties of a councilor are to:
      1) provide continuity of leadership for the Section and mentoring of new Section officers;
      2) attend the ADEA Annual Session and interim Fall meetings of the ADEA Council of Sections;
      3) serve as a delegate in the ADEA House of Delegates during the ADEA Annual Session;
      4) assist in planning, implementing, and assessing Section programs and projects;
      5) prepare and submit the Section annual report after each ADEA Annual Session to the Council of Sections staff liaison; and
      6) serve as Section liaison with the Council of Sections Administrative Board.
   b. Chair. The duties of the chair are to:
1) provide leadership in the coordination of Section activities;
2) chair Section meetings;
3) plan programs for Section meetings; and
4) serve as a delegate in the ADEA House of Delegates during the ADEA Annual Session.

c. **Chair-Elect.** The duties of the chair-elect are to:
   1) serve as chair in the absence of the chair;
   2) perform any Section-related duties requested by the chair;
   3) serve as chair of the nominating committee to select candidates for Section office; and
   4) serve as the program chair for the Section and be responsible for submitting program proposals annually to the ADEA Annual Session Program Committee for review.

d. **Secretary.** The duties of the secretary are to:
   1) record the minutes of Section meetings and disseminate them to the Section membership;
   2) submit the minutes and current officer contact information to the Section councilor for submission with the Section annual report;
   3) publish and disseminate a Section newsletter; and
   4) perform any Section-related duties requested by the chair.

3. **Succession.** Each year the secretary succeeds to the office of chair-elect, and the chair-elect succeeds to the office of chair. There is no automatic succession to the office of councilor.

4. **Nominations.** Before each ADEA Annual Session, the nominating committee (chair-elect and two Section members who are not officers) nominates one or more individuals for the office of secretary. Every third year, the committee nominates one or more individuals for the office of councilor. Additional nominations for these offices may be made from the floor at the Section Annual Session business meeting.

5. **Election.** Section officers are elected at an ADEA Annual Session Section business meeting. The method of voting is left to the discretion of the Section chair.

6. **Installation.** All section officers take office after the conclusion of the Closing of the House of Delegates at the ADEA Annual Session.

7. **Consecutive and Simultaneous Terms of Office.** A Section councilor may serve two consecutive three-year terms. A person may not hold more than one Section officer position simultaneously or hold office in more than one Section simultaneously.

8. **Replacement of Vacancy.** If the position of chair, chair-elect, or secretary becomes vacant, the remaining Section officers appoint another member of the Section to serve out the unexpired term. If the councilor is unable to serve for any reason, a new councilor will be elected by mail or electronic ballot by the Section members to serve out the unexpired term.

**Section G. Quorum.** Sections have no quorum requirement for the conduct of business.

**Section H. Rules.** The rules for Sections are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

**Chapter XI: Special Interest Groups**

**Section A. Functions.** A Special Interest Group (SIG) provides an opportunity for its members to exchange information and work together on specific academic or administrative interests in dental, allied dental, and advanced dental education. The structure of a SIG provides an opportunity and allows a means for a group of ADEA members to focus on areas of common interest.

1. A SIG may be assigned tasks by the ADEA Board of Directors, ADEA House of Delegates, or the Council of Sections Administrative Board on related studies of benefit to the Association and its members.
2. Each SIG chair may be an active but nonvoting member of the Council of Sections.
3. A SIG is not represented in the ADEA House of Delegates and may not submit a resolution to the ADEA House of Delegates.

**Section B. Participation and Membership in a SIG.** A Special Interest Group consists of any Individual, Student, Retired, and Honorary ADEA member interested in the SIG’s particular academic or administrative area. An ADEA member may join any number of SIGs and attend any meetings of a SIG to which he or she belongs.

**Section C. Special Interest Groups Listing.** The Association has the following SIGs:
- Career Development for the New Educator
- Cariology
- Dental Hygiene Clinical Coordinators
- Foreign-Educated Dental Professionals
- Implant Dentistry
- Legal Issues
- Temporomandibular Disorders
- Tobacco-Free Initiatives

**Section D. Formation of a Special Interest Group**
1. To form a new Special Interest Group, an individual or group must:
   a. Notify the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison of the intent to propose a new SIG.
   b. Prepare a proposal to support the case following criteria established by the Council of Sections Administrative Board.
   c. Submit the completed proposal to the chair of the Council of Sections Administrative Board and the Council of Sections staff liaison.
2. The Council of Sections Administrative Board considers each proposal.
   a. If the proposal is approved, the Council of Sections Administrative Board forwards its recommendation to the ADEA Board of Directors for review at the Board meeting subsequent to approval of the proposal.
   b. If the proposal is approved by the Board of Directors, the SIG begins operation immediately upon notification by the chair of the Council of Sections Administrative Board.

**Section E. Becoming a Section**
1. After two to five years of viable leadership and sustainable membership, a SIG may apply to form a Section although it is not required to do so.
2. If the SIG chooses to form a Section, it must form a leadership organizational structure similar to that of a Section by electing or appointing a chair, chair-elect, and secretary.

**Section F. Review.** Each year, the Council of Sections Administrative Board reviews each SIG and its performance based on criteria established by the Council of Sections Administrative Board.
1. The Administrative Board may impose corrective actions, including probation, for a SIG that fails to submit an annual report or perform prescribed functions.
2. The Council of Sections Administrative Board may disband a SIG.

**Section G. Officer and Term of Office.** Each Special Interest Group must have a chair, who serves a one-year term. The SIG may have a leadership structure similar to that of a Section (i.e., chair, chair-elect, and secretary), but it is not required to do so.
1. **Qualifications.** A person must be a member of the Association and a member of the SIG to be eligible for office in that SIG.
2. Duties
   a. Chair. The duties of the chair are to:
      1) provide leadership in the coordination of SIG activities;
      2) chair SIG meetings;
      3) plan programs for SIG meetings;
      4) record the minutes of SIG meetings and disseminate them to the SIG membership; and
      5) submit the SIG annual report, business meeting minutes, and current officer contact information to the Council of Sections staff liaison;
   b. If a SIG chooses to have a leadership organizational structure similar to that of a Section, see Chapter X. Section F. Articles 2b-2d for officer duties.

3. Succession. If a SIG chooses to have a leadership organizational structure similar to that of a Section (i.e., chair, chair-elect, and secretary), the secretary succeeds to the office of chair-elect, and the chair-elect succeeds to the office of chair.

4. Nominations. If a SIG has a leadership organizational structure similar to that of a Section, before each ADEA Annual Session, the nominating committee (chair-elect and two SIG members who are not officers) nominates one or more individuals for the office of secretary.

5. Elections. Each year, a chair is elected to serve a one-year term. SIG officers are elected at an ADEA Annual Session SIG business meeting.

6. Installation. A Special Interest Group officer takes office at the conclusion of the ADEA Annual Session.

7. Consecutive and Simultaneous Terms of Office. A Special Interest Group chair may serve a one-year term. If the SIG chooses to maintain one officer position versus creating the organizational structure of a Section, the position of chair must be reaffirmed by the membership annually. A person may not hold office in more than one SIG simultaneously.

8. Replacement Due to Vacancy
   a. If the position of chair becomes vacant, the SIG members must nominate and elect another member of the SIG to serve out the unexpired term by mail or electronic ballot.
   b. If a SIG chooses to have a leadership organizational structure similar to that of a Section (i.e., chair, chair-elect, and secretary), the remaining officers will appoint a SIG member to serve out the unexpired term.

Section H. Quorum. Special interest groups have no quorum requirement to conduct business.

Section I. Rules. The rules for Special Interest Groups are included in Chapter XII (Rules for Councils, the Corporate Council, Sections, and Special Interest Groups) of these Bylaws.

Chapter XII: Rules for Councils, the Corporate Council, Sections, and Special Interest Groups
The above groups are hereinafter referred to in this chapter as “component groups” or “groups.”

Section A. Finances. Component groups conduct their own financial affairs; however, records and accounts are maintained in the Central Office. A special allocation, the amount of which is determined annually by the Board of Directors and House of Delegates, is available for the group’s annual expenditures. The allocated funds may be used by a group for any reasonable expenditures. The group may charge annual session expenditures to the Association’s master account, provided that an appropriate request is submitted to the Central Office at least sixty days before an annual session. Groups anticipating expenditures in excess of their annual allocation must submit to the Board of Directors a written request for additional expenditures. In addition, all group requests for funding from outside organizations must receive prior Board of Directors’ approval.
Section B. Employment. Component groups may not employ an individual whose services may require reimbursement by the Association, except on authorization of the Board of Directors.

Section C. Contracts. Component groups may not produce a contract that in any way involves the Association, except on authorization of the Board of Directors.

Section D. Establishment of Policy. Component groups have the privilege of recommending Association policy. However, they are not authorized to initiate or implement a new policy or to alter or extend an existing policy without prior reviews and approval by the Board of Directors and the House of Delegates.

Section E. Public Statements. Component groups and their members may not issue a public statement in the name of either the group or the Association unless 1) authority has been granted by the Board of Directors, and 2) the statement is clearly in accord with policies of the Association as expressed by the House of Delegates and the Board of Directors.

Section F. Communication. Communications dealing with major component-group activities or policy should be sent to all group members by the chair or another officer.

Section G. Relations with Other Organizations and Agencies. No component group is authorized to appoint an official representative to another organization unless authorized to do so by the Board of Directors.

Section H. Relations with Other Component Groups. Component group chairs should refer to the executive director all matters that properly are the concern of another component group. Requests for information or assistance from another component group should be channeled through the executive director’s office.

Section I. Additional Rules for Component Groups. Component groups may prepare additional rules needed to conduct their affairs, provided that those rules are consistent with the Association’s Bylaws. Such additional rules should be transmitted to the executive director for his or her records.

Section J. Rules of Order. The rules contained in the latest edition of Sturgis’s Standard Code of Parliamentary Procedure govern the component groups’ deliberations in all cases when not in conflict with these Bylaws.

Section K. Mail Ballots. Component groups are authorized to transact business by mail ballot. Mail ballots may be sent and returned by mail, facsimile transmission (fax), and/or electronic mail (email). The results of mail ballots are as binding as those obtained at official meetings. The following regulations apply to all mail ballots:
1. Mail ballots should be initiated by an officer or appropriate staff member;
2. Each mail ballot should include enough information to allow recipients to register an opinion on the issue in question;
3. A majority affirmative vote of the ballots cast is required for approval; and
4. Ballots not returned within thirty days will not be counted.

Chapter XIII: Executive Director
Section A. Function. The executive director is the Association’s appointed chief administrative officer. In the absence of any other persons so appointed or elected by the Association, the executive director shall serve as the secretary and the treasurer of the Association.

Section B. Appointment. The executive director is appointed by the Board of Directors.

Section C. Tenure of Office and Salary. The Board of Directors determines the tenure of office and salary of the executive director. No one term may exceed five years.

Section D. Duties
1. To serve as the principal spokesperson for the Association, along with the president of the Board of Directors, in dealing with the profession and the public;
2. To serve as the chief administrator of the Central Office and all of its branches;
3. To provide for the maintenance of the Central Office and all property and offices owned or operated by the Association;
4. To employ and evaluate all members of the Association’s staff;
5. To coordinate the activities of all committees, councils, administrative boards, standing committees, and other Association component groups;
6. To approve applications for affiliate institutional membership;
7. To serve as the custodian of all monies, securities, and deeds belonging to the Association;
8. To prepare financial reports for the Board of Directors;
9. To disburse the Association’s funds at the direction of the Board of Directors, provided those disbursements are consistent with the annual budget approved by the House of Delegates;
10. To cause all employees entrusted with Association funds to be bonded by a surety company and to determine the amount of the bond;
11. To supervise the publication and distribution of all Association publications;
12. To determine the time and location of annual sessions;
13. To notify individual and institutional members of annual and special sessions of the House of Delegates;
14. To provide a program for annual sessions;
15. To present an annual report of the activities of the Central Office;
16. To publish an annual Proceedings of the Association; and
17. To perform such other duties as may be determined by the Board of Directors and the president.

Chapter XIV: Editor and Official Publication

Section A. Appointment of the Editor. The Association’s editor is appointed by the Board of Directors.

Section B. Tenure of Office and Remuneration. The Board of Directors determines the tenure of office and remuneration for the editor. No one term may exceed five years.

Section C. Duties of the Editor
1. To serve as the editor of the Journal of Dental Education;
2. To consult with the Board of Directors in the selection of the Editorial Review Board;
3. To exercise, with the Editorial Review Board, editorial control over the Journal of Dental Education, subject to the policies and procedures established by the Board of Directors and these Bylaws; and
4. To perform such other duties as may be determined by the Board of Directors.
Section D. Official Publication
1. Title. The Association publishes an official journal under the title of the Journal of Dental Education, hereinafter referred to as “the journal.”
2. Objective. The objective of the journal is to report, chronicle, and evaluate scientific and professional developments and Association activities of interest to dental and allied dental educators.
3. Frequency of Issue and Subscription Rate. The frequency of issue and the subscription rate of the journal are determined by the Board of Directors on recommendations of the editor and the Editorial Review Board.
4. Editor. The Association’s editor is the editor of the journal.

Chapter XV: Representatives to Other Organizations

Section A. Nominees for Membership on the Council on Dental Education and Licensure, Commission on Dental Accreditation, and the Joint Commission on National Dental Examinations. When necessary, the Board of Directors confers between November 1 and December 31 to select a candidate(s) for nomination to membership on the American Dental Association’s Council on Dental Education and Licensure, a candidate(s) for nomination to the Commission on Dental Accreditation, and a candidate(s) for nomination to membership on the Joint Commission on National Dental Examinations. The candidates are nominated at the same time the Board of Directors selects a nominee for president-elect. Additional nominations may be made from the floor at the Opening Session of the House of Delegates. If there are additional nominations, the election procedures are the same as those provided in Chapter III of these Bylaws. If there are no additional nominations, nominees are declared elected at the Opening Session. Individuals may not serve simultaneously as a principal officer of ADEA (president, president-elect, or immediate past president) and as a member of the American Dental Association’s Council on Dental Education and Licensure and the Commission on Dental Accreditation.

Section B. Representatives to Other Organizations. Representatives to other organizations are appointed by the Board of Directors, which also determines the organizations to which the Association appoints such representatives.

Chapter XVI: Conflicts of Interest
Individuals who serve as Board of Directors members or are appointed or elected to represent the Association in its relations with other private organizations or government agencies; who serve as council, section, and/or special interest group officers; who serve in an advisory or consultative role for the Association individually or through group or committee assignments; or who are otherwise involved in Association policy and administrative matters do so in a representative or fiduciary capacity and, at all times while serving in such positions, shall further the interests of the Association as a whole. Those individuals should avoid:
1. Placing themselves in a position where personal or professional interests may conflict with their duty to the Association;
2. Using information learned through their position for personal gain or advantage; and
3. Obtaining for a third party an improper gain or advantage.

Individuals described in this chapter shall disclose to the executive director any situation that might be construed as placing the individual in a position of having an interest that may conflict with his or her duty to the Association. When doubt exists about whether there is a conflict, the doubt will be resolved by a majority vote of the Board of Directors.
While serving the Association, the individual shall comply with this conflicts of interest policy and avoid even the appearance of impropriety. When the conflict is relevant to a pending matter, the interested individual shall retire from the room, shall not participate in any deliberation or provide any information regarding the matter under consideration, and shall not vote on the matter. These actions should be noted in the meeting minutes.

Such individuals have an ongoing duty to promptly inform the executive director of any potential conflicts relevant to Association matters that have not previously been disclosed.

Chapter XVII: Indemnification and Limitation of Liability

Section A. Indemnification. Unless expressly prohibited by law, the Association shall fully indemnify any person made, or threatened to be made, a party to an action, suit, or proceeding (whether civil, criminal, administrative, or investigative) by reason of the fact that such person, or such person’s testator or intestate, is or was a director, officer, employee, or agent of the Association or serves or served any other enterprise at the request of the Association, against all expenses (including attorneys’ fees), judgments, fines, and amounts paid or to be paid in settlement incurred in connection with such action, suit, or proceeding.

Section B. Limitation of Liability. Provided the corporation maintains liability insurance with a limit of coverage of not less than $200,000 per individual claim and $500,000 per total claims that arise from the same occurrence, officers, directors, and other persons who perform services for the Association and who do not receive compensation other than reimbursement of expenses (“volunteers”) shall be immune from civil liability. Additionally, persons regularly employed to perform a service for a salary or wage (“employees”) shall not be held personally liable in damages for any action or omission in providing services or performing duties on behalf of the Association in an amount greater than the amount of total compensation (other than reimbursement of expenses) received during the twelve months immediately preceding the act or omission for which liability was imposed. Regardless of the amount of liability insurance maintained, this limitation of liability for volunteers and employees shall not apply when the injury or damage was a result of the volunteer or employee’s willful misconduct, crime (unless the volunteer or employee had reasonable cause to believe that the act was lawful), transaction that resulted in an improper personal benefit of money, property, or service to the volunteer or employee, act or omission that occurred prior to the effective date of the District of Columbia Nonprofit Corporation Amendment Act of 1992, or act or omission that was not in good faith and was beyond the scope of authority of the corporation pursuant to this act or the corporate charter. This limitation of liability shall not apply to any licensed professional employee operating in his or her professional capacity. The Association is liable only to the extent of the applicable limits of insurance coverage it maintains.

Chapter XVIII: Amendments

Section A. Procedure to Amend the Bylaws. These Bylaws may be amended at an annual session of the House of Delegates by a two-thirds affirmative vote of the members present and voting, provided the proposed amendment is presented in writing to the House during the Opening Session. The vote on the amendment, or amendments, is taken during the Closing Session of the House of Delegates.

Section B. Procedure to Amend the Articles of Incorporation. The Articles of Incorporation of the Association may be amended at an annual session of the House of Delegates by a two-thirds affirmative vote of the members present and voting, provided the proposed amendment is
presented in writing to the House during the Opening Session. The vote on the amendment, or amendments, is taken during the closing session of the House of Delegates.
ADEA Policy Statements
As revised and approved by the 2008 House of Delegates

Introduction

These policy statements as revised by the 2008 House of Delegates are intended as recommendations and guidelines for dental and allied dental education institutions and programs and personnel.

When used in this document, “dental education” refers to all aspects of academic dental, allied dental, and advanced dental institutions, unless otherwise indicated.

When used in this document, the term “institution” refers to the academic unit in which the educational program is housed.

The general topic of each policy statement appears in boldface at the beginning of the statement. All policy statements are subject to a sunset review every five years.

I. Education

A. Admissions

All dental education institutions and programs should:

1. Diverse System of Higher Education

   • Support and help enhance the diverse system of higher education. Continued autonomy and growth in the private and public sectors depend on the preservation of this diversity. The nation’s private and public systems of higher education are complementary and interdependent. Their preservation depends on the continued attention of all institutional members and ADEA itself. Students must have the freedom to choose, from the broad spectrum of dental education institutions and programs, the institution or program best designed to meet the student’s specific needs.

2. Number and Types of Practitioners Educated

   • Use the public’s need and demand for dental services as the criteria for determining the number and types of practitioners educated at an academic dental institution; and in partnership with appropriate federal, state, and local health agencies and state and local dental societies, constantly assess those needs and demands and the ability of the existing number and distribution of practitioners to meet them. Through ADEA, work with appropriate federal and state agencies to ensure consistent methods for collecting and assessing data to monitor demographic, epidemiological, and professional practice trends, so that dental education institutions and programs do not over- or underproduce practitioners in given areas. Collaborate with state and local dental societies and jointly advocate for federal and state funds and programs that will assist academic dental institutions in meeting projected workforce number and composition requirements, along with incentives and programs designed to achieve a more equitable distribution of practitioners to improve access to oral health care.

3. Preprofessional Recruitment Programs

   • Encourage their faculty and students to develop and sponsor preprofessional recruitment programs that help potential students assess career options, financial considerations, and various educational programs. Target high school and college students and education counselors at all levels about career options and appropriate academic preparatory requirements and interface with other professional organizations in these efforts.
4. Admissions Criteria
   • Base admissions policies on specific objectives, criteria, and procedures designed to identify students with high standards of integrity, motivation, and resourcefulness and the basic knowledge and attitudes required for completing the curriculum. Nondiscriminatory policies should be followed in selecting students.

5. Recruitment, Retention, Access: Best Practices
   • The American Dental Education Association strongly endorses the continuous use of recruitment, admission, and retention practices that achieve excellence through diversity in American dental education. Dental education institutions and programs should identify, recruit, and retain underrepresented minority students and identify, recruit, and retain women students where inequities exist. Dental education institutions and programs should accept students from diverse backgrounds, who, on the basis of past and predicted performance, appear qualified to become competent dental professionals. Such efforts to achieve a diverse student body are predicated upon a highly qualified applicant pool and the support of private and public funding that benefits qualified disadvantaged individuals regardless of race, religion, ethnic background, gender, or sexual orientation. Dental education institutions should seek to identify and implement best practices in the recruitment and retention of underrepresented groups, including but not limited to:
     • Commitment and proactive leadership to diversity initiatives from deans and program directors;
     • Identification and implementation of admissions committee practices that promote diversity;
     • Identification and use of noncognitive factors in admissions decisions;
     • Regional collaboration among dental education programs to increase the numbers and qualifications of underrepresented individuals applying to dental education programs; and
     • Collaboration with other organizations focused on increasing the numbers of underrepresented minorities in the health professions.

6. Institutions and Programs That Are Closing
   • If ceasing to accept new applicants, 1) adhere to the policy of the Commission on Dental Accreditation on termination of accredited education programs, 2) make a strong effort to complete the training of matriculated students, and 3) ensure that the school’s or program’s educational standards are maintained. Should the closing institution/program be unable to maintain a quality program, however, the institution/program should facilitate the transfer of students to other accredited institutions/programs.

7. Accepting Students from Institutions and Programs That Are Closing
   • All academic dental institutions should accept students from academic dental institutions/programs that are closing and assist those students in continuing their education in a reasonable amount of time and at reasonable expense.

8. All predoctoral institutions should:
   • Preprofessional Education Requirements
     • Grant final acceptance only to students who have completed at least two academic years of preprofessional education (which must include all of the prerequisite courses for dental school), and who have completed the Dental Admission Test or the Canadian Dental Aptitude Test. Applicants should be encouraged to earn their baccalaureate degrees before entering dental school.
Early Selection Programs

- Have the option of waiving for students accepted for an early selection program the requirement for at least two years of pre-professional education. An early selection program is one where a formal and published agreement exists between a dental school and an undergraduate institution(s) that a student, either upon the student’s admission to the undergraduate institution or at some time before the completion of the student’s first academic year at the undergraduate institution, is guaranteed admission to the dental school, provided that the student successfully completes the dental school’s entrance requirements and normal application procedures.

Class to Which Applied

- Consider students for acceptance to only the class to which they have applied.

Earliest Notification Date

- Notify applicants, either orally or in writing, of provisional or final acceptance no earlier than December 1 of the academic year prior to the academic year of matriculation.

Applicant Response Periods

- Allow an applicant who has been given a provisional or final acceptance between December 1 and December 31 of the academic year prior to the academic year of matriculation a response period of no fewer than forty-five days to reply to the offer. For applicants who have been accepted between January 1 and January 31, the minimum response period shall be thirty days, and for applicants accepted on or after February 1, the minimum response period may be reduced to fifteen days. The response period may be lifted after July 15, or two weeks before the beginning of the academic year, whichever comes first.

Applicants Holding Positions at Multiple Institutions

- Dental schools participating in AADSAS will report to AADSAS by May 1 the names and identification numbers of candidates who have paid a deposit and/or hold a position in their entering class. After May 5, AADSAS will report to each institution the names of candidates in their entering class who are holding acceptance(s) at additional institutions. Dental schools will have the option of rescinding an offer of admission to candidates who have paid deposits and are holding positions at multiple institutions. Dental schools with candidates holding multiple positions on May 1 of the year of admission will give such candidates a minimum fifteen-day notice if they choose to withdraw them from the entering class. This policy will be evaluated every two years by the ADEA Section on Dental School Admissions Officers to assess its impact on applicants and dental schools and provide applicants a reasonable time frame to complete their enrollment process.

B. Ethics and Professionalism

Dental education institutions and programs should:

1. Ethical Behavior

   - Through faculty development and other means, emphasize to faculty the importance of ethical behavior in the profession and emphasize this importance to their students. Further, dental education institutions and programs should implement criteria with
appropriate due process procedures for dismissal or other actions when students violate ethical behavior.

2. Formal Instruction in Ethical and Professional Behavior
   • Provide students with formal instruction in ethics and professional behavior, and make the students aware of acceptable professional conduct in instructional and practice settings. Institutions and programs should ensure that student clinical experiences foster ethical patient care.

3. The Profession’s Societal Obligation
   • Ensure that both faculty and students are aware of the profession’s societal obligation. Provide formal instruction and faculty role models so that students clearly understand that society grants the privilege of professional education and self-regulation and that in return the oral health professional enters an implicit contract to serve the public good. Market forces, societal pressures, and professional self-interest should not compromise the professional objective of equitable and adequate oral health care for all Americans.

4. Serving in Areas of Need
   • Offer programs that encourage students to serve in areas of oral health care need. These programs should be equally available to all students at a given educational institution and, when possible, implement an interdisciplinary care model.

5. Community Service
   • Encourage students to participate in outreach programs and, upon graduation, to participate in community service.

6. Professional Organizations
   • Encourage students to participate in professional organizations.

7. Sexual Harassment Policy
   • Work with their parent institutions to have up-to-date policies and well-defined procedures for preventing and responding to incidents involving sexual harassment. Dental education institutions and programs should strive to go beyond legal compliance and risk management considerations to create and sustain a positive learning and working environment. While there are numerous definitions of sexual harassment, institutions and programs are encouraged to develop their own definitions that could be applied in a broad context, including *quid pro quo* and hostile environments.*
   • Dental education institutions and programs should, in concert with their parent institution, demonstrate their commitment to preventing and dealing with sexual harassment by:
     • educating faculty, staff, students, and residents about the issue;
     • employing prompt and equitable grievance procedures;
     • setting forth formal and informal procedures and sanctions for dealing with instances of sexual harassment;
     • creating an environment that encourages persons to come forward with problems;
     • ensuring that policies address sexual harassment by any individuals in an interactive or supervisory role, whether they be peers, patients, students, or a third party;
     • including safeguards protecting confidentiality and prohibiting retaliation or reprisals;
     • implementing a process to continually monitor all aspects of the policy; and
     • reviewing and updating the policy periodically.
8. Information Management
Dental education institutions and programs should demonstrate their commitment to the ethical and professional management of information by:
- a. educating faculty, staff, and students on the issues of copyright and fair use of information both professionally and personally;
- b. following copyright and fair use guidelines in the processes of information production and dissemination within the institution;
- c. providing faculty, staff, and students with formal instruction on “information privacy” including their rights and responsibilities in safeguarding information that is confidential, both to the institution and individuals; and
- d. following recognized guidelines, laws, and standards of care for management of patient information.

9. Confidentiality
- Educate staff, students, and faculty to respect and protect patient confidentiality as part of professional interactions.

C. Curriculum

Curriculum Management
All dental education institutions and programs should:

1. Control and Management of Curriculum
   - Accept the right and responsibility for the curricula and academic programs under their purview, including the elimination of unplanned redundant material and management of the density of the curricula.

2. Flexibility and Experimentation
   - Support curriculum flexibility, evaluation, and experimentation in teaching methods, and oppose any attempt to change state practice acts that restrict such flexibility and experimentation.

3. Student Performance
   - Use stated criteria and demonstrated competencies as the primary basis for judging student performance.

4. Course Changes
   - Defer anticipated changes in the objectives or other aspects of an ongoing course until the course is completed.

5. Examination Policies
   - Develop institution- and program-wide examination policies. These policies should address such areas as:
     - Examinations reflecting stated course objectives;
     - Informing students of examination results in a timely manner; and
     - Providing for faculty-student discussion of examination content and results.

6. Competencies
   - Provide all resources, including patient experiences, to allow students to reach competency and demonstrate continuing competency in all areas defined by the institution.

7. Dental Institution/Program Affiliations
   - Institute and periodically update formal affiliations among dental schools and dental hygiene, assisting, and laboratory technology education programs.

8. Curriculum Length
• **Predoctoral Programs**: should have four academic year curricula or the equivalent of four-year curricula provided in a flexible format.
• **Dental Hygiene Programs**: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.
• **Dental Assisting Programs**: should have curricula in a flexible format that consists of a minimum of one academic year or equivalent.
• **Dental Laboratory Technology Programs**: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.

9. Clinical Guidelines
   • Provide predoctoral, advanced, and allied students with written clinical guidelines and expectations for graduation as soon as possible.

Curriculum Content
All dental education institutions and programs should:
1. **Goals and Objectives**
   • Base their curricula on sound, current educational philosophy and pedagogy in order to achieve defined goals and objectives that reflect contemporary methods of oral health care delivery.
2. **New Ideas and Methods**
   • Introduce new ideas and methods in their teaching in order to meet the changing needs of their students and the patients they will serve.
3. **Physical, Biological, Technical, and Behavioral Sciences**
   • Teach their students the physical, biological, technical, and behavioral sciences relevant to the practice of modern oral health care delivery.
4. **Working Within an Integrated Health System**
   • Develop and support new models of oral health care that involve other health professionals as team members in assessing the oral health status of patients and teach dental students to assume leadership roles in the detection, early recognition, and management of a broad range of complex oral and general diseases and conditions. When possible, interdisciplinary educational opportunities should be pursued.
5. **Student-Patient Contact**
   • Develop, review, and maintain appropriate clinical policies to ensure optimum clinical education and patient-centered care.
6. **Dental Research**
   • Predoctoral, advanced dental, baccalaureate, and graduate dental hygiene programs: Teach the value, design, and methodology of dental research so that graduates may evaluate research findings and apply them to their practices.
   • Certificate or associate degree dental hygiene, dental assisting, and dental laboratory technician programs: Teach the value of and apply scientific concepts from research findings.
7. **Basic Cardiac Life Support**
   • Ensure appropriate training and certification in basic cardiac life support for all students before they begin clinical activity and throughout clinical training. The training should be basic cardiac life support for the health professional and should be provided in accordance with accepted standards and recommended guidelines.
8. **Oral Health Care Team**
   • Provide experiences working as a member of an interdisciplinary health care team.
9. **Information Technology**
• Provide formal instruction, develop skills, and provide opportunities in the use of computer-based applications and information systems. Support the timely access to information by faculty, staff, and students to enhance their knowledge, critical thinking, and decision-making processes and promote quality patient care.

10. Cultural and Linguistic Competence
• All dental education institutions should include cultural and linguistic concepts as an integral component of their curricula to facilitate the provision of oral health care services. Cultural and linguistic concepts should be included in the measurable dental curriculum objectives.

11. Care of Patients with Special Needs
• Work with the American Dental Association Commission on Dental Accreditation to adopt or strengthen accreditation standards at all levels of dental education related to competency in treatment of people with special needs. Include a requirement that graduates of dental education programs be able to manage or treat, consistent with their educational level, a variety of patients with complex medical and psychosocial conditions, including those with developmental and other disabilities, the very young, the elderly, and individuals with complex psychological and social conditions.

12. Preparation for Patients with Special Needs
• Include both didactic instruction and clinical experiences involving special population groups such as the elderly, the very young, and patients with mental, medical, or physical disabilities in pre- and postdoctoral education as well as allied dental education.

Dental hygiene education programs should:
1. Transfer of Credit
   • Design curricula that facilitate transfer of credit from certificate and associate degree programs to baccalaureate degree programs in the same or a related discipline.
2. Prepare Graduates for New and Emerging Responsibilities
   • Monitor and anticipate changes in supervision requirements within the state and modify the curriculum and extramural experiences of students so as to prepare them to provide more extended services in a variety of practice settings.
3. Collegiate-Level Dental Hygiene Curricula
   • Develop and maintain curricula that are collegiate-level and lead to an associate or higher degree.
4. Baccalaureate and Advanced Degree Hygiene Programs
   • Be encouraged to offer baccalaureate and advanced degree programs for dental hygienists.

D. Faculty Recruitment and Retention
All dental education institutions and programs should:
1. Faculty Qualifications
   Recruit faculty who have backgrounds in and current knowledge of the subject areas they are teaching and, where appropriate, educational theory and methodology, curriculum development, and test construction, measurement, and evaluation. Full-time dental assisting and dental laboratory technology faculty should hold a minimum of a baccalaureate degree. Full-time dental hygiene faculty should hold a minimum of a master’s degree or should be in the process of obtaining a master’s degree. Full-time dental faculty should hold a degree that is consistent with their teaching and research responsibilities.
2. Promotion Criteria
Develop and utilize promotion criteria that include teaching, research (if appropriate to the type of academic setting), and service, and relate those criteria to the activity assignment profile of each faculty member.

3. Faculty and Administrative Evaluation
   1) Evaluate faculty members’, including administrative personnel, effectiveness in order to improve the quality of the educational program; 2) see that evaluation is formal and encompasses all areas of faculty and administrative members’ activity assignment profiles; 3) conduct evaluation at scheduled intervals, with input from a broad cross-section of appropriate personnel at the institution; and 4) give evaluation results appropriate emphasis when reappointment, promotion, and tenure are being considered.

4. Gender and Minority Representation
   Identify, recruit, and retain underrepresented minorities to faculty positions and promote, when qualified, underrepresented minorities to senior faculty and administrative positions, proportional to their distribution in the general population. Appropriate gender equity should be a goal of any faculty recruitment, retention, and promotion plan.

5. Debt Repayment
   Develop funding sources for debt repayment for young faculty.

6. Alternative Compensation
   Creatively evaluate and implement nonmonetary incentives valued by faculty.

7. Allied Dental Faculty
   Employ, as faculty of dental students, allied dental personnel who are graduates of programs accredited by the Commission on Dental Accreditation or the Canadian Dental Association.

8. Mentoring Programs
   Develop and support formal mentoring programs as a means of recruiting, preparing, and retaining new dental and allied dental faculty, as well as a vehicle for developing and retaining existing faculty.

E. Faculty Development

Introduction
   Faculty development is a continuous process, providing opportunities for professional growth within the academic environment. The purpose of faculty development is to enhance the ability of faculty to perform their expected functions as dental educators. Faculty development programs should 1) cover teaching, research, and service; 2) assist faculty in selecting activities that fulfill their goals and those of the department and institution; and 3) prepare faculty to assume leadership positions in dental and higher education. The institution and faculty share the responsibility for seeking and supporting faculty development. Faculty development programs should be broad-based and meet individual programmatic needs.

   Dental education institutions and programs should:

1. Emphasize Faculty Development
   Emphasize faculty development by providing or making available in-service training, instructional development support, teaching evaluation reports, scholarly activities, academic promotion guidance, and the technical and behavioral skills that facilitate the academic growth of the individual faculty member. Programs to encourage and train additional future dental and allied dental educators should also be available. Programs to train additional dental and allied dental educators should include advanced education in the discipline, as well as educational pedagogy.

2. Mentoring Programs
   Mentoring programs for junior faculty should be developed and supported as a means of retaining faculty and ensuring their potential for future advancement. Such mentoring programs
also have the potential to encourage senior faculty to maintain their currency and to create collaborative research and scholarship opportunities.

3. Financial Support
   Provide financial support and other needed resources for faculty development programs, including incentives for faculty mentors.

4. Sabbaticals and Leaves
   Grant faculty sabbaticals and other leaves with the same frequency and on the same basis as for other academicians in the educational institution.

5. Evaluating Faculty Development Programs
   Periodically evaluate the availability, quality, and observable impact of faculty development initiatives in the departments, programs, sections, divisions, and other components of the institution or program.

F. Committees
   Dental education institutions and programs should:
   
   1. Student Members
      Allow students to serve as members with full standing on appropriate committees, with the student members’ privileges including, but not limited to, permission to 1) speak on any agenda items, 2) introduce and speak to any new business, and 3) vote on appropriate issues.

G. Counseling
   Dental education institutions and programs should:
   
   1. Financial Aid Obligations
      Encourage close working relationships between their admissions and financial aid offices in order to counsel students early and effectively on their financial aid obligations and debt management.
   
   2. Psychological
      Provide student psychological counseling services by formally trained individuals knowledgeable about the particular problems faced by faculty, staff, and students.
   
   3. Alcohol, Tobacco, and Other Drug Abuse
      Provide education on alcohol, tobacco, and other drugs of abuse.
   
   4. Referrals for Substance Abuse
      Provide faculty, staff, and students with confidential referral mechanisms on substance abuse evaluation and treatment.
   
   5. Advanced Education and Professional Opportunities
      Counsel students on postdoctoral education and professional opportunities, and counsel undergraduate allied dental students on baccalaureate and graduate education opportunities.
   
   6. Medical
      Provide education and counseling on chronic diseases.
   
   7. Academic Counseling
      Provide academic counseling, including time and stress management, and study and test-taking skills.
   
   8. Advanced Education and Career Choices
      Encourage students to consider careers in research, education, administration, dental public health service, and the military.

H. Accreditation
   Dental education institutions and programs should:
   
   1. Recognized Agencies
Participate in an accreditation program conducted by a nongovernmental agency recognized by the secretary of the U.S. Department of Education or its equivalent.

2. Commission on Dental Accreditation
   Recognize the Commission on Dental Accreditation and the Canadian Dental Association, through its Council on Education, as the official accrediting agencies for those dental and allied dental education programs within the purview of the commission and the Canadian Dental Association.

3. Non-Recognized Specialties
   Ensure that dental education programs in special areas not recognized by the Commission on Dental Accreditation undergo institutional and external review at intervals comparable to those for recognized programs.

4. Opposition to Preceptorship Training
   Oppose preceptorship training or other nonaccredited alternative programs for dentists, dental hygienists, dental assistants, and dental laboratory technicians.

I. Finance
   Federal and state governments should:

1. Public Funds for Dental Education
   Support public and private dental education institutions and programs, including providing funds to the fullest extent possible for student assistance, faculty salaries, maintenance, modernization, and construction of teaching facilities.

2. Funds for Advanced Education
   Provide support for advanced education programs preparing dentists and dental hygienists for careers in education, research, and public service.

3. Supplemental Funds
   Seek and use supplemental public and private funds if the conditions for accepting those funds do not jeopardize the quality of education or result in loss of control of the educational process. Institutions are encouraged to use such funds only for targeted projects and not for ongoing support.

4. Clinic Fee Schedules
   Adopt clinic fee schedules that adequately reflect the value of given services. Such reimbursement should be the same as that given to other providers in other settings for the same service. Further, dental education institutions and programs should ensure a fee schedule that promotes educational services to the student and provides care to the underserved.

5. Policies on Patient Debt Management and Fee Collections
   Provide students, before their clinical experience, with a written statement of the school’s policy on patient debt management and fee collection.

6. Support for Careers in Education, Research, and Public Service
   Provide fellowships, assistantships, loans, and loan forgiveness to support dental and allied dental personnel preparing for careers in education, research, and patient care services.

J. Advanced Education
   Dental education institutions and programs offering advanced education should:

1. Classic Education Patterns
   Conform their graduate dental education programs to classic educational patterns applicable to other academic disciplines, terminating in a graduate degree under the auspices of the university’s graduate school or a comparable agency of the university.

2. Requirements for Master’s and Doctoral Degrees
Award master’s and doctoral degrees in programs that include research and require a thesis or dissertation.

3. Specialty Program Requirements
Not require applicants to complete a general practice residency as a prerequisite for possible admission to a specialty education program.

4. Advanced Education Program Affiliations
Affiliate these advanced education programs with teaching hospitals and/or academic health centers, preferably those with dental schools or dental departments.

5. Promoting the Goal of Advanced Education
Coordinate the educational goals, objectives, and competencies of predoctoral and advanced education to effect a designed continuum of the educational phases of a dental practitioner and ensure readiness as one moves from phase to phase. Encourage all dental graduates to pursue postdoctoral dental education in an advanced general dentistry or other advanced dental education program and continue to monitor the feasibility of providing an opportunity for a year of advanced education for all dental graduates. If feasible, advocate that all dental graduates participate in a year of service and learning in an accredited PGY-1 program.

6. Advanced Education and Residency Positions in Primary Care Dentistry
Work to help ensure that the number of positions in advanced general dentistry and other advanced education programs in primary care dentistry is adequate to provide all dental graduates an opportunity to pursue postdoctoral dental education.

7. Funding
Advocate for increased funding and loan forgiveness for General Practice Residency and Advanced Education in General Dentistry Programs and accredited advanced dental education programs, particularly primary care programs, so that the number of positions and funding are sufficient to provide opportunities for all dental graduates to pursue a year of service and learning in an accredited PGY-1 program.

8. Graduate Medical Education (GME)
Work with hospitals and organized dentistry groups to increase the number of and funding for dental residency training positions through GME.

9. Stipends
Whenever possible, provide stipends to dental residents and allied dental students in advanced education and clinical specialty programs.

Dental schools should:
1. Disclosure of Class Rankings. Disclose (with student consent) the class rankings, or equivalent measures of performance, of students applying to advanced education programs.

2. Integration of New Knowledge and Skills. Allow for dynamic incorporation of new knowledge and skills and/or standards of care.

3. Interdisciplinary Communication. Develop mechanisms for effective communication between organizations establishing credentialing and accreditation of advanced dental education training programs/residencies and those administering programs, as well as between the specialties themselves. Develop constructive relations between ADEA sections representing advanced education and specialty boards or organizations bestowing status on practicing members.

K. Continuing Education
Dental education institutions and programs should:

1. Encouragement
   Strongly encourage their students to become lifelong learners and to participate meaningfully in continuing education throughout their professional careers.
2. Student Attendance  
   Give their students an opportunity to attend continuing education courses and professional development opportunities.
3. Faculty Participation  
   Create incentives for their faculty to conduct, attend, or participate in continuing education courses, and recognize attendance at ADEA annual sessions as a continuing education activity.
4. Content  
   Offer continuing education programs in the clinical, technical, behavioral, and biomedical sciences to improve the competencies of practitioners in general and specialty practice areas.
5. Cooperation with Dental, Allied Dental, and Other Professional Organizations  
   Cooperate with appropriate dental organizations in providing continuing education.
6. Evaluation  
   Frequently evaluate their continuing education courses for quality and content, soliciting impressions from appropriate groups about their continuing education needs.
7. Community Service  
   Develop mechanisms for academic dental institutions to encourage learning and to provide ongoing services in the form of information and training to former students and area professionals.

II. Research

A. Fundamental and Applied Research  
   Dental education institutions and programs have the right and responsibility to conduct fundamental and applied research in the natural and social sciences and in the area of health services, in particular as it relates to oral health disparities. Dental education institutions and programs should actively foster and support basic and applied clinical research. Incentives should be provided to encourage both faculty and students to actively participate in research as appropriate to the type of academic setting.

B. Research Findings in Courses  
   Dental educators should be expected to include new information and research findings in their courses of instruction and to encourage students to engage in critical thinking and research. Students should be encouraged to contribute to the development of new knowledge for the profession.

C. Commercial Sponsors  
   ADEA encourages dental education institutions and programs and dental educators to interact with commercial and other extramural sponsors of research, clinical trials, and demonstration projects, under conditions in which the academic rights of faculty are protected. These conditions include rights of publication, ownership of intellectual property, and rights of patent and copyright within institutional policy, subject to appropriate contractual protection of the sponsor’s legitimate interests.

D. Publication of Commercially Sponsored Research  
   ADEA encourages publication by faculty of the results of research, clinical trials, and demonstration projects supported by commercial and other extramural sponsors. Peer review by scientist/educators with expertise in the relevant field(s) of the research or project is the best means of ensuring the quality of the publication. ADEA discourages submission of manuscripts to any publisher that allows sponsors of the work to influence editorial policy or judgment after the completion of the peer review process.
E. Excellence in Teaching
Dental education institutions and programs should promote excellence in teaching through active programs of research on the teaching/learning process. Faculty members should be encouraged to conduct both quantitative and qualitative studies of educational programming including case studies that examine the impact of these various educational programs on student attainment of outcomes.

F. Scholarship
Dental education institutions and programs should encourage a broad range of scholarship from their faculty. Faculty members should be encouraged and rewarded, if appropriate to the academic setting, through the tenure and/or promotion and review process for systematically developing and validating new educational programs; for evaluating, analyzing, and interpreting the impact of educational programs on students and patients; and for publishing reports of these endeavors.

III. Licensure and Certification

A. Goals
ADEA supports achievement of the following goals for dentists and dental hygienists who are students or graduates of accredited programs and have successfully completed the National Board Dental Examinations or the National Board Dental Hygiene Examinations: freedom in geographic mobility; elimination of those licensure and regulatory barriers that restrict access to care; elimination of the use of patients in clinical examinations; and high reliability of any licensure examination process and content as well as predictive validity of information used by licensing authorities to make licensing decisions.

B. Achieving Goals
In order to achieve these goals, the Association should work diligently, both independently and cooperatively, with appropriate organizations and agencies, to support appropriate demonstration projects, pilot programs, and other ways to explore development of alternative testing methods and to develop uniform, valid, and reliable methods that can be used nationally to measure the competencies necessary for safe entry into independent practice as licensed dentists and legally authorized practice as licensed dental hygienists. In the interest of ensuring high-quality oral health care, ADEA has always supported periodic third-party evaluation of dental and dental hygiene students and graduates through mechanisms like the National Dental and Dental Hygiene Board Examinations. In considering the clinical competence of dental and dental hygiene students and graduates, ADEA also supports the development and administration of a national clinical examination. ADEA also supports with the American Dental Association the principle that a clinical examination requirement may also be met by successful completion of a postgraduate program in a general dentistry or dental specialty training program, at least one year in length, which is accredited by the Commission on Dental Accreditation.

ADEA also strongly supports development of means for licensing authorities to assess continuing competency. With valid, reliable, and fair methods for continuing competency determinations, initial licensure examinations may become unnecessary.

C. Allied Dental Personnel
In addition, the Association supports the following principles concerning the licensure and certification of allied dental personnel. Qualified dental hygienists should be appointed to all
agencies legally authorized to grant licenses to practice dental hygiene. Dental hygienists should participate in the examination of candidates for dental hygiene licensure and be full voting and policymaking members of licensing authorities in all matters relating to the practice of dental hygiene. Successful completion of an accredited program should be a prerequisite for eligibility for the certification examination of the National Board for Certification of dental laboratory technicians and the Dental Assisting National Board for dental assistants.

D. Preparing Students for Licensure in Any Jurisdiction

Institutions that conduct dental and allied dental education programs have the right and responsibility to prepare students for licensure examinations in any jurisdiction in the United States, Puerto Rico, and Canada.

Individuals or students applying for dental hygiene licensure in any jurisdiction must successfully complete the didactic, laboratory, and clinical instruction and meet the competencies for providing patient care as required by the dental education Accreditation Standards of the Commission on Dental Accreditation.

IV. Access and Delivery of Care

A. Health Care Delivery and Quality Review

Dental education institutions and programs and ADEA should be leaders in developing effective health care delivery systems and quality review mechanisms and in preparing their students to participate in them.

B. Scope of Services

Dental education institutions and programs should provide treatment consistent with contemporary standards of care.

C. Dental Health Personnel

Dental educators and ADEA should inform policymakers and the public that:

1. Dental education institutions and programs are important national, regional, state, and community resources.
2. Dental education institutions and programs have a vital role in providing access to oral health care to all, with special consideration for the underserved.
3. Dental education institutions and programs are a vital component of the health sciences segment of universities.
4. Dental education institutions and programs, through their graduates, contribute significantly to meeting the oral health needs of the public.
5. Dental education institutions and programs collaborate and create linkages with community-based agencies to increase access to care.
6. Dental education institutions and programs prepare their graduates to provide services in a variety of settings to reduce barriers to care and provide more accessible care to various population groups.

D. Dental Insurance, Federal, and State Programs

ADEA should be a strong advocate on both the federal and state levels for:

1. Strengthening reimbursement and inclusion of meaningful dental and oral health care services provided under Medicaid and the State Children’s Health Insurance Program.
2. Strengthening Medicare by seeking inclusion of medically necessary oral health care services for populations covered under the program.
3. Encouraging states to appoint a chief dental officer for every state.
4. Educating federal and state policymakers about the lack of dental insurance and its relationship to access to oral health care for underserved and unserved populations.

V. Health Promotion and Disease Prevention

A. Standards
   Dental education institutions and programs have the obligation to maintain standards of health care and professionalism that are consistent with the public’s expectations of the health professions.

B. Dental Caries
   1. Fluoride. ADEA supports and encourages fluoridation of community water supplies and the use of topical fluoride. Community water fluoridation is safe, practical, and the most cost-effective measure for the prevention of dental caries.
   2. Dental Sealants. ADEA supports and encourages widespread use of dental sealants and fluoride varnishes as a significant cost-effective primary preventive method for the prevention of dental caries.

C. Periodontal Disease
   1. ADEA supports and encourages research into the correlation between oral and general health, including the possible link between periodontal disease and heart and lung diseases, stroke, diabetes, low birth rates, and premature births.
   2. ADEA supports and encourages the education of students, professionals, and the public on behaviors that will prevent disease and promote health, including preventive oral health care measures, proper nutrition, and tobacco cessation.

D. Infectious Diseases
   1. Human Dignity. All dental personnel are ethically obligated to provide patient care with compassion and respect for human dignity.
   2. Refusal to Treat Patients. No dental personnel may ethically refuse to treat a patient solely because the patient is at risk of contracting, or has, an infectious disease, such as human immunodeficiency virus (HIV) infection, acquired immunodeficiency virus (AIDS), or hepatitis B or C infections. These patients must not be subjected to discrimination.
   3. Confidentiality of Patients. Dental personnel are ethically obligated to respect the rights of privacy and confidentiality of patients with infectious diseases.
   4. Confidentiality of Faculty, Student, and Staff. Dental education institutions and programs are ethically obligated to protect the privacy and confidentiality of any faculty member, student, or staff member who has tested positive for an infectious disease. Dental personnel who pose a risk of transmitting an infectious agent must consult with appropriate health care professionals to determine whether continuing to provide professional services represents a material risk to the patient. If a dental faculty, student, or staff member learns that continuing to provide professional services represents a material risk to patients, that person should so inform the chief administrative officer of the institution. If so informed, the chief administrative officer should take steps consistent with the advice of appropriate health care professionals and with current federal, state, and/or local guidelines to ensure that such individuals not engage in any professional activity that would create a risk of transmission of the infection to others.
   5. Counseling and Follow-Up Care. The chief administrative officer must facilitate appropriate counseling and follow-up care, and should consider establishing retraining and/or counseling programs for those faculty, staff, and students who do not continue to
perform patient care procedures. Such counseling should also be available to students who find they cannot practice because of 1) permanent injury that occurs during dental training, 2) illnesses such as severe arthritis, 3) allergies to dental chemicals, or 4) other debilitating conditions. Dental education institutions and programs should make available institutional guidelines and policies in this area to current and prospective students, staff, and faculty.

6. Protocols. Chief administrative officers of dental education institutions and programs must establish and enforce written preclinical, clinical, and laboratory protocols to ensure adequate asepsis, infection and hazard control, and hazardous waste disposal. These protocols should be consistent with current federal, state, and/or local guidelines and must be provided to all faculty, students, and appropriate support staff. To protect faculty, students, staff, and patients from the possibility of cross-contaminations and other infection, asepsis protocols must include a policy in adequate barrier techniques, policies, and procedures.

7. Testing for Infectious Diseases and Immunization. Chief administrative officers must facilitate the availability of testing of faculty, staff, and students for those infectious diseases presenting a documented risk to dental personnel and patients. Further, the administrative officers must make available the hepatitis B vaccine and appropriate vaccine follow-up to employees such as faculty and staff, in accordance with Occupational Safety and Health Administration (OSHA) regulations. Also, in accordance with Centers for Disease Control and Prevention (CDC) guidelines, all students should 1) demonstrate proof of immunity, 2) be immunized against the hepatitis B virus as part of their preparation for clinical training, or 3) formally decline vaccination. Students who decline to be vaccinated should be required to sign a formal declination waiver form, consistent with procedures promulgated by OSHA for employees. Chief administrative officers should also strongly encourage appropriate faculty, staff, and students to be immunized against not only hepatitis B, but also other infectious diseases such as mumps, measles, and rubella, using standard medical practices. In addition, all dental education institutions and programs should require prematriculation and annual testing for tuberculosis.

E. Alcohol, Tobacco, and Other Drug Hazards

1. Discouraging Alcohol, Tobacco, and Other Drug Abuse. Institutional and individual members are urged to:
   - discourage use of excessive amounts of alcohol,
   - discourage the use of illegal and/or harmful drugs,
   - establish tobacco-free environments and tobacco use policies,
   - incorporate information about the adverse health effects of all types of tobacco in course offerings and its application to clinical practice, and
   - provide training on general, culturally competent, and gender-specific tobacco prevention and cessation techniques for application in clinical practice.

2. Tobacco-Free Environments
   Institutional and individual members should have tobacco-free environments on their campuses and in their health science centers and patient-care facilities. Institutions should also encourage and support continued research related to the health effects of tobacco use.

3. Community Education Programs
   Institutional and individual members are encouraged to participate in the development of community education programs dealing with the health hazards of alcohol, tobacco, and other drug use.

F. Child Abuse/Neglect and Domestic Violence

1. Familiarity with Signs and Symptoms
Dental and allied dental education institution officials and educators should become familiar with all signs and symptoms of child abuse/neglect and family violence that are observable in the normal course of a dental visit and should report suspected cases to the proper authorities, consistent with state laws.

2. Instruction in Recognizing Signs

Dental and allied dental education institution officials and educators should instruct all of their students, faculty, and clinical staff on how to recognize all signs and symptoms of child abuse/neglect and domestic violence observable in a dental visit and how to report suspected cases to the proper authorities, consistent with state laws.

3. Monitoring Regulations

Dental and allied dental education institution officials should monitor state and federal legislative and regulatory activity on child abuse/neglect and family violence and make information on these subjects available to all students, faculty, and clinical staff.

VI. Partnerships

A. Dental education institutions and programs and ADEA should develop partnerships among health care organizations, corporate entities, and state and federal government to collectively educate the public on the importance of oral health and the significant role it has in total health.

B. Dental education institutions and programs should prepare graduates to work with community-based programs to expand disease prevention and health promotion techniques to meet the needs of various populations including the indigent, minorities, the elderly, and other underserved groups.

C. Dental education institutions and programs and ADEA should create, expand, and enhance awareness and a strong knowledge base among lawmakers and the public about the role of oral disease on total health.

VII. Public Policy Advocacy

A. ADEA and its membership should work together to identify and promote emerging issues in public policy and take action to secure federal and state policies and programs that support the mission of ADEA.

B. ADEA should work to form and maintain strategic alliances that will promote the public policy objectives of the Association.

C. Dental educators should participate actively in promoting and securing public policy objectives with federal, state, and local executive branch and legislative bodies that promote and secure the public policy issues of ADEA.

D. Dental educators and students should work to ensure that policy decisions that may critically affect dental education be formulated in conjunction with representatives of appropriate educational institutions and organizations.