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Schedule of the ADEA House of Delegates

Opening of the ADEA House of Delegates

Saturday, March 17, 2007, 4:30 – 5:30 p.m., Hilton New Orleans Riverside, Grand Ballroom C and D

Voting for President-elect

Sunday, March 18, ballots may be cast between the hours of 8:00 a.m. and 5:00 p.m., ADEA registration area in front of Hall J, Ernest N. Morial Convention Center

Monday, March 19, ballots may be cast between the hours of 8:00 a.m. and 5:00 p.m., ADEA registration area in front of Hall J, Ernest N. Morial Convention Center

Tuesday, March 20, ballots may be cast between the hours of 8:00 a.m. and 5:00 p.m., ADEA registration area in front of Hall J, Ernest N. Morial Convention Center

Reference Committee Hearings

Reference Committee on Association Administrative Affairs
  Tuesday, March 20, 1:15 to 2:15 p.m., Convention Center Room 296

Reference Committee on Association Policy is scheduled from
  Tuesday, March 20, 3:00 to 4:00 p.m., Convention Center Room 296

Closing of the ADEA House of Delegates

Wednesday, March 21, noon to 1:00 p.m., Hilton New Orleans Riverside, Grand Ballroom C and D

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 23. For the names of the members of the Reference Committees and the resolutions assigned to them, please see pages 20 and 21.
Members of the 2007 ADEA House of Delegates

ADEA Board of Directors

Dr. Kenneth L. Kalkwarf, President, University of Texas Health Science Center at San Antonio
Dr. Eric J. Hovland, Immediate Past President, Louisiana State University
Dr. James Q. Swift, President-Elect, University of Minnesota
Prof. Cheryl Westphal, Vice President for Allied Dental Program Directors, New York University
Ms. Candy B. Ross, Vice President for the Corporate Council, DEXIS
Dr. Ronald J. Hunt, Vice President for Deans, Virginia Commonwealth University
Dr. John W. Killip, Vice President for Faculties, University of Missouri-Kansas City
Dr. Sheila H. Koh, Vice President for Hospitals and Advanced Educational Programs, University of Texas Health Science Center at Houston
Dr. Sandra C. Andrieu, Vice President for Sections, Louisiana State University
Dr. Christopher S. Arena, Vice President for Students, University of Medicine and Dentistry of New Jersey
Dr. Richard W. Valachovic, Executive Director, American Dental Education Association

ADEA Council of Allied Dental Program Directors

Administrative Board
Dr. Susan Bailey Crim, Chair, University of Louisville
Dr. Cindy Amyot, Chair-elect, University of Missouri-Kansas City
Dr. Susan Kass, Secretary, Miami-Dade College
Prof. Tami Grzesikowski, Member-at-Large, St. Petersburgh College
Prof. Cheryl Westphal, Vice President, New York University

Additional Delegates

Dental Assisting
Prof. Colleen Bradshaw, Palm Beach Community College
Dr. Carolyn Breen, University of Medicine and Dentistry of New Jersey
Prof. Donna Estes, Texas State Technical College

Dental Hygiene
Dr. Shirley Beaver, Kennedy-King College
Dr. Susan Duley, Clayton State University
Dr. Ellen Grimes, University of Vermont
Prof. Gwen Hlava, University of Nebraska
Prof. Shawn Kiser, Pennsylvania College of Technology
Prof. Carrie Mason, Louisiana State University
Dr. Sally Mauriello, University of North Carolina at Chapel Hill
Prof. Trisha Nunn, Utah College of Dental Hygiene
Prof. Lisa Rowley, Pacific University
Prof. Paula Spaight, San Juan College
Dental Laboratory Technology
Prof. Lenny Aucoin
Louisiana State University

Special/Advanced Programs
Prof. Sheryl Syme
University of Maryland

ADEA Council of Deans

Administrative Board
Dr. Jerold S. Goldberg, Chair, Case School of Dental Medicine
Dr. Richard N. Buchanan, Chair-elect, University at Buffalo
Dr. John N. Williams, Secretary, University of North Carolina at Chapel Hill
Dr. Teresa A. Dolan, Member-at-Large, University of Florida
Dr. Ronald J. Hunt, Vice President, Virginia Commonwealth University

Additional Delegates
Dr. Carole A. Anderson
The Ohio State University
Dr. Charles N. Bertolami
University of California, San Francisco
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. Wood E. Currens
University of Louisville
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. 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. Spencer N. Frankl
Boston University
Dr. Steven W. Friedrichsen
Creighton University
Dr. Russell O. Gilpatrick
University of Tennessee
Dr. Jerold S. Goldberg
Case School of Dental Medicine
Dr. Lawrence Goldblatt
Indiana University
Dr. Charles Goodacre
Loma Linda University
Dr. Bruce Graham
University of Illinois at Chicago
Dr. James R. Hupp
University of Mississippi
Dr. Marjorie K. Jeffcoat
University of Pennsylvania
Dr. David Johnsen
University of Iowa
Dr. Denise K. Kassebaum
University of Colorado
Dr. James J. Koelbl
West Virginia University
Dr. Ira B. Lamster
Columbia University
Dr. Parick M Lloyd
University of Minnesota
Dr. William K. Lobb Marquette University
Dr. R. Lamont MacNeil University of Connecticut
Dr. Lonnie H. Norris Tufts University
Dr. No Hee Park University of California, Los Angeles
Dr. Peter J. Polverini University of Michigan
Dr. Michael J. Reed University of Missouri-Kansas City
Dr. John W. Reinhardt University of Nebraska
Dr. Barry R. Rifkin Stony Brook University
Dr. Yilda Rivera University of Puerto Rico
Dr. Leo E. Rouse Howard University
Dr. John J. Sanders Medical University of South Carolina
Dr. Victor A. Sandoval University of Nevada, Las Vegas
Dr. Harold C. Slavkin University of Southern California
Dr. Martha J. Somerman University of Washington
Dr. H. Robert Steiman University of Detroit Mercy
Dr. Christian S. Stohler University of Maryland
Dr. Martin F. Tansy The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Huw F. Thomas University of Alabama
Dr. Sharon P. Turner University of Kentucky
Dr. Robert A. Uchin Nova Southeastern University
Dr. Richard I. Vogel New York University
Dr. Stephen K. Young University of Oklahoma

Non-Hospital Based Advanced Dental Education Programs
Dr. Rolf G. Behrents Saint Louis University
Dr. Dominick P. DePaola Forsyth Institute
Dr. Cyril Meyerowitz University of Rochester
Dr. Roger L. Nelson Mayo Graduate School of Medicine
Dr. Steven R. Sewall Medical College of Wisconsin

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 Kay H. Malone United States Army
Colonel David F. Murchison United States Air Force Dental Service
Captain Robert M. Taft United States Navy Dental Corps
Dr. Timothy O. Ward Department of Veterans Affairs

Association of Canadian Faculties of Dentistry
Dr. Marie E. Dagenais McGill University
ADEA Council of Faculties

Administrative Board
Dr. Diane C. Hoelscher, Chair, University of Detroit Mercy
Dr. Patricia Nihill, Chair-elect, University of Illinois at Chicago
Dr. Nadeem Karimbux, Secretary, Harvard School of Dental Medicine
Dr. Michael A. Siegel, Member-at-Large, Nova Southeastern University
Dr. John W. Killip, Vice President, University of Missouri-Kansas City

Additional Delegates
Dr. Nancy S. Arbee, Tufts University
Dr. Laura Caroline Barratt, Creighton University
Dr. Patricia A. Bauer, University of Michigan
Dr. Carol A. Bibb, University of California, Los Angeles
Dr. Daniel W. Boston, The Maurice H. Kornberg School of Dentistry, Temple University
Dr. Grishondra Branch-Mays, University of Maryland
Dr. B. Ellen Byrne, Virginia Commonwealth University
Dr. Madelyn Coar, University of Alabama
Dr. Thomas L. Coury, University of Oklahoma
Dr. Marsha A. Cunningham, University of Iowa
Dr. Joseph A. D’Ambrosio, University of Connecticut
Dr. Debra A. Dixon, Southern Illinois University
Dr. Kenneth R. Etzel, University of Pittsburgh
Dr. Vicky Evangelidis-Sakellson, Columbia University
Dr. Simpson Evans, University of Tennessee
Dr. Kim E. Fenesy, University of Medicine and Dentistry of New Jersey
Dr. Nicholas J. Grimaudo, University of Florida
Dr. John F. Guarente, Boston University
Dr. Kevin M. Gureckis, University of Texas Health Science at San Antonio
Dr. Wayne W. Herman, Medical College of Georgia
Dr. Edwin H. Hines, Meharry Medical College
Dr. Andrea D. Jackson, Howard University
Dr. T. Roma Jasinevicius, Case School of Dental Medicine
Dr. Bernard Aaron Karshmer, University of Colorado
Dr. Gordon G. Keyes, West Virginia University
Dr. Kenneth Arthur King, University of Tennessee
Dr. Lisa J. Koenig, Marquette University
Dr. Allan J. Kucine, Stony Brook University
Dr. Peter M. Loomer, University of California, San Francisco
Dr. Ana Nereida Lopez, University of Puerto Rico
Dr. William P. Lundergan, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Michael D. McCunniff, University of Missouri-Kansas City
Dr. 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. John E. Peterson  Loma Linda University
Dr. Elizabeth S. Pilcher  Medical University of South Carolina
Dr. David L. Pitts  University of Washington
Dr. Karin Quick  University of Minnesota
Dr. Robert G. Rashid  The Ohio State University
Dr. Sandra K. Rich  University of Southern California
Dr. Francis G. Serio  University of Mississippi
Dr. Yolanda Annetta Slaughter  University of Pennsylvania
Dr. Chet A. Smith  Louisiana State University
Dr. Robert D. Spears  Baylor College of Dentistry
Dr. Henry St. Germain  University of Nebraska
Dr. Jeffery C.B. Stewart  Oregon Health & Science University
Prof. Donna P. Warren-Morris  University of Texas Health Science Center at Houston
Dr. Karen P. West  University of Kentucky
Dr. Wendy Sue Woodall  University of Nevada, Las Vegas
Dr. Sherrie W. Zaino  University of Louisville

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**ADEA Council of Sections**

**Administrative Board**
Dr. Ronald W. Botto, Chair, University of Illinois at Chicago
Dr. Lily T. Garcia, Chair-elect, University of Texas Health Science Center at San Antonio
Dr. William Davenport, Secretary, University of Nevada, Las Vegas
Dr. Allen Otsuka, Member-at-Large, Southern Illinois University
Dr. Sandra C. Andrieu, Vice President, Louisiana State University

**Additional Delegates**

**Academic Affairs**
Dr. Birgit Junfin Glass, Councilor, University of Texas Health Science Center at San Antonio
Dr. Karen P. West, Chair, University of Kentucky

**Anatomical Sciences**
Dr. Jennifer Brueckner, Councilor, University of Kentucky
Dr. Pamela Stein, Chair, University of Kentucky

**Behavioral Sciences**
Dr. Evelyn L. Donate-Bartfield, Councilor, Marquette University
Dr. Marita Rohr Inglehart, Chair, University of Michigan

**Biochemistry and Nutrition**
Dr. Alan E. Levine, Councilor, University of Texas Health Science Center at Houston
Prof. Linda Boyd, Chair, Georgia Perimeter College

**Business and Financial Administration**
Mr. Kenneth Tomlinson, Councilor (Interim), University of Florida
Mr. John Barch, Chair (Interim), University of Texas Health Science Center at San Antonio
Clinic Administration
Dr. Lex MacNeil, Councilor, University of British Columbia
Dr. Mert Aksu, Chair, University of Detroit Mercy

Clinical Simulation
Dr. Frank Licari, Councilor, University of Illinois at Chicago
Dr. Dr. Riki Gottlieb, Chair, Virginia Commonwealth University

Community and Preventive Dentistry
Dr. Val Spolsky, Councilor, University of California, Los Angeles
Dr. Donna Grant-Mills, Chair, Howard University

Comprehensive Care and General Dentistry
Dr. Alan W. Budenz, Councilor, University of the Pacific Arthur A. Dugoni School of Dentistry
Dr. Fred Fendler, Chair, University of the Pacific Arthur A. Dugoni School of Dentistry

Continuing Education
Dr. William Butler, Councilor, University of Texas Health Science Center at San Antonio
Dr. Vincent Liberto, Chair, Louisiana State University

Dental Anatomy and Occlusion
Dr. Sheryl Kane, Major, Councilor, United States Air Force
Dr. Stanley Nelson, Chair, University of Nevada, Las Vegas

Dental Assisting Education
Prof. Linda Stewart, Councilor, University of North Carolina at Chapel Hill
Prof. Ethel Campbell, Chair, University of North Carolina at Chapel Hill

Dental Hygiene Education
Prof. Lorie A. Holt, Councilor, University of Missouri-Kansas City
Prof. Elizabeth Hughes, Chair, Indiana University

Dental Informatics
Dr. Elise S. Eisenberg, Councilor, New York University
Dr. David Ord, Chair-elect, University of Nevada, Las Vegas

Dental School Admissions Officers
Dr. Joseph McManus, Councilor, Columbia University
Ms. Anne Berg, Chair, Harvard School of Dental Medicine

Development, Alumni Affairs, and Public Relations
Ms. Joanne L. Mayne, Councilor, University of Southern California
Mr. Brooks Scudder, Chair, University of Kentucky

Educational Research/Development and Curriculum
Dr. Judith Skelton, Councilor, University of Kentucky
Dr. Margrit Maggio, Chair, University of Pennsylvania
Endodontics
Dr. Roberta Pileggi, Councilor, University of Florida
Dr. Bruce C. Justman, Chair, University of Iowa

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

Graduate and Postgraduate Education
Dr. Gerald Glickman, Councilor, Baylor College of Dentistry
Dr. Harvey Kessler, Chair, Baylor College of Dentistry

Microbiology
Dr. M. Jane Gillespie, Councilor, Southern Illinois University
Dr. Karl Kingsley, Chair, University of Nevada, Las Vegas

Minority Affairs
Dr. Todd Ester, Councilor, University of Michigan
Dr. Cherae Farmer-Dixon, Chair, Meharry Medical College

Operative Dentistry and Biomaterials
Dr. Kevin Frazier, Chair, Medical College of Georgia
Dr. Alan Ripps, Chair-elect, Louisiana State University

Oral and Maxillofacial Radiology
Dr. Margot Van Dis, Councilor, Indiana University
Dr. Robert Cederberg, Chair, Arizona School of Dentistry and Oral Health

Oral and Maxillofacial Surgery/Anesthesiology/Hospital Dentistry
Dr. William Synan, Councilor, University of Iowa
Dr. Michael Goupil, Chair, University of Connecticut

Oral Biology
Dr. Mark S. Wolff, Councilor, New York University
Dr. Anthony Iacopino, Chair, Marquette University

Oral Diagnosis/Oral Medicine
Dr. Thomas P. Shopper, Councilor, Louisiana State University
Dr. Michael Landers, Chair, Case School of Dental Medicine

Orthodontics
Dr. David Covell, Councilor, Oregon Health & Science University
Dr. Calogero Dolce, Chair, University of Florida

Pathology
Dr. Alice Curran, Councilor, University of North Carolina at Chapel Hill
Dr. Michael Kahn, Chair, Tufts University
**Pediatric Dentistry**
Dr. Joan Kowolik, Councilor, Indiana University
Dr. Neva Penton Eklund, Chair, University of Mississippi

**Periodontics**
Dr. Dwight McLeod, Councilor, Southern Illinois University
Dr. Sharon Lanning, Chair, University of Michigan

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

**Postdoctoral General Dentistry**
Dr. Heidi Crow, Councilor, University at Buffalo
Dr. Craige Olson, Chair, University of Utah Health Science Center

**Practice Administration**
Dr. Dave Dunning, Councilor, University of Nebraska
Dr. Mildred Arroyo McClain, Chair, University of Nevada, Las Vegas

**Prosthodontics**
Dr. Lisa Lang, Councilor, University of Texas Health Science Center at San Antonio
Dr. Kenneth Gehrke, Chair, University of Illinois at Chicago

**Student Affairs and Financial Aid**
Dr. Carolyn Booker, Councilor, Virginia Commonwealth University
Dr. H. Philip Pierpont, Chair, University of Texas Health Science Center at Houston

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

**Administrative Board**
Dr. Todd E. Thierer, Chair, University of Rochester
Dr. Stephen Wilson, Chair-elect, Cincinnati Children’s Hospital
Dr. C. Lynn Hurst, Secretary, University of Nevada, Las Vegas
Dr. John R. Agar, Member-at-Large, University of Connecticut
Dr. Sheila H. Koh, Vice President, University of Texas Health Science Center at Houston

**Additional Delegates**
Dr. Tracy Dellinger, University of Mississippi, Academy of General Dentistry/AEGD
Dr. Robert J. Flinton, University of Medicine and Dentistry of New Jersey, American College of Prosthodontists
Dr. George Gallagher, Boston University, American Academy of Oral and Maxillofacial Pathology
Dr. Paul Glassman, University of the Pacific Arthur A. Dugoni School of Dentistry, Special Care Dentistry/GPR
Dr. Vincent J. Iacono, Stony Brook University, American Academy of Periodontology
Dr. William T. Johnson, University of Iowa, American Association of Endodontists
Dr. Katherine Kula, University of Missouri-Kansas City, American Association of Orthodontists

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as of March 14, 2007
Dr. George M. Kushner  University of Louisville, American Association of Oral and Maxillofacial Surgeons
Dr. Alan Lurie  University of Connecticut, American Academy of Oral and Maxillofacial Radiology
Dr. Neva P. Eklund  American Academy of Pediatric Dentistry
Dr. Robert J. Weyant  American Association of Public Health Dentistry

ADEA Council of Students

Administrative Board
Mr. Chad Foster, Chair, University of Southern California
Mr. Joseph Field, Chair-elect, University of Southern California
Ms. Dayne Jensen, Secretary, University of Nevada, Las Vegas
Mr. Garrett Criswell, Member-at-Large, University of California, San Francisco
Dr. Christopher Arena, Vice President, University of Medicine and Dentistry of New Jersey

Additional Delegates
Predoctoral Dental Students-Northeast
Mr. Daniel Callahan  Tufts University
Mr. Karn Dev  Boston University

Predoctoral Dental Students-Southeast
Ms. Shelly Prakash  University of Florida
To be determined

Predoctoral Dental Students-South Central
Ms. Liza Shevchenko  University of Texas Health Science Center at Houston
Mr. Steve Tseng  University of Texas Health Science Center at San Antonio

Predoctoral Dental Students-Midwest
Ms. Kelli Jobman  University of Nebraska
Mr. Daren Mairs  University of Iowa

Predoctoral Dental Students-Pacific
Dr. Julio Escobar  University of California, San Francisco
To be determined

Predoctoral Dental Students-Ohio Valley
Mr. Darryl Gilmore  Howard University
Mr. Matthew Gornick  University of Pittsburgh

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

Postdoctoral Dental Students- Non-Hospital Programs
To be determined
To be determined
Allied Dental Students—Dental Hygiene
To be determined
To be determined

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

Administrative Board
Ms. Jennifer L. Spresser, Chair-elect, OMNI Preventive Care, a 3M ESPE Company
Ms. Barbara Nordquist, Member-at-Large, Discus Dental, Inc.
Ms. Candy Ross, Vice President, DEXIS
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 48-70. 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.

House of Delegates. The 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 Councils of Deans and Faculties are delegates. The numbers of delegates from the Councils of Allied Dental Program Directors, Hospitals and Advanced Educational Programs, Students, and the Corporate Council are based on percentages of those councils’ members. The number of section delegates depends on the number of sections. The councilor and chair from each Section serve as delegates.

ADEA Board of Directors. The Board of Directors is the ADEA’s administrative body and is responsible for running the Association’s affairs between 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 nonhospital-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 36 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 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 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 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.
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 can be introduced either between 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 Annual Session. Only delegates can introduce resolutions at Annual Sessions 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 Executive Director who then presents it to the Board of Directors for consideration before the next Annual Session.

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

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 constitutes a quorum for the transaction of business at regular or special sessions.

How Reference Committees Function

Purpose. Before each ADEA Annual Session, the Board of Directors appoints two Reference Committees, the Reference Committee on Association Administrative Affairs and the Reference Committee on Association Policy. Most resolutions to be considered by the 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 Annual Session participants. Reference Committee chairs have the authority to determine whether a nonmember may speak.

At their hearings, each Reference Committees 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 2007 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 member, Jane Hamblin, Associate Executive Director for Member Services, at hamblinj@adea.org or 202-289-7201 ext. 180 for any further information you need.
1. Organizational Structure of the American Dental Education Association

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S E C T I O N S

<table>
<thead>
<tr>
<th>Academic Affairs</th>
<th>Anatomical Sciences</th>
<th>Behavioral Sciences</th>
<th>Biochemistry and Nutrition</th>
<th>Business and Financial Administration</th>
<th>Clinic Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Simulation</td>
<td>Community and Preventive Dentistry</td>
<td>Comprehensive Care and General Dentistry</td>
<td>Continuing Education</td>
<td>Dental Anatomy and Occlusion</td>
<td>Dental Assisting Education</td>
</tr>
<tr>
<td>Dental Hygiene Education</td>
<td>Dental Informatics</td>
<td>Dental School Admissions Officers</td>
<td>Development, Alumni Affairs, and Public Relations</td>
<td>Educational Research/Development and Curriculum</td>
<td>Endodontics</td>
</tr>
<tr>
<td>Gerontology and Geriatrics Education</td>
<td>Graduate and Postgraduate Education</td>
<td>Microbiology</td>
<td>Minority Affairs</td>
<td>Operative Dentistry and Biomaterials</td>
<td>Oral and Maxillofacial Radiology</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery, Anesthesia, and Hospital Dentistry</td>
<td>Oral Biology</td>
<td>Oral Diagnosis/Oral Medicine</td>
<td>Orthodontics</td>
<td>Pathology</td>
<td>Pediatric Dentistry</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Physiology, Pharmacology and Therapeutics</td>
<td>Postdoctoral General Dentistry</td>
<td>Practice Administration</td>
<td>Prosthodontics</td>
<td>Student Affairs and Financial Aid</td>
</tr>
</tbody>
</table>
2. What Happens to Resolutions Introduced at an Annual Session

3. What can happen to a resolution introduced between annual sessions
ADEA Reference Committees

Additional information on Reference Committees appears in “Introduction to the ADEA Governing Process,” which immediately precedes this section. That material explains the purpose of Reference Committees and the ground rules governing their hearings at the ADEA Annual Session.

The Board of Directors has selected the following members to serve on this year’s Reference Committees:

ADEA Reference Committee on Association Administrative Affairs
Dr. Robert Rashid, The Ohio State University, Council of Faculties, Chair
Prof. Tami Grzesikowski, St. Petersburg College, Council of Allied Dental Program Directors
Dr. Teresa A. Dolan, University of Florida, Council of Deans
Dr. Stephen Wilson, Cincinnati Children’s Hospital Medical Center, Council of Hospitals and Advanced Education Programs
Dr. Elise Eisenberg, New York University, Council of Sections
Mr. Chad Foster, University of Southern California, Council of Students
Mr. Desi Nuckolls, Procter & Gamble Professional Oral Health, Corporate Council

ADEA Reference Committee on Association Policy
Dr. Kenneth Etzel, University of Pittsburgh, Council of Faculties, Chair
Dr. Carolyn Breen, University of Medicine and Dentistry of New Jersey, Council of Allied Dental Program Directors
Dr. Denise Kassebaum, University of Colorado, Council of Deans
Dr. C. Lynn Hurst, University of Nevada, Las Vegas, Council of Hospitals and Advanced Education Programs
Dr. William Synan, University of Iowa, Council of Sections
Mr. Joseph Field, University of Southern California, Council of Students
Ms. Deborah M. Lyle, Waterpik Technologies, Inc. Corporate Council

Meeting Times and Locations of Hearings of Reference Committees

Reference Committee on Association Administrative Affairs
Tuesday, March 20, 1:15 to 2:15 p.m., Convention Center Room 296

Reference Committee on Association Policy
Tuesday, March 20, 3:00 to 4:00 p.m., Convention Center Room 296
Resolutions to be Considered by the ADEA House of Delegates

While there are five Resolutions (1H-2007 through 5H-2007) that will be acted upon by the House at its Opening Session on Saturday, March 17, from 4:30 to 5:30 p.m. (Hilton New Orleans Riverside Grand Ballroom C and D), there are four resolutions (6H-2007 through 9H-2007) 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 Tuesday, March 20, these four resolutions (and any that are presented from the floor) will be considered by the House at its Closing Session on Wednesday, March 21, from noon to 1:00 p.m. in the Hilton New Orleans Riverside Grand Ballroom C and D. 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 Reference Committee on Association Administrative Affairs

The Reference Committee on Association Administrative Affairs will hold a hearing on resolutions 6H-2007, 8H-2007, and 9H-2007 at its hearing, which will be Tuesday, March 20, from 1:15 to 2:15 p.m. in Room 296 of the Convention Center. Additional resolutions introduced at the Opening Session of the House may be referred to this committee.

Resolutions to be Heard by the Reference Committee on Association Policy

The Reference Committee on Association Policy will hear resolution 7H-2007 on Tuesday, March 20 from 3:00 to 4:00 p.m. in Room 296 of the Convention Center. 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 17, 2007, 4:30 – 5:30 p.m., Hilton New Orleans Riverside, Grand Ballroom C and D

Call to Order--ADEA President Kenneth L. Kalkwarf
Report of Quorum--ADEA Executive Director Richard W. Valachovic
Approval of the Minutes of the Previous Session
Reports
  President-elect’s Address—Dr. James Q. Swift
  Executive Director’s Report—Dr. Richard W. Valachovic
  Report of the Nominating Committee—Dr. Eric J. Hovland
Referrals of Reports and Resolutions
—Recess, until March 21, 2007, noon

Closing Session
Wednesday, March 21, noon to 1:00 p.m., Hilton New Orleans Riverside, Grand Ballroom C and D

Call to Order—ADEA President Kenneth L. Kalkwarf
Report of Quorum—ADEA Executive Director Richard W. Valachovic
Consideration of Reference Committee Reports and Action on Resolutions
Unfinished Business
New Business
President’s Address—Dr. Kenneth L. Kalkwarf
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 indicate the name of the designate on the ADEA Annual Session registration form and sign it.

**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 Annual Session participants are not only invited but also encouraged to attend the House 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. Kenneth L. Kalkwarf—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 Executive Director is the recording officer of the 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 the next page. 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 Annual Session. Such resolutions are often referred to the Board of Directors, councils, and/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 House 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 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>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>No</td>
<td>Yes*</td>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Amend*</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>Majority*</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>Yes*</td>
<td>Yes</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>Amend*</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes*</td>
<td>Yes</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>Yes*</td>
<td>Yes</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>Rewordable Motions</td>
<td>Close debate, limit debate, amend</td>
</tr>
<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>
</tbody>
</table>

(continued on next page)

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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 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>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>Any error</td>
<td>None</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 a.m. and 5 p.m. on Sunday, March 18; Monday, March 19; and Tuesday, March 20. Voting will be in the ADEA registration area outside of Hall J in the 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 nominating process for 2007 is recapped here:

* 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 knew the identity of all nominees.
* The deadline for submitting nominations was November 1, 2006.
* The Nominating Committee voted to select the candidate(s) to stand for election.

Upon the recommendation of the Nominating Committee, the Board of Directors presents two candidates for 2007-08 ADEA President-elect. (The office leads in successive years to the offices of President and Immediate Past President.) The candidates are

- Dr. Charles N. Bertolami, Dean and Professor, University of California, San Francisco School of Dentistry,
- Dr. John Killip, Assistant Dean for Student Programs and Clinical Professor, University of Missouri-Kansas City School of Dentistry.

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

Dr. Bertolami has been a member of AADS/ADEA for 25 years. He received the D.D.S. degree from Ohio State University. He then enrolled in the Doctor of Medical Sciences (D.Med.Sc.) degree program at Harvard University and subsequently completed residency training in oral and maxillofacial surgery at the Massachusetts General Hospital. He has taught at the University of Connecticut, Harvard, and the University of California, Los Angeles (UCLA), where he served concurrently as Chair of Oral and Maxillofacial Surgery, Chief of the UCLA Medical Center’s Dental Service, and Associate Dean for Faculty Affairs. He was appointed Dean at the University of California, San Francisco (UCSF) in 1995.

Dr. Bertolami has had diverse service opportunities, including serving as President of the American Association for Dental Research (AADR). He has accepted major assignments as a reviewer for NIDCR/NIH including chairing or co-chairing the NIH Blue Ribbon Panel on Research Training and Career Development and the dental school infrastructure grant review process (both R24 and U24). He chaired ADEA’s first President’s Task Force on Future Faculty and is currently co-chairing an ADEA-American Association of Medical Colleges (AAMC) panel on Curriculum and Clinical Training in Oral Health for Physicians and Dentists.

Dr. Bertolami’s research has focused on wound healing and connective tissue repair; however, more recently his contributions have dealt with curricular reform, the significance of research in dental education and practice, and ethics.

John Killip, D.D.S.
Dr. Killip graduated from the University of Missouri-Kansas City (UMKC) School of Dentistry in 1968, and has pursued his own interests in two main capacities: first as a dental practitioner in the U.S. Army (1968-71) and in private family practice (1971-88), then as a dental educator at UMKC (1989-present), including service as Assistant Dean for Student Programs for the past five years. In addition to laboring as a practitioner, educator and administrator, he has contributed to the welfare of the dental education profession since 1993 through continuous service in ADEA.

In 1995 Dr. Killip participated in the AADS summer Faculty Development Program and joined the ADEA Council of Faculties. He was elected to the ADEA Council of Faculties Administrative Board in 1998 and served as Chair of the Council in 2001-02. He served on the Annual Session Planning Committee and chaired the ADEA Academy of Dental Educators Taskforce. Dr. Killip is currently facilitating the ADEA Scholarship of Teaching...
and Learning Community of Interest (SoTL COI), and serves on the ADEA Board of Directors as the Vice President for Faculties. An ADA member for 35 years, he now serves as an Alternate to the House of Delegates of the Missouri Dental Association. He is a Fellow in the American College of Dentists and a member of Omicron Kappa Upsilon, which he served in 2004-05 as UMKC chair. He received the 2000-01 William J. Gies Educational Fellowship. Dr. Karl Haden, Dr. Pam Overman, and Dr. Killip received a Carnegie Foundation CASTL grant to initiate the ADEA Council of Facilities Scholarship of Teaching and Learning activities.

Report of the ADEA Board of Directors on Resolutions for Consideration by the 2007 ADEA House of Delegates

The ADEA House of Delegates will consider the nine resolutions in this report, plus any additional ones introduced at the Opening Session. The House will act on Resolutions 1H-2007 through 5H-2007 at its Opening Session on Saturday, March 17, 2007, from 4:30 to 5:30 p.m. The House will act on all others at its Closing Session on Wednesday, March 21, 2007, from noon to 1:00 p.m. Both sessions will be held in the Hilton New Orleans Riverside, Grand Ballroom C and D. The resolutions from the Board of Directors in the report are sequenced as follows:

Resolutions to be Acted on at the Opening Session

1H-2007 Commission on Dental Accreditation Member
2H-2007 Council on Dental Education and Licensure (CDEL) Member
3H-2007 Commission on Dental Accreditation Student Commissioner
4H-2007 Gies Appointment
5H-2007 Appreciations

Resolutions to be Acted on at the Closing Session

6H-2007 Gay-Straight Alliance
8H-2007 Approval of the Fiscal Year 2008 Budget
9H-2007 Midwestern University Provisional Membership

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-2007
Commission on Dental Accreditation Member

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

- Dr. Ann Boyle, Dean, Southern Illinois University (2007)
- Dr. Cecile Feldman, Dean, University of Medicine and Dentistry (2008)
- Dr. James Koelbl, Dean, West Virginia University (2009)
- Dr. Michael Reed, Dean, University of Missouri-Kansas City (2010)

Dr. Boyle will complete her term on the Commission on Dental Accreditation (CODA) this fall at the 2007 ADA Annual Session. She is not eligible for an additional term. Thus, the 2007 ADEA House will have to elect a new Commission member. To replace Dr. Boyle on the Commission, the ADEA Board of Directors is recommending that the House elect Dr. Sharon P. Turner, Dean, University of Kentucky, School of Dentistry, to a four-year term to expire in 2011.

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 following instructions apply only if an election is necessary. Otherwise, delegates will declare Dr. Turner elected by acclamation at the Opening Session of the House. If there should be an additional nomination(s), delegates will be able to vote for the CODA member by secret ballot between the hours of 8:00 a.m. and 5:00 p.m. on Sunday, March 18, Monday, March 19, and Tuesday, March 20. Voting will be in the ADEA registration area outside of Hall J in the Convention Center. Only delegates (or their official designates) can vote, and they must surrender their voter registration card to receive a ballot.

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

1H-2007. Resolved, that the House of Delegates elect Dr. Sharon P. Turner to a four-year term on the Commission on Dental Accreditation with the term to begin at the conclusion of the 2007 ADA Annual Session and end at the conclusion of the 2011 ADA Annual Session.
RESOLUTION 2H-2007
Council on Dental Education and Licensure Member

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

- Dr. John Reinhardt, University of Nebraska (2007)
- Dr. Stephen Young, University of Oklahoma (2008)
- Dr. William Lobb, Marquette University (2009)
- Dr. James Hupp, University of Mississippi (2010)

The ADEA Bylaws allow delegates to nominate additional candidates for CDEL membership at the Opening Session of the House. (Please note: 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.

Dr. Reinhardt will complete his term on CDEL this fall at the 2007 ADA Annual Session. He is not eligible for an additional term. Thus, the 2007 ADEA House will have to elect a new CDEL member. To replace Dr. Reinhardt on the Council, the Board of Directors is recommending that the House elect Dr. Cyril Meyerowitz, Chair, Eastman Department of Dentistry and Director, Eastman Dental Center, University of Rochester, to a four-year term to expire in 2011.

The following instructions apply only if an election is necessary. Otherwise, delegates will declare Dr. Meyerowitz elected by acclamation at the Opening Session of the House. If there should be an additional nomination(s), delegates will be able to vote for the CDEL member by secret ballot between the hours of 8:00 a.m. and 5:00 p.m. on Sunday, March 18, Monday, March 19, and Tuesday, March 20. Voting will be in the ADEA registration area. Only delegates (or their official designates) can vote, and they must surrender their voter registration card to receive a ballot.

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

2H-2007. Resolved, that the House of Delegates elect Dr. Cyril Meyerowitz to a four-year term on the Council on Dental Education and Licensure with the term to begin at the conclusion of the 2007 ADA Annual Session and end at the conclusion of the 2011 ADA Annual Session.
RESOLUTION 3H-2007
Commission on Dental Accreditation Student Commissioner

Under the rules of the Commission on Dental Accreditation, the American Dental Education Association and the American Student Dental Association jointly appoint one student commissioner every two years. The tradition has been that each association alternates in recommending an individual to be appointed to this position for approval by the governing bodies of both associations. In 2003, ADEA recommended the appointment of Mr. James Harrison, University of Louisville, to a two-year term to expire in 2005.

The ADEA board of Directors recommends that the House elect Mr. Jason Pickup, University of Nevada, Las Vegas, to a two-year term to begin at the conclusion of the 2007 ADA Annual Session and end at the conclusion of the 2009 ADA Annual Session.

The ADEA Bylaws allow delegates to nominate additional candidates for CODA Student Commissioner at the Opening Session of the House. 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 following instructions apply only if an election is necessary. Otherwise, delegates will declare Mr. Pickup elected by acclamation at the Opening Session of the House. If there should be an additional nomination(s), delegates will be able to vote for the CODA member by secret ballot between the hours of 8:00 a.m. and 5:00 p.m. on Sunday, March 18; Monday, March 19; and Tuesday, March 20. Voting will be in the ADEA registration area. Only delegates (or their official designates) can vote, and they must surrender their voter registration card to receive a ballot.

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

3H-2007. Resolved, that the House of Delegates elect Mr. Jason Pickup to a two-year term on the Commission on Dental Accreditation with the term to begin at the conclusion of the 2007 ADA Annual Session and end at the conclusion of the 2009 ADA Annual Session.
RESOLUTION 4H-2007
2007 Gies Appointment

In order to enhance their abilities 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 Foundation is ADEA’s fund for dental education. It identifies and
secures resources to help ensure and enhance excellence in teaching, research, and
patient care and to develop leaders to address critical issues in dental education.

By 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 2007 and
ending in July 2009 with the appointment of a new member at the ADEA Annual
Session.

The Board of Directors recommends that the House elect Dr. John Killip, University of
Missouri-Kansas City, to a two-year term to expire in 2009.

4H-2007. Resolved, that the 2007 House of Delegates appoint Dr. John
Killip of the University of Missouri-Kansas City, to a two-year term to expire
in 2009, 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 Annual Session. The ADEA Board of Directors expresses its sincere appreciation to the following companies and organizations for their generous support. The organizations 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.

ADEA AADSAS supported the ADEA Sections on Dental School Admissions Officers and on Student Affairs and Financial Aid Diversity and Access to Dental Careers Conference held as a part of the ADEA Fall 2006 Meetings.

The Academy of Dentistry forPersons with Disabilities supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The Academy of General Dentistry supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The Academy of Osseointegration supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

ACP Education Foundation supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The ADEA Council of Sections cosponsored the 2006 Deans’ Conference and supported the online Journal of Dental Education.

The ADEA Council of Students supported National Dental Student Lobby Day.

The ADEAGies Foundation supported the ADEA Diversity and Access to Dental Careers Conference and the Second ADEA Advanced Dental Education Summit. It funded the ADEA/William J. Gies Foundation Education Fellowship and the ADEA/William J. Gies Foundation Research Scholarship.

A-dec sponsored a luncheon and welcome reception at the 2006 ADEA Deans’ Conference and cosponsored a reception for the 2006 mid year meeting of the Section on Business and Financial Administration and the Section on Clinic Administration. It also sponsored a reception at the 2006 ADEA Allied Dental Program Directors’ Conference.

AEGIS Communications, LLC cosponsored the welcoming reception at the 2006 ADEA Deans’ Conference.

Align Technology, Inc. sponsored a breakfast at the 2006 Allied Dental Program Directors’ Conference and was a general sponsor of the 2006 ADEA Deans’ Conference.
The American Academy of Oral and Maxillofacial Pathology supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Academy of Oral and Maxillofacial Radiology supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Academy of Pediatric Dentistry supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Academy of Periodontology supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Association for Dental Research sponsored National Dental Student Lobby Day.

The American Association of Endodontists supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Association of Hospital Dentists supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Association of Oral and Maxillofacial Surgeons supported the Second ADEA Advanced Dental Education Summit, held as a part of the ADEA Fall 2006 Meetings, and National Dental Student Lobby Day in 2006.

The American Association of Orthodontists supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Association of Public Health Dentistry supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American College of Prosthodontists supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American College of Prosthodontists Education Foundation supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

The American Dental Association provided support for the Sections on Admissions, Financial Aid and Student Affairs mid year meeting and the Second ADEA Advanced Dental Education Summit, held as a part of the ADEA Fall 2006 Meetings. It provided travel stipends for the RWJF/AAMC/ADEA Summer Medical and Dental Education Program.

The American Dental Association Foundation continued its support as a Founding Sponsor of the ADEA Center for Educational Policy and Research.
The American Dental Association Political Action Committee supported National Dental Student Lobby Day.

American Eagle Instruments sponsored an educational program on curriculum change at the 2006 Deans’ Conference and an educational program on new student demographics at the mid year meeting of the Section on Business and Financial Administration and Section on Clinic Administration. It also cosponsored lunch and a presentation at the 2006 Allied Dental Program Directors’ Conference.

The American Student Dental Association sponsored National Dental Student Lobby Day.

The American Society of Geriatric Dentistry supported the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings.

axiUm Software provided a break for the midyear meeting of the ADEA Section on Business and Financial Administration and Clinic Administration.

Brasseler USA sponsored the golf tournament reception and prizes at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the ADEA Section on Clinic Administration and golf tournament prizes at the 2006 ADEA Deans’ Conference.

Colgate Oral Pharmaceuticals, Inc., a subsidiary of Colgate-Palmolive Company, sponsored the Discourse and Dessert plenary at the 2006 Annual Session. Colgate again provided generous support for the ADEA/Colgate Oral Pharmaceuticals Allied Dental Educators’ Fellowship and for the Allied Dental Leadership Development Program. Colgate was a founding and continuing supporter of the online Journal of Dental Education. It cosponsored Lunch and Learn Sessions at the 2006 ADEA Allied Dental Program Directors’ Conference and sponsored conference portfolios at the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration. Colgate also sponsored the New Deans’ Workshop at the 2006 ADEA Deans’ Conference.

Collegiate Funding Services, LLC supported National Dental Student Lobby Day.

The DentalEZ Group sponsored the President’s Reception at the 2006 Annual Session.

DentaPure provided program support for the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration.

DENTSPLY International, Inc. hosted a reception at the 2006 ADEA Deans’ Conference and at the 2006 ADEA Annual Session. It provided support for the Allied Dental Faculty Leadership Development Program. DENTSPLY Professional and DENTSPLY Alliance sponsored a breakfast at the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration; and DENTSPLY Professional and DENTSPLY Pharmaceuticals sponsored the conference portfolios for the 2006 Allied Dental Program Directors’ Conference.

Discus Dental, Inc. sponsored the keynote address at the 2006 ADEA Allied Dental Program Directors’ Conference and an educational session at the 2006 ADEA Deans’
Conference. It also sponsored the golf tournament beverage cart for the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration.

*EMS Electro Medical Systems* sponsored an educational session on advocating for change at the 2006 ADEA Allied Dental Program Directors' Conference.

*Fortress Insurance Company* was a founding and continuing supporter of the online *Journal of Dental Education*.

*GC America, Inc.* supported the golf tournament beverage cart at the 2006 ADEA Deans’ Conference and continued support as a Founding Sponsor of the ADEA Center for Educational Policy and Research.

*Geico®* sponsored National Dental Student Lobby Day.

*G. Hartzell and Son* cosponsored the welcome reception at the 2006 Allied Dental Program Directors’ Conference.

*GlaxoSmithKline* cosponsored the welcoming reception at the 2006 Deans’ Conference. It was a founding and continuing supporter of the online *Journal of Dental Education*, and it continued sponsorship for the ADEA/GlaxoSmithKline Sensodyne® Excellence in Teaching Award. It sponsored Faculty Development Workshops at the 2006 ADEA Annual Session and continued support for the GSK Prosthodontics Endowment in the William J. Gies Foundation of ADEA to support ADEA’s Section on Prosthodontics. It sponsored *Oral Health for Independent Older Adults: ADEA/GSK Predoctoral Curriculum Resource Guide*. GlaxoSmithKline cosponsored the opening reception at the ADEA Fall 2006 Meetings.

*Henry Schein, Inc./Sullivan-Schein Dental* cosponsored the TechExpo at the 2006 ADEA Annual Session and a break at the 2006 ADEA Deans’ Conference. It also sponsored an educational session on ethics at the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration and cosponsored a dinner at the ADEA Allied Dental Program Directors’ Conference.

*Hu-Friedy Mfg. Co., Inc.* sponsored the Women Administrators’ Breakfast at the 2006 Deans’ Conference and cosponsored a reception for the 2006 mid year meeting of the Section on Business and Financial Administration and the Section on Clinic Administration. It also sponsored a tour, reception, and dinner at the 2006 ADEA Allied Dental Program Directors’ Conference. It was a founding and continuing supporter of the online *Journal of Dental Education*.

*The Josiah Macy Jr. Foundation* funded in part ADEA's ExploreHealthCareers.org

*Kahler Slater* sponsored Lunch for Golfers at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration and at the ADEA Deans’ Conference. They were a cosponsor of the President’s Reception at the 2006 ADEA Annual Session.

*KaVo Dental Corporation/Gendex Imaging/DEXIS* sponsored a welcome reception for the 2006 mid year meeting of the ADEA Section on Business and Financial
Administration and the Section on Clinic Administration. It sponsored a breakfast at the 2006 ADEA Deans’ Conference.

*Liaison International, Inc.* provided general support for the 2006 ADEA Sections on Dental School Admission Officers and on Student Affairs and Financial Aid Annual Interim Meeting.

The *National Dental Association Foundation* continued support of the ADEA Sections on Dental School Admission Officers and on Student Affairs and Financial Aid Diversity and Access to Dental Careers Conference.

*Nobel Biocare* supported the VIP Breakfast at the 2006 ADEA Annual Session and was a general sponsor of the 2006 ADEA Deans’ Conference.

*OMNI Preventive Care, a 3M ESPE Company,* sponsored an educational program on the future of the allied dental professions at the 2006 ADEA Allied Dental Program Directors Conference.

*Oral-B Laboratories* supported the online *Journal of Dental Education* and the ADEA Leadership Institute. It sponsored the ADEA/Oral-B Laboratories Scholarship for Dental Hygiene Students Pursuing Academic Careers and the portfolios at the 2006 ADEA Annual Session,

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

*OraPharma, Inc.* cosponsored the President’s Reception at the 2006 ADEA Annual Session. It sponsored a dinner, a morning break and an educational session at the 2006 ADEA Deans’ Conference. It was a general sponsor of the 2006 ADEA Allied Dental Program Directors’ Conference and the Second ADEA Advanced Dental Education Summit held as a part of the ADEA Fall 2006 Meetings. It also supported the online *Journal of Dental Education*.

*Pacific Dental Services, Inc.* cosponsored the President’s Reception at the 2006 ADEA Annual Session and provided general meeting support for the 2006 Deans’ Conference.

*Pfizer Consumer Healthcare Division of Pfizer Inc.* provided general sponsorship for the ADEA Leadership Institute. It continued to support the ADEA/Listerine® Preventive Dentistry Scholarship and the ADEA/Pfizer, Inc./Enid A. Neidle Scholarship-in-Residence Program for Women. Pfizer sponsored a break at the 2006 ADEA Allied Dental Program Directors’ Conference and a breakfast at the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration. It sponsored an educational session and the audience response system at the 2006 ADEA Deans’ Conference.

*Philips Oral Healthcare, Inc.* sponsored the conference lanyards at the 2006 ADEA Allied Dental Program Directors Conference.

*Planmeca, Inc.* sponsored a break at the 2006 ADEA Allied Dental Program Directors’ Conference.
Premier Dental Products Company supported a box lunch for nongolfers at the mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration. It sponsored a break at the ADEA Allied Dental Program Directors’ Conference in 2006.

The Procter & Gamble Company sponsored a breakfast and the meeting portfolios at the 2006 ADEA Deans’ Conference. It sponsored the allied dental hygiene clinic coordinators’ lunch and cosponsored the TechExpo at the 2006 ADEA Annual Session. It sponsored the 2006 Predental Advisors’ Workshop. Procter & Gamble sponsored a lunch at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration. It was a cosponsor of the ADEA Allied Dental Faculty Leadership Development Program, as well as the sponsor of a breakfast at the 2006 ADEA Allied Dental Program Directors’ Conference. It cosponsored the ADEA Sections on Dental School Admission Officers and on Student Affairs and Financial Aid 2006 Interim Meeting and the Diversity and Access to Dental Careers Conference, held as a part of the ADEA Fall 2006 Meetings and provided general support for the 2006 ADEA Sections on Dental School Admission Officers and on Student Affairs and Financial Aid. It continued its support as a Founding Sponsor of ADEA’s Center for Educational Policy and Research. It was a founding and continuing supporter of the online Journal of Dental Education.

The Robert Wood Johnson Foundation cosponsored the AAMC/ADEA Summer Medical and Dental Education Program and continued its support as a Founding Sponsor of ADEA’s Center for Educational Policy and Research.

Sallie Mae and USA funds provided general support for the 2006 ADEA Sections on Dental School Admission Officers and on Student Affairs and Financial Aid Annual Interim Meeting, held as a part of the ADEA Fall 2006 Meetings.

SDI, Inc. sponsored a breakfast at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration.

Sigma Phi Alpha, the dental hygiene honor society, continued to sponsor the Linda E. DeVore Scholarship.

Sirona Dental Systems, LLC sponsored an educational program on electronic patient records at the 2006 midyear meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration, and session on curriculum change at the 2006 ADEA Deans’ Conference. It cosponsored the TechExpo at the ADEA 2006 Annual Session.

Special Care Dentistry supported the Second ADEA Advanced Dental Education Summit in 2006.

Stage Front Presentation Systems sponsored an educational session on IT infrastructure at the 2006 midyear meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration.

Straumann USA provided general support for the 2006 ADEA Deans’ Conference and the awards program and publication at the 2006 Annual Session.
Sunstar Americas, Inc. sponsored the ADEA/Sunstar Americas Inc./Harry W. Bruce, Jr. Legislative Fellowship program and dinner, the Presidents’s Reception and the Meeting-at-a–Glance at the 2006 ADEA Annual Session. It was a founding and continuing sponsor of the online Journal of Dental Education. The company sponsored a reception at the 2006 ADEA Deans’ Conference, and a workshop on trends in allied dental education at the 2006 ADEA Allied Dental Program Directors’ Conference. It also cosponsored the Allied Dental Faculty Leadership Development Program.

3M ESPE sponsored the Hospitality and WiFi Centers at the 2006 ADEA Annual Session.

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 Special Interest Group. It cosponsored a lunch at the 2006 Allied Dental Program Directors’ Conference and supported the Allied Dental Leadership Development program.

Two-Ten Health supported a breakfast at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration, and a break at the 2006 ADEA Deans’ Conference.

Ultradent Products, Inc. provided golf shirts and a break at the 2006 mid year meeting of the ADEA Section on Business and Financial Administration and the Section on Clinic Administration and at the Deans’ Conference. It supported the Second ADEA Advanced Dental Education Summit in 2006 held as a part of the ADEA Fall 2006 Meetings.

Virginia Dental Association provided support for the AAMC/ADEA Summer Medical and Dental Education Program.

VitalSource Technologies, Inc. sponsored the ADEA Council of Students/Vital Source Technologies, Inc. Junior Faculty Award and an educational session at the 2006 ADEA Deans’ Conference.

Waterpik Technologies cosponsored the Welcome Reception at the 2006 ADEA Allied Dental Program Directors’ Conference.

The Young Dental/Athena Champion Manufacturing Company sponsored Lunch and Learn Sessions at the 2006 Allied Dental Program Directors’ Conference.

Zimmer Dental sponsored the President’s Reception, keycards, lanyards, and pens at the 2006 ADEA Annual Session. It sponsored an educational session at the 2006 mid year meeting of the Section on Business and Financial Administration and the Section on Clinic Administration and supported the Second ADEA Advanced Dental Education Summit, held as a part of the ADEA Fall 2006 Meetings. It sponsored a breakfast at the 2006 ADEA Deans’ Conference.
The Board of Directors asks the House to approve the following resolution:

5H-2007. Resolved, that the American Dental Education Association expresses its sincere appreciation to the following organizations for their generous support of the Association’s activities and programs between the start of the 2006 ADEA Annual Session and the start of the 2007 ADEA Annual Session:

ADEA AADSAS
The Academy of Dentistry for Persons with Disabilities
The Academy of General Dentistry
The Academy of Osseointegration
The ADEA Council of Sections
The ADEA Council of Students
The ADEAGies Foundation
A-dec
AEGIS Communications, LLC
Align Technologies
American Academy of Oral and Maxillofacial Pathology
American Academy of Oral and Maxillofacial Radiology
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 Hospital Dentists
The American Association of Oral and Maxillofacial Surgeons
The American Association of Orthodontists
The American Association of Public Health Dentistry
American College of Prosthodontists;
American College of Prosthodontists Education Foundation
American Dental Association; American Dental Association Foundation:
American Dental Association Political Action Committee
American Eagle Instruments, Inc.
The American Student Dental Association
The American Society of Geriatric Dentistry
axiUm Software
Brasseler USA
Colgate-Palmolive Company/Colgate Oral Pharmaceuticals, Inc.
Collegiate Funding Services, LLC
The DentalEZ Group
DentaPure
DENTSPLY International, Inc.; DENTSPLY Professional; DENTSPLY Alliance
Discus Dental, Inc.
EMS Electro Medical Systems
Fortress Insurance Company
GC America, Inc.
Geico®
G. Hartzell and Son
GlaxoSmithKline

(continued)
Henry Schein, Inc./Sullivan-Schein Dental
Hu-Friedy Mfg. Co., Inc.
The Josiah Macy Jr. Foundation
Kahler Slater
KaVo Dental Corporation/Gendex Imaging
Liaison International, Inc.
National Dental Association; National Dental Association Foundation
Nobel Biocare
OMNI Preventive Care, a 3M ESPE Company
Oral-B Laboratories
Oral Health America, the Beauchamp Funds, and the George H. Whiteley Memorial Foundation
OraPharma, Inc.
Pacific Dental Services, Inc.
Pfizer Consumer Healthcare Division of Pfizer Inc.
Philips Oral Healthcare, Inc.
Planmeca, Inc.
Premier Dental Products Company
The Procter & Gamble Company; Crest® Dental ResourceNet of Procter & Gamble
Robert Wood Johnson Foundation
Sallie Mae and USA Funds
SDI, Inc.
Sigma Phi Alpha
Sirona Dental Systems, LLC
Special Care Dentistry
Stage Front Presentations
Straumann USA
Sunstar Americas, Inc.
Tom’s of Maine
Two-Ten Health
Ultradent Products, Inc.
Virginia Dental Society
VitalSource Technologies
Waterpik Technologies
Young Dental/Athena Champion Manufacturing Company
Zimmer Dental
Actions at the Closing Session of the ADEA House of Delegates

RESOLUTION 6H-2007
Gay-Straight Alliance

The ADEA Board of Directors supports the Council of Sections’ request for elevation of the Special Interest Group, the Gay-Straight Alliance, to Section status because of its increase in membership and compliance with all requirements to change its status.

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

6H-2007. Resolved, that the Special Interest Group, Gay-Straight Alliance, become the Gay-Straight Alliance Section.

RESOLUTION 7H-2007
Clinical Prevention and Population Health Curriculum Framework

Background: In 2002 the Association of Academic Health Centers and the Association of Teachers of Preventive Medicine formed the Healthy People Curriculum Task Force. Dr. Chester W. Douglass was asked by ADEA to sit on this task force. The goal of the task force is to accomplish the Healthy People 2010 objective “to increase the proportion of schools of medicine, schools of nursing and health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.” To this end, the task force developed the “Clinical Prevention and Population Health Curriculum Framework.” The task force was composed of clinical health professions from allopathic medicine, dentistry, nursing, nurse practitioners, osteopathic medicine, pharmacy and physician assistants. The Framework contains four main components and 19 domains. The four main components of the curriculum framework are: (1) evidence base of practice, (2) clinical preventive services – health promotion, (3) health systems and health policy, and (4) community aspects of practice. Each of the health professions represented is to determine the level of relevance and depth of the domains that is consistent with its educational mission.

Our efforts to disseminate the work of the task force within dental education resulted in a symposium at the 82nd Annual Session of the ADEA; the inclusion of the Symposium PowerPoint presentations on the ADEA web site under “Resources” (http://www.adea.org/resources/default.htm); a panel discussion on “Interprofessional Education in Clinical Prevention and Population Health” at the 12th Congress of Health Professions Educators; and two round table discussions at the 2005 and 2006 National Oral Health Conferences. The formal resolution to accept and endorse the Curriculum Framework was considered by the Section on Community and Preventive Dentistry at the 83rd Annual Session of ADEA. It passed unanimously.

Further reading relevant to this issue follows the resolution.

Cost Impact: None
The ADEA Board of Directors supports and endorses this, and asks the House to approve the following resolution:

7H-2007 Resolved, that the ADEA House of Delegates endorses the Clinical Prevention and Population Health Curriculum Framework, and encourages all dental and dental hygiene education programs to consider adopting some or all of the four components and 19 domains that comprise the framework.
Clinical Prevention and Population Health
Curriculum Framework for Health Professions
Janet Alfan, PhD, RN, Tirta Agar Barwick, Suzanne Cashman, ScD,
James F. Cawley, MPH, PA-C, Chris Day, MPH, Chester W. Douglass, DMD, PhD,
Clyde H. Evans, PhD, David R. Garr, MD, Rika Maeshiro, MD, MPH,
Robert L. McCarthy, PhD, Susan M. Meyer, PhD, Richard Riegelman, MD, PhD,
Sarena D. Scofer, MD, Joan Stanley, PhD, RN, CRNP, Melinda Swenson, PhD, FNP,
Howard S. Triefbaum, DO, PhD, MPH, Peggy Timodo, DDS, MPH,
Kathryn E. Werner, MPA, Douglas Wood, DO

Why a Clinical Prevention and Population Health
Curriculum Framework?
Richard K. Riegelman, MD, PhD, Clyde H. Evans, PhD, David R. Garr, MD

Healthy People Curriculum Task Force
A Commentary by the Surgeon General
Richard H. Carmona, MD, MPH, FACS

Clinical Prevention and Population Health
Getting There from Here
Timothy S. Carey, MD, MPH, William L. Roper, MD, MPH
Teaching Preventive Medicine

Clinical Prevention and Population Health
Curriculum Framework for Health Professions

Janet Allan, PhD, RN, Timi Agar Barwick, Suzanne Cashman, ScD, James F. Cauley, MPH, PA-C,
Chris Day, MPH, Chester W. Douglass, DMD, PhD, Clyde H. Evans, PhD, David R. Garr, MD,
Rika Maeshiro, MD, MPH, Robert L. McCarthy, PhD, Susan M. Meyer, PhD, Richard Riegelman, MD, PhD,
Serena J. Seifer, MD, Joan Stanley, PhD, RN, CRNP, Melinda Swenson, PhD, FNP,
Howard S. Teitelbaum, DO, PhD, MPH, Peggy Timothee, DDS, MPH, Kathryn E. Werner, MPA,
Douglas Wood, DO

Abstract: The Clinical Prevention and Population Health Curriculum Framework is the initial product of the Healthy People Curriculum Task Force convened by the Association of Teachers of Preventive Medicine and the Association of Academic Health Centers. The Task Force includes representatives of allopathic and osteopathic medicine, nursing and nurse practitioners, dentistry, pharmacy, and physician assistants. The Task Force aims to accomplish the Healthy People 2010 goal of increasing the prevention content of clinical health professional education. The Curriculum Framework provides a structure for organizing curriculum, monitoring curriculum, and communicating within and among professions. The Framework contains four components: evidence base for practice, clinical preventive services—health promotion, health systems and health policy, and community aspects of practice. The full Framework includes 19 domains. The title "Clinical Prevention and Population Health" has been carefully chosen to include both individual and population-oriented prevention efforts. It is recommended that all participating clinical health professions use this title when referring to this area of curriculum. The Task Force recommends that each profession systematically determine whether appropriate items in the Curriculum Framework are included in its standardized examinations for licensure and certification and for program accreditation.


Introduction
Increasingly, members of the health professions, policymakers, and the American public understand the importance of health promotion, disease prevention, and population health across a spectrum of issues affecting health, including chronic disease management, emerging infectious diseases, emergency preparedness, disparities in health and healthcare services, and the impact of behavior and lifestyle choices. Increasingly, we realize the inadequacy of disease-based, episodic, acute care intervention for addressing these issues. Nevertheless, a focus on prevention and population health continues to lag behind the emphasis on one-on-one treatment. Until prevention is thoroughly integrated into all aspects of our healthcare system, measurable progress addressing these issues will elude us.

An essential element of any effort to change a healthcare system must be the education of future clinicians who will practice new approaches in new contexts. Thus, an unambiguous emphasis on individual- as well as population-based prevention must be part of clinicians' education. Although a few innovative methods to integrate clinical prevention and population health into clinician training have been developed, structured, comprehensive curriculum incorporates these topics into most health professionals' education.

The goal of implementing such a curriculum is not new. “Some 40 years of effort…to teach prevention as an integral part of clinical medicine…has met with limited success,” wrote Barker and Jonas over 2 decades ago after reviewing the literature and their own
experience. Despite past limited success, the time may be ripe for making real progress.

The events of fall 2001, the severe acute respiratory syndrome (SARS) epidemic, and West Nile virus have highlighted the critical role of prevention and public health. The Institute of Medicine (IOM) reports on medical errors and the quality of care highlighted the need to improve patient safety and restructure care systems. Another IOM report called for "transforming the content, methods, approaches, and settings used in health professions education" in response to the "changing needs of the population and changing demands of practice."

Healthy People 2010 encourages the reexamination of clinical education by including an objective "to increase the proportion of schools of medicine, schools of nursing and health professional training schools whose basic curriculum for healthcare providers includes the core competencies in health promotion and disease prevention."

Need for a New Curriculum

Traditionally, each health profession designed, developed, and implemented its own curriculum framework. The approach presented here (1) assumes the need for and value of a common curriculum framework articulating the content that all health professions students should know and skills they all should have; (2) articulates how to organize such a framework; and (3) specifies what it should be called.

To integrate clinical prevention and population health into clinical practice, this approach assumes the need for effective interprofessional communications and collaboration. A mutually agreed upon curriculum framework articulating key elements of prevention and population health sciences provides not only the common, core subject matter, but also increases the opportunity for education and training in multiprofessional teams.

Healthy People Curriculum Task Force

Background

The release of Healthy People 2010 joined the need for more effective prevention education with the need for greater interprofessional education and practice. Although not specifically recommended by Healthy People 2010, if a prevention framework is to be widely used, it must be widely accepted across the core health professions—a goal that will be achievable if the framework is developed by leaders from the core clinical professions. The task of developing such a framework provided the impetus for the Association of Teachers of Preventive Medicine (ATPM) to join with the Association of Academic Health Centers to convene the Healthy People Curriculum Task Force, which is composed of a senior academic member and the executive director (or designee) from the following clinical health professional organizations:

- Allopathic Medicine—Association of American Medical Colleges
- Dentistry—American Dental Education Association
- Nursing—American Association of Colleges of Nursing
- Nurse Practitioners—National Organization of Nurse Practitioner Faculties
- Osteopathic Medicine—American Association of Colleges of Osteopathic Medicine
- Pharmacy—American Association of Colleges of Pharmacy
- Physician Assistants—Association of Physician Assistant Programs

The Task Force also includes representation from the Student Health Alliance (a consortium of 11 health profession student organizations) and two resource groups, the Association of Schools of Public Health (ASPH) and Community-Campus Partnerships for Health.

This unprecedented assemblage of diverse health professions stakeholders developed the Clinical Prevention and Population Health Curriculum Framework (Framework) that could be used by schools from at least the seven represented health professions.

The progenitor for the Framework was conceived almost 20 years ago when ATPM assembled a group of leaders in prevention to articulate the basic prevention content for a comprehensive medical education curriculum. The resulting Inventory of Knowledge and Skills Relating to Disease Prevention and Health Promotion provided the guidepost for schools' efforts to broaden prevention training. Despite the intent that this document be "shared across many disciplines," it was associated with medical training and rarely used by other health professions.

Framework: Process and Intent

Building on the above inventory, in 2003, the Task Force developed a preliminary curriculum framework in clinical prevention and population health. Widespread web-based review and evaluation of this document were sought from academics, students, practitioners, and through the participating organizations. Consultants recommended by ASPH provided comment on the preliminary document. In March 2004, representatives from all seven clinical professions on the Task Force unanimously approved the Framework.

The Framework provides a set of components and domains that constitute a foundation for education in clinical prevention and population health. The aim is
to encourage each participating clinical health profession to review its curriculum recommendations and/or requirements and consider changes compatible with the Framework.

The Framework allows considerable flexibility for each clinical health profession to determine the depth of curriculum that is recommended, the timing for teaching the material, and the method(s) for delivery. The goal is to provide general recommendations and identify content areas that may require greater emphasis. It is also the intent to point out opportunities for interprofessional education and collaboration. The Framework is designed for degree programs rather than postgraduate or residency training, although it is hoped that these programs will build upon the Framework.

The Framework should be viewed as providing the foundation for a curriculum that spans the years of clinical health professional training. The curriculum content will generally need to be incorporated in more than one module or course in a degree program. Therefore, a mechanism for integrating this curricular content is important. Integration provides the opportunity to stress the interactive or synergistic nature of the factors affecting health and the development and outcome of disease (as stressed in recent IOM reports). The Framework also reflects the IOM’s emphasis on health policy, ethics, and global health as components of public health education.

The name “clinical prevention and population health” has been carefully chosen to include both individual- and population-oriented preventive efforts as well as the interactions between them. It is recommended that participating health professions use this title when referring to this area of the curriculum.

### Framework Content

The Framework consists of four components—evidence base of practice, clinical preventive services—health promotion, health systems and health policy, and community aspects of practice—with 18 domains. These components are recommended as a structure for organizing and monitoring curriculum, and communicating within and among disciplines. Within each component, the numbered domains are designed to outline content to reflect both individual clinical prevention and population health. The numbered domains allow each profession to identify the content considered relevant to its educational efforts. Finally, the listed items in each domain represent examples of the types of materials a particular profession may choose to encourage or require in its curriculum.

### Evidence Base of Practice

1. Epidemiology and biostatistics
   - Rates of disease (e.g., incidence, prevalence, case fatality)
   - Types of data (e.g., nominal, continuous, qualitative)
   - Statistical concepts (e.g., estimation [relative risk/odds ratio and number needed to treat], statistical significance/confidence intervals, adjustment for confounding variables, causation)

2. Methods for evaluating health research literature
   - Study designs (e.g., surveys, observational studies, randomized clinical trials)
   - Quality measures (e.g., validity, accuracy, reproducibility, biases)
   - Sampling and statistical power

3. Outcome measurement, including quality and costs
   - Measures of mortality (e.g., infant mortality rates, life expectancy)
   - Measures that include quality of life/utility (e.g., quality-adjusted life years)
   - Measures that include cost (e.g., cost-effectiveness, incremental cost-effectiveness)
   - Measures of quality of health care (e.g., health status disparities, health plan employer data and information set [HEDIS])

4. Health surveillance
   - Vital statistics/legal documents (e.g., birth certificates, death certificates)
   - Disease surveillance (e.g., passive surveillance [reportable disease], active surveillance for epidemic and bioterrorism)
   - Biological, social, economic, geographic, and behavioral risk factors

5. Determinants of health
   - Burden of illness (e.g., distribution of morbidity and mortality by age, gender, race, socioeconomic status, geography)
   - Contributors to morbidity and mortality (e.g., genetic, behavioral, socioeconomic, environmental, health care [access and quality])

### Clinical Preventive Services—Health Promotion

1. Screening
   - Approaches to testing and screening (e.g., range of normal, sensitivity, specificity, predictive value, target population)
   - Criteria for successful screening (e.g., effectiveness, benefits and harms, cost, patient acceptance)
   - Evidence-based recommendations

2. Counseling
   - Approaches to culturally appropriate behavioral change (e.g., counseling skill training, motivation)
   - Clinician-patient communication (e.g., patient participation in decision making, informed consent, risk communication, advocacy)
   - Criteria for successful counseling (e.g., effectiveness, benefits and harms, cost, patient acceptance)
   - Evidence-based recommendations

3. Immunization

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2007 ADEA House of Delegates Manual
as of March 14, 2007
Approaches to vaccination (e.g., live vs dead vaccine, pre-vs post-exposure, boosters, target population, population-based immunity)
Criteria for successful immunization (e.g., effectiveness, benefits and harms, cost, patient acceptance)
Evidence-based recommendations

4. Chemoprevention
Approaches to chemoprevention (e.g., pre- vs post-exposure, time limited vs long-term)
Criteria for successful chemoprevention (e.g., effectiveness, benefits and harms, cost, patient acceptance)
Evidence-based recommendations

Health Systems and Health Policy
1. Organization of clinical and public health systems
Clinical health services (e.g., continuum of care—hospital, ambulatory, home, long-term care)
Public health responsibilities (e.g., public health functions [Institute of Medicine]: ten essential services of public health)
Relationships between clinical practice and public health

2. Health services financing
Clinical services coverage and reimbursement (e.g., Medicare, Medicaid, employment-based, uninsured)
Methods of financing of healthcare institution (e.g., hospitals, long-term care, community health centers)
Methods of financing of public health services
Other models (e.g., international comparisons)

3. Health workforce
Methods of regulation of professions and health care (e.g., certification, licensure, institutional accreditation)
Discipline-specific history, philosophy, roles, responsibilities
Racial/ethnic workforce composition, including under-represented minorities
Relations of discipline to other healthcare professionals
Legal and ethical responsibilities of healthcare professionals (e.g., malpractice, healthcare information privacy, confidentiality)

4. Health policy process
Process of health policymaking (e.g., local, state, federal governments)
Methods for participation in the policy process (e.g., advocacy, advisory processes)
Impact of policies on health care and health outcomes, including impacts on vulnerable populations

Community Aspects of Practice
1. Communicating and sharing health information with the public

Methods of assessing community needs/strengths and options for intervention (e.g., community-oriented primary care)
Media communications (e.g., strategies of using mass media, risk communication)
Evaluation of health information (e.g., websites, mass media, patient information [including literacy level and cultural sensitivity])

2. Environmental health
Sources, media, and routes of exposure to environmental contaminants (e.g., air, water, food)
Environmental health risk assessment and risk management (e.g., genetic, prenatal)
Environmental disease prevention focusing on susceptible populations

3. Occupational health
Risks from employment-based exposures
Methods for control of occupational exposures
Exposure and prevention in healthcare settings

4. Global health issues
Roles of international organizations
Disease and population patterns in other countries (e.g., burden of disease, population growth, health and development)
Effects of globalization on health (e.g., emerging and re-emerging diseases/conditions)

5. Cultural dimensions of practice
Cultural influences on clinicians’ delivery of health services
Cultural influences on individuals and communities (e.g., health status, health services, health beliefs)
Culturally competent health care

6. Community services
Methods of facilitating access to and partnerships for health care
Evidence-based recommendations for community preventive services
Public health preparedness (e.g., terrorism, natural disasters, injury prevention)

Framework: Interpretation
The following discussion addresses the four components. A full discussion of all elements of the Framework, including the 19 domains and general recommendations for implementation is included at www.apha.org. This full document includes recommendations for timing and coordination of the curriculum, integration of curriculum content, and competency assessment.

Evidence Base of Practice
This component aims to operationalize the background needed to incorporate evidence into practice. The level of quantitative and qualitative analysis and study design understanding needed may vary from one...
profession to another. However, the numbered domains are designed to identify core competencies that are considered generally applicable for clinical health professional education. This component may be implemented using a variety of educational methods. Practice with structured reading of the health research literature will help ensure that students understand the relevance of these concepts.

Clinical Preventive Services–Health Promotion

This component aims to ensure that students not simply memorize recommended interventions, but understand the science needed to produce and interpret evidence-based recommendations for an intervention or service. This component is intended to parallel the structure established by the U.S. Preventive Services Task Force. The four domains within this component are intentionally structured in parallel, implying a similarity in approach and depth of understanding.

Each of the four domains could be subsumed into broader clinically oriented education. While it is desirable to connect each domain of this component with other clinically oriented education, it is important that a coherent approach be preserved for teaching the principles of screening, counseling, immunization, and chemoprevention.

Some clinical health professions may encourage or require knowledge of the content of specific evidence-based recommendations. However, that knowledge is considered separate from accomplishing the aims of this component.

Health Systems and Health Policy

A systematic approach to this component has not been part of most clinical health professional curricula. The development of a coherent curriculum that provides a framework for students to use as they experience the U.S. healthcare system is essential to accomplishing the intent of this component.

This component may be particularly amenable to interprofessional educational efforts, since the required level of knowledge is not likely to vary by discipline. Although ethical responsibilities are included under the Health Workforce domain, the integration of ethical issues throughout the entire framework is recommended.

Health policy is not generally required by current accreditation standards or included in most clinical health professions education curricula. Nevertheless, the Task Force overwhelmingly endorsed its inclusion here. The intent is to provide students with a basic understanding of policies that affect their practice and the health of their patients and communities, processes through which policies are developed, and opportunities to participate in policymaking.

Community Aspects of Practice

This component aims to integrate individual clinical prevention with the population health focus of the Framework. Community is defined broadly to include geographically defined communities as well as those defined by similar demographics, interests, or experiences (e.g., age, employment, diseases, health risks).

The need for community-based learning experiences outside traditional institutional settings is fundamental to this component. Service learning, community-based clinical rotations (e.g., public health departments and community health centers), community-based research, and international health experiences are possible ways to attain this goal. These might include education in the evaluation of web-based information, particularly from sites used by patients learning firsthand about environmental and occupational exposures and understanding the structure of international efforts to address current and emerging health problems. The CDC Guide to Community Preventive Services can help support the development of prevention education across the health professions.

Integration and Competency Assessment

Integration of the four components is highly desirable. To integrate the curriculum, one might illustrate the options for intervention from primary prevention through rehabilitation; the level of intervention from the individual to the high-risk group to the general population; and the methods of behavioral intervention, including education, motivation, and training in counseling skills. Such integration may require incorporating specific curricular content near the end of the degree program.

Each clinical profession should address the methods used to evaluate students and to ensure their levels of competency. The Task Force recommends that each profession systematically determine whether appropriate items in the Framework are included as part of its standardized examinations for licensure and certification.

The Task Force encourages clinical health professionals to explore creative methods for implementing the Framework using the opportunities it provides for interprofessional education. In addition, teaching the content contained in the Framework needs to emphasize the involvement of a range of health professionals beyond those represented on the Task Force.

Future Task Force Activities

The Framework presented here will be used through 2008–2009, when it will be extensively reviewed and revised. Data collection on inclusion of Framework content elements in the curricula of each of the seven professions is underway, in order to meet the require-
elements of the Healthy People 2010 midcourse review in 2005. The Framework has been endorsed by several professions on the Task Force, and explorations with their accrediting bodies have begun.

To help disseminate and implement the Framework, the Task Force plans to develop an online Clinical Prevention and Population Health Resource Center. A web-based searchable database could eventually provide access to curricula for each of the 19 domains of the Framework, and searches would be possible to identify curricula for specific clinical disciplines and for teaching using a variety of formats. Linkages to educational consultations and continuing education programs may also be available through the Resource Center.

The Task Force will examine other options for implementing the Framework. For instance, the Task Force will examine the implications of the IOM recommendation that "all undergraduates should have access to education in public health." To facilitate implementation of the Framework, graduate-level health professional programs might recommend an undergraduate public health course as part of their preprofessional preparation.

The Task Force succeeded in bringing together a wide spectrum of clinical health profession groups and developed a common framework for organizing, implementing, and monitoring curricula in clinical prevention and population health. Continued success will require building on this interprofessional communication and collaboration to develop models for interprofessional education.

This publication/project was made possible through Cooperative Agreements between the Office of Disease Prevention and Health Promotion (ODPHP) and the ATPM (award HPU010052-03), and the Health Resources and Services Administration (HRSA) and ATPM (award U78 HP001065). Its contents are the responsibility of the authors and do not necessarily reflect the official views of ODPHP, HRSA, or ATPM.

References

Why a Clinical Prevention and Population Health Curriculum Framework?

Richard K. Riegelman, MD, PhD, Clyde H. Evans, PhD, David R. Garr, MD

The accompanying article describes the Clinical Prevention and Population Health Curriculum Framework (Framework), unanimously approved by the Healthy People Curriculum Task Force representing seven clinical health professions. The Task Force was convened by the Association of Teachers of Preventive Medicine and the Association of Academic Health Centers with support from the Department of Health and Human Services' Office of Disease Prevention and Health Promotion and Health Resources and Services Administration. It represents a unique collaborative effort aimed at developing a common framework and common strategy for improving clinical health professional education.

To understand the construction of this document, its selection of content, and its future potential, it is important to appreciate the strategy and goals behind its development. The required level of core content in this area was assumed to be similar enough across key health professions that a common curriculum framework could be developed while still allowing each profession to tailor its own curriculum.

The goal of the Framework is to provide a structure for (1) communication and collaboration within and among health professions, (2) organizing curriculum, and (3) monitoring curriculum. A consistent title and common terminology were considered essential to facilitate communication among the professions. It is strongly recommended that all participating clinical health professions adopt the terminology "clinical prevention and population health" to describe this content area. It is also recommended that the four components be called evidence base for practice, clinical preventive services—health promotion, health systems and health policy, and community aspects of practice.

The four components of the Framework are designed to provide a common structure for the curriculum. The domains of these components serve as a checklist for monitoring curriculum and potentially for ensuring that students' knowledge is appropriately examined using standardized testing methods.

A number of compromises were inherent in the process of developing the Framework. The first compromise was between incorporating the Framework content into the overall curriculum versus teaching the materials as discrete courses. The Framework encourages inclusion of components of the Framework throughout the degree program, but also stresses the need for integration and synthesis of the materials near the end of the health professional degree program using case studies, experiential learning, or other active participation teaching methods.

A second compromise was between providing basic knowledge and skills and providing an introduction to more advanced or specialized content areas. Basic knowledge and skills are emphasized. Introductory to selected issues relevant to all health professionals such as health policy, global health, and environmental health are included in the Framework. Hard choices were made to ensure that the curriculum is realistic and acceptable to the participating clinical health professions. It was decided to exclude other important but more specialized curricula such as leadership skills, administrative knowledge, and program planning and evaluation.

Finally, it was recognized that there are limitations in the ability to create a common curriculum framework. Thus, the Task Force intentionally avoided recommendations regarding the number of curriculum hours as well as the specific methods for instruction or testing.

Despite some inherent limitations, the Clinical Prevention and Population Health Curriculum Framework is expected to serve as a vehicle for communication, organization, and monitoring of curricula. It is a work in progress that is intended for ongoing discussion and revision. We invite the readership of the American Journal of Preventive Medicine to actively participate in this process.

The collaboration among health professions demonstrated in the development of the Framework will hopefully mark the beginning of a continuing effort to make clinical prevention and population health a central feature of clinical health professional education and an opportunity for interprofessional education.

Reference
Healthy People Curriculum Task Force
A Commentary by the Surgeon General
Richard H. Carmona, MD, MPH, FACS

The implementation of disease prevention and health promotion activities throughout the nation continues to be an important goal. The United States realized significant health gains in the past century; however, significant challenges remain. For decades, we have not done enough about our unhealthy eating habits, lack of physical activity, and other poor choices that negatively impact our individual and societal health.

Approximately half of all deaths each year in the United States are preventable, caused by modifiable behaviors such as tobacco use, poor nutrition, and physical inactivity. Recent events such as the outbreak of severe acute respiratory syndrome, the obesity epidemic, and the events of September 11, 2001, highlight the need for a network of healthcare professionals who can effectively respond to public health threats. The patient-provider relationship has also changed to encompass a shared decision-making process that is dependent on strong health literacy skills and coordination among a team of multidisciplinary health professionals.

To meet these challenges, we must redefine how we educate our future healthcare professionals. As Surgeon General, my job is to protect and advance the health of the nation. To accomplish that mission, we must move our society and our health professions from the current treatment-oriented focus to a prevention-oriented focus.

Contemporary education in the health professions is a result of numerous events over the past century. The influential leadership of William Osler focused the training of health professionals in large, centralized medical centers. The release of the Flexner Report spurred the standardization of medical education and the formation of various accreditation organizations. Ultimately, all health profession training programs were standardized, with periodic reviews to maintain accreditation status. In addition, advances in technology, basic science research, and medical and surgical interventions took a reductionist view of disease management with an emphasis on highly trained specialists to treat organ-specific diseases. Together, these events formed the foundation for contemporary health professions education with a primary focus on the diagnosis and treatment of diseases. The role of prevention is rarely emphasized.

In this issue, Allan et al. introduce a prevention curriculum that can be incorporated into the training of all clinical health professions. This curriculum was developed by a consortium of leaders, including allopathic physicians, osteopathic physicians, nurses, nurse practitioners, dentists, pharmacists, and physician assistants. These healthcare leaders were assembled by the Association of Teachers of Preventive Medicine and the Association of Academic Health Centers with support from the Office of Disease Prevention and Health Promotion of the Office of Public Health and Science, U.S. Department of Health and Human Services. They were acting to meet the following Healthy People 2010 objective: "Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for healthcare providers includes the core competencies in health promotion and disease prevention."

This "basic curriculum" contains four core components with 19 domains that can be considered for inclusion in educational programming. The content, timing, and method of delivery are ultimately decided by each institution. This allows for a set of common prevention principles to be tailored to each profession. It builds on the traditional health professions curricula by placing equal importance on diagnosis, treatment, clinical preventive services, and population-level services.

The time is right for health profession education to align its focus with disease prevention and health promotion principles as the core of healthcare practice. This curriculum will help future generations of health professionals to view public health and clinical preventive services as integrated skills necessary for all health professionals—rather than as separate skills necessary for only a few.

I congratulate the consortium on developing a curriculum that transcends boundaries to facilitate a uniform approach to prevention education. The timeliness and importance of this curriculum are reflected in its unanimous acceptance by the representatives of all seven disciplines in the consortium.

Address correspondence to Office of the Surgeon General, 5600 Fishers Lane, Room 18-06, Rockville MD 20857.

Am J Prev Med 2004;27(5)
We know that prevention makes sense, that it works, and that it can be cost-effective. Several federal programs address prevention, including the development of national health objectives (Healthy People2010), evidence-based prevention guidelines (Guide to Clinical Preventive Services and Guide to Community Preventive Services), and integrated community interventions that address the burden of chronic disease (President’s HealthyPeople2010 initiative). Further support through funding, policy development, and educational programming will strengthen our ability to protect and advance the health of all Americans. These efforts, combined with the widespread implementation of a prevention curriculum, will help move U.S. health professions and the society in a healthier direction.

References
Clinical Prevention and Population Health
Getting There from Here

Timothy S. Carey, MD, MPH, William L. Roper, MD, MPH

All health professions engage in preventive activities. The science of prevention has advanced substantially over the past 20 years. These advances range from clinical applications of the basic science of immunization and chemoprevention to social science approaches such as enhancing provider—patient communication, or implementation of preventive practice approaches in communities through social marketing and mass communication. In addition, clinical epidemiology and evidence-based practice methods have generated systematic and regularly updated summaries of evidence for preventive interventions, giving providers and the public much more confidence in the effectiveness of recommended interventions.

The Association of Teachers of Preventive Medicine (ATPM) is to be congratulated for its efforts to provide a comprehensive curricular outline, as well as the recommendation that all health professions incorporate prevention into their curricula. The specific emphases within the curriculum should, of course, vary across professions. For example, preventive principles are extraordinarily important within dentistry, but detailed knowledge of immunization schedules will likely not be appropriate. The ATPM’s ongoing efforts to provide curricular examples will be very useful to deans and course directors.

The breadth of the ATPM’s effort is remarkable. Issues of clinical epidemiology, health policy, and many other areas are important, but not unique, to prevention. Acute and chronic clinical care and health policy also need to be informed by data on the incidence and prevalence of disease, positive and negative predictive value of diagnostic tests, and payment issues. Whether these curricular components are taught in a course titled “prevention,” “health policy,” or “clinical epidemiology” is much less important than that they be taught, and taught well. We accept as a given that every curricular hour in health profession schools is currently accounted for and jealously guarded by course directors. Creating new courses with additional contact hours for students may be difficult from both logistical and political perspectives. Implementation of these curricular elements will require leadership on the part of deans, curriculum coordinators, and department chairs. Equally important will be creativity in recognizing where these curricular components are already taught, and then modifying and incorporating them into the overall prevention and community health curriculum.

The ATPM can serve its constituent institutions well by providing examples and case studies of such coordinating functions. For example, global health issues may already be partially addressed through an infectious disease course discussing emerging infections and their transmission across continents. If such a lecture or seminar already exists, the necessary additional step is to place the topic of emerging illnesses into the context of community practice.

Three of the four major curricular components will almost certainly seem quite intuitive to readers: evidence base of practice, clinical preventive services, and community aspects of practice. The ATPM recognizes that health systems and health policy as core components of clinical prevention and population health may seem novel. We agree with the ATPM committee regarding the importance of this knowledge, although perhaps for somewhat different reasons. Knowing how a preventive intervention is implemented is critically important in understanding how to get from the evidence base for the effectiveness of colon cancer screening to development of appropriate payment methodology for cancer preventive interventions. Recognizing that lack of appropriate payment may be a reason for inadequate implementation of a preventive intervention is important, just as knowing the positive predictive value of the screening test is important.

One unstated rationale of the committee’s work relates to the importance of professionalism in “health profession schools.” Health professionals are not simply technicians implementing guidelines and protocols. Part of our professional obligation is to further our professions through advancing knowledge and intervening to improve the health of the populations we serve. Knowledge of the structure of the U.S. healthcare system can lead to more constructive channeling of frustration, as well as provide guidance regarding ways to modify healthcare policies to encourage increased

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Am J Prev Med 2004;27(3)
utilization of appropriate preventive interventions. Tailoring the content of the healthcare policy curriculum toward these ends can provide students with curricular tools that they can appropriately use throughout their careers.

Some course content in healthcare policy may focus too much on the latest "breaking news" in health, such as the details related to the recent Medicare drug benefit legislation. While interesting and topical, such a current events approach may not provide appropriate analytic tools for the future to the student. An examination of ways in which the current U.S. healthcare system provides incentives (and too often, disincentives) for preventive interventions would be important and useful. Because prevention is delivered by many professionals and various components of the healthcare system, especially important will be discussions of the interactions between the public and personal healthcare systems. A clear-eyed view of the limitations of those current interactions will be especially important.

This approved curricular framework is an important intermediate step to build on the remarkable progress of the basic and applied sciences of prevention. Just as placing a preventive guideline on a website or a laminated card may do little to change provider behavior, publishing a curricular framework will itself do little to change the behavior of health science schools. While this work is excellent and necessary, it is not sufficient. Implementation, coordination, and most importantly leadership will be needed to move this framework into practice.

Reference

RESOLUTION 8H-2007
Approval of the Fiscal Year 2008 Budget

In addition to the following overview, delegates should refer to Exhibits 1-2007 and 2-2007 below. Exhibit 1-2007 shows restricted income for fiscal years 2004 through 2008 and Exhibit 2-2007 shows restricted expenditures for the same years. The ADEA fiscal year runs from July 1 through June 30.

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

Overview of the Proposed ADEA Fiscal Year 2008 Budget

The proposed FY2008 (July 1, 2007, through June 30, 2008) Association budget was developed over the last six 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 FY2008 budget reflects the current level of programming and services with a focus on the Association's recently revised strategic goals. In particular, the Association's budget proposal supports the goals of delivering services and programs that are highly valued by members.

ADEA continues to implement and expand the efforts related to Open Membership. In addition several major initiatives are underway for the current and 2008 fiscal year including an expanding role for ADEA globally, a potential new matching service for PASS, significant enhancements to AADSAS, implementing a formal professional development strategy for members, and investing in a knowledge management data warehouse. This data warehouse is expected to house and archive all of ADEA's key survey, applicant, publication and other important dental education information. This system is intended to enable staff and ultimately members to have real-time access to archived data more easily from one system. This system will also support the work of the entire Association and particularly the Division of Knowledge Management. The FY08 budget also includes managing the ExploreHealthCareers.org website, a dynamic, multidisciplinary, interactive health careers resource for students, advisors, and health educators. ADEA is seeking additional outside funding to support this effort.

Furthermore, the proposed budget anticipates a break-even bottom line with no surplus or deficit generated by operations after the contribution to reserves. The contribution to reserves is estimated at $600,000 as scheduled by the Board of Directors in September 2002. As much as possible, budget projections are based on historical information from FY2006 and FY2007 (note that we were only through half of FY2007 when the proposed FY2008 budget was being prepared).

DOCUMENTS ATTACHED

The spreadsheet accompanying this overview includes the following comparative data:
- actual revenue and expense for fiscal years 2004, 2005, and 2006;
- the house approved budget for fiscal year 2007; and
- the staff proposed budget for fiscal year 2008.

REVENUE

The proposed total budgeted revenue for the Association in FY2008 is $14,727,655. This is a 15% increase from the FY2007 budget, while only a 7% increase from the actual revenue for FY2006. The increase is primarily driven by anticipated increases in publications income, anticipated increases in application fee revenue, and anticipated increases in contributions, grants, and meeting registration.
Membership Dues

Modest changes in total dollars by category are driven by changes in number of members based on staff estimates.

Active
There is no change in the active dues fee structure from FY2007 to FY2008. The increase is driven by the addition of one dental school.

Affiliate
The FY2008 budget in affiliate dues has been decreased from FY2007 based on the following projected change in Member Institutions. There is no proposed change in the affiliate dues structure. The proposed budget is based on 115 allied members at $945, 25 advanced members at $984, 25 non-hospital members at $3,998, 10 Canadian members at $1,815, and 6 Federal members at $3,922.

Corporate
The proposed budgeted total dues revenue in this category is based on 50 corporate members at $3,400.

Individual
The proposed budgeted total dues revenue in this category is based on the individual member count as of November 1, 2006, of 467 individual members at $125, 17 retired members, and $3,120 in dues for the Leadership Institute Alumni Association.

Student
A modest amount of student dues is budgeted for members who are 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 200 student members at $40.

Publications Revenue

The total publications revenue budget for FY2008 is approximately 40% more than FY2007 budget revenue in this category, and the change results from anticipated increases in advertising rates and volume. ADEA is now able to offer more opportunities through print and web-based advertising to advertisers, which include many of our institutional and corporate members.

Journal of Dental Education and Bulletin of Dental Education Online
Revenues of $177,939 are projected for FY2008 based on FY2006 actual data.

ADEA Opportunities for Minority Students in United States Dental Schools

ADEA Official Guide to Dental Schools
Sales of the hard copy edition of $97,591 are projected for FY2008 which is consistent with FY2006 sales. In addition, a new online Official Guide to Dental Schools is expected to generate sales of $50,000 and advertising revenue of $25,000 in FY08.

ADEA Directory of Institutional Members
Advertising and publication sales are budgeted at $50,485, based on 2006 actual data. This amount is comprised of advertising of $48,185 and publication sales of $2,300.
Web Advertising
The proposed budget of $17,333 for FY2008 is based on a modest increase from the FY2007 budget.

JDE Advertising
The proposed budget of $280,812 for FY2008 is based on an approximate 10% rate increase from the FY2006 actual figure. The addition of 30 new agencies and the increase in the number of subscribers both entice advertisers. JDE has developed a strong track record with online advertising.

BDE Advertising
The proposed budget for FY2008 is $57,000 and represents a modest increase from the FY2006 actual data.

Other Publications/Reprints
Other publications such as the ADEA Faculty Salary Survey Report, the ADEA Senior Survey Report, a new publication tentatively titled “A Survival Guide for New Faculty,” as well as JDE reprints, JDE pay-per-view, and JDE continuing education, webinars, ADEA Annual Session book sales, and other new online initiatives are budgeted at $282,067 for FY2008.

Application Fees
AADSA
The proposed FY2008 revenue budget for AADSAS is $7,373,170. This is based on current year-to-date experience and on an expected increase in applicants and a minimal increase in fees. The proposed increase in fees will not change the fees charged to individuals applying to ten or fewer dental schools (approximately 50% of the applicant pool). The fee reduction program, which reduces or eliminates the financial burden for qualifying applicants, has been greatly expanded in the FY2008 budget. The AADSAS revenue projection is based on FY2006 historical and current FY2007 data through November 2006.

PASS
The proposed FY2008 revenue budget for PASS is $1,710,000 and represents a 4% increase from the FY2006 data. The PASS revenue projection is based on FY2006 historical and current FY2007 data through November 2006.

AClient User Fee
Income of $89,100 has been budgeted for FY2008 and represents no change from the FY2007 budget.

Grants and Contributions
Foundation Support
Budgeted support of $200,000 is based on anticipated continued support for the AAMC/ADEA/RWJF Summer Medical and Dental Education Program (SMDEP).

Fellowships and Scholarships
Budgeted at $88,000 based on ADEA’s portfolio of annual fellowships and scholarships.
**Sponsor Fees**
Budgeted at $818,358 and includes sponsorship of the ADEA Annual Session in the amount of $287,600 and other conferences and programs in the amount of $530,758. These figures are based on prior year actual figures and current expectations and commitments already made for FY2008.

**Corporate Support (Other)**
This item is budgeted at $30,000 for support of the Leadership Development for Diversity Officers initiative.

**Other Contributions**
This is budgeted at $27,700 and includes contributions from the ADEAGies Foundation for ADEA’s Leadership Institute and the Allied Leadership Program.

**Meetings Registration Income**
Total meeting revenue is budget at $1,055,573 for FY2008 and includes both meeting registration and exhibitor fees. This does not include corporate support for meetings, which is noted above under Sponsor Fees revenue and totals $818,358. Association meetings have been budgeted for FY2008 based on the Board’s articulated goal of financial neutrality while taking into account specific subsidies as approved by the Board of Directors.

**Annual Session and Exhibitor Fees**
Registration and exhibitor fees for the March 2008 Annual Session in Dallas are budgeted at $758,523 for FY2008 based on a $329 member registration fee, a $629 nonmember fee, and prior year actual attendance figures. This represents a modest increase consistent with previous decisions of 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.

**Other Conferences**
The meeting registrations for all conferences are budgeted at $246,050 with the expectation that registration fees and sponsorships will cover the fully loaded costs of each meeting, as approved by the ADEA Board of Directors. There will not be an International Women’s Leadership conference in FY2008.

Multimedia broadcasts of meeting programmatic content are expected to generate $40,000 in revenue on a pay-per-view basis.

**Other Income**
Other Income has been projected at $323,000 in FY2008, which is primarily income from the ADEA investment portfolio. Based on actual results through November 2006, the FY2007 activity is consistent with FY2006 results and is on target to exceed budget for FY2007.
EXPENSES

Total expenses recommended in the proposed FY2008 budget are $14,722,655. This is a 15% increase from the FY2007 expense budget, while only a 13% increase from the actual expenses for FY2006. This increase is driven by a 21% increase in Personnel Costs (which includes employee salaries, temporary help, payroll taxes, benefits, legal fees, auditing fees, consultants, speaker honoraria, stipends, and investment fees), a 9% increase in Travel Costs, and a 10% increase in Other Costs as compared to the FY2007 budget.

Personnel Costs and Fees
Total Personnel Costs and Fees are projected at $7,191,516 in the proposed FY2008 budget. This is a 19% increase from FY2006 actual Personnel Costs and Fees.

Full-time Salaries
A 5% pool is budgeted for salary adjustments in FY2008. The increase in full-time salaries also takes into account the addition of two new positions in Information Technology and two new positions in Publications. In addition to these four positions there are five additional positions included in FY2008 salary expense that were added after the FY2007 personnel budget was developed. These additional positions drive the increases in payroll taxes and benefits as well.

Temporary Salaries
Expenses for temporary staff are budgeted at $192,000 based on projections for FY2007 and represent a decrease of more than 50% from the FY2006 actuals due to efficiencies gained by the enhancements to AADSAS including the transcript verification service launched in FY2007 and an electronic letters of recommendation service planned for FY2008. These services provide a significant increase in the usability for both applicants and admissions officers.

Benefits
Employee benefits are conservatively budgeted at 18% of salaries, assuming that all new positions will be filled and that employees filling these positions will be eligible for all benefits during FY2008. Based on information provided by ADEA's insurance carriers, health insurance costs are expected to increase by approximately 11%. The benefits expense projections include employee retirement benefits as well as health insurance. For FY2008 ADEA has also implemented a new employee benefit which increases the employer-paid portion of the health and dental insurance by 10%.

Legal and Auditing Fees
The legal and audit fees are based on historical experience and projections of required services in FY2008.

Consultants/Honoraria
Consultant expense is budgeted at $1,599,523 and includes expenses for consulting services, honoraria, and stipends. Specifically, honoraria and stipends are budgeted at $186,800. The proposed consultant budget includes services for outsourced accounting, human resources, development, and editorial and production services as well as consultants for both the ADEA CCI and GME initiatives.
Travel
Travel expenses are budgeted based on a 9% increase from the FY2007 budget and expectations for FY2008.

Other Costs
Bank and Credit Card Charges
With the increased level of credit card payments via the online application process for membership and application services, expenses are projected at $258,500 for credit card processing fees for FY2008. The projection is based on FY2006 actual data.

Developmental Programming
This is budgeted at $488,320 based on current software vendor agreements. This proposed budget represents a 15% increase from FY2006 actual data to include new projects such as the development of the ExploreHealthCareers website, development of a data warehouse in the Division of Knowledge Management, and the online *Official Guide to Dental Schools*.

Data Processing
Data processing is budgeted based on the costs for the transcript verification service as well as the proposed electronic letters of recommendation service for AADSAS.

Computer Operations
This is proposed at $291,105. This expense includes payments for AClient User Fee, a state legislative monitoring service, hosting the association management system, Association Anywhere, hosting the online *Journal of Dental Education*, and the implementation of an information security system.

Office Supplies
This is budgeted at $113,400 for FY2008. The reduction from 2006 actuals is based mainly on the cost savings associated with launching the proposed electronic letters of recommendation service for AADSAS.

Rent and Refurbishing Expense
The budget for rent is $588,100 based on the 10 year office lease effective as of September 1, 2004.

Equipment Rental
The budget for equipment rental is $179,734, which primarily includes equipment rented during meetings and conferences, and the office equipment that is leased and used at ADEA’s office. In the past this expense was included in the meetings expense line item for on site audio visual costs. In the FY2007 and FY2008 budget this particular expense has been broken out.

Insurance
Insurance expense is budgeted at $80,000 based on estimates provided by insurance vendors for the Association’s directors and officers’ insurance and business insurance rates for FY2008.

Memorials and Contributions
Budgeted at $52,500. The decrease from prior year is due to the end of the five-year period of the Memorandum of Understanding signed in 2001 that required ADEA to make an annual contribution to the ADEAGies Foundation. The five-year period ended in December 2006.

*Employee Professional Development*
Employee Professional Development is allocated at a flat rate per employee, in addition to any specific requests by senior staff.

*Miscellaneous Expense*
The proposed budget for miscellaneous expenses includes $25,000 for administrative support for the ADEA President’s home institution. This is an increase from $15,000 and reflects the increased administrative personnel costs.

*Meetings Expense*
Meeting Expense is budgeted at $1,556,818 which is slightly higher than the FY2006 actual data. These costs are related only to on site expenses such as food and beverage, room nights, and meeting room expenses. Association meetings have been budgeted for FY2008 based on the Board of Directors’ goal for all of ADEA meetings of financial neutrality while taking into account specific subsidies as approved by the Board of Directors.

*Awards and Fellowships*
This is budgeted at $88,000 for ADEA’s portfolio of annual fellowships and scholarships.

*Marketing*
This is budgeted at $221,421 for existing advertising sales commission expense as well as newly proposed expenditures for advertising, marketing and affinity items, new products, services, technology, and attendance marketing. This is consistent with the FY2007 budget and is driven largely by Association’s continued efforts related to Open Membership and specifically the campaigns under way to increase both the allied and advanced dental education institutional membership.

*Contribution to Reserves*
$600,000 is the proposed budget for the contribution to reserves for FY2008.

All other expenses such as: telephone and fax; postage and freight; printing and reproduction; depreciation and amortization; repairs and maintenance; dues, subscriptions, and membership fees; recruitment and retention expenses; and miscellaneous expenses were based on FY2006 actual expenses and expectations for FY2008.
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<thead>
<tr>
<th></th>
<th>FY 2004 Revenue</th>
<th>FY 2005 Revenue</th>
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<td>AADSAS</td>
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<td><strong>GRANTS</strong></td>
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<td>W.K. Kellogg Foundation</td>
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<td>Sponsor Fees</td>
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<td><strong>MEETINGS REGISTRATION</strong></td>
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<td>Annual Session/Exhibits Fees</td>
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<td>Deans’ Conference Fees</td>
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<td>Other Meetings</td>
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<td><strong>TOTAL MEETINGS REGISTRATION</strong></td>
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<td><strong>OTHER INCOME</strong></td>
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<tr>
<td>Investment &amp; Other Income</td>
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<td>369,332</td>
<td>343,843</td>
<td>202,149</td>
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<td><strong>TOTAL REVENUES</strong></td>
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<td>11,491,469</td>
<td>13,753,437</td>
<td>12,722,06</td>
<td>14,727,655</td>
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### Exhibit 2-2007 Expense Budget

#### Fiscal Year 2008

<table>
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<tr>
<td><strong>Full-time salaries</strong></td>
<td>2,721,301</td>
<td>2,904,297</td>
<td>3,248,180</td>
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<td><strong>Temporary salaries</strong></td>
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<td>235,697</td>
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<td>314,194</td>
<td>588,889</td>
<td>588,198</td>
<td>684,000</td>
<td>588,100</td>
</tr>
<tr>
<td><strong>Capital Expenditures</strong></td>
<td>155</td>
<td>6,234</td>
<td>33,491</td>
<td>700</td>
<td>5,237</td>
</tr>
<tr>
<td><strong>Depreciation/Amortization</strong></td>
<td>245,169</td>
<td>352,524</td>
<td>386,636</td>
<td>362,537</td>
<td>410,333</td>
</tr>
<tr>
<td><strong>Equipment Rental</strong></td>
<td>113,539</td>
<td>32,940</td>
<td>28,737</td>
<td>191,418</td>
<td>179,734</td>
</tr>
<tr>
<td><strong>Repairs &amp; Maintenance</strong></td>
<td>19,497</td>
<td>33,380</td>
<td>52,187</td>
<td>78,245</td>
<td>84,580</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td>46,786</td>
<td>72,434</td>
<td>80,510</td>
<td>75,000</td>
<td>80,000</td>
</tr>
<tr>
<td><strong>Memorial/Contributions</strong></td>
<td>273,237</td>
<td>248,715</td>
<td>533,346</td>
<td>325,000</td>
<td>52,500</td>
</tr>
<tr>
<td><strong>Dues/Subscript./Membership Fees</strong></td>
<td>52,661</td>
<td>62,389</td>
<td>98,717</td>
<td>98,098</td>
<td>157,592</td>
</tr>
<tr>
<td><strong>Employee Prof. Development</strong></td>
<td>12,813</td>
<td>32,103</td>
<td>34,367</td>
<td>54,060</td>
<td>71,110</td>
</tr>
<tr>
<td><strong>Miscellaneous Expense</strong></td>
<td>26,298</td>
<td>51,728</td>
<td>3,274</td>
<td>45,465</td>
<td>46,065</td>
</tr>
<tr>
<td><strong>Meeting Expense</strong></td>
<td>1,285,560</td>
<td>1,577,533</td>
<td>1,453,475</td>
<td>1,667,583</td>
<td>1,556,818</td>
</tr>
<tr>
<td><strong>Recruitment &amp; Retention</strong></td>
<td>11,624</td>
<td>2,266</td>
<td>4,117</td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td><strong>Awards &amp; Fellowships</strong></td>
<td>1,735,519</td>
<td>130,705</td>
<td>258,210</td>
<td>97,400</td>
<td>88,000</td>
</tr>
<tr>
<td><strong>Marketing</strong></td>
<td>54,198</td>
<td>8,602</td>
<td>7,334</td>
<td>253,114</td>
<td>221,421</td>
</tr>
<tr>
<td><strong>Bad Debt Expense</strong></td>
<td>73,831</td>
<td>65,088</td>
<td>42,935</td>
<td>1,500</td>
<td>-</td>
</tr>
<tr>
<td><strong>Contribution to Reserves</strong></td>
<td>452,000</td>
<td>617,000</td>
<td>705,500</td>
<td>500,000</td>
<td>600,000</td>
</tr>
<tr>
<td><strong>OTHER COSTS, TOTAL</strong></td>
<td>5,985,703</td>
<td>5,332,783</td>
<td>6,505,439</td>
<td>6,325,278</td>
<td>6,998,872</td>
</tr>
<tr>
<td><strong>TOTAL EXPENSES</strong></td>
<td>11,305,958</td>
<td>11,239,572</td>
<td>12,966,521</td>
<td>12,722,066</td>
<td>14,727,655</td>
</tr>
<tr>
<td><strong>NET SURPLUS (DEFICIT)</strong></td>
<td>(1,058,959)</td>
<td>251,897</td>
<td>786,916</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: Net Surplus (Deficit) In FY2004 and FY2006 is a result of temporarily restricted revenues (e.g. grant funds) and not from general operations. Net Surplus in FY2005 is a result of general operations.
RESOLUTION 9H-2007
Provisional Membership of Midwestern University College of Dental Medicine

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.

Midwestern University College of Dental Medicine has made a timely application for Provisional Membership in writing and does meet the criteria for Provisional Membership. Its first dental school class will begin in the fall of 2008. The Board of Directors asks the House of Delegates to approve the following resolution:

9H-2007. Resolved, that the House of Delegates approve Midwestern University College of Dental Medicine’s application for Provisional Membership in ADEA.
I bring you greetings from Washington, D.C., a city that occasionally rises above red tape and partisan politics to pay tribute to enduring creativity. This happens to be the year of “Shakespeare in Washington,” a six-month celebration of the great Bard who had something meaningful to say about pretty much any situation. He had everyday common sense, too. This is from Much Ado About Nothing: “There was never yet philosopher,” Shakespeare wrote, “that could endure the toothache patiently.”

You get the picture. It’s hard to turn a street corner right now in Washington without running into something Shakespearean. We have Hamlet performed by tiny Ninja puppets. We have Shakespeare in Tlingit. We have Shakespeare in Hebrew. It is a very globalized Shakespeare that we’re seeing! And that resonates with me because our dental education community is going global as well.

So when we think about the theme of this Annual Session, “Creating Opportunities,” we should be thinking in part in global terms. When Shakespeare paid homage to “the great globe itself” he may have been talking about the Globe Theater, which was his world. Our “great globe” truly is the whole wide world, the flat world, the world that is being linked in amazing new ways by technology.

In A Midsummer Night’s Dream, Oberon boasts that “We the globe can compass soon/Swifter than the wandering moon.” But thanks to technology, we are lots swifter than that.

By using computers, email, fiber optic networks, teleconferencing, and new software, writes Thomas L. Friedman, “It is now possible for more people than ever to collaborate and compete in real time with more other people on more different kinds of work from more different corners of the planet and on a more equal footing than at any previous time in the history of the world.”

Friedman, of course, is the author of a best-seller, The World Is Flat, and he and others have written extensively about the way that this ability to collaborate and compete has brought relative prosperity to distant parts of the globe. And prosperity has released pent-up consumer demand, including demand for oral health services.

You can get some idea of unmet need and potential demand by looking at the ratio of dentists to population. In the United States, it is one to about 2,000. In India, it is one to more than 30,000. No wonder that India, which had 50 dental schools five years ago, now has 220 dental schools. No wonder that dental education knowledge has become a highly valued international commodity.

If you need proof that knowledge can be golden, consider the University of Adelaide, in South Australia. About a year and a half ago, it sold its dental curriculum for the equivalent of five million U.S. dollars. This kind of licensing of intellectual property will only increase as time goes on. Now think how much intellectual property is represented by our membership. All of you are stewards of knowledge that the globalized world
needs and wants. In that truth there is tremendous opportunity for the dental education community.

There is opportunity for ADEA, as well, to lead the way — not only helping our members share their knowledge with the world, but helping them benefit from international collaboration. Disease, after all, knows no boundaries, and neither does learning.

Think about a second kind of opportunity, if you will. Think about the oral health care service to the American public that may never come to be unless we keep working at it and make it happen.

ADEA’s long-held position is that, without minority practitioners, access to oral health care will be limited or absent in minority communities throughout the nation. Moreover, at the end of September 2006 the ADEA Board of Directors endorsed a statement of policy on diversity and inclusion. It says, in part, that “Diversity and inclusion are critical components of success in a global context and in an ever-changing world.” Furthermore, “ADEA believes that the number of graduates of dental and allied dental programs should reflect their representation in the population and the communities in which they will serve. Recruitment, retention, and graduation of practitioners from disadvantaged groups are goals that are important for the public’s health.”

Blacks, Hispanics, and Native Americans are the underrepresented minorities in the ranks of dental students. The percentage of Blacks and Hispanics in the general population is more than twice the percentage of Blacks and Hispanics enrolled in dental schools. For Native Americans, the disparity is just slightly less.

For some time we’ve known what we wanted to do about these disparities, guided by the recommendations of three recent landmark reports. All three are familiar to this audience — the “Missing Persons” report of the Sullivan Commission on Diversity in the Healthcare Workforce, the report of the Institute of Medicine Committee on Increasing the Diversity of the U.S. Health Care Workforce, and “Oral Health in America: A Report of the Surgeon General.” All three are major national efforts to alert the country to unmet health care needs and inequitable access to care.

We’ve known what we wanted to do, but we didn’t have the resources to do it. Now we have managed to put those resources together, to position ADEA as a leader in response to the recommendations of these major reports, and we are encouraged by what’s happening. Here are some highlights of what we’re doing.

- ADEA administers the ADEA Access to Dental Careers (ADC for short) grants in collaboration with The Robert Wood Johnson Foundation Pipeline Grant. These ADEA/W.K. Kellogg Foundation grants, totaling $1.6 million, are expected to increase minority recruitment and retention. They provide direct educational assistance to predoctoral and postdoctoral dental students. In addition, ADEA received another $500,000 grant award from the California Endowment so that four California dental schools could be added to the ADC grants program. More than 230 students have been helped by the ADC grants.
- In November, ADEA acquired www.explorehealthcareers.org. This website gives students — and advisors — a free, reliable, and comprehensive source of accurate, up-to-date information about all the health professions, including dentistry and emphasizing the allied dental professions. This is a very interesting
and engaging website that ADEA is managing. It is funded in part by a grant from the Josiah Macy, Jr. Foundation. And it has, as a primary mission, addressing the underrepresentation of minorities in the health care workforce and the lack of health professionals in underserved communities. To me, one of the best things about this site is that young minority students can read interviews and see pictures of practicing dental professionals, some of whom look like them. Instant role models!

- ADEA and the Association of American Medical Colleges have been awarded an $18.4 million grant from The Robert Wood Johnson Foundation to administer the AAMC/ADEA Summer Medical and Dental Education Program. This program funds collaborative efforts by 12 U.S. institutions — including 12 medical schools and nine dental schools — to increase their underrepresented minority enrollment. These programs include recruitment and six-week summer academic enrichment programs for freshmen and sophomore college students. Of the 954 students who have attended these programs, about half are Black and 20% are Hispanic.

- We are moving ahead with the ADEA/W.K. Kellogg Foundation Minority Dental Faculty Development Program. The W.K. Kellogg Foundation has awarded ADEA $2.4 million for a five-year period ending in 2009 for this effort. We have made seven grants that will be evaluated as models for minority faculty recruitment and development. We expect that the lessons we learn from these models will benefit all faculty recruitment efforts.

- We are continuing to work with predental advisors on a regional basis to enhance their recruitment skills for dentistry. In fact, these advisors were meeting in workshops before this Annual Session even got going. These are the people on the front line, the ones who know that you’ve got to reach students early and expand their world to include the possibility of preparing for a career in science — and specifically in dentistry.

There is some encouraging news about Hispanic applicants to dental schools: The number of Hispanic applicants to ADEA’s Associated American Dental School Application Service (AADSAS) increased 11% this application cycle. The numbers of Black and Native American applicants are relatively stable. And for the sixth year in a row, AADSAS applicants increased — this year by 8% — to a total of 11,225.

Since 2001, the AADSAS applicant pool has increased 76%. While finding this abundance of academically qualified applicants welcome news, admissions committees are challenged to look beyond grades and Dental Admission Test (DAT) scores to identify traits that will contribute to a rich and diverse student population.

For its part, AADSAS has met the challenge of keeping up with the burgeoning applicant pool by going fully electronic as of the new cycle that launches May 15. Using online real-time technology, AADSAS will collect letters of recommendation, whether hard copies or electronic documents, and make them available electronically to the schools. In addition, all applicant data will be available through the Admissions Officers Portal.

Meanwhile PASS, ADEA’s application service for advanced dental education, implemented real-time technology in the cycle that has just concluded. A record 509 advanced dental education programs now participate in PASS, and more than 3,000 individuals submitted applications in the 2007 cycle.
Last year when I reported to you at this time, ADEA had just initiated its groundbreaking Open Membership initiative, offering free membership to every faculty and staff member and every student of a member institution. As I told you then, the technology behind this Open . . . Wider . . . campaign dictated that our standing membership be zeroed out, so technically we started 2006 with no members at all. We would have been happy to reach 5,000. In fact, at the end of December 2006, ADEA membership was approaching 15,000 individual members, and we still want to bring all 60,000 potential members and every postdoctoral and allied dental program into the fold. Which brings me to our third great arena of opportunity — serving our greatly expanded membership and the Institutional Members.

I don't see a great divide here. What helps individuals helps institutions, and the opposite is true as well. Furthermore, the work that our advocacy team does on Capitol Hill benefits the entire universe of dental education, members and nonmembers alike. We just want to turn every potential member into an actual member. That's what will produce the greatest political clout.

That said, there is reason to be upbeat about our advocacy efforts. The fact that the Democrats have returned to power means that Congress will have more interest in and a more intense focus on health care, particularly on lack of access and on the uninsured. How Democratic legislators approach these issues remains to be seen.

No one expected much from the lame duck session that ended in December, because Congressional leadership was about to change. Many advocates just threw in the towel, but our people decided to work as though the 109th Congress, before it became history, was really going to take important action. On the reauthorization of the National Institutes of Health, for instance, including the National Institute of Dental and Craniofacial Research, we were told that we — we being ADEA, the American Association for Dental Research, and the American Dental Association — were the only groups raising concerns about the bill. It seems as though other advocacy groups had either bought into the proposed bill or didn’t see the bill as having a chance of moving.

The dental community, in contrast, worked diligently to raise concerns about some of the bill’s provisions within key Senate offices. We activated our dental schools and grassroots advocates in key districts. We also reached out to a number of other groups within the broader biomedical community. In the end, the groundswell of advocacy forced Congress to consider our specific concerns and revise the legislation. The NIH reauthorization bill passed, after 13 years in limbo, in the middle of the night. Most, if not all, of the ADEA-AADR-ADA legislative goals were achieved.

Likewise, the dental coalition was hard at work to influence the Ryan White CARE Act, which Congress also approved in the dead of the night. ADEA, AADR, and ADA persuaded Congress to include a provision in the bill that designates oral health care as a “core medical service.” This is an important development that guarantees that more Ryan White funds will be targeted to oral health care services. The designation also establishes parity between medical and dental services. ADEA, AADR, and ADA successfully beat back an effort to eliminate the Community-Based Dental Partnership Program and shored up support for the Dental Reimbursement Program that has returned more than $111 million to academic dental institutions for HIV/AIDS care. In spite of our best efforts, however, both programs remain significantly underfunded.
Congress also passed a stopgap measure that averted a federal funding crisis in the State Children’s Health Insurance Program (SCHIP) that would have posed a serious threat to children’s dental coverage in the program. So — urged on by dogged advocacy — a do-little Congress, in the wee small hours of the morning, passed three bills of great importance to academic dental institutions.

Success is sweet, but there is not much time to savor it before we move on with other priorities for the 110th Congress.

- Ryan White and NIH have been reauthorized, but the provisions of the law still have to be implemented. We need to pay particular attention and respond to the proposed regulations for these bills.
- Title VII Health Professions legislation and SCHIP are up for reauthorization, which can reshape the character and nature of federal programs.
- ADEA-AADR field advocacy workshops, which educate, motivate, and activate members on behalf of dental education and research, will continue. Successful workshops at the University of Pittsburgh; the University of North Carolina at Chapel Hill; the University of Medicine and Dentistry of New Jersey; the University of Nevada, Las Vegas; and the University of Louisville have prompted six additional schools to request a workshop on their campuses. When we inaugurated the program last year, our goal was to conduct three field advocacy workshops a year. We surpassed that goal and now believe we can do as many as one a month. Just invite us and we’ll be there.
- Part of our legislative priority awareness is that there is always the unexpected, something you couldn’t anticipate that arrives on the scene and gobbles up time and resources. Graduate Medical Education (GME) is a good example. For years hospitals and residency programs, including ADEA members, have relied on a 1999 letter from a top official of the Centers for Medicare and Medicaid Services (CMS), which said that didactic activities of medical or dental residents are related to patient care and can be counted toward graduate medical education funding. Now CMS is taking the exact opposite tack. We haven’t budged them yet, but we haven’t given up. My point is that when you deal with government, expect the unexpected. Take nothing for granted.

ADEA doesn’t take its members for granted, either. I don’t know if you realized this, but ADEA doesn’t offer multiyear memberships. We ask you to renew your membership every year because we want you to confirm your commitment to ADEA. ADEA’s commitment is to make it possible for you to experience the Association as a real community.

I believe you can see a hunger for affinity when you look at what happened to the membership of ADEA Sections and Special Interest Groups after Open Membership was launched. One section, Oral Biology, grew by 2,500%. The Section on Dental Hygiene Education grew from 321 members to 1,043. That makes it the second-largest section; Comprehensive Care and General Dentistry leads with 1,283 members, more than 14 times its pre-Open Membership size.

I mentioned that ADEA had nearly 15,000 individual members. It must not go without mention that some 7,800 of these — more than half — are students in dental, allied
dental, and advanced dental education programs. Here too we have a great opportunity to build affinity for academic dentistry and to join with our, mostly, younger colleagues in tackling the issues that face us today. I’ll tell you in a minute about our Fall Meetings, which were attended by a record number of 80 students — in December, right before Finals Week. Now, if that isn’t a sign of an interest in ADEA and in the work of dental education, I don’t know what is!

Affinity extends beyond individuals to institutions. Since we started our Open . . . Wider . . . campaign, 24 new allied programs, four advanced programs, six hospital programs, and eight new corporations have joined ADEA as Institutional Members. We are working hard to bring more institutions into our fold, and our member services staff members are taking great delight in providing the kinds of services and programs that will suit this ever-expanding network of institutional members.

When we created the ADEA Division of Knowledge Management a little over a year ago, we envisioned members connecting and sharing and learning around issues of mutual interest via the Internet, and now that concept has become a reality. ADEA’s Communities of Interest (COIs), which debuted this past June, are crafted to connect you with knowledge you need and with other ADEA members who share your concerns. Each community has facilitators, discussions, news, resources, opportunities for collaboration, links, frequently asked questions, a photo album, an events calendar, and a poll. They are kind of like an online interactive academic swap meet.

The first ADEA Community of Interest, Scholarship of Teaching and Learning, or SoTL, launched just this summer, now has more than 280 members. At this Annual Session, SoTL facilitators are hosting lunches centered on their topics. Those attending have been asked to bring content related to the topic to share with the others at the lunch. Then, after the Session, they’ve been asked to continue the dialogue online in the SoTL Community of Interest. And that’s one effective way to build affinity.

Since the initial launch, four new communities have debuted: ADEA Admissions, Financial Aid, and Student Affairs (AFASA); ADEA Gay-Straight Alliance; ADEA Allied Dental Education Summit; and ADEA Commission on Change and Innovation School (ADEA CCI) Liaisons. This year we will launch the ADEA Student Community and the ADEA Annual Session Attendee Collaboration Site.

Other important projects are coming out of the ADEA Division of Knowledge Management. ADEA is dedicated to expanding the information it gathers, analyzes, and reports, so that members have quick and accurate access to trends in dental education and other information about our profession. We’re very proud that ADEA’s 2006 “Trends in Dental Education,” an online resource, won Association Trends Magazine’s bronze award in the All Media contest. This is a prestigious award for the “best of the best in association media.”

ADEA also is developing a new interactive site with the working title of “ADEA Resources Benchmarking Tool,” as well as an “ADEA Data Warehouse.”

The benchmarking tool will enable each dental school to make direct benchmarking comparisons of a wide variety of data, from applicant and enrollee information to salaries and compensation.
The ADEA Data Warehouse, which will be under construction most of this year, will consolidate the rich data that ADEA has mined about dental education, creating a new information systems infrastructure that will allow us to react quickly to business needs. Through specific interfaces, users will be able to slice, dice, benchmark, and compare data. If we want to track trends in underrepresented minority applicants and matriculants over several years, we can go to the ADEA Data Warehouse. If we want to improve curriculum or manage teaching resources, we can try combining data from ADEA’s Applicant Analysis, ADEA’s Survey of Dental Seniors, and ADEA’s Survey of Dental Educators. The Warehouse will put all of our data to work for all of us, and that’s something to look forward to.

In addition to compiling data over the next year, the ADEA Division of Knowledge Management also is compiling compendiums of resources. The first one published and available is “Challenges, Obligations, and Imperatives: The Recruitment and Retention of Underrepresented Minority Students in Dentistry.” It includes nearly 60 resources related to this topic. Next out is a compendium of resources about dental faculty recruitment, retention, and quality of life.

Among this year’s opportunities for professional development, I want to mention the AADR/ADEA Academic Dental Careers Fellowship Program. New last year, it gives 11 dental and allied dental students the chance to experience the benefits and rewards of teaching. This yearlong program to mentor students interested in academic careers was launched with a $100,000 grant from the American Dental Association Foundation. It is presented by ADEA and the American Association for Dental Research.

Last year, two ADEA meetings stood out. One was the first-ever ADEA Allied Dental Education Summit, which took as its subject nothing less than the future of the allied professions and their role in solving the dilemma of access to care. That was in June. Then, in December, another “first-ever:” the first convening of five different meetings in one location, which we called the ADEA Fall 2006 Meetings. These meetings, attended by more than 450 registrants, were linked by the theme of “Connecting, Converging, Creating.” They also were linked by the chance to come together in plenary sessions to hear presentations on such challenging topics as using the noncognitive variable system to seek diversity and the “coloring of America” by demographic change.

And so we come to this meeting in this place on our great globe — this storied, magical, unique, greatly injured but greatly resilient city. This is a city renewing itself, which makes it a very appropriate setting for revitalizing ourselves professionally.

It’s been 16 years since ADEA’s Annual Session last met here in New Orleans. Some of us attended that 1991 Session and the earlier Sessions in 1982 and 1979. They were productive and memorable meetings, all of them, but I guarantee that none of them had happier news: This summer, the Louisiana State University School of Dentistry is coming home to New Orleans.

I dug down in my bag of Shakespeare quotations to try to find one that did justice to the dental school’s heroic effort in leaving New Orleans in 2005 and setting up full operation in Baton Rouge. This is what I found, from King John: “Courage mounteth with occasion.” The occasion, of course, was the destruction that Hurricane Katrina wreaked on the school’s physical site. And the courage was manifested by Dean Eric Hovland and by everyone who helped him make the move and restore classes and services —
faculty, staff, and students. All parts of the dental education community and the dental industry supported the reopening in Baton Rouge, with coordination from ADEAassist, our award-winning disaster relief fund. But the kudos belong to you and your people, Dean Hovland. We salute you and wish you much joy in your homecoming.

I extend my thanks to our Board of Directors, including Ken Kalkwarf, Eric Hovland, Jim Swift, Sandra Andrieu, Chris Arena, John Killip, Sheila Koh, Candy Ross, Ron Hunt, and Cheryl Westphal, for their service to the Association during this year. I also thank all of the volunteers who serve in leadership positions on our councils, committees, and commissions, and as our representatives to other associations and organizations.

So we return to the theme of this Annual Session, “Creating Opportunities.” There are global opportunities based on unmet need for oral health care in the far corners of the world. There are opportunities to provide for the future oral health of our own country — by ensuring that underrepresented minorities are engaged by and prepared for careers in the dental and allied dental professions. And there is a great arena of opportunity in serving our expanded — and, we hope, still expanding — ranks of members and their home institutions. We have our work cut out for us.

The ADEAGies Foundation. In 2007 we celebrate the fifth anniversary of the creation of the ADEAGies Foundation, a public foundation. At the foundation’s inception, ADEA agreed to match the original $1.5 million in funding. We reached this goal during 2006.
New Chief Administrators at Member Institutions

New Dental School Deans
Since the 2006 Annual Session, U.S. and Canadian dental schools have appointed the following new deans whose service began between the end of the 2006 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. Carole A. Anderson, Interim Dean, The Ohio State University
Dr. Wood E. Currens, Acting Dean, University of Louisville
Dr. Russell J. Czerw, Chief, Army Dental Corps
Dr. Douglas Dederich, Acting Chair, Department of Dentistry, University of Alberta
Dr. Denise Kassebaum, Dean, University of Colorado
Dr. R. Lamont MacNeil, Dean, University of Connecticut
Dr. Randy Mazurat, Acting Dean, Faculty of Dentistry, University of Manitoba
Dr. Victor A. Sandoval, Interim Dean, University of Nevada, Las Vegas
Dr. Charles F. Shuler, Dean, Faculty of Dentistry, University of British Columbia
Dr. Robert M. Taft, Dean, Naval Postgraduate Dental School
Dr. Gerry Uswak, Dean, University of Saskatchewan
Dr. Richard I. Vogel, Interim Dean, New York University

Other New Administrators at Member Institutions
ADEA Member Institutions have reported the following appointments since the 2006 ADEA Annual Session. The Board of Directors congratulates these new administrators.

University of Illinois at Chicago, Dr. Luisa DiPietro, Director, Center for Wound Repair and Tissue Regeneration
Indiana University-Purdue University Fort Wayne Dental Education, Prof. Wilhemina Leeuw and Prof. Deborah Stuart, Interim Co-Directors, Dental Assisting
University of Iowa and Dows Institute for Dental Research, Dr. Galen Schneider, Department Executive Officer of Prosthodontics
Lutheran Medical Center Department of Dental Medicine, Dr. Jeffrey Burns, Program Director, General Practice Residency
University of Michigan, Dr. Stephen C. Bayne, Chair, Department of Cariology, Restorative Sciences, and Endodontics
University of Nebraska, Dr. Timothy Durham, Chair, Department of Hospital Dentistry
University of Nebraska, Dr. Mary Lynn Froeschle, Director, Continuing Education
University of Nebraska, Dr. Merlyn Vogt, Director, Alumni Affairs
University of New Haven Dental Hygiene Department, Prof. Rosa Mo, Chair, Division of Health Professions
New York University, Dr. Michael C. Alfano, Executive Vice President
Normandale Community College Dental Hygiene Program, Prof. Doris Hill, Dean, Health Science Division
Northeast Wisconsin Technical College, Prof. Kay Tupala, Dean, Health Sciences
Nova Southeastern University, Dr. Romer Ocanto, Chair, Department of Pediatric Dentistry
Old Dominion University Clinical Sciences Department, Prof. Deborah B. Bauman, Chair, Dental Hygiene
Palm Beach Community College, Prof. Nancy C. Zinser, Associate Dean of Health Sciences
Palm Beach Community College, Prof. Colleen Bradshaw, Department Chair, Dental Health Services
Parkland College, Prof. Bobbi Scholze, Chair, Department of Health Professions
Rochester General Hospital, Dr. Samantha Vitagliano, Director, General Practice Residency
Rochester General Hospital, Dr. Jolly Caplash, Division Head, Oral and Maxillofacial Surgery
Shasta College Center for Human Development, Prof. Joan Bosworth, Dean, Dental Hygiene Department
Shasta College Center for Human Development, Prof. Charles D. Cort, Director, Dental Hygiene Department
University of Southern Indiana, Prof. Kimberly G. Hite, Program Director, Dental Assisting
St. Cloud Technical College, Prof. Mary Leblanc, Interim Director, Dental Assisting
Truckee Meadows Community College, Vickie J. Kimbrough, Director, Dental Hygiene/Dental Assisting
University of Washington, Dr. Rebecca Slayton, Graduate Program Director, Department of Pediatric Dentistry
Westmoreland County Community College, Prof. Kathie Malloy, Dean, Dental Hygiene Department
West Los Angeles College, Prof. Aracely Aguiar, Director, Department of Dental Hygiene

New Affiliate Members
Since February 1, 2006, these programs and schools have become Affiliate Members. The Board of Directors welcomes them to ADEA.

Austin Community College Department of Dental Hygiene, Prof. Renee S. Cornett, Program Director (Texas)
Burlington County College Department of Dental Hygiene, Prof. Linda Hecker, Program Director (Pemberton, New Jersey)
Central Community College, Dr. Deborah Brennan, Chief Dental Administrator; Prof. Wanda Cloet, Dental Hygiene Program Director; Prof. Marie Cecil, Dental Assisting Program Director (Hastings, Nebraska)
Community College of Denver Dental Hygiene Program, Prof. Stephanie Harrison, Director (Colorado)
Delta College, Prof. Pamela Smith, Program Director (University Center, Michigan)
Faulkner State Community College Dental Assisting Program, Prof. Michele Snider, Instructor/Coordinator (Bay Minette, Alabama)
Eastern Washington University Department of Dental Hygiene, Prof. Rebecca Stolberg, Program Director (Spokane)
Ferris State University Dental Hygiene Program, Prof. Theresa A. Raglin, Department Head (Big Rapids, Michigan)
Florida Community College at Jacksonville Dental Hygiene and Dental Assisting Programs, Dr. Jeffrey R. Smith, Program Director
Grand Rapids Community College Dental Assisting and Dental Hygiene, Prof. Bunny Bookwalter, Director (Michigan)
Gundersen Lutheran Medical Center Oral and Maxillofacial Surgery Program, Dr. Ronald L. Guttu, Director (LaCrosse, Wisconsin)
Idaho State University, Prof. Kathleen O. Hodges, Department Chair (Pocatello)
Interfaith Medical Center of Brooklyn, Dr. Ingrid Dowrich, Chief Dental Administrator and Program Director; Dr. Lynn Gargano, Pediatric Dentistry Program Director (New York)
Iowa Central College, Prof. Renee Piper, Dental Hygiene Program Director (Ft. Dodge)
Jamaica Hospital Dental Center Department of Dentistry, Dr. Deborah Anne Pasquale,
GPR Program Director (New York)
Lansing Community College Dental Hygiene Program, Prof. Sherry Kohlman, Director
(Michigan)
Lewis & Clark Community College, Prof. Michelle Shingley, Program Director (Godfrey,
Illinois)
Medical College of Wisconsin, Froedtert Memorial Lutheran Hospital, Division of Oral
and Maxillofacial Surgery, Dr. Steven R. Sewall, Chief (Milwaukee)
Midlands Technical College Allied Dental Education Programs, Dr. Martha Hanks,
Department Head; Prof. Maria Marchant, Expanded Duty Dental Assisting Program
Director (West Columbia, South Carolina)
New York City College of Technology, Dental Hygiene Department, Dr. Leonard
Friedman, Director (Brooklyn)
Peninsula Hospital Center, Dental Department, Dr. Leonard E. Schiffman, Director (Far
Rockaway, New York)
Santa Fe Community College Dental Program, Prof. Karen Autrey, Director; Dr. Aamna
Nayyar, Director, Dental Department (Gainesville, Florida)
St. Luke’s Hospital and Health Network Dental Residence Program, Dr. Daniel K.
Boden, Program Director (Bethlehem, Pennsylvania)
St. Vincent Charity Hospital/Saint Luke’s Medical Center Division of Dentistry, Dr.
William F. Lavigna, Program Director (Cleveland, Ohio)
Tri-State Business Institute Dental Assisting and Dental Hygiene, Prof. Susan Carlson,
Program Director (Erie, Pennsylvania)
Tunxis Community College Allied Health Department, Profs. Mary Bencivengo and
Claudia Turcotte, Dental Hygiene Program Coordinators (Farmington, Connecticut)
Tyler Junior College Dental Hygiene Department, Prof. Carrie L. Hobbs, Department
Chair (Texas)
Vancouver College of Dental Hygiene, Prof. Lidia Di Nicolo, Director (British Columbia)
Western Kentucky University Allied Health/Dental Hygiene Program, Prof. Lynn Austin,
Director (Bowling Green)

New Corporate Members
These companies have become Corporate Members since February 1, 2006. The Board
of Directors welcomes them to ADEA

ADA Insurance Plans
Citibank, The Student Loan Corporation
Dental EZ Group
DentaPure
Kahler Slater
Lifecore Biomedical, Inc.
Planmeca USA Inc.
Sallie Mae – Graduate & Professional Programs
SDI – Southern Dental Industries
In Memoriam

With regret, the Board of Directors announces these deaths of members as reported by Member Institutions.

Dr. William Ammons, University of Washington
Dr. David Anderson, Loma Linda University
Dr. Barbara Andoh, Columbia University
Dr. Michael Aronwits, University of Detroit Mercy
Dr. George Barankovich, University of Pittsburgh
Mr. Richard S. Carroll, Harvard School of Dental Medicine
Dr. Josué Castillo, University of Puerto Rico
Dr. Hubert R. Catchpole, University of Illinois at Chicago
Dr. Melvin I. Cohen, Harvard School of Dental Medicine
Dr. Donald Compaan, University of Washington
Dr. Leonard Crayle, University of Detroit Mercy
Dr. Jaime De Jesús, University of Puerto Rico
Dr. Frank Dobronte, University of California, San Francisco
Dr. Clifton O. Dummett, Jr., Louisiana State University
Dr. R. Jerome Ennis, University of California, San Francisco
Dr. Patrick Ferrillo, Baylor College of Dentistry
Dr. Harold Fullmer, University of Alabama at Birmingham
Dr. W. Robert Hiatt, University of Missouri-Kansas City
Dr. Alan Horowitz, University of Detroit Mercy
Dr. Sidney L. Horowitz, Columbia University
Dr. Paul Hungerman, University of Detroit Mercy
Dr. Valdemars Jekkals, University of Washington
Dr. Arthur W. Johnson, Loma Linda University
Dr. Edward Johnston, Loma Linda University
Dr. Edward G. Kaufman, New York University
Dr. John Killilea, Harvard School of Dental Medicine
Dr. Joel J. Kudler, University of California, San Francisco
Dr. John Leonora, Loma Linda University
Dr. Felix Mabunay, University of Pittsburgh
Dr. Edward Maggiore, University of California, Los Angeles
Dr. Fred Meese, University of Kentucky
Dr. John Mills, University of Alabama at Birmingham
Dr. Paul Kenneth Morse, Medical College of Georgia
Dr. Edward Lee Mosby, University of Missouri-Kansas City
Dr. Melvin L. Moss, Columbia University
Dr. Donald R. Nelson, Medical University of South Carolina
Ms. Loa Petri, University of Detroit Mercy
Dr. James W. “Woody” Powell, University of Tennessee
Dr. Don Price, University of Illinois at Chicago
Dr. Michael T. Rainwater, Medical College of Georgia
Dr. Morris Ruben, Boston University
Dr. Herbert Schilder, Boston University
Dr. Robert Schultz, University of California, San Francisco
Dr. Hans S. Sjören, Loma Linda University
Dr. E. Steven Smith, University of Nevada, Las Vegas
Dr. Howard M. Sukurov, Harvard School of Dental Medicine
Dr. Daniel C. Sullivan, University of California, San Francisco
Dr. Julius Tarshis, Columbia University
Dr. José Torres, University of Puerto Rico
Dr. Roland Walters, Loma Linda University
Dr. William R. Wege, Medical College of Georgia
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 Executive Director
Dr. Richard Valachovic, Executive Director
Dr. James Mulvihill, Director of Institutional Advancement and Corporate Relations
Dr. Linda Hanlon, Special Liaison to the ADEA Council of Allied Dental Program Directors

Division of Knowledge Management
Ms. Sue Sandmeyer, Associate Executive Director

Division of Member Services
Dr. Jane Hamblin, Associate Executive Director
Mr. Sean Carter, Membership Manager
Ms. Toni Fanelli, Senior Administrative Assistant
Ms. Lauren Gaffney, Manager of Public Relations and Publications
Ms. Sulu Ghoting, Sales and Promotion Associate
Mr. Gustavo Mendoza, Art Director
Ms. Merideth Menken, Director of Publications
Ms. Cherrill Anson, Consultant
Ms. Kris Aulenbach, Consultant

Office of Professional Development
Mr. Bart Ecker, Senior Director
Ms. Robyn Carson, Meetings Manager
Ms. Renee Latimer, Meetings Manager
Mr. Jermaine Mason, Administrative Assistant
Ms. Simone Smith, Meetings Manager

ADEA Center for Educational Policy and Research
Dr. Richard Weaver, Acting Center Director
Ms. Jackie Chmar, Policy Analyst

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

Division of Application Services
Dr. Anne Wells, Associate Executive Director
Ms. Cynthia Gunn, Customer Service Manager
Mr. Joshua Hargrove, AADSAS Official Document Coordinator
Mr. Aree Henderson, Customer Service Representative
Ms. Chonté James, Director, AADSAS
Ms. Yolanda Jones, PASS Operations Manager
Mr. Carl Kelly, Customer Service Representative
Ms. LaShaun Littlejohn, Customer Service Representative
Ms. Monique Morgan, Senior Project Manager, AADSAS
Ms. Leslie Payne, Customer Service Representative
Mr. Peter Storandt, Director of Marketing and Program Development--PASS
Ms. Jettie Taylor, Customer Service Representative
Mr. Drake Washington, Research Specialist

ADEA Center for Public Policy and Advocacy
Mr. Jack Bresch, Associate Executive Director and Center Director
Ms. Gina Luke, Director of Legislative Policy Development
Ms. Monette McKinnon, Director of Grassroots Advocacy and State Issues
Ms. Myla Moss, Director of Congressional Relations and Regulatory Affairs

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, Network Manager
Mr. Satyan Ramanna, Senior Systems Analyst

Office of the Editor, Journal of Dental Education
Dr. Olav Alvares, Editor
Prof. William Hendricson, Associate Editor
Appendix A
ADEA Bylaws

As approved by the 2006 House of Delegates

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. Memberships become effective as soon as the activation is processed and remain in effect for the following twelve months.

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).

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 preceding 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 councilor 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 committee 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. Sections are programmatic groups that provide an opportunity for the members of each to exchange information on that section’s specific academic and/or administrative interests. 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. Sections are further encouraged to undertake on their own initiative projects and studies of benefit to the Association and its members. Further, sections may submit resolutions to the House of Delegates.

Section B. Composition. Each section consists of individual ADEA members (including student, retired, and honorary members) who are interested in the section’s particular academic or administrative area(s). The Association has the following thirty-six sections:

- Academic Affairs
- Anatomical Sciences
- Behavioral Sciences
- Biochemistry and Nutrition
- 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
- Gerontology and Geriatrics Education
- Graduate and Postgraduate Education
Section C. Membership in Sections. ADEA individual members may join as many sections as they wish and may attend the meetings of any others. Section members may vote and participate in the business affairs of all sections to which they belong.

Section D. Formation. Individuals wishing to form a new section should request an application from the Central Office. The completed application should be received in the Central Office no later than August 1. Staff submits the application (if received by that date) to the Council of Sections Administrative Board for consideration at its fall meeting. The board in turn forwards its recommendation to the Board of Directors. If one or both of those bodies approves the application, it is then forwarded to the House of Delegates. Only the House has the authority to officially approve new sections. If both the Administrative Board and Board of Directors disapprove the application, it is not forwarded to the House. However, the individuals wishing to form the section may, in effect, appeal these decisions by having a delegate introduce a resolution to the House proposing the formation of the new section. The following criteria are used in considering applications:

1. Evidence that the subject area exists at a majority of the member institutions involved in the general area of which the subject is a component;
2. The stated goals and objectives of the proposed section;
3. Evidence that no existing section(s) could accommodate the needs of the proposed section;
4. A statement outlining the themes and topics that the proposed section might address; and
5. Estimated membership.

New sections begin operations immediately upon approval by the House of Delegates. New sections are on probationary status for two years following approval, and are then evaluated by the Council of Sections Administrative Board according to the criteria outlined in Section E below. During the probationary period, each new section is subject to all the privileges and responsibilities of regular sections, including the rights of its councilor and chair to sit in the House of Delegates and serve as voting members of the Council of Sections.

Section E. Review. Each year, the Council of Sections Administrative Board reviews the sections, including any sections that have completed probationary periods at the most recent annual session. Reviews are based on criteria established by the Council of Sections Administrative Board.

The Administrative Board may recommend supportive or corrective actions for those sections that fail to submit their annual reports or to perform their prescribed functions. Recommendations that sections be put on probation, dissolved, merged, or changed to special interest group status are forwarded to the Board of Directors, which has the authority to impose probation, effective for one year from the next annual session. To be effective, all actions must be approved by the House, whose decision cannot be appealed.

Section F. Officers
1. **Names.** Each section has a councilor, chair, chair-elect, and secretary.

2. **Qualifications.** A person must be an individual member of the Association and a member of a section to be eligible for office in that section.

3. **Duties**
   a. **Councilors.** Duties:
      1) To provide continuity of leadership for the section;
      2) To attend the ADEA annual sessions and interim meetings of the Council of Sections;
      3) To serve as a delegate in the House of Delegates during the annual sessions;
      4) To assist in planning, implementing, and assessing section programs and projects;
      5) To ensure the preparation of the section’s annual report that is submitted to the ADEA Central Office after annual sessions; and
      6) To serve as section liaison with the Council of Sections Administrative Board.

   b. **Chairs.** Duties:
      1) To provide leadership in the coordination of section activities;
      2) To chair section meetings;
      3) To plan programs for section meetings; and
      4) To serve as a delegate to the House.

   c. **Chairs-Elect.** Duties:
      1) To serve as chair 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 section office.

   d. **Secretaries.** Duties:
      1) To record the minutes of section meetings;
      2) To submit the minutes of section annual session meetings to the Central Office within sixty days after an annual session; and
      3) To perform any duties requested by the chair

4. **Succession.** Each year the secretary succeeds to the office of chair-elect, and the chair-elect succeeds to the office of chair. Every year, sections may elect or reelect, as necessary, a councilor to fill vacant positions. Councilors may serve up to two three-year terms.

5. **Nominations.** Before each annual session, the chair-elect and two section members who are not officers nominate one or more individuals for the office of secretary. Every third year, this nominating 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’s annual session meeting.

6. **Election.** Section officers are elected at annual session meetings. The method of voting is left to the discretion of section chairs.

7. **Installation.** All section officers are installed at section annual session meetings.

8. **Terms of Office.** Section chairs, chairs-elect, and secretaries serve one-year terms. Section councilors serve three-year terms and are limited to two such terms.

9. **Replacement.** If a section officer, other than councilor, is unable to serve for any reason, the other three officers appoint another section member to serve out the unexpired term. If the councilor is unable to serve for any reason, a new councilor will be elected by mail ballot by the section members to serve out the unexpired term. An individual may not hold two or more section offices simultaneously.

**Section G. Sessions.** Section officers plan annual session programs and submit program details to the Central Office for publication in the annual session program. The schedule of section programs is determined by the Board of Directors. Sections able to provide funding may also hold an additional meeting(s) between annual sessions.

**Section H. Quorum.** Sections have no quorum requirement.

**Section I. 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. Special interest groups may be established to provide an opportunity for their members to exchange information on specific academic and/or administrative interests. Groups are established to represent discrete interests in dental and allied dental education, but do not qualify for section status or represent individuals who seek section status. Groups may be assigned tasks by the House of Delegates and Board of Directors.

Section B. Composition. Special interest groups consist of individual ADEA members (including student, honorary, and retired members).

Section C. Membership in Special Interest Groups. The number of special interest groups that individual members may join is unlimited.

Section D. Formation. Individuals wishing to form a new special interest group should first notify the Central Office. Staff submits the request to the Council of Sections Administrative Board, which then forwards its recommendation to the Board of Directors. Both bodies must support the request for the special interest group to be formed. The following criteria are used in considering applications:
1. Evidence that the subject area exists in at least some of the member institutions involved;
2. That the stated goals and objectives of the proposed special interest group meet criteria established by the Council of Sections Administrative Board;
3. Evidence that no existing section(s) or other special interest group(s) could accommodate the needs of the proposed special interest group;
4. A statement outlining the themes and topics that the proposed special interest group might address; and
5. Size of the estimated membership.

Section E. Officer. Each special interest group has a chair.

Qualifications for Being Chair. A person must be an individual member of the Association and a member of the special interest group.

Section F. Quorum. Special interest groups have no quorum requirement.

Section G. 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.
Appendix B
ADEA Policy Statements

As revised and approved by the 2006 House of Delegates

Introduction

These policy statements as revised by the 2006 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:

a. **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.

b. **Early Selection Programs.** Have the option of waiving for students accepted for an early selection program the requirement for at least two years of preprofessional 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.

c. **Class to Which Applied.** Consider students for acceptance to only the class to which they have applied.

d. **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.

e. **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.

f. 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:

a. educating faculty, staff, students, and residents about the issue;
b. employing prompt and equitable grievance procedures;
c. setting forth formal and informal procedures and sanctions for dealing with instances of sexual harassment;
d. creating an environment that encourages persons to come forward with problems;
e. 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;
f. including safeguards protecting confidentiality and prohibiting retaliation or reprisals; and
g. implementing a process to continually monitor all aspects of the policy.

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:
   a. Examinations reflecting stated course objectives;
   b. Informing students of examination results in a timely manner; and
   c. 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.

   a. Predoctoral Programs: should have four academic year curricula or the equivalent of four-year curricula provided in a flexible format.
   b. Dental Hygiene Programs: should have curricula in a flexible format that consists of a minimum of two academic years or equivalent.
   c. Dental Assisting Programs: should have curricula in a flexible format that consists of a minimum of one academic year or equivalent.
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.
   a. 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.
   b. 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. Include cultural and linguistic concepts as an integral component of their curricula to facilitate the provision of oral health care services.

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.

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**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 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.

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**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:

**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.

Federal, state, and private entities should:

2. Funds for Advanced Education. Provide support for advanced education programs preparing dentists and dental hygienists for careers in education, research, and public service.

Dental education institutions and programs should:

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.


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.

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**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
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 prematricu-lation 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:
   a. discourage use of excessive amounts of alcohol,
   b. discourage the use of illegal and/or harmful drugs,
   c. establish tobacco-free environments and tobacco use policies,
   d. incorporate information about the adverse health effects of all types of tobacco in course offerings and its application to clinical practice, and
   e. 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.