



GUIDELINES FOR CASE REPORTS FOR ASSOCIATE FELLOW MEMBERSHIP*

General Information

As specified in the *Requirements for Associate Fellow Membership*, candidates must submit three case reports for Part 2 (oral/case) of the examination. The candidate must have provided surgical and/or restorative treatment for each of the submitted cases. Each case must be on a different patient and must be complete with the final prosthesis in function for at least one year by the beginning of the examination period.

When applications for the examination are received in the Headquarters Office, each candidate is issued an examination number. Candidates must use their assigned number to identify all materials submitted for the examination.

Case reports are due in the Headquarters Office 45 days before the examination period begins. The applicant is responsible for insuring that the case materials arrive by that date; therefore, use of a delivery process that allows verification of receipt in the Headquarters Office is recommended. **The submitted reports become the property of the American Academy of Implant Dentistry and will not be returned. After the report submission deadline, the applicants whose case reports have been received in the Headquarters Office will be notified of the specific date and time of their examinations.**

Case Requirements

Associate Fellow candidates must prepare written narrative (prose) reports for three (3) cases on three (3) different patients, which meet the following criteria:

- Single tooth
- Edentulous segment of two (2) or more adjacent teeth with a minimum of two implants
- One of the following options:
 - An edentulous arch (The presence of non-clinically relevant impacted teeth is acceptable, e.g., horizontally or bony impacted third molars. If root-form or plate-form implants are used, the case must include a minimum of four (4) implants.)
 - Immediate placement of one or more implants in the maxillary anterior segment, i.e., cuspid to cuspid.
 - A horizontal onlay graft of at least 1 cm in ridge length that results in a net increase of ridge width of at least 3mm facial to lingual (minimum 1 implant.)
 - A vertical onlay graft, which is at least 1 cm in ridge length, that increases the vertical height of the ridge at least 2 mm superior to inferior (minimum 1 implant)
 - Lateral wall sinus augmentation which results in an increase of at least 5 mm height (minimum 1 implant.)

The cases presented for the examination must include implants that are at least 3 mm in diameter and must have been in function with the final prosthesis for at least one year by the beginning of the examination period.

DO NOT SUBMIT CASES OF LESS THAN ONE YEAR IN FUCTION. Function is measured from the date of the final prosthesis to the first day of the examination period.

* Approved by the Admissions and Credentials Board, September 1997; revised to April 2018.

Case Reports

The three case reports must be submitted in electronic format either by online submission to the link provided by the AAID in your confirmation letter or a memory stick (USB flash drive).

Each electronic case report must include the following three files: written report, photographs and radiographs. Templates are provided for each of these three files as noted in the following sections of these instructions. Name each file by candidate number, case type and report type (e.g. AF001 Single Tooth Written, AF001 Single Tooth Radiographs, AF001 Single Tooth Photographs). The submitted reports become the property of the American Academy of Implant Dentistry and will not be returned. Save a copy in your files.

In addition to the three electronic case reports that include the three narrative (prose) reports, provide a fourth file that includes a copy of the patient release form for each case report.

Each file should be labeled with the candidate's examination number. As noted in the *Guidelines for Case Reports for Associate Fellow Membership*, the candidate will receive this number after his or her application for the examination is received in the AAID Headquarters Office.

Failure to comply with the case report guidelines, including the radiographs, photographs and medical histories, will greatly affect the candidate's case report score.

Case report templates can be downloaded at www.aid.com/cases in the Credentialing section of aid.com or by contacting the AAID Headquarters office. See [Instructions for Submission of Electronic Case Reports](#) for more information preparing your cases using the templates.

WRITTEN REPORT

Candidates must develop narrative (prose) reports for each of their cases that include the pertinent information listed in the following outline. In the report, the arch that was treated must be specified; and the teeth must be identified by name, not number. If an abbreviation is used in the narrative (prose) reports, it must be explained the first time that it is used.

For each report, complete the Case Report Checklist that is the first page of the written report template.

The candidate's name and office name and address must *not* appear anywhere in the reports except on the patient release form. Also, the patient's address should NOT appear in the report. Submit a copy of the patient release form; do NOT include the patient release form in the electronic case report.

WRITTEN REPORT OUTLINE

I. Patient Examination

A. History

1. Chief complaint
2. Secondary complaint(s), if applicable
3. Health history when the implant(s) was placed, which has the patient's signature (Either scan in the health history or provide a print copy with the electronic report. **If the health history is not in the English language, an English translation must also be submitted.**)
4. Laboratory findings (e.g., CBC, SMA, PTT, INR), if applicable
5. Current medications

B. Clinical examination

1. Existing dentition
2. Adjacent soft tissues
3. Periodontal charting, if applicable
4. Lip line
5. Temporomandibular joint function

- 6. Parafunctional habits
- 7. Hard and soft tissue anatomy of edentulous areas
- 8. Other findings
- C. Radiographic examination
 - 1. Findings
 - 2. Limitations
- D. Preoperative diagnosis
- E. **Patient consent form for treatment with the patient's signature** (Either scan in the health history or provide a print copy with the electronic report.)

II. Development of the Treatment Plan

- A. Treatment goals
 - 1. Patient desires
 - 2. Functional
 - 3. Esthetic
 - 4. Hygiene
 - 5. Limitations
 - a. Medical conditions
 - b. Physical
 - c. Psychological
 - d. Evaluation of existing natural dentition
- 1. Crown - root ratio
- 2. Periodontal condition
- 3. Abutment suitability
- 4. Alignment
- 5. Restorative needs
- C. Interarch relationships
 - 1. Occlusion
 - 2. Jaw relation
 - 3. Temporomandibular joint function
- D. Evaluation of edentulous ridge
 - 1. Amount of resorption
 - 2. Soft and hard tissue anatomy
 - a. Deficiencies
 - b. Limitations
 - 3. Suitability for implant(s)
- E. Prosthetic restoration selection
 - 1. Advantages
 - 2. Disadvantages
 - 3. Alternatives
 - 4. Rationale
- F. Hard and soft tissue modifications
 - 1. Grafts
 - 2. Osteoplasties
 - 3. Gingivoplasties
- G. Implant selection rationale
 - 1. Type
 - 2. Number
 - 3. Placement position(s)

III. Surgical and Prosthetic Report

- A. Surgical procedures (written, detailed surgical operative report that includes treatment dates)
 - 1. Type and amount of anesthesia
 - 2. Instruments and materials used
 - 3. Suture type and technique
 - 4. Surgical and postoperative complications

- B. Prosthetic procedures (written, detailed operative report, step-by-step, how used and why; include treatment dates)
1. Materials used (as applicable)
 - a. Impression
 - b. Die
 - c. Model
 - d. Transfer
 - e. Abutment
 - f. Restorative
 - g. Cementation
 2. Techniques
 - a. Preparation
 - b. Impression
 - c. Bite registration
 - d. Temporization
 - e. Articulation (e.g., hinge, face bow, semi-adjustable)
 3. Prosthetic delivery
 - a. Evaluation of fit
 - b. Occlusion/adjustment
 - c. Placement
 4. Follow-up

IV. Clinical Résumé

- A. Comparison of preoperative and postoperative diagnoses
- B. Type of patient instructions given (e.g., preoperative, postoperative, diet, temporization, prosthetic)
- C. Complications
- D. Patient acceptance and prognosis

V. Release of Information Form, signed by the patient (**Provide a copy of this form.**)

PHOTOGRAPHS

Post-completion photographs that meet the criteria listed in this section and show clearly the views listed below are required for each case. These photographs must clearly depict the soft tissue relationship to the implant prosthesis. The tooth (teeth) of interest must be shown in each of the photographs.

All photographs must be of good quality (diagnostic value) and should be made with a digital camera with a SRL lens of the macro type and a ring flash. (You may use a digital camera without an SRL lens and a ring flash; however, such photos often are not of diagnostic value.)

Cheek retractors must be used for all intraoral photos, and a high quality side view mirror must be used for all posterior views.

All visual images presented in the photographs must be in their natural state and must not have been altered by a graphics editing program such as Adobe Photoshop. DO NOT adjust brightness, contrast, color, stretch, draw, etc. on the photographs.

- I. **STANDARD PHOTOGRAPHS.** Eight post-completion photographs that clearly show the views listed below are required for each case:
1. Centric occlusion, right
 2. Centric occlusion, left
 3. Anterior Centric
 4. Anterior Protrusive
 5. Lateral view of left working

6. Lateral view of right working
7. Occlusal maxillary
8. Occlusal mandibular

II. ADDITIONAL PHOTOGRAPHS REQUIRED (by case type)

- A. Single tooth
 - i. Standard photographs only
- B. Edentulous segment of two or more adjacent teeth
 - i. Standard photographs only
- C. Immediate placement of one or more implants in the maxillary anterior segment cases (*13 photos total*)
 - i. Standard photographs
 - ii. Plus five additional photographs:
 1. Frontal view of proposed immediate site in the aesthetic zone prior to extraction.
 2. Occlusal view of the proposed immediate site prior to immediate implant placement.
 3. Frontal view of the proposed immediate site prior to immediate implant placement.
 4. Occlusal view of the immediately placed implant.
 5. Frontal view of immediate provisional.
- D. Edentulous cases (*8 – 11 photos total*)
 - i. Standard photographs
 - ii. *Cases that include a removable prosthesis, three additional photographs are required*
 1. Occlusal view of the superstructure without the removable prosthesis in place.
 2. Frontal view of the superstructure without the removable prosthesis in place.
 3. View of the intaglio (tissue side) surface of the removable prosthesis
- E. Graft cases (*14 photos total*)
 - i. Standard photographs
 - ii. Plus six additional photographs
 1. Pre-surgical occlusal view showing the atrophic ridge
 2. Pre-surgical facial (lateral) view showing the atrophic ridge
 3. Immediate post-surgical occlusal view
 4. Immediate post-surgical facial (lateral) view
 5. Occlusal view of healed site, typically 4 - 6 months after ridge augmentation and pre-implant placement
 6. Facial (lateral) view of healed site, typically 4 - 6 months after ridge augmentation and pre-implant placement

All photographs must comply with applicable patient privacy laws.

Sample photographs can be found online in the Credentialing section of www.aaid.com.

Do not submit any photographs that are not required.

RADIOGRAPHS

Radiographs of the following views must be submitted with each case report. All radiographs must be of diagnostic quality and have minimal distortion, and bone levels must be obvious.

1. Presurgical panograph or a full-mouth radiographic series.
2. Post-surgical (within one week of surgery) panograph or a post-surgical periapical radiograph for a single-tooth-implant.
3. Post-prosthetic (on the day of final insertion) with prosthesis or bar superstructure in place; either panographic or periapical radiographs are acceptable.

4. Completed case radiograph, taken within 12 months of the candidate's oral/case examination date. Either a panograph or a full-mouth radiographic series is acceptable.

For Grafting case, two additional radiographs are required:

5. Cross sectional cone beam radiograph of the augmentation site both BEFORE the augmentation's placement.
6. Pre-prosthetic cross sectional cone beam radiograph of augmentation site that shows
 - a. 3 mm gain in bone for onlay grafts
 - b. 5 mm gain in bone for sinus grafts

If a CT scan has been made for a case, a panoramic view and representative slices of the scan may be submitted but are **not** required.

MATERIALS TO BRING TO THE EXAMINATION

Subperiosteal Cases: Candidates who are presenting a subperiosteal implant case **must bring** the bone model from either the direct bone impression or CT scan to the examination. Do **not** submit these models with the case reports.

Study Models. During the case presentations, the candidate may use study models, but they are **not** required. Candidates who plan to use study models should bring them to the examination. Do **not** submit study models with the case reports.