

AMA Scope of Practice Data Series

*A resource compendium for
state medical associations and
national medical specialty societies*

demographics

education and training

licensure and regulation

professional organization

current literature

Oral and Maxillofacial Surgeons

American Medical Association
September 2009

Disclaimer: This module is intended for informational purposes only, may not be used in credentialing decisions of individual practitioners, and does not constitute a limitation or expansion of the lawful scope of practice applicable to practitioners in any state. The only content that the AMA endorses within this module is its policies. All information gathered from outside sources does not reflect the official policy of the AMA.



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I. Overview

The American Medical Association (AMA) Advocacy Resource Center has created this information module on oral and maxillofacial surgeons to serve as a resource for state medical associations, national medical specialty societies and policymakers. This guide is one of 10 separate modules collectively comprising the AMA Scope of Practice Data Series, each covering a specific non-physician health care profession.

Without a doubt, limited licensure health care providers play an integral role in the delivery of health care in the United States. Efficient delivery of care, by all accounts, requires a team-based approach, which cannot exist without inter-professional collaboration between physicians, nurses and other non-physician health care providers. With the appropriate education, training and licensing, these providers can and do provide safe and essential health care to patients. The health and safety of patients are threatened, however, when non-physician providers are permitted to perform services that are not commensurate with their education or training.

Each year, in nearly every state and at times on the federal level, non-physician health care providers lobby state legislatures, their own state regulatory boards or federal regulators for expansions of their scopes of practice. While some scope expansions may be appropriate, others definitely are not. It is important, therefore, to be able to explain to legislators and regulators the limitations in the education and/or training of non-physician health care providers that may result in the substandard or potentially harmful care of patients. Those limitations are brought clearly into focus when compared with the comprehensiveness and depth of the medical education and training of physicians.

Issues of access to qualified physicians in rural or underserved areas provide these providers with what, at first glance, seems to be a legitimate rationale for lobbying for expanded scope of practice. However, solutions to actual or perceived work force shortages simply cannot justify practice expansions that expose patients to unnecessary health risks.

In November 2005, the AMA House of Delegates approved Resolution 814, which called for the study of the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes and peer review of non-physician health care providers. By surveying the type and frequency of bills introduced in state legislatures, and in consultation with state medical associations and national medical specialty societies, the AMA identified 10 distinct non-physician professions that are currently seeking scope-of-practice expansions that may be potentially harmful to the public.

Each module in the AMA Scope of Practice Data Series is intended to assist in educating policymakers on the qualifications of a particular non-physician health care profession, as well as on the qualifications physicians possess that prepare them to accept the responsibility for full, unrestricted licensure to practice medicine in all its branches. It is within the framework of education and training that health care professionals are best prepared to deliver safe, quality care under legislatively authorized state scopes of practice.

It is the AMA's intention that these Scope of Practice Data Series modules provide background information for state- and federal-based advocacy campaigns where the health and safety of patients may be threatened as a result of unwarranted scope-of-practice expansions sought by non-physician health care providers.

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II. Introduction

The American Medical Association (AMA) is pleased to offer this informative module on oral and maxillofacial surgery (OMS) with the intention of aiding physicians in countering the advocacy efforts of oral and maxillofacial surgeons (also known as oral surgeons) to expand their scopes of practice to include elective cosmetic surgical procedures outside the oral and maxillofacial region and other procedures involving the soft tissues of the oral and maxillofacial region, head and neck region. This module examines the education and training of oral and maxillofacial surgeons, as well as board certification information, licensure requirements and current scope of practice for oral and maxillofacial surgeons in all 50 states. Also included are resources related to state oral and maxillofacial surgery board operation and a bibliography of medical and dental journal articles. This information will assist state medical associations and national medical specialty societies in educating legislators and regulators to evaluate oral and maxillofacial surgeons' attempts to expand their scopes of practice beyond that which their education and training have prepared them to safely perform.

While all oral and maxillofacial surgeons attend dental school, some additionally pursue a medical degree. In fact, a significant proportion of accredited training programs in oral and maxillofacial surgery require their trainees to attend medical school after graduating from dental school. This module focuses on those oral surgeons who do not pursue the medical degree.

The scope of practice for oral surgeons has been legislatively expanded in several states to include cosmetic surgery. State statutory definitions of the practice of dentistry are frequently used as the basis for determining the scope of OMS practice.¹ The American Dental Association (ADA) and the American Association of Oral and Maxillofacial Surgeons lobby for an extraordinarily broad definition of dentistry which grants state dental boards significant leeway in interpreting which procedures a dentist and/or an oral and maxillofacial surgeon may legally perform. In 1997 the ADA adopted the current model definition of the practice of dentistry:

The evaluation, diagnosis, prevention and/or treatment (non-surgical, surgical or related procedures) of diseases, disorders, and/or conditions of the oral cavity, maxillofacial area *and/or the adjacent and associated structures and their impact on the human body*; provided by a dentist, within the scope of his or her education, training and experience, in accordance with the ethics of the profession and applicable law.² (emphasis added)

It is not under contention in this module that oral surgeons are qualified to perform surgical procedures treating or correcting dental conditions within the maxillofacial (oral cavity) area. However, the surgical or medical treatment of any condition of the skin, eyelids, eyes, ears, nose or other structures in the head and neck region is clearly beyond the scope of dental training and practice. Patient safety is best protected when a licensed and trained physician provides medical and surgical care for areas outside of the maxillofacial area.

It is the AMA's position that education and training best prepare health care professionals to provide safe, high-quality care to patients. The quality of medical school training in the surgical and medical care of patients is far more encompassing than that of dental school, exposing medical students to numerous aspects of surgical care, including the pre-, peri-, and post-operative medical care of patients. Indeed, the comprehensive education a medical student receives provides the core foundation of medical knowledge upon which the new physician builds by choosing a residency in which he or she obtains advanced surgical preparation and training.

Physicians receive comprehensive medical and surgical training in the provision of aesthetic and reconstructive facial surgery through different accredited residency programs. Under the supervision of licensed physicians, residents in these surgical training programs assess patients' medical conditions and histories to evaluate their suitability for undergoing plastic or reconstructive surgery. Common to all surgical residency programs is not only advanced training in the techniques of surgery, but also in medical assessment, operative management

1. Web. American Association of Oral and Maxillofacial Surgeons (AAOMS). www.aaoms.org/gov_affairs.php?id=20. Retrieved May 24, 2008.

2. Web. American Dental Association (ADA). Current Policies. www.ada.org/prof/resources/positions/doc_policies.pdf. Retrieved November 4, 2008.

and monitoring of patients, and post-operative and follow-up medical care. Patients seeking facial plastic surgery may include trauma and burn victims, individuals born with congenital conditions, as well as patients seeking to improve their appearance through elective surgery.

Physicians pursuing residency training in plastic surgery devote an initial three years to learning the fundamentals of general surgery. After this broad exposure to surgery, the plastic surgery resident then progresses to three more years studying the sophisticated art of improving the human form's appearance and function through reconstructive and aesthetic surgery. Plastic surgeons are trained to provide reconstructive and aesthetic surgery on the entire body, including the facial region.

Otolaryngologists are physicians trained in the medical and surgical management and treatment of patients with diseases and disorders of the ear, nose, throat, and related structures of the head and neck. Residents in otolaryngology spend one year in a general surgery internship, also learning the principles of the care and management of surgical patients. The otolaryngology resident then devotes an additional four years to the medical and surgical care of the head and neck area, improving the function and/or appearance of anatomical structures through corrective, reconstructive, and aesthetic surgical procedures.

Oral and maxillofacial training programs for dentists simply cannot duplicate the medical education that physicians receive, which prepares the physician to assess and respond to unexpected medical complications observed during surgery, manage the post-operative recovery and follow-up care of patients, and fully address the systemic needs of surgical patients who may have chronic health conditions that can exacerbate their risks for adverse events during surgery.

The OMS training programs provide oral surgeons-in-training broad exposure to the principles of oral and maxillofacial surgery. However, the training a dentist receives in facial cosmetic and head and neck surgery is minimal. In fact, accreditation standards of the ADA's Commission on Dental Accreditation, the body that accredits OMS training programs, requires that OMS trainees perform (or act as first assistants) on only 75 major OMS surgeries. Furthermore, only a minimum of 10 surgeries need be accrued in the category of reconstructive and cosmetic surgery, with no experience

required for any single cosmetic procedure, including but not limited to, procedures such as rhinoplasty (plastic surgery on the nose), blepharoplasty (plastic surgery on eyelid), or rhytidectomy (facelift). Nonetheless, oral surgeons frequently incorporate these procedures into the elective cosmetic surgery services offered by their practices.

The AMA stands ready to assist state and specialty medical societies in their efforts to preserve the highest quality of care and protect the safety of patients. The American Society of Plastic Surgeons and the American Academy of Otolaryngology-Head and Neck Surgery similarly welcome inquiries and requests for assistance with OMS scope-of-practice issues.

The AMA holds patient safety in the highest regard, and opposes the practice of medicine by those oral surgeons who have not obtained a medical degree. We hope that the information contained in this module will provide the tools necessary to allow physicians to present relevant facts in response to non-physician oral and maxillofacial surgeons' efforts to increase their scope of practice to include the provision of elective cosmetic surgery on areas other than the oral cavity.

Advocacy Resource Center
American Medical Association

AMA Scope of Practice Data Series module distribution policy

The modules are advocacy tools used to educate legislators, regulatory bodies and other governmental decision makers on the education and training of physician and non-physician health care providers. As such, the AMA will distribute the modules to the following parties:

- (1) State medical associations
- (2) State medical boards
- (3) National medical specialty societies
- (4) National medical organizations

In line with the express purpose of the modules being governmentally directed advocacy, it will not be the policy of the AMA to provide the modules to individual physicians.

Organizations supplied with the modules shall mirror the intent, purpose and standards of the AMA distribution guidelines.

III. Oral and maxillofacial surgery as a profession

Definition(s)

Oral and maxillofacial surgery (OMS), commonly known to the general public simply as “oral surgery,” is the practice of dentistry that includes the diagnosis and treatment of disease, injuries, and defects involving the oral and maxillofacial region. According to the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional association representing oral and maxillofacial surgeons, these providers treat conditions, defects, injuries and esthetic aspects of the mouth, teeth, jaws and face. Their training includes a four-year graduate degree in dentistry and the completion of a four-year specialty postgraduate training program in OMS.³

OMS is listed as a dental specialty in the nationally recognized *Occupational Outlook Handbook* of the U.S. Department of Labor. That reference describes the role of an oral and maxillofacial surgeon as follows: to perform surgery on mouth, jaws and related head and neck structure to execute difficult and multiple extractions of teeth; to remove tumors and other abnormal growths; to correct abnormal jaw relations by mandibular or maxillary revision; to prepare mouth for insertion of dental prosthesis; or to treat fractures of the jaws.⁴

Specialization

Most dentists practice general dentistry while some choose to specialize. There are nine dental specialties recognized by the American Dental Association (ADA).⁵ The ADA reports that 80 percent of U.S. dentists are general practitioners, while the remaining

20 percent specialize in one of the nine specialty areas.⁶ Orthodontists make up the largest group of specialists, while oral and maxillofacial surgeons constitute the second largest group.⁷ The nine ADA-recognized dental specialty areas include:

- *Oral and maxillofacial surgeons* operate on the mouth and jaws. They diagnose and treat diseases, injuries and defects involving the hard and soft tissues of the oral and maxillofacial region.
- *Orthodontists* straighten teeth by applying braces or retainers. They diagnose, prevent, and correct malocclusion and abnormalities of orofacial structures
- *Prosthodontists* treat patients with missing or deficient teeth. They offer rehabilitation and maintenance of the oral function by using permanent fixtures, such as crowns and bridges, or removable fixtures such as dentures.
- *Endodontists* perform root canals. They diagnose, prevent and treat diseases and injuries of the pulp and associated conditions.
- *Periodontists* prevent, diagnose and treat diseases of the gums and bone that support the teeth.
- *Oral and maxillofacial pathologists* study oral diseases. They research and diagnose diseases affecting the oral and maxillofacial regions using clinical, radiographic, microscopic, biochemical or other examinations.
- *Oral and maxillofacial radiologists* diagnose diseases in the oral and maxillofacial region through the use of imaging technologies.
- *Public health dentists* promote dental health in the community through education and research. They administer dental care programs for the prevention and control of dental diseases.
- *Pediatric dentists* focus on dentistry for children.⁸

3. Web. American Association of Oral and Maxillofacial Surgeons (AAOMS). Public Information. www.aaoms.org/oms.php. Retrieved May 24, 2008.

4. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. *Occupational Outlook Handbook* 2008-09 Edition. www.bls.gov/oco/ocos072.htm. Retrieved May 24, 2008.

5. Web. American Dental Association (ADA). www.ada.org/prof/ed/specialties/definitions.asp. Retrieved June 4, 2008.

6. Web. American Dental Association (ADA). Infopak: Careers in Dentistry. www.ada.org/prof/ed/careers/infopaks/careers.pdf. Retrieved May 24, 2008.

7. Web. American Dental Association (ADA). www.ada.org/prof/ed/specialties/definitions.asp. Retrieved June 4, 2008.

8. *Id.*

General duties and responsibilities

Oral and maxillofacial surgeons examine patients to determine the nature and extent of abnormalities and injuries of jaws and adjacent bones and tissues. They perform oral surgical operations to remove infected, impacted, or malposed teeth; prepare jaws for prosthodontic appliances; and remove abnormal growths, cysts, and foreign bodies from jaws and oral structures.⁹ Dental implants and extraction of wisdom teeth are the most common procedures performed by oral and maxillofacial surgeons. The AAOMS notes that major areas of OMS practice include:

- Administration of anesthesia in dental offices and ambulatory care settings
- Dentoalveolar surgery (extraction of diseased or impacted teeth, preparation of the mouth for dentures, treatment of oral infections and biopsy of suspicious lesions of the hard and soft tissue)
- Surgical correction of maxillofacial deformities of the jaw, facial skeleton and associated soft tissues
- Orthognathic surgery to correct developmental growth abnormalities of the jaws and facial bones
- Cleft and craniofacial surgery to correct congenital and acquired defects of the maxillofacial region (this includes participating on multidisciplinary teams to correct cleft lip and palate)
- Maxillofacial trauma (repair facial injuries, set fractured jaw and facial bones, reconnect severed nerves and ducts, and treat other injuries of the face and neck region)
- Surgical and non-surgical management of temporomandibular joint disorders
- Management of pathological conditions of the oral and maxillofacial region, including cysts, benign and malignant tumors, severe infections of the oral cavity and salivary glands and reconstruction of the mouth and face following tumor removal
- Reconstructive and cosmetic surgery of the jaw, facial bone and facial soft tissues¹⁰

9. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. Occupational Outlook Handbook 2008-09 Edition. www.bls.gov/oco/ocos072.htm. Retrieved May 24, 2008.

10. Web. AAOMS. www.aaoms.org/credential_resources.php. Retrieved May 24, 2008.

While these are major areas of practice identified by AAOMS, there has been significant debate in the states between OMSs and the medical community concerning the adequacy of the training OMSs receive to prepare them to safely provide care to patients with some of the conditions listed.

Employment types and locales

While some dentists work as partners or associates to other dentists, most dentists own their own practices, operating as sole practitioners with a small staff.¹¹ Of those dentists in private practice, 78 percent are sole proprietors.¹² Those dentists who are not in private practice are often employed in hospitals or offices of physicians, as well as public health agencies and the military.^{13 14} Of those dentists specializing in oral and maxillofacial surgery, 30 percent are reported to be self-employed while the remaining 70 percent work in partnerships or other health care settings.¹⁵

In the care of patients with injuries or lesions that involve complicated dental surgical problems, oral surgeons may be part of the surgical team or may act independently in the area of their competence to provide needed care. In the hospital setting, oral surgeons may be included as members of the department of surgery,¹⁶ and may work alongside physicians, including radiologists, anesthesiologists, pathologists, oncologists, otolaryngologists-head and neck surgeons, neurosurgeons and plastic surgeons, as well as other dental specialists, such as orthodontists and/or prosthodontists.

11. Web. BLS, U.S. Department of Labor. www.bls.gov/oes/current/oes291022.htm. Retrieved May 24, 2008.

12. *Id.*

13. *Id.*

14. Web. ADA. "Infopak: Careers in Dentistry." www.ada.org/prof/ed/careers/infopaks/careers.pdf. Retrieved May 24, 2008.

15. Web. BLS, U.S. Department of Labor. www.bls.gov/oes/current/oes291022.htm. Retrieved May 24, 2008.

16. Web. American College of Surgeons (ACS). Statement on Principles. www.facs.org/fellows_info/statements/stonprin.html. Retrieved June 28, 2008.

Brief history of the profession

The early years of the 18th century marked the emergence of the father of modern dentistry, Pierre Fauchard. His revolutionary book, *The Surgeon Dentist, A Treatise on Teeth (Le Chirurgien Dentiste)*, was the first to describe a comprehensive system for the practice of dentistry. In 1760 John Baker, an immigrant from England, was the first trained dentist to practice in America.¹⁷

By the mid-19th century, the first American dental journal was published, the first dental school and national dental organization were formed, and the first act regulating dentistry was adopted. By the end of the century, toothpaste was invented and there was widespread adoption of oral hygiene.¹⁸

The dental specialty of oral and maxillofacial surgery was developed in the U.S. military. Prior to World War I, no formal training programs existed for the treatment of maxillofacial injuries. In July of 1917, then Surgeon General William Gorgas organized a working group called the “Section of Plastic and Oral Surgery.” The group’s task was to train general surgeons and dentists to work together to treat soldiers’ maxillofacial wounds. Approximately 164 physicians and 123 dentists were trained in 3–6 week courses, and then were assigned in teams, composed of one physician and one dentist, to each unit overseas. The program continued to educate both physicians and dentists in the treatment of maxillofacial injuries; graduates of these courses continued to be sent overseas, and also served in field and base hospitals during WWI.¹⁹

The U.S. military currently continues its tradition of preparing oral and maxillofacial surgeons, offering 10 accredited OMS programs in 2008: two Air Force programs (Wilford Hall Medical Center at Lackland AFB in Texas; and David Grant USAF Medical Center at Travis AFB in California); two Navy programs (Portsmouth Naval Medical Center in Virginia; and The Naval Medical Center in San Diego); and six U.S.

Army training programs (Walter Reed Army Medical Center in Washington; Madigan Army Medical Center in Tacoma, Washington; Brooke Army Medical Center in Houston; Womack Army Medical Center at Fort Bragg, North Carolina; Tripler Army Medical Center in Honolulu; and Eisenhower Army Medical Center at Fort Gordon, Georgia).²⁰

Demographics of the profession

Number of dentists and oral and maxillofacial surgeons in the work force

According to the Bureau of Labor Statistics (BLS), dentists held approximately 161,000 jobs in 2006.²¹ Oral and maxillofacial surgeons held 7,700 jobs that year as well.²²

Salary data

The BLS reports that the median annual earnings of salaried dentists in 2007 were \$141,010.²³ Salaried dentists tend to earn less than their counterparts who are self-employed in private practice.²⁴ Also, dental specialists historically earn significantly more than that of general dental practitioners.²⁵

In 2004 CNN’s *Money* magazine reported that the average pay for an oral and maxillofacial surgeon was \$211,766 with an anticipated 10-year growth rate around 16 percent.²⁶ According to the BLS, the mean annual wage for oral and maxillofacial surgeons in 2007 was \$178,440.²⁷

17. Web. ADA. History of Dentistry. www.ada.org/public/resources/history/timeline_ancient.asp. Retrieved June 28, 2008.

18. *Id.*

19. Strother M. “Maxillofacial surgery in WWI: the role of dentists and surgeons.” *Journal of Oral and Maxillofacial Surgery*. August 2003, p 493.

20. Web. AAOMS. www.aaoms.org/docs/residency/program_list.pdf. Retrieved May 24, 2008.

21. Web. BLS, U.S. Department of Labor. www.bls.gov/oco/ocos072.htm. Retrieved May 24, 2008.

22. *Id.*

23. Web. BLS, U.S. Department of Labor. www.bls.gov/oes/current/oes291021.htm. Retrieved August 16, 2008.

24. *Id.*

25. Web. ADA. Dentistry Fact Sheet. www.ada.org/public/careers/team/dentistry_fact.pdf. Retrieved August 16, 2008.

26. Web. CNN Money. “Money Magazine’s Best Jobs.” money.cnn.com/magazines/moneymag/bestjobs/snapshots/102.html. Retrieved May 24, 2008.

27. Web. BLS, U.S. Department of Labor. www.bls.gov/oes/current/oes291022.htm. Retrieved May 27, 2008.

The BLS forecasts that employment of dentists will grow at the average rate (an increase of 9 percent) for all occupations through 2016. Most jobs available to dentists and dental specialists will result from the retirement of a large number of baby boomer dentists.²⁸ The BLS projects that as the baby-boom generation ages, the need for specialty services, such as oral surgery, will increase. Today's elderly are more likely to retain their natural teeth, and will consequently require more specialized dental care than in the past.

28. Web. BLS, U.S. Department of Labor.
www.bls.gov/oco/ocos072.htm. Retrieved May 24, 2008.

IV. Billing for services

Medicare

Medicare does not include a dental plan. However, Medicare will pay for dental services that are an integral part either of a covered procedure (e.g., reconstruction of the jaw following accidental injury), or for extractions done in preparation for the radiation treatment of neoplastic diseases involving the jaw. Coverage is not determined by the value or the necessity of the dental care but rather by the type of service provided and the anatomical structure on which the procedure is performed.²⁹ There is an exception which allows for Medicare coverage when the dental procedure itself is so severe as to require hospitalization.³⁰

Medicaid

State Medicaid agencies administer their own plans but must meet federal guidelines set by the Centers for Medicare and Medicaid Services.

While states are not required to include dental services for adults (individuals 21 and older) in their Medicaid plans, Medicaid's comprehensive child health program, Early and Periodic Screening, Diagnostic and Treatment, requires dental services that focus on the prevention, early diagnosis and treatment of medical conditions.³¹

Medical and surgical services of a dentist are those services that if furnished by a physician, would be considered physician's services. They are services that, in accordance with state law, may be performed by either a physician or a dentist. The predominant reimbursement methodology used by states for medical/surgical services of a dentist is "fee for service." This means that the state has established a maximum payment amount for a particular service, or uses the maximum applicable to the Medicare program for the service, and pays the lesser of the provider's charge or this amount.³²

29. Web. Centers for Medicare and Medicaid Services (CMS). "Medicare Dental Coverage." www.cms.hhs.gov/MedicareDentalCoverage/. Retrieved August 20, 2008.

30. *Id.*

31. Web. Centers for Medicare and Medicaid Services "Medicaid Dental Coverage." www.cms.hhs.gov/MedicaidDentalCoverage/. Retrieved August 8, 2008.

32. Web. The Kaiser Commission on Medicaid and the Uninsured. www.kff.org/medicaid/benefits/service.jsp Retrieved August 20, 2008. The Kaiser Commission gathered its information from "Medicaid State Plans and State Plan amendments submitted to and approved by the Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS).

Medicaid coverage of medical/surgical services of a dentist for adults

State	Coverage
Alabama	Fee-for-service reimbursement.
Alaska	Fee-for-service reimbursement.
Arizona	Fee-for-service reimbursement.
Arkansas	Coverage limited to 12 visits per year irrespective of setting included in limits for other specified practitioners. Fee-for-service reimbursement.
California	\$1 per visit copayment requirement. Prior approval required for specified services. Fee-for-service reimbursement.
Colorado	Fee-for- service reimbursement.
Connecticut	Fee-for-service reimbursement.
Delaware	Fee-for- service reimbursement.
District of Columbia	Coverage limited to trauma care. Fee-for-service reimbursement.
Florida	\$2 per day copayment requirement for oral surgery. Fee-for-service reimbursement.
Georgia	\$2 per day copayment requirement for oral and maxillofacial surgery. Prior approval required for specified services. Fee-for-service reimbursement.
Hawaii	Coverage limited to emergency treatment for relief of pain and infection, frequency of X-rays limited by type. Fee-for-service reimbursement.
Idaho	Prior approval required for specified services. Coverage limited to preventive and restorative services. Fee-for-service reimbursement.
Illinois	Fee-for-service reimbursement.
Indiana	Prior approval required for specified services including non-emergency services provided on an inpatient hospital basis and oral surgery. Second opinions required for specified procedures, ambulatory services limited. Fee-for-service reimbursement.
Iowa	\$2 per day copayment required. Services limited to what a physician would provide. Fee-for-service reimbursement.
Maine	Prior approval required for non-emergency services. Fee-for-service reimbursement.
Maryland	Prior approval required for specified services.Services for non-pregnant adults limited to trauma care and emergency treatment rendered in a hospital emergency department. Fee-for-service reimbursement.
Massachusetts	Fee-for-service reimbursement.

Michigan	Prior approval required for specified services. Coverage limited to emergency treatment for relief of pain and infection. Fee-for-service using physician fee schedule reimbursement.
Minnesota	Prior approval required for specified services. Fee-for-service reimbursement.
Mississippi	\$3 per visit copayment requirement. Limited to trauma care and emergency treatment for relief of pain and infection. Fee-for-service reimbursement with annual maximum for specified services.
Missouri	\$0.50–\$3 per service depending on copayment requirement. Fee-for-service reimbursement.
Montana	\$3 per visit copayment requirement. Prior approval required for oral surgery. Fee-for-service or percentage of charge reimbursement.
Nebraska	\$2 per visit copayment requirement for specialists. Prior approval required for services provided on an inpatient hospital basis. Services limited to what a physician would provide. Fee-for-service reimbursement.
Nevada	Fee-for-service reimbursement.
New Hampshire	Prior approval required for services provided on an inpatient hospital basis. Fee-for-service reimbursement.
New Jersey	Prior approval required for specified services, and x-ray services costing more than \$35. Specified procedures require a second opinion. Fee-for-service reimbursement.
New Mexico	\$5–\$7 copayment requirement. Prior approval required for services provided on an inpatient hospital basis. Fee-for-service reimbursement.
New York	Fee-for-service reimbursement.
North Carolina	\$3 per episode of treatment copayment requirement. Prior approval required for specified services including complex oral surgeries. Fee-for-service reimbursement.
North Dakota	\$2 per visit copayment requirement. Fee-for-service reimbursement.
Ohio	Services limited to extractions, surgical excisions and incisions. Fee-for-service reimbursement.
Oklahoma	Services limited to what a physician would provide. Fee-for-service reimbursement.
Oregon	\$3 per visit copayment requirement for Group A individuals. Prior approval required for specified services. Specified services require a second opinion for Group A individuals. Coverage is limited to emergency treatment for pain and infection for Group B individuals. Fee-for-service reimbursement.
Pennsylvania	\$0.50–\$3 per service depending on copayment requirement. Fee-for-service reimbursement.
Rhode Island	Prior approval required for specified services. Fee-for-service reimbursement.

South Carolina	Fee-for-service reimbursement.
South Dakota	Cosmetic surgery limited to post-trauma conditions. Fee-for-service, or percentage of charge for unlisted services reimbursement.
Tennessee	\$15 per visit copayment requirement for Group B1 individuals. \$25 per visit copayment requirement. Note: Rule 1200-13-13-.04 states that Dental Services are not covered for persons aged 21 and older. Additionally Rule 1200-13-13-.10(b) 23 states that dental services are specifically excluded from coverage under the TennCare program.
Texas	Prior approval required for specified surgical procedures and services. Fee-for-service or global reimbursement.
Utah	10% of copayment required for Group C individuals. Coverage limited to trauma care and emergency treatment for relief of pain and infection for Group B & C individuals. Fee-for-service reimbursement.
Vermont	Coverage limited to 1 inpatient hospital visit per day. Fee-for-service reimbursement.
Virginia	Coverage limited to trauma care and oral surgery. Fee-for-service reimbursement.
Washington	Fee-for-service reimbursement.
West Virginia	Coverage limited to trauma care including maxillofacial surgery and emergency treatment for relief of pain and infection. Fee-for-service reimbursement.
Wisconsin	\$0.50–\$3 per service copayment requirement depending on payment. Prior approval required for specified services. Fee-for-service reimbursement.
Wyoming	Fee-for-service reimbursement.

V. Education and training of oral and maxillofacial surgeons

Dental school

Prior to acceptance into a post-graduate training program which prepares the dentist to specialize in oral and maxillofacial surgery, oral and maxillofacial surgeons (OMSs) first obtain a dental degree through an accredited dental school. Colleges of dentistry offer a four-year graduate program. Most graduates receive the degree of Doctor of Dental Surgery (DDS). Some dental schools award the alternate Doctor of Dental Medicine (DMD) degree.³³ There is no difference, however, between the two degrees. Dentists who hold a DDS or DMD receive the same education. While individual universities determine which degree is awarded, both degree programs adhere to the same curriculum standards as set by the American Dental Association (ADA) Commission on Dental Accreditation (CODA).³⁴

Interestingly, a 2000 editorial in the *Journal of Oral and Maxillofacial Surgery* discussed the confusion among the public regarding the existence of two different degrees in dentistry. The article references a 1999 survey, the findings of which the author notes, “clearly indicate that there is considerable confusion on the part of the public about the training and scope of those who have a DDS and those who have a DMD degree.”³⁵ The author suggests adopting a single degree within the profession, and notes that the 1999 survey found that “many of the respondents commented at the end of the interview that the DMD sounds more like a medical doctor because of the MD part of the abbreviation, and therefore those with this degree were able to perform more complex procedures.”³⁶ Not surprisingly, the author concluded,

“it is time to eliminate ambiguity, maximize public understanding, and adopt the degree that engenders the greatest public confidence. This is definitely the DMD degree.”³⁷

According to the ADA Web site, in 2005 there were 10,731 applicants and 4,688 first-year enrollees to U.S. dental schools.³⁸ The average annual tuition at dental schools in 2005 was \$24,286.³⁹

Dental school admission criteria

The American Dental Education Association (ADEA) is the professional organization representing the interests of dental schools and post-doctoral dental education/training programs in North America. The ADEA has developed dental school admission standards. The ADEA encourages dental schools to accept only students who have completed at least two years of undergraduate education and have taken the Dental Admission Test.⁴⁰ The ADEA suggests that dental schools encourage applicants to earn their baccalaureate degrees before entering dental school. Most first year dental students have obtained a bachelor's degree, but some are accepted to dental school after two or three years of undergraduate study and may finish their bachelor's degree while in dental school.⁴¹

33. Web. American Dental Education Association (ADEA). “ADEA Official Guide to Dental Schools”. www.adea.org/dental_education_pathways/aadsas/Documents/OG08_1-77_r4.pdf. Retrieved June 28, 2008.

34. Web. ADA. Dentistry Definitions. www.ada.org/prof/ed/specialties/definitions.asp#dds. Retrieved May 24, 2008.

35. Laskin DM. “Public Perception of the Dental Degree.” *J Oral Maxillofac Surg* 58:591-592, 2000. Referencing a survey published in the *Journal of American Colleges of Dentistry*, *J Am Coll Dent* 66:29, 1999.

36. *Id.*

37. *Id.*

38. Web. ADA. “Applicants and Enrollees.” Referencing Chmar JE et al, “US Dental school applicants and enrollees: 2005 entering class.” *J Dent Educ* 2007; 71:1098-1123. Retrieved September 5, 2008. www.adea.org/publications/adeadentaledatagance/Pages/ApplicantsandEnrollees.aspx

39. Web. ADA. Tuition. www.adea.org/publications/adeadentaledatagance/Pages/Tuition.aspx. Retrieved September 5, 2008.

40. Web. American Dental Education Association (ADEA). ADEA Official Guide to Dental Schools. www.adea.org/dental_education_pathways/aadsas/Documents/OG08_1-77_r4.pdf. Retrieved June 28, 2008.

41. Web. National Institute of Health; Office of Science Education. Oral and Maxillofacial Surgeon. science-education.nih.gov/LifeWorks.nsf/Alphabetical+List/Oral+and+Maxillofacial+Surgeon. Retrieved June 28, 2008.

Dental Admission Test (DAT)

The DAT consists of 180 multiple-choice test items and requires four hours and 15 minutes for administration. There are four topic areas covered in the DAT. Exam content and weight are as follows:

DAT topics	Number of questions
Natural sciences	100
Biology	40
General chemistry	30
Organic chemistry	30
Perceptual ability	90
Reading comprehension	50
Quantitative reasoning	40

DAT scores are reported as a standard score rather than a percentage or raw score. Scores range from 1 to 30 with the score of 17 usually signifying average performance on a national basis.⁴²

Each accredited dental school has its own application process and set of admission requirements; however, common college-level course requirements include:⁴³

Course	Undergraduate prerequisite hours
Biology with lab	8
General/Inorganic chemistry with lab	8
Organic chemistry	8
Physics	8
English	6–8
Math	6

42. Web. ADA. Dental Admission Testing Examinee Guide. www.ada.org/prof/ed/testing/dat/dat_examinee_guide_2008.pdf. Retrieved August 2, 2008.

43. Web. Based on information from the University of Pennsylvania School of Dental Medicine: www.dental.upenn.edu. Columbia University College of Dental Medicine: cpmcnet.columbia.edu/dept/dental. University of Michigan School of Dentistry: www.dent.umich.edu. University of California at San Francisco School of Dentistry: dentistry.ucsf.edu/. Retrieved August 20, 2008.

General requirements for admission into a doctoral program in dentistry are: overall DAT score of approximately 20; an average GPA of 3.5; and undergraduate coursework in biology, chemistry, English, math and physics.⁴⁴

Dental school curriculum requirements

Since 1973 the ADA's CODA has been continuously recognized by the U.S. Department of Education as the specialized accrediting agency in dental education.⁴⁵ CODA accredits dental schools, advanced dental training programs and allied dental education programs. The mission of CODA is to serve the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. Activities for CODA include: formulating and approving accreditation standards by which programs are evaluated; establishing policies and procedures for conducting the accreditation program; determining and publicizing program accreditation status; and appointing consultants and site visitors to assist in accreditation activities.⁴⁶ CODA reviews and recommends the accreditation status of OMS training programs at least every five years.⁴⁷

CODA has developed standards related to the following topics for accreditation purposes: institutional commitment and program effectiveness; program director and teaching staff; facility and resources; and curriculum and program duration.

44. *Id.*

45. In 1973 the House of Delegates for the American Dental Association approved the establishment of a Commission on Accreditation of Dental and Dental Auxiliary Educational Programs. In 1979 this name was changed to Commission on Dental Accreditation. ADA. Commission on Dental Accreditation (CODA). www.ada.org/prof/ed/accred/commission/epp.asp. Retrieved June 20, 2008.

46. Web. ADA. www.ada.org/prof/ed/accred/commission/index.asp. Retrieved August 11, 2008.

47. Web. AAOMS. "Dental Students – Selecting a Program." www.aaoms.org/dental_students.php#2. Retrieved May 27, 2008.

There are currently 57 CODA-accredited dental schools in the United States and 10 in Canada.^{48 49} Below are the pertinent accreditation standards related to dental school biomedical and clinical sciences curriculum.⁵⁰

- Biomedical science instruction in dental education must ensure an in-depth understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems.
- The biomedical knowledge base must emphasize the orofacial complex as an important anatomical area existing in a complex biological interrelationship with the entire body.
- Information on abnormal biological conditions must be provided to support a high-level understanding of the etiology, epidemiology, differential diagnosis, pathogenesis, prevention, treatment and prognosis of oral and oral-related disorders.
- Biomedical science knowledge must be of sufficient depth and scope for graduates to apply advances in modern biology to clinical practice and to integrate new medical knowledge and therapies relevant to oral health care.
- At a minimum, graduates must be competent in providing oral health care within the scope of general dentistry as defined by the school, for the child, adolescent, adult and geriatric patient, including:
 - Patient assessment and diagnosis
 - Comprehensive treatment planning
 - Health promotion and disease prevention
 - Informed consent
 - Anesthesia and pain and anxiety control
 - Restoration of teeth
 - Replacement of teeth
 - Periodontal therapy
- Pulpal therapy
- Oral mucosal disorders
- Hard and soft tissue surgery
- Dental emergencies
- Malocclusion and space management
- Evaluation of the outcomes of treatment
- Graduates must be competent in providing appropriate life support measures for medical emergencies that may be encountered in dental practice.
- Graduates must be competent in the use of critical thinking and problem solving related to the comprehensive care of patients.

Dental school curriculum

First and second years

Dental students spend the majority of their first two years studying biological sciences and learning the structure, function and diseases of the human body. During this time, dental students take basic sciences courses such as anatomy, physiology, biochemistry, microbiology and pharmacology. Classes also include dental-specific biology sciences such as oral anatomy, oral pathology and oral histology. In many dental schools, first- and second- year dental students take courses in providing care to diverse populations and principles of oral diagnosis and treatment. Dental procedures are initially practiced on models of the mouth and teeth. In some schools, dental students begin interacting with patients and providing basic oral health care during their first or second year.⁵¹

Also during the first or second year of dental school, students typically take a gross anatomy course with cadaver lab that allows dental students to study human anatomy with a focus limited to the head and neck. Students may also take a practical course focused on obtaining a medical history for application in later dental clinic settings.⁵²

48. Web. ADA. www.ada.org/prof/ed/programs/search_ddsdmd_us.asp. Retrieved August 11, 2008.

49. Web. Canadian Dental Association. Accredited Education Programs. www.cda-adc.ca/en/cda/cdac/search_aep/search1.asp?lstProvince=0&optProgram=1. Retrieved August 11, 2008.

50. Web. ADA. Commission on Dental Accreditation (CODA) "Accreditation Standards for Dental Education Programs," p. 12-16. www.ada.org/prof/ed/acc/standards/predoc.pdf. Note that not all standards related to the dental school curriculum are listed here. Retrieved August 4, 2008.

51. Web. American Dental Education Association (ADEA). www.adea.org/dental_education_pathways/educational_resources/Documents/OG_ch2.pdf. Retrieved August 12, 2008.

52. Web. Tufts University School of Medicine. dental.tufts.edu/1186142167927/TUSDM-Page-dental2w_1186142327816.html#med2. Retrieved August 11, 2008.

Third and fourth years

The third and fourth years of dental school focus primarily on clinical study designed to provide competence in prevention, diagnosis and treatment of oral diseases and disorders within the scope of general dentistry. Dental students apply basic principles and techniques related to oral diagnosis, treatment planning, restorative dentistry, periodontics, oral surgery, orthodontics, pediatric dentistry, prosthodontics and endodontics. Students learn to provide direct patient care to chronically ill, disabled, geriatric and pediatric patients. Dental students rotate through various dental clinics to treat patients under the supervision of a licensed dentist.⁵³

Dental school graduates

In 2007 there were 4,714 graduates of U.S. dental schools.⁵⁴ Of those graduates, the ADA reports that approximately 12 percent enrolled in postgraduate training programs in one of the nine recognized dental specialties, including OMS.⁵⁵

OMS training programs

According to the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization representing oral and maxillofacial surgeons, there are 99 CODA-accredited OMS training programs in the United States.⁵⁶ During the 2007–2008 academic year, 990 dentists were enrolled in OMS training programs.⁵⁷ According to the Advanced Education and Professional Affairs department of the AAOMS, approximately 180–190 trainees complete OMS training annually.⁵⁸

Some OMS training programs have affiliations with dental schools and medical schools. Other programs

are based primarily in hospitals. Although many OMS trainees receive a stipend from federal Graduate Medical Education (GME) funds, the ADA reports that many postgraduate dental programs charge tuition and/or fees to its trainees.⁵⁹ For example, in the 2005–2006 academic year, tuition and fees for the following postdoctoral dental specialty programs were:

Oral and maxillofacial surgery \$12,200
Endodontics \$23,743
Pediatric dentistry \$16,737
Prosthodontics (all types) \$21,405

It is not noted whether these post-doctoral specialty programs result in the award of an academic degree, or are simply clinical training programs for dental graduates. However, it is also noted that “Many postdoctoral programs provide stipends that cover tuition and fees for first-year students.”⁶⁰

Admission requirements for OMS training programs

Post-doctoral OMS training programs have less uniform admissions standards than do dental schools. Common admissions requirements are: a DDS or DMD degree from an accredited U.S. or Canadian dental school, National Dental Board Examination scores (90 percent or higher average on Part 1), satisfactory academic records, letters of recommendation and references. In addition to these requirements, some OMS programs may require dual admission to medical school or PhD programs.⁶¹

Categories of OMS training programs

As mentioned previously, upon completion of dental school, approximately 12 percent of new graduates enroll in advanced dental specialty education training programs. Those dentists who choose the OMS specialty have three different training pathways to consider.⁶² The traditional method is to enter a four-year OMS certificate training program, which awards the trainee a certificate of completion in OMS and qualifies the

53. Web. American Dental Education Association (ADEA). www.adea.org/dental_education_pathways/educational_resources/Documents/OG_ch2.pdf. Retrieved August 12, 2008.

54. Web. American Dental Education Association (ADEA). www5.adea.org/ide/2_1_3.htm. Retrieved August 5, 2008.

55. Web. National Institute of Health; Office of Science Education Oral and Maxillofacial Surgeon. science-education.nih.gov/LifeWorks.nsf/Alphabetical+List/Oral+and+Maxillofacial+Surgeon?OpenDocument&ShowTab=All&. Retrieved May 27, 2008.

56. Web. AAOMS. Dental Students – Selecting a Program. www.aaoms.org/dental_students.php#2 Retrieved May 27, 2008.

57. *Id.*

58. E-mail message from AAOMS. Dated September 25, 2006.

59. Web. ADA. Tuition. www.adea.org/publications/adeadentaledatagance/Pages/Tuition.aspx. Retrieved September 5, 2008.

60. *Id.*

61. Web. Baylor College of Dentistry: www.tamcd.edu; University of Alabama: main.uab.edu/ofs/; University of Texas Southwestern Medical Center: www.utsouthwestern.edu/; University of Texas Health Science Center: www.uthscsa.edu/. Retrieved May 28, 2008.

62. Web. AAOMS. Dental Students – Selecting a Program. www.aaoms.org/dental_students.php#2 Retrieved May 27, 2008.

trainee to sit for the OMS certification examination. No additional degrees are awarded through this training route.

In the second option, a candidate can attend a 5–7 year program in which the trainee is accepted into a four-year OMS certificate program, and also receives advance standing as a second- or third-year student in medical school upon completion of the OMS training. In these programs, the trainee will be awarded an OMS certificate and may optionally complete a medical degree following OMS training, if the trainee qualifies for admission into the medical school. Upon successful completion of both the OMS training and medical school, the trainee obtains a certificate of completion in OMS and a medical degree.

In the third option, the applicant enters a “dual degree” OMS training program. These programs combine either an MD or PhD with the OMS certificate program. The student is *guaranteed* a place in either medical school or a PhD program in addition to his or her placement in the OMS program. The MD/OMS dual degree programs integrate mandatory medical training and 30 months of OMS training. Upon completion, the resident is awarded an OMS certificate and an MD degree. Typically, in the PhD dual degree programs, students spend their first three years obtaining a PhD before completing the OMS certificate requirements. Most students take 7–8 years to complete the PhD/OMS certificate programs.

Of the 99 OMS training programs, 10 are military/federal programs that offer trainees the single OMS certificate upon completion. Of the remaining 89 OMS training programs, 47 offer the single OMS certificate, while the remaining 42 offer the dual MD/OMS or PhD/OMS degrees upon completion.⁶³

The OMS training programs offered through the Baylor College of Dentistry provide an illustration of the structure of the varied pathways to receive OMS training:⁶⁴

63. Web. AAOMS. Accredited Advanced Training Programs in Oral and Maxillofacial Surgery. www.aaoms.org/docs/residency/program_list.pdf. Retrieved May 28, 2008.

64. Web. Baylor College of Dentistry. www.bcd.tamhsc.edu/oralsurgery/postdoc/postdoc.html. Retrieved August 13, 2008.

Four-year OMS certificate program

The 48-month certificate-only program in OMS is made available primarily for U.S. military service trainees. The first 12 months of the program include time on the OMS service, and also rotations on the general surgery, medicine and anesthesia services at Baylor University Medical Center, functioning at the resident level. The remaining three years of the program are primarily spent on the OMS service, with intermittent rotations of one month each to the oral pathology, head and neck surgery, and oculoplastic surgery services.

MD/OMS dual degree program

The MD/OMS dual degree program is a combined program leading to a certificate in OMS and an MD degree. The minimum duration of study is 72 months. After completion of dental school, the trainee attends Texas Tech University Medical School in Lubbock as a full-time medical student with advanced standing in the second-year medical class. Six months of the fourth- year medical school program are spent on the oral and maxillofacial surgery service. After completion of medical school, the resident completes a one-year general surgery internship at Baylor University Medical Center. The remaining 24 months of the program are spent on the OMS service at Baylor College of Dentistry and Baylor University Medical Center.

Year 1	Advanced placement as a second-year medical student at the Texas Tech University School of Medicine
Year 2	Medical school, year 3
Year 3	Medical school, year 4; 6 months' rotation spent on the OMS service; after completion, awarded MD degree
Year 4	1-year general surgery internship at Baylor University Medical Center
Year 5	OMS service/training
Year 6	OMS service/training

PhD/OMS dual degree certificate program

The OMS and PhD program in craniofacial biology is a sequential post-dental school program with the PhD study and dissertation completed first, followed by the OMS training. The PhD program is jointly conducted through Baylor College of Dentistry. This course of study requires courses and research leading to preparation and defense of the student's PhD dissertation. The program design requires completion of the PhD degree, including dissertation and defense, prior to entering the OMS clinical training program.

CODA curriculum accreditation standards for OMS training programs

CODA, the accrediting body of the American Dental Association, has developed the following standards related to curriculum that are required for accreditation of all OMS certificate and dual degree MD/OMS or PhD/OMS programs:⁶⁵

- OMS training program must be a minimum of 48 months of full-time study.
 - Each OMS student must devote a minimum of 30 months to clinical oral and maxillofacial surgery.
 - Twelve months of training on the oral and maxillofacial service must be at a senior level, of which 6 months' training must occur in the final year.
 - Training in a private practice facility must be no longer than two months of the 30-month requirement.
 - Didactic and clinical courses regarding medical history and physical evaluation must be initiated in the first year of OMS training. This is required in order to ensure that students apply the principles of physical diagnosis to adults and pediatric patients throughout the training program.
 - The OMS training program must include integrated training in basic and clinical sciences.
 - Introduction in the basic biomedical sciences at a level beyond that of pre-doctoral dental school. Curriculum must include courses in anatomy, physiology, pharmacology, microbiology, and pathology. Instruction may be provided through formal courses, seminars, conferences or rotations to other services of the hospital.
- Integrated clinical science curriculum must include rotations off the OMS service, lectures and seminars given during the OMS training program by OMS trainees and staff.
 - The OMS training program must include the following rotations:
 - 30 months of clinical oral and maxillofacial surgery
 - 4 months of anesthesia rotation functioning at a level commensurate to an anesthesia resident, including regular on-call responsibilities
 - 4 months of general surgery rotation functioning at a level commensurate to a surgery resident, including regular on-call responsibilities
 - 2 months of clinical medicine rotation to gain the highest level of educational opportunity available, even if trainee does not have complete management authority over patients (this experience may be at medical student level or higher)
 - 6 months of expanded clinical or research opportunities
 - 2 months of additional clinical or medical education rotations
 - The OMS training program must include rotations in outpatient OMS procedures, ambulatory anesthesia, and emergency care.
 - OMS students must administer anesthesia to a minimum of 100 ambulatory OMS patients per year, 10 of which must be general anesthesia.
 - In the final year, OMS students must perform major oral and maxillofacial surgery on 75 patients.
 - For the surgery to be counted, the OMS student must be the operating surgeon or first assistant to an OMS attending staff member and the patient must be on the OMS service.
 - The OMS student must play a significant role in determining the diagnosis, providing preoperative care, selecting and performing the appropriate operative procedure and managing the postoperative course.
 - Surgery performed by OMS students while rotating on or assisting with other services cannot be counted toward this requirement.

65. Web. ADA. CODA. All OMS training programs awarding the certificate of completion must adhere to these standards, whether they are stand-alone training programs or dual degree programs. "Accreditation standards for advanced specialty education programs in oral and maxillofacial surgery." ada.org/prof/ed/accred/standards/oms.pdf. Retrieved June 25, 2008.

- Of the 75 major surgical patients required in the final year of OMS training, there must be at least 10 patients in each category of surgery. The categories of major surgery are defined as:

Trauma

Trauma management includes, but is not limited to, tracheostomies, open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region and repair of facial, oral, soft tissue injuries and injuries to specialized structures.

Pathology

Pathology management includes, but is not limited to, major maxillary sinus procedures, treatment of temporomandibular joint pathology, cystectomy of bone and soft tissue, sialolithotomy (removal of calculus from a salivary gland or duct⁶⁶), sialoadenectomy (excision of salivary gland⁶⁷), management of head and neck infections, including incision and drainage procedures, fifth nerve surgery and surgical management of benign and malignant neoplasms.

Orthognathic surgery

Orthognathic surgery includes correction of deformities in the mandible and the middle third of the facial skeleton. This includes, but is not limited to, deformities of the mandible, maxilla, zygoma and other facial bones.

Reconstructive and cosmetic surgery

Reconstructive surgery includes both bone grafting and soft tissue grafting procedures, augmentation procedures, temporomandibular joint reconstruction, facial cleft repair and insertion of craniofacial implants. Cosmetic surgery includes, but is not limited to, rhinoplasty (plastic surgery on the nose⁶⁸), blepharoplasty (plastic surgery on eyelid⁶⁹),

rhytidectomy (facelift⁷⁰), genioplasty (plastic surgery of the chin⁷¹), lipectomy (the excision of subcutaneous fatty tissue especially as a cosmetic surgical procedure⁷²), otoplasty (plastic surgery of the external ear⁷³) and scar revision.

While these CODA standards provide detailed requirements for the structure of the OMS training program, they fail to establish specific requirements in certain critical areas. The standards do not establish a minimal requirement of cases to perform for outpatient OMS procedures. Similarly, while the emergency care standard specifies that the OMS student must assume major responsibility for the care of oral and maxillofacial injuries, it does not establish a minimum number of cases or minimum length of rotation. Limited experience in these critical areas raises valid concerns for patient safety, especially for those trainees who lack the additional clinical education and training obtained through the medical training in the dual degree MD/OMS programs.

Also of concern is the fact that these standards provide only a maximum of six months of general surgery experience; four months if the OMS trainee does not opt for two additional months of general surgery training. Furthermore, the training an OMS receives in cosmetic and reconstructive surgery is minimal. Under the standards, an OMS trainee need act as first assistant or surgeon on a minimum of only 10 cosmetic or reconstructive surgeries.

OMS training program curriculum: didactic program

OMS training programs are primarily clinically based. Nonetheless, the programs do have didactic requirements that are usually met in the early years of the program. In the case of an MD/OMS dual-degree program, some didactic courses may have been completed in the medical school program.

Topics covered in didactic courses often include specialty areas of dentistry, physical diagnosis, hospital dentistry, treatment planning, medical emergencies, conscious

66. Web. Dental Dictionary (online). www.dentaldictionary.net. Retrieved August 17, 2008.

67. *Id.*

68. Web. Merriam-Webster's Medical Dictionary (online). www.medical.merriam-webster.com. Retrieved August 17, 2008.

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Id.*

sedation, oral pathology/medicine, pharmacology, infection control, surgical implants, head and neck anatomy, literature reviews, and practice management.⁷⁴

OMS training program curriculum: clinical experiences

All OMS trainees participate in clinical rotations as the major focus of their training. While all OMS training programs have the common goal of preparing the trainee for OMS board certification, the clinical rotations of the many programs vary. Trainees in dual-degree programs may count some of their medical rotation experience toward the curriculum standard requirements listed in the previous section. Clinical rotations may include the following medical and dental services:⁷⁵

- Oral and maxillofacial surgery
- Surgical intensive care unit
- Anesthesiology
- General surgery
- Plastic and reconstructive surgery
- Emergency medicine
- Neurosurgery
- Otolaryngology
- Cleft lip and palate
- Trauma surgery
- Pathology

Although OMS programs may vary in the sequence in which students take their rotations, all have similar

rotation lengths (approximately four weeks each). The following curriculum is representative of four-year OMS certificate training programs. Note that the OMS trainee typically gains exposure to medical and surgical specialties during his or her first year of training, and then spends the majority of the remaining three years on the oral and maxillofacial surgery service.

Virginia Commonwealth University OMS training program⁷⁶

First year

The first year of a Virginia Commonwealth University (VCU) OMS program, the trainee focuses primarily on inpatient care responsibilities in the pre- and post-operative periods, as well as the hospital outpatient minor surgery clinic. Rotations include:

- Physical diagnosis (eight weeks)
- OMS hospital clinic (six months)
- General surgery (one month)
- Surgical oncology (one month)
- Trauma surgery (two months)
- Internal medicine (one month)
- Emergency medicine (one month)

Second year

The second year is similar to the first, with the addition of clinical rotations structured to nurture the increasing autonomy of the trainee while he or she participates on the OMS service under the direct supervision of OMS service faculty.

- OMS service: in hospital, operating room or school clinic settings (six months)
- Anesthesia (four months)
- Cardiology (one month)
- Surgical ICU (one month)

74. Web. UCLA School of Dentistry. www.uclasod.dent.ucla.edu/admissions/index.asp?id=362. University of Alabama School of Dentistry – Oral and Maxillofacial Surgery – OFS Residency Program. www.main.uab.edu/ofs/Templates/Inner.aspx?pid=92166. Medical College of Wisconsin. www.mcw.edu/display/router.asp?docid=2770. U.S. Army – Southeast Regional Dental Command and Dental Activity – Oral and Maxillofacial Surgery Training Program. www.serdc.amedd.army.mil/oral_max.htm. University of Iowa. www.dentistry.uiowa.edu/public/clinics/oralsurg/oralmagp.html. University of Southern California. www.usc.edu/hsc/dental/academic_programs/oral_maxillofacial/program_overview.htm. Virginia Commonwealth University Oral and Maxillofacial surgery. www.dentistry.vcu.edu/omfs/residency/curriculum.html#first. Retrieved August 12, 2008.

75. *Id.* (excerpted from all)

76. Web. Virginia Commonwealth University Oral and Maxillofacial Surgery. www.dentistry.vcu.edu/omfs/residency/curriculum.html#first. Retrieved August 8, 2008.

Third year

In the VCU OMS program trainee's third year, his or her participation and responsibility in patient management increases. Still under the supervision of the attending OMS staff, the trainee assumes responsibility for the day-to-day consultative and administrative details of the service. Third-year rotations include:

- OMS hospital operating room (three months)
- Private OMS service at local hospitals with local surgeons or in the faculty practice at VCU (six months)
- OMS school clinic (three months)

Fourth year

The fourth-year trainee assumes total responsibility for the organization and operation of the service and assists in the organization of the academic program and teaches junior trainees and dental students on the OMS service. In addition, the fourth-year trainees, known as chief residents at VCU, staff all major OMS operating room cases, where, according to CODA standards, they must complete at least 75 major OMS surgeries.

OMS fellowships

A fellowship in oral and maxillofacial surgery is defined by the ADA as “a planned post-residency program that contains education and training in a focused area of the specialty. The focused areas include: esthetic oral and maxillofacial surgery, oral and maxillofacial oncology, pediatric oral and maxillofacial surgery, maxillofacial trauma and craniofacial surgery.”⁷⁷ Like OMS training programs, these OMS fellowships are accredited by CODA. Information regarding the frequency with which OMS trainees pursue fellowship training is not available on the CODA Web site.

Accreditation requirements include: a duration of no less than one year, and the inclusion of both didactic and clinical educational components. Each OMS specialty fellowship is required to meet certain clinical requirements that are documented in CODA's *Accreditation Standards for Clinical Fellowship Training Programs in Oral and Maxillofacial Surgery*.⁷⁸ For example, CODA requires that the surgical experience for the fellowship in esthetic OMS includes a minimum of 125 maxillofacial esthetic cases. These procedures include, but are not limited to, blepharoplasty, brow lifts, treatment of skin lesions, cheiloplasty, genioplasty, otoplasty, rhinoplasty and rhytidectomy.

77. Web. ADA. Fellowship Accreditation Standards.
www.ada.org/prof/ed/accred/standards/omsf.pdf. Retrieved July 8, 2008.

78. *Id.*

VI. Oral and maxillofacial surgeon licensing and board certification

Dental licensing

State boards of dentistry are created by state legislatures to govern the qualifications and practice of dentistry. To qualify for licensure as a dentist in all 50 states and the District of Columbia, candidates must graduate from an ADA-accredited dental school, and pass written and practical examinations.⁷⁹

The written examination requirement is fulfilled by the National Board Dental Examination (NBDE).⁸⁰ This test consists of two parts. Part I is usually taken after students have completed their second year of dental school. It is a computer-based, comprehensive test that is administered in one day. Part I of the NBDE consists of 400 multiple-choice items with even distribution of the following topics: anatomic sciences, biochemistry, physiology, microbiology, pathology, and dental anatomy and occlusion.⁸¹ Students must successfully complete Part I in order to become eligible to take Part II of the examination. Part II of the NBDE consists of 500 multiple-choice items and is administered over one and a half days. Part II tests nine dental discipline areas: endodontics, operative dentistry, oral and maxillofacial surgery, oral diagnosis, orthodontics-pediatric dentistry, patient management, periodontics, pharmacology and prosthodontics.⁸²

States often grant licensure by recognition. Specifically, where an applicant for licensure has already obtained a license in another state, he or she is granted a license in the new state based on the applicant's having successfully met the licensure requirements in the other state/jurisdiction.⁸³

All states require licensure as a dentist in order for a candidate to practice and specialize as an oral and maxillofacial surgeon. Other state requirements for practice as an oral and maxillofacial surgeon vary. Nevertheless, in general, states require that oral and maxillofacial surgeons practicing in their respective states either complete an accredited educational OMS program or hold diplomate status in the specialty, signified by board certification in OMS. Some state dental boards also require oral and maxillofacial surgical specialty examinations.⁸⁴

Board certification for oral and maxillofacial surgeons

The American Board of Oral and Maxillofacial Surgery (ABOMS) is the certifying board for oral and maxillofacial surgery in the United States, and is recognized and approved by the Council on Dental Education of the ADA. The ABOMS is responsible for reviewing all applicants for board certification, as well as administering the examinations involved in the certification process. Those individuals who demonstrate achievement of the requisite training, experience and knowledge are granted diplomate certificates.⁸⁵ Board certification is not a requirement for OMS practice but is often a criterion for gaining surgical privileges in many hospitals, surgery centers or managed care organizations.⁸⁶

There are two pathways for ABOMS board certification:

- Candidates for board certification must have graduated from an accredited dental school and must be licensed in the state in which they practice. In addition, a candidate must have completed an OMS training program approved by CODA; or

79. Web. National Institute of Health; Office of Science Education. *science.education.nih.gov/LifeWorks.nsf/Alphabetical+List/Oral+and+Maxillofacial+Surgeon?OpenDocument&ShowTab=3&*. Retrieved May 28, 2008.

80. Web. ADA. *www.ada.org/prof/ed/testing/index.asp*. Retrieved August 2, 2008.

81. Web. ADA. National Board Dental Examination Part I: Candidate's Guide *www.ada.org/prof/ed/testing/nbde01/nbde01_candidate_guide_2008.pdf*. Retrieved August 2, 2008.

82. Web. ADA. National Board Dental Examination Part II: Candidate's Guide. *www.ada.org/prof/ed/testing/nbde02/nbde02_candidate_guide_2008.pdf*. Retrieved August 2, 2008.

83. Web. ADA. *www.ada.org/prof/prac/licensure/information.asp*. Retrieved August 2, 2008.

84. *Id.*

85. Web. American Board of Oral and Maxillofacial Surgery (ABOMS). *www.aboms.org/General_information/CertificationProcess.htm*. Retrieved May 27, 2008.

86. Web. AAOMS. *www.aaoms.org/dental_students.php#9*. Retrieved August 5, 2008.

- Candidates who have received training in programs not accredited by CODA must provide verification of their OMS training having provided equivalent educational backgrounds. In addition, these applicants must have:
 - Completed at least 12 months of oral and maxillofacial surgery training at the senior resident level, or
 - Completed an accredited fellowship that is a minimum of 12 months in duration, or
 - Served 12 consecutive months as a full-time faculty member in an accredited OMS training program during the past two years and have an active state license.⁸⁷

Applicants for board certification in oral and maxillofacial surgery must provide evidence of their educational and training qualifications. In addition, letters of recommendation from board-certified oral and maxillofacial surgeons attesting to the applicant's acceptable ethical and moral standing are also required as part of the certification procedure.⁸⁸

In 2007 ABOMS received 458 applications and certified 153 candidates. While 6,666 total ABOMS board certifications have been granted, 4,620 certifications are considered active.⁸⁹

National board certification exam

The ABOMS board certification process consists of two examinations: the qualifying (written) examination and the oral certifying examination. A candidate must pass the qualifying exam before being permitted to sit for the oral certifying examination.⁹⁰ Once certified, the candidate becomes a diplomate of the board.⁹¹

87. Web. American Board of Oral and Maxillofacial Surgery (ABOMS). www.aboms.org/General_information/CertificationProcess.htm. Retrieved May 27, 2008.

88. Web. ABOMS. www.aboms.org/General_information/CertificationProcess.htm. Retrieved May 27, 2008.

89. These figures are through December 31, 2007. Web. ADA. "Report of the ADA – Recognized dental specialty certification boards." www.ada.org/prof/ed/specialties/specialty_certifying_report.pdf. Retrieved August 19, 2008.

90. Web. ABOMS. Candidates. www.aboms.org/Candidates/Candidates.htm. Retrieved August 3, 2008.

91. Web. ABOMS. www.aboms.org/Candidates/Candidates.cfm. Retrieved August 3, 2008.

The qualifying exam is a seven-hour computer-based exam given every January, and must be taken after the completion of OMS training.⁹² It contains 300 or more multiple-choice questions in the following subject areas:

- Medical assessment and management
- Anesthesia
- Dentoalveolar
- Trauma
- Orthognathic/cleft/craniofacial
- Cosmetic
- Temporomandibular/facial pain
- Pathology
- Reconstruction

In January 2008, a total of 253 candidates sat for the qualifying exam. The success rate for the 210 first time-takers was 80.8 percent. The success rate for the 43 repeat takers was 55.8 percent. The 198 total successful candidates constituted an overall pass rate of 78.3 percent.⁹³

The oral certifying exam consists of four 45-minute sessions given in one day each February. Candidates have three opportunities to take the oral examination after passing the qualifying exam. The oral exam evaluates skills in the following three areas:

- Data gathering/diagnosis/treatment plan
- Management
- Treatment variations/complications.

Four surgery topics are covered in the oral examination:⁹⁴

- Dentoalveolar, implants, temporomandibular (TMJ) joint disorders, facial pain, infections
- Trauma, orthognathic surgery, esthetic surgery

92. *Id.*

93. Web. ABOMS. Study Resource for the 2009 Qualifying Certification Examinations. www.aboms.org/Candidates/StudyResources/StudyResources.htm. Retrieved August 2, 2008.

94. *Id.*

- Pathology, reconstruction, clefts, obstructive sleep apnea
- Anesthesia, perioperative medical care.

In February 2008, 81 percent of 183 first-time candidates and 66.6 percent of 18 repeat candidates were successful for an overall pass rate of 80 percent.⁹⁵

OMS board recertification

As of 1990, recertification is required every 10 years, and involves successful completion of a computerized examination. The recertification exam emphasizes clinical OMS practice, and consists of eight topic modules: core (75-minute time limit); implants (35 minutes); trauma (35 minutes); orthognathic (35 minutes); cosmetic (35 minutes); TMJ (35 minutes); pathology (35 minutes); and reconstruction (35 minutes).⁹⁶ The test material is taken from current publications and literature in oral and maxillofacial surgery. Individuals who were issued certification prior to 1990 are not required, but are encouraged, to participate in the recertification process.⁹⁷ In 2007 158 candidates recertified, though 912 applicants have recertified since 1990.⁹⁸

95. *Id.*

96. Web. Pearson Education, Inc. ABOMS exam details. www.vue.com/servlet/vue.web2.core.Dispatcher?wsid=1219342250265&HasXSes=Y&wsid=62688046&webViewID=10010296&examCode=ABOMS-RE. Retrieved August 20, 2008.

97. Web. ABOMS. www.aboms.org/General_Information/reCertification.htm. Retrieved August 20, 2008.

98. Web. ADA. "Report of the ADA – Recognized dental specialty certification boards." www.ada.org/prof/ed/specialties/specialty_certifying_report.pdf. Retrieved August 19, 2008.

VII. Education and training of plastic surgeons and otolaryngologists

Physician specialty certification in plastic surgery or otolaryngology is obtained only through rigorous post-graduate training in an accredited medical residency program and by passing a specialty board certification examination. A physician enters residency training after graduating from a four-year medical school, where the first and second years are spent learning the scientific principles of human anatomy and physiology, biochemistry, pharmacology, genetics, microbiology, immunology, pathology of disease states, and similar courses in both the natural and behavioral sciences, as well as in introductory clinical experiences. The third and fourth years of medical school are devoted to full-time clinical rotations and clerkships where the medical student is introduced to the comprehensive clinical care of patients, primarily in the hospital inpatient setting.

Medical students who attend schools accredited by the Liaison Committee on Medical Education are required to care for patients in both inpatient and outpatient settings in the following clinical rotations: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.⁹⁹ Similarly, students at colleges of osteopathic medicine that are accredited by the American Osteopathic Association's Commission on Osteopathic College Accreditation must receive education in the following clinical disciplines: internal medicine, family medicine, pediatrics, geriatrics, obstetrics and gynecology, preventive medicine and public health, psychiatry, surgery and radiology.¹⁰⁰

All medical students must also select a number of specialty elective rotations to round out their exposure to the branches of medicine, ensuring a broad and comprehensive medical knowledge base upon which he or she builds by choosing an area of practice specialization for graduate medical education, commonly known as residency. Medical students considering careers as surgeons typically select elective rotations in surgery

or its specialties in order to gain more exposure to the aspects and techniques of the surgical care of patients.

Established in 1981, the Accreditation Council for Graduate Medical Education (ACGME) is a private, non-profit council that evaluates and accredits medical residency programs in the United States. The mission of the ACGME is to improve health care by assessing and advancing the quality of resident physicians' education through accreditation. Each of the 26 medical specialties has ACGME program requirements for graduate medical (residency and fellowship) education.¹⁰¹ Both plastic surgery and otolaryngology are recognized as medical specialties by the American Board of Medical Specialties. In addition to residency training, which encompasses facial and head and neck cosmetic surgical training, training and specialization opportunities are available to medically-trained surgeons wishing to refine their skills in facial cosmetic and reconstructive surgery.

Plastic surgeons

There are two approved educational training models for plastic surgeons: the independent model and the integrated model. Several additional organizations involved in the medical education of plastic surgeons provide governance over these models. The Residency Review Committee for Plastic Surgery of the ACGME sets educational standards and accredits plastic surgery residencies. The American Board of Plastic Surgery sets educational requirements, examines and certifies graduates of the plastic surgery residency programs.

In both the independent and integrated models, plastic surgery is divided into two parts: prerequisite training and requisite training. Prerequisite training is the acquisition of a basic surgical science knowledge base and experience with basic principles of surgery. Requisite

99. Web. Liaison Committee on Medical Education (LCME). LCME Accreditation Standards with annotations. www.lcme.org/functionslist.htm#curriculum%20management. Retrieved July 21, 2008.

100. Web. American Osteopathic Association (AOA). College of Medicine Accreditation Standards and Procedures. www.osteopathic.org/pdf/SB03-Standards%20of%20Accreditation%20July%202008.pdf. Retrieved September 22, 2008.

101. Web. Accreditation Council on Graduate Medical Education (ACGME). ACGME at a Glance. www.acgme.org/acWebsite/newsRoom/newsRm_acGlance.asp. Retrieved November 17, 2008.

training consists of plastic surgery principles and practice, including advanced knowledge in specific plastic surgery techniques.¹⁰²

In the independent model, residents complete their prerequisite training outside of the plastic surgery residency, whereas in the integrated model, residents complete both their prerequisite and requisite training within one single plastic surgery residency training program. For example, a new medical school graduate wishing to pursue plastic surgery as a career may choose to spend three years in a general surgery residency (for his or her prerequisite training), then enter a three-year plastic surgery residency program (for requisite training). Moreover, some academic medical centers offer a combined or coordinated 3+3-year program, which allows residents to complete their prerequisite general surgery training and plastic surgery residency in the same facility or institution.¹⁰³

The independent model also permits physicians in other surgical specialty training programs, such as otolaryngology, neurosurgery, orthopedic surgery or urology, to enter a plastic surgery residency program after successful completion of the initial prerequisite surgical residency. Oral surgeons who have obtained an MD degree can enter an ACGME-accredited plastic surgery residency program so long as their prerequisite training—the OMS training program—is accredited by the ADA and contains at least 24 months of general surgery training.¹⁰⁴

There are 20 integrated model plastic surgery residency training programs in the United States. Training in the integrated model, where the resident completes a single training program, requires six years of ACGME-accredited plastic surgery residency. No less than two years of this program must be concentrated in plastic surgery, and the final 12 months must entail senior-level clinical plastic surgery responsibility.¹⁰⁵

102. Web. Accreditation Council on Graduate Medical Education (ACGME). Plastic Surgery Residency Review Committee. Pathways into Plastic Surgery. www.acgme.org/acWebsite/RRC_360/360_pathways.pdf. Retrieved November 5, 2008.

103. *Id.*

104. *Id.* However, most ADA-accredited OMS training programs offer far less general surgery training (a minimum of 4 months) than do ACGME-accredited prerequisite surgical training programs.

105. Web. Accreditation Council on Graduate Medical Education (ACGME). Plastic Surgery Residency Review Committee. Pathways into Plastic Surgery. www.acgme.org/acWebsite/RRC_360/360_pathways.pdf. Retrieved November 5, 2008.

ACGME educational standards for plastic surgery residencies require that plastic surgery residents obtain specific clinical competencies in the following areas:

- Congenital defects of the head and neck, including clefts of the lip and palate, and craniofacial surgery
- Neoplasms of the head and neck surgery, including neoplasms of the head and neck, and the oropharynx
- Cranio-maxillofacial trauma, including fractures
- Aesthetic (cosmetic) surgery of the head and neck, trunk, and extremities
- Plastic surgery of the breast
- Surgery of the hand/upper extremities
- Plastic surgery of the lower extremities
- Plastic surgery of the trunk and genitalia
- Burn reconstruction
- Microsurgical techniques applicable to plastic surgery
- Reconstruction by tissue transfer, including flaps and grafts
- Surgery of benign and malignant lesions of the skin and soft tissues¹⁰⁶

Moreover, plastic surgery residency programs are strongly suggested to have specific clinical experience in the following areas:

- Acute burn management
- Anesthesia
- Oral and maxillofacial surgery
- Dermatology
- Oculoplastic surgery or ophthalmology
- Orthopaedic surgery¹⁰⁷

In addition, residents in ACGME-accredited plastic surgery training programs must demonstrate knowledge of established and evolving biomedical, clinical, epi-

106. Web. Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Medical Education in Plastic Surgery. www.acgme.org/acWebsite/downloads/RRC_progReq/360_plastic_surgery_07012009.pdf. November 5, 2008.

107. *Id.*

demological and social-behavioral sciences, as well as the application of this knowledge to patient care. These requirements are met by mandatory scholarly activities including conferences that include pertinent basic science subjects, such as anatomy, physiology, pathology, embryology, radiation biology, genetics, microbiology, pharmacology, as well as practice management, ethics and medico-legal topics. Plastic surgery residents must also participate in, and present educational material at, conferences; and must be exposed to the concepts of surgical design, surgical diagnosis, embryology, surgical and artistic anatomy, surgical physiology and pharmacology, wound healing, surgical pathology and microbiology, adjunctive oncological therapy, biomechanics, rehabilitation and surgical instrumentation.¹⁰⁸

Otolaryngologists

Residency training in otolaryngology requires five years of supervised medical and surgical training, where the otolaryngology resident acquires the knowledge and experience necessary to provide the comprehensive evaluation, as well as medical and surgical management, of patients of all ages having diseases and disorders of the ears, upper respiratory and upper alimentary systems and related structures, and the head and neck. The residency should include instruction in the clinical aspects of the diagnosis, medical and/or surgical therapy, and the prevention of and rehabilitation from diseases, neoplasms, deformities, disorders and/or injuries of the ears, upper respiratory and upper alimentary systems, the face, the jaws, and other head and neck systems; head and neck oncology; and facial plastic and reconstructive surgery.¹⁰⁹

108. *Id.*

109. Web. ACGME. ACGME Program Requirements for Graduate Medical Education in Otolaryngology. www.acgme.org/acWebsite/downloads/RRC_progReq/280otopr707.pdf. Retrieved November 24, 2008.

The initial year of residency training in otolaryngology provides broad exposure to the care of patients with all types of medical and surgical conditions, including rotations in emergency medicine, anesthesia, critical care, and neurological surgery. Additional experiences in the first year typically include general surgery, pediatric surgery, vascular surgery, thoracic surgery, surgical oncology or plastic surgery.¹¹⁰

The four subsequent years of otolaryngology-specific medical and surgical training provide the resident with experience in direct and progressively responsible patient management, culminating in sufficient independent responsibility for clinical decision-making to evidence the fact that the graduating resident has developed sound clinical judgment and possesses the ability to formulate and carry out appropriate management plans. ACGME standards for otolaryngology residency training require that the resident must manage the pre-, peri-, and post-operative/procedural care for patients requiring surgery or invasive procedures in the following categories:

- General otolaryngology, including pediatric otolaryngology, rhinology, bronchoesophagology and laryngology
- Head and neck oncologic surgery
- Facial plastic and reconstructive surgery of the head and neck
- Otology and neurotology¹¹¹

Otolaryngology residents should perform a sufficient number and variety of surgical procedures to ensure education in the entire scope of the specialty. There must be adequate distribution and sufficient complexity of cases within the principal categories of the specialty.¹¹²

110. *Id.*

111. *Id.*

112. *Id.*

VIII. Professional organization

American Association of Oral and Maxillofacial Surgeons (AAOMS) is the not-for-profit professional association serving the specialty of oral and maxillofacial surgery.

American Association of Oral and Maxillofacial Surgeons
9700 W. Bryn Mawr Ave.
Rosemont, IL 60018-5701
(800) 822-6637

The AAOMS currently has an affiliation base of more than 7,000 fellows, members and residents in the United States. Membership requirements vary depending on what membership category for which an individual is applying. The membership categories that the AAOMS recognizes are: resident member; candidate status; component OMS society membership; fellow; member; federal service fellow and member; faculty fellow and member; affiliate member; and provisional fellow/member. A little more than half of the members fall into the “Fellow” category. For a complete listing of membership requirements for each membership category, refer to the AAOMS Web site.¹¹³

American Dental Association (ADA) is the professional association of dentists committed to the public’s oral health, ethics, science and professional advancement.

American Dental Association
211 E. Chicago Ave.
Chicago, IL 60611-2678
(312) 440-2500

There are more than 153,000 members of the ADA. Membership requirements of the association vary greatly depending on the types of membership, which are: affiliate membership; associate membership; ASDA/ADA predoctoral membership; charitable organization practitioner membership; federal dental service membership; graduate student membership; life members membership; non-practicing dentists membership; provisional membership; retired life members; retired member membership; and tripartite membership.¹¹⁴

Related professional organizations

American Dental Education Association (ADEA) is the leading national organization for dental education with its membership composed of all US and Canadian dental schools, advanced dental education programs, hospital dental education programs, allied dental education programs, corporations, faculty, and students.

American Dental Education Association
1400 K Street, N.W., Suite 1100
Washington, DC 20005

113. Web. AAOMS. Retrieved September 12, 2006.
www.aaoms.org/aboutus.cfm.

114. Web. ADA. Retrieved September 12, 2006. www.ada.org/.

IX. Professional journals of interest

The Journal of the American Dental Association (JADA)
www.jada.ada.org

Journal of Oral and Maxillofacial Surgery (JOMS)
www2.joms.org

Journal of Dental Education
www.jdentaled.org

Appendix

Roster of state dental boards

Alabama Board of Dental Examiners
5346 Stadium Trace Parkway, Ste. 112
Hoover, AL 35244
Phone: (205) 985-7267
Web site: www.dentalboard.org

Alaska Board of Dental Examiners
P.O. Box 110806
Juneau, AK 99811-0806
Phone: (907) 465-2542
Web site: www.dced.state.ak.us/occ/pden.htm

Arizona State Board of Dental Examiners
5060 N.19th Ave., Ste. 406
Phoenix, AZ 85015
Phone: (602) 242-1492
Web site: www.azdentalboard.org

Arkansas State Board of Dental Examiners
101 E. Capitol Ave., Ste. 111
Little Rock, AK 72201
Phone: (501) 682-2085
Web site: www.asbde.org

Dental Board of California
1432 Howe Ave., Ste. 85
Sacramento, CA 95825
Phone: (916) 263-2300
Web site: www.dbc.ca.gov

Colorado Board of Dental Examiners
1560 Broadway, Ste. 1350
Denver, CO 80202
Phone: (303) 894-7800
Web site: www.dora.state.co.us/dental

Connecticut Department of Public Health –
Dental Licensure
410 Capitol Ave.
MS# 12APP
P.O. Box 340308
Hartford, CT 06134-0308
Phone: (860) 509-7603
Web site: www.ct-clic.com/detail.asp?code=1688

Delaware Board of Dental Examiners
Cannon Building, Ste. 203
861 Silver Lake Blvd.
Dover, DE 19904
Phone: (302) 744-4533
Web site: www.professionallicensing.state.de.us/boards/dental/index.shtml

Florida Board of Dentistry
4052 Bald Cypress Way
Tallahassee, FL 32399-3257
Phone: (850) 245-4474
Web site: www.doh.state.fl.us/mqa/dentistry/index.html

Georgia Board of Dentistry
237 Coliseum Drive
Macon, GA 31217-3858
Phone: (478) 207-2440
Web site: www.sos.state.ga.us/plb/dentistry

Hawaii Board of Dental Examiners
DCCA-PVL
Attn: DENTAL
P.O. Box 3469
Honolulu, HI 96801
Phone: (808) 586-2702
Web site: www.hawaii.gov/dcca/areas/pvl/boards/dentist

Idaho State Board of Dentistry
P.O. Box 83720
Boise, ID 83720-0021
Phone: (208) 334-2369
Web site: www2.state.id.us/isbd/index.htm

Illinois Division of Professional Regulation
320 W. Washington St.
Springfield, IL 62786
Phone: (217) 785-0800
Web site: www.idfpr.com/dpr/WHO/dent.asp

Indiana Professional Licensing Agency
Attn: State Board of Dentistry
402 W. Washington St., Room W072
Indianapolis, IN 46204
Phone: (317) 234-2057
Web site: www.in.gov/pla/bandc/isbd

Iowa Board of Dental Examiners
400 S.W. Eighth St., Ste. D
Des Moines, IA 50309-4687
Phone: (515) 281-5157
Web site: www.state.ia.us/dentalboard

Kansas Dental Board
900 S.W. Jackson, Room 564-S
Topeka, KS 66612-1230
Phone: (785) 296-6400
Web site: www.accesskansas.org/kdb

Kentucky Board of Dentistry
10101 Linn Station Road, Ste. 540
Louisville, KY 40223
Phone: (502) 429-7280
Web site: www.dentistry.ky.gov

Louisiana State Board of Dentistry
365 Canal St., Ste. 2680
New Orleans, LA 70130
Phone: (504) 568-8574
Web site: www.lsbdl.org

Maine Board of Dental Examiners
143 State House Station
161 Capitol St.
Augusta, ME 04333-0143
Phone: (207) 287-3333
Web site: www.mainedental.org

Maryland State Board of Dental Examiners
Spring Grove Hospital Center
Benjamin Rush Building
55 Wade Ave.
Catonsville, MD 21228
Phone: (410) 402-8500
Web site: <http://dhmh.state.md.us/dental>

Massachusetts Board of Registration in Dentistry
Division of Health Profession Licensure
239 Causeway St., Second Floor, Ste. 200
Boston, MA 02114
Phone: (617) 973-0971
Web site: www.mass.gov/dph/boards

Michigan Board of Dentistry
Capitol View Building
201 Townsend St.
Lansing, MI 48913
Phone: (517) 373-3740
Web site: www.michigan.gov/mdch/0,1607,7-132-27417_27529_27533---,00.html

Minnesota Board of Dentistry
University Park Plaza
2829 University Ave., S.E., Ste. 450
Minneapolis, MN 55414-3246
Phone: (612) 617-2250
Web site: www.dentalboard.state.mn.us

Mississippi State Board of Dental Examiners
600 E. Amite St., Ste. 100
Jackson, MS 39201-2801
Phone: (601) 944-9622
Web site: www.msbde.state.ms.us/mainpg.htm

Missouri State Dental Board
3605 Missouri Blvd.
P.O. Box 1367
Jefferson City, MO 65102-1367
Phone: (573) 751-0040
Web site: www.pr.mo.gov/dental.asp

Montana Board of Dentistry
301 South Park, Fourth Floor
P.O. Box 200513
Helena, MT 59620-0513
Phone: (406) 841-2390
Web site: www.mt.gov/dli/bsd/license/bsd_boards/den_board/board_page.asp

Nebraska Department of Health and Human Services
Regulation & Licensure
P.O. Box 95007
Lincoln, NE 68509-5007
Phone: (402) 471-2133
Web site: www.hhs.state.ne.us/reg/regindex.htm

Nevada State Board of Dental Examiners
6010 S. Rainbow Blvd., Ste. A-1
Las Vegas, NV 89118
Phone: (702) 486-7044
Web site: www.nvdentalboard.org

New Hampshire Board of Dental Examiners
2 Industrial Park Drive
Concord, NH 03301-8520
Phone: (603) 271-4561
Web site: www.state.nh.us/dental

New Jersey State Board of Dentistry
124 Halsey St.
Newark, NJ 07102
Phone: (973) 504-6200
Web site: www.state.nj.us/lps/ca/medical/dentistry.htm

New Mexico Board of Dental Health Care
P.O. Box 25101
Santa Fe, NM 87504-5101
Phone: (505) 476-4680
Web site: www.rld.state.nm.us/b&c/dental/index.htm

New York State Office of the Professions – Dentistry
Office of the Professions
State Education Building, Second Floor
Albany, NY 12234
Phone: (518) 474-3817
Web site: www.op.nysed.gov/dent.htm

North Carolina State Board of Dental Examiners
15100 Weston Parkway, Ste. 101
Cary, NC 27513
Phone: (919) 678-8223
Web site: www.ncdentalboard.org/default.asp

North Dakota State Board of Dental Examiners
P.O. Box 7246
Bismarck, ND 58507-7246
Phone: (701) 258-8600
Web site: www.nddentalboard.org

Ohio State Dental Board
Riffe Center
77 S. High St., 18th Floor
Columbus, OH 43215-6135
Phone: (614) 466-2580
Web site: www.dental.ohio.gov

Oklahoma Board of Dentistry
201 N.E. 38th Terrace, #2
Oklahoma City, OK 73105
Phone: (405) 524-9037
Web site: www.state.ok.us/~dentist

Oregon Board of Dentistry
1600 S.W. Fourth Ave., Ste. 770
Portland, OR 97201
Phone: (503) 229-5520
Web site: www.oregon.gov/Dentistry

Pennsylvania State Board of Dentistry
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: (717) 783-7162
Web site: www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&q=432687

Rhode Island Board of Examiners in Dentistry
Department of Health
3 Capitol Hill, Room 105
Providence, RI 02908
Phone: (401) 222-2827
Web site: www.health.ri.gov/hsr/professions/dental.php

South Carolina Board of Dentistry
Synergy Business Park
Kingstree Building
110 Centerview Drive
Columbia, SC 29210
Phone: (803) 896-4599
Web site: www.llr.state.sc.us/POL/Dentistry

South Dakota State Board of Dentistry
P.O. Box 1037
Pierre, SD 57501-1037
Phone: (605) 224-1282
Web site: www.state.sd.us/doh/dentistry

Tennessee Board of Dentistry
227 French Landing, Ste. 300
Nashville, TN 37243
Phone: (615) 532-3202
Web site: www2.state.tn.us/health/Boards/Dentistry/index.htm

Texas State Board of Dental Examiners
William P. Hobby Building
333 Guadalupe St.
Tower 3, Suite 800
Austin, TX 78701
Phone: (512) 463-6400
Web site: www.tsbde.state.tx.us

Utah Dentist and Dental Hygienist Licensing Board
Division of Occupational and Professional Licensing
Attn: Dental Board
160 E.300 South
Salt Lake City, UT 84111
Phone: (801) 530-6628
Web site: www.dopl.utah.gov/licensing/dental.html

Vermont Board of Dental Examiners
26 Terrace St., Drawer 09
Montpelier, VT 05609-1101
Phone: (802) 828-2390
Web site: www.vtprofessionals.org/opr1/dentists

Virginia Board of Dentistry
6603 W. Broad St., Fifth Floor
Richmond, VA 23230-1712
Phone: (804) 662-9906
Web site: www.dhp.state.va.us/dentistry/default.htm

Washington State Dental Quality Assurance
Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 47865
Phone: (360) 236-4700
Web site: www.fortress.wa.gov/doh/hpqa1/HPS3/Dental/default.htm

West Virginia Board of Dental Examiners
207 S. Heber St.
Beckley, WV 25801
Phone: (877) 914-8266
Web site: www.wvdentalboard.org

Wisconsin Professional Licensing – Dentistry Examining Board
P.O. Box 8935
Madison, WI 53708-8935
Phone: (608) 266-2112
Web site: www.drl.wi.gov/boards/den/index.htm

Wyoming Board of Dental Examiners
Occupational Licensing Administrator
1800 Carey Ave., Fourth Floor
Cheyenne, WY 82002
Phone: (307) 777-6529
Web site: www.plboards.state.wy.us/dental/index.asp

Roster of state dental and oral and maxillofacial surgery associations

Alabama Dental Association
836 Washington Ave.
Montgomery, AL 36104-3839
Phone: (334) 265-1684
Web site: www.aldaonline.org

Alaska Dental Association
9170 Jewel Lake Road, Ste. 203
Anchorage, AK 99502-5381
Phone: (907) 563-3003
Web site: www.akdental.org

Arizona Dental Association
3193 N. Drinkwater Blvd.
Scottsdale, AZ 85251-6491
Phone: (480) 344-5777
Web site: www.azda.org

Arkansas State Dental Association
7480 Highway 107
Sherwood, AR 72120
Phone: (501) 834-7650
Web site: www.dental-asda.org

California Dental Association
1201 K St.
Sacramento, CA 95814
Phone: (916) 443-0505
Web site: www.cda.org

Colorado Dental Association
3690 S. Yosemite, Ste. 100
Denver, CO 80237-1808
Phone: (303) 740-6900
Web site: www.cdaonline.org

Connecticut State Dental Association
835 W. Queen St.
Southington, CT 06489
Phone: (860) 378-1800
Web site: www.csda.com

Delaware State Dental Society
The Christiana Executive Campus
200 Continental Drive, Ste. 111
Newark, DE 19713
Phone: (302) 368-7634
Web site: www.delawarestatedentalsociety.org

District of Columbia Dental Society
502 C St., N.E.
Washington, DC 20002-5810
Phone: (202) 547-7613
Web site: www.dcdental.org

Florida Dental Association
1111 E. Tennessee St., Ste. 102
Tallahassee, FL 32308-6913
Phone: (850) 681-3629
Web site: www.floridadental.org

Florida Society of Oral and Maxillofacial Surgeons
4850 Golden Parkway, Ste. B-417
Buford, GA 30518
Phone: (877) 831-2500
Web site: www.fsoms.org

Georgia Dental Association
7000 Peachtree Dunwoody Road, N.E.
Suite 200, Building 17
Atlanta, GA 30328-1655
Phone: (404) 636-7553
Web site: www.gadental.org

Georgia Society of Oral and Maxillofacial Surgeons
4850 Golden Parkway, Ste. B-417
Buford, GA 30518
Phone: (770) 271-0453
Web site: www.ga-oms.org

Hawaii Dental Association
1345 S. Beretania St., Ste. 301
Honolulu, HI, 96814-1821
Phone: (808) 593-7956
Web site: www.hawaiidentalassociation.net

Idaho State Dental Association
1220 W. Hays St.
Boise, ID 83702-5315
Phone: (208) 343-7543
Web site: www.isdaweb.com

Illinois State Dental Society
1010 S. Second St.
P.O. Box 376
Springfield, IL 62705
Phone: (217) 525-1406
Web site: www.isds.org

Illinois Society of Oral and Maxillofacial Surgeons
222 E. Wisconsin Ave., Ste. 214
Lake Forest, IL 60045
Phone: (847) 482-0222
Web site: www.isoms.net/

Indiana Dental Association
P. O. Box 2467
Indianapolis, IN 46206-2467
Phone: (317) 634-2610
Web site: www.indental.org

Iowa Dental Association
5530 W. Parkway, Ste. 100
Johnston, IA 50131
Phone: (515) 986-5605
Web site: www.iowadental.org

Kansas Dental Association
5200 S.W. Huntoon St.
Topeka, KS 66604-2398
Phone: (785) 272-7360
Web site: www.ksdental.org

Kentucky Dental Association
1920 Nelson Miller Parkway
Louisville, KY 40223-2164
Phone: (502) 489-9121
Web site: www.kyda.org

Louisiana Dental Association
7833 Office Park Blvd.
P. O. Box 261173
Baton Rouge, LA 70809-7604
Phone: (225) 926-1986
Web site: www.ladental.org

Maine Dental Association
P. O. Box 215
Manchester, ME 04351-0215
Phone: (207) 622-7900
Web site: www.medental.org

Maryland State Dental Association
6410 Dobbin Road, Ste. F
Columbia, MD 21045-4774
Phone: (410) 964-2880
Web site: www.msda.com

Massachusetts Dental Society
2 Willow St., Ste. 200
Southborough, MA 01745-1027
Phone: (508) 480-9797
Web site: www.massdental.org

Michigan Dental Association
230 Washington Square, North, Ste. 208
Lansing, MI 48933-1312
Phone: (517) 372-9070
Web site: www.smilemichigan.com

Minnesota Dental Association
2236 Marshall Ave.
Saint Paul, MN 55104-5758
Phone: (651) 646-7454
Web site: www.mndental.org

Mississippi Dental Association
2630 Ridgewood Road, Ste. C
Jackson, MS 39216-4903
Phone: (601) 982-0442
Web site: www.ms dental.org/cms/

Missouri Dental Association
3340 American Ave.
Jefferson City, MO 65109
Phone: (573) 634-3436
Web site: www.modental.org

Montana Dental Association
P. O. Box 1154
17 1/2 S. Last Chance Gulch
Helena, MT 59624
Phone: (406) 443-2061
Web site: www.mtdental.com

Nebraska Dental Association
3120 O St.
Lincoln, NE 68510-1533
Phone: (402) 476-1704
Web site: www.nedental.org

Nevada Dental Association
8863 W. Flamingo Road, Ste. 102
Las Vegas, NV 89147-8718
Phone: (702) 255-4211
Web site: www.nvda.org

New Hampshire Dental Society
23 South State St.
Concord, NH 03301
Phone: (603) 225-5961
Web site: www.nhds.org

New Jersey Dental Association
One Dental Plaza
P.O. Box 6020
North Brunswick, NJ 08902-6020
Phone: (732) 821-9400
Web site: www.njda.org

New Mexico Dental Association
9201 Montgomery Blvd, N.E., Ste. 601
Albuquerque, NM 87111
Phone: (505) 294-1368
Web site: www.nmdental.org

New York State Dental Association
121 State St., Fourth Floor
Albany, NY 12207-1622
Phone: (518) 465-0044
Web site: www.nysdental.org

North Carolina Dental Society
P. O. Box 4099
Cary, NC 27519-4099
Phone: (919) 677-1396
Web site: www.ncdental.org

North Dakota Dental Association
P. O. Box 1332
Bismarck, ND 58502-1332
Phone: (701) 223-8870
Web site: www.nddental.com

Ohio Dental Association
1370 Dublin Road
Columbus, OH 43215-1009
Phone: (614) 486-2700
Web site: www.oda.org

Oklahoma Dental Association
317 N.E. 13th St.
Oklahoma City, OK 73104
Phone: (405) 848-8873
Web site: www.okda.org

Oregon Dental Association
P.O. Box 3710
Wilsonville, OR 97070-3710
Phone: (503) 218-2010
Web site: www.oregondental.org

Pennsylvania Dental Association
P. O. Box 3341
Harrisburg, PA 17105-3341
Phone: (717) 234-5941
Web site: www.padental.org

Rhode Island Dental Association
200 Centerville Road, Suite 7
Warwick, RI 02886-4339
Phone: (401) 732-6833
Web site: www.ridental.com

South Carolina Dental Association
120 Stonemark Lane
Columbia, SC 29210-3841
Phone: (803) 750-2277
Web site: www.scda.org

South Dakota Dental Association
804 N. Euclid, Suite 103
Pierre, SD 57501-1194
Phone: (605) 224-9133
Web site: www.sddental.org

Tennessee Dental Association
660 Bakers Bridge Ave., Suite 300
Franklin, TN 37067
Phone: (615) 628-0208
Web site: www.tenn dental.org

Texas Dental Association
1946 S. IH-35, Suite 400
Austin, TX 78704
Phone: (512) 443-3675
Web site: www.tda.org

Utah Dental Association
1151 E. 3900 South, Suite 160
Salt Lake City, UT 84124-1216
Phone: (801) 261-5315
Web site: www.uda.org

Vermont State Dental Society
100 Dorset St., Suite 18
South Burlington, VT 05403-6241
Phone: (802) 864-0115
Web site: www.vsds.org

Virginia Dental Association
7525 Staples Mill Road
Richmond, VA 23228
Phone: (804) 261-1610
Web site: www.vadental.org

Washington State Dental Association
1001 Fourth Ave., Suite 3800
Seattle, WA 98154
Phone: (206) 448-1914
Web site: www.wsda.org

West Virginia Dental Association
2016 1/2 Kanawha Blvd. E.
Charleston, WV 25311-2204
Phone: (304) 344-5246
Web site: www.wvdental.org

Wisconsin Dental Association
6737 W. Washington St., Suite 2360
West Allis, WI 53214
Phone: (414) 276-4520
Web site: www.wda.org

Wyoming Dental Association
P.O. Box 40019
Casper, WY 82604
Phone: (307) 237-1186
Web site: www.wyda.org

National association policy concerning oral and maxillofacial surgeon scope of practice

American Medical Association

H-475.983 Definition of Surgery

Our AMA adopts the following definition of “surgery” from American College of Surgeons (Statement ST-11): Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel. Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212; A-07)

H-475.992 Definitions of “Cosmetic” and “Reconstructive” Surgery

(1) Our AMA supports the following definitions of “cosmetic” and “reconstructive” surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third-party

payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03)

H-35.990 Non-Physician Measurement of Body Functions

In the public interest, the AMA recommends that non-physicians who perform tests such as blood pressure or blood sugar measurements advise the examinee to communicate these findings to a licensed physician. (Sub. Res. 59, I-80; CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-160.936 Comprehensive Physical Examinations by Appropriate Practitioners

AMA policy supports the position that performance of comprehensive physical examinations to diagnose medical conditions be limited to licensed MDs/DOs or those practitioners who are directly supervised by licensed MDs/DOs; and the AMA will actively work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs/DOs. (Sub. Res. 210, I-96)

H-160.949 Practicing Medicine by Non-Physicians

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously

supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00)

H-215.995 Hospital Admission Histories and Physicals

Our AMA believes that the best interests of hospitalized patients are served when admission history and physical exams are performed by a physician, recognizing that portions of the histories and physical exams may be delegated by the physician to others whose credentials are accepted by the medical staff. (I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

American Society of Plastic Surgeons

Dental Scope of Practice: Issue Brief

In 1997 the American Dental Association (ADA) approved a change to the organization's definition of the practice of dentistry. According to the ADA, dentistry is defined as:

"The evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of the diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body." (emphasis added)

Since that time, the dental lobby has approached a large number of state legislatures with proposals to revise their state's legal definition of dentistry according to the ADA's updated definition. For states that have adopted this broad and ambiguous language in their dental practice law, the consequence has been an opportunity for dentists to argue that the legal scope of their profession includes cosmetic surgical procedures, such as rhinoplasty (nose reshaping), blepharoplasty (eyelid surgery), rhytidectomy (face lift), otoplasty (ear surgery) and liposuction.

Unfortunately, plastic surgery and organized medicine have generally not been effective at countering the highly organized and motivated dental offensive. Each year more state legislatures are approving legislation based on the ADA definition, and more non-physician oral surgeons are getting the green light to do the same procedures plastic surgeons spend years in medical and surgical training to perform.

However, there is proof that a successful campaign against the dental profession's attempts to encroach into the practice of medicine is possible, if physicians commit to waging a sustained and organized advocacy effort. The work of a coalition of surgical specialties and the Medical Society of the State of New York was pivotal to the passage of legislation in November 2001 which could serve as a model in other states. The language in the New York law specifies that dentistry includes treatment, diagnosis, operating, prescribing, etc., of the oral and "maxillofacial area related to restoring and maintaining dental health," thereby narrowing and clarifying the state's legal definition of dentistry.

To support grassroots advocacy of the dental scope of practice issue, the ASPS has developed tools to communicate plastic surgery's opposition to state dental scope expansion proposals. Please contact an ASPS government affairs associate at 847/228-9900 for more information.

Literature and resources

The “dual degree:” does it change the scope of practice for oral and maxillofacial surgery?

Byrne RP. *Tex Dent J*. 2004 Apr;121(4):304-9.

The scope of practice for OMS is not, nor should it ever be, an issue of single or dual degree but must be related to the surgeon being trained to competence in the procedures performed. Future evolution will be based on continual advancements in the specialty and related areas as well as the development of new techniques. While the medical education may improve a core fund of general knowledge, the surgical residency and/or fellowship is the determinant of surgical competence and scope of practice.

PMID: 15150890 [PubMed - indexed for MEDLINE]

The consequences of expanded oral surgery scope of practice in Richmond, Virginia.

Ladocsi LT, Zinsser JW. *Plast Reconstr Surg*. 2007 Jan;119(1):387-400.

BACKGROUND: On March 25, 2001, the Commonwealth of Virginia changed the definition of dentistry and expanded the scope of practice of single-degree oral surgeons to include cosmetic procedures previously restricted to physicians. The Board of Dentistry established standards for practice under the new scope. Suggestions made by the Board of Medicine regarding these standards were disregarded. The authors reviewed the events and consequences surrounding the redefinition of dentistry. **METHODS:** Events between January 1, 2000, and January 1, 2005, were reviewed. Data were gathered from public records and Internet sites, reports of physicians practicing cosmetic surgery in the Richmond metropolitan area, hospital staff committees, and medical societies. **RESULTS:** Physicians in Virginia were ill prepared to participate in the legislative process. Physicians treating patients unhappy with the results of cosmetic procedures by local oral surgeons described errors in preoperative diagnosis, failure to perform the appropriate surgical procedure, or inability to perform the appropriate procedure properly. A survey of cosmetic surgeons showed that 50 percent had cared for similar patients. There was no evidence to demonstrate a significant economic effect from increased competition by oral surgeons. The authors were unable to show that

oral surgeons practicing in the Richmond metropolitan area are able to match the community standard for providing care. **CONCLUSIONS:** The authors continue to regard scope of practice as an educational issue. On the basis of their review, it is not clear that standards promulgated by the Virginia Board of Dentistry have thus far produced surgeons capable of matching the Richmond community standard for cosmetic surgery. PMID: 17255698 [PubMed - indexed for MEDLINE]

Cosmetic blepharoplasty.

Niamtu J 3rd. *Atlas Oral Maxillofac Surg Clin North Am*. 2004 Mar;12(1):91-130.

Cosmetic blepharoplasty is the hallmark of facial rejuvenation and is rewarding for the surgeon and patient. No other cosmetic procedure is more common in the 40- to 65-year age group. This procedure carries a steep learning curve, but the training of an oral and maxillofacial surgeon is adequate to begin learning this procedure. Proper diagnosis and adherence to strict preoperative, intraoperative, and postoperative protocols are paramount to avoiding complications that may be serious. The author, like many surgeons, enjoys this procedure and believes that its place in the contemporary scope of oral and maxillofacial surgery is well established.

PMID: 15062338 [PubMed - indexed for MEDLINE]

Carotid artery-cavernous sinus fistula.

Harris AE, McMenamin PG. *Arch Otolaryngol*. 1984 Sep;110(9):618-23

Carotid artery-cavernous sinus fistula is a lesion most often associated with massive head trauma. The maxillofacial surgeon must be able to diagnose this major complication of head trauma, use proper diagnostic techniques, and initiate appropriate therapeutic regimens. The symptoms of pulsatile headache, bruit, and visual change accompany the physical findings of bruit, conjunctival engorgement, chemosis, proptosis, and ophthalmoplegia. A number of procedures have been devised to correct this difficult lesion, ranging from cervical ligation to balloon occlusion. Two cases of carotid artery-cavernous sinus fistula are reported in detail, documenting clinical findings, treatment, and long-term sequelae. Although surgical treatment is not within the scope of this specialty, the otolaryngologist must understand the vascular dynamics and surgical procedures related to this traumatic lesion.

PMID: 6477284 [PubMed - indexed for MEDLINE]

Patient's perceptions of the scope of oral and maxillofacial surgery.

Dubois DD, Chinnis RJ, Pizer ME. *J Oral Surg.* 1981 Jul;39(7):518-21.

The primary purpose of this study was to determine a measure of selected patients' perceptions of the scope of services provided by the oral and maxillofacial surgeon. Data were collected from 403 patients by a questionnaire and were combined with data from the participating patients' charts. Analysis and interpretation of the data disclosed two trends: patients perceived that problems of odontogenic origin should be treated by dentists or oral surgeons, and patients perceived that problems of nonodontogenic origin should be treated by medical professionals rather than by oral and maxillofacial surgeons. If these patients are representative of the general population, then these trends strongly suggest a need for greater public and professional dental educational opportunities about the scope of services rendered by the oral and maxillofacial surgeon. It is recommended that dental societies and dental schools assume the lead in offering these opportunities.

PMID: 6940959 [PubMed - indexed for MEDLINE]

Perception of oral maxillofacial surgery by health-care professionals.

Rocha NS, Laureano Filho JR, Silva ED, Almeida RC. *Int J Oral Maxillofac Surg.* 2008 Jan;37(1):41-6.

Oral and Maxillofacial Surgery (OMFS), a dentistry specialty recognized by the Federal Dentistry Board in the mid-1960s, is responsible for the diagnosis, and clinical and surgical treatment of traumatic, congenital, developmental and iatrogenic lesions in the maxillofacial complex. Even today, difficulties are experienced owing to the lack of knowledge of the general public and health professionals concerning the scope of OMFS. To investigate recognition of the scope of OMFS, 400 questionnaires were sent to dentistry students, medical students, dentists and doctors, in 4 equal groups. The questionnaire covered 26 clinical situations in four different specialties (OMFS, Plastic Surgery, Ear Nose and Throat Surgery, Head and Neck Surgery) and an option with no specialty specified. Each interviewee had to correlate the clinical situation with the respective specialist. For facial trauma, dento-facial deformi-

ties, mandibular reconstruction and temporomandibular joint surgery, most respondents would consult the OMF surgeon for treatment (mean, 90%). In cases of oral biopsy and treatment of benign mandibular tumours the mean referral rate to OMFS was low (48%). On the basis of the questionnaire responses, a good level of knowledge of the scope of OMFS was found. In order to ensure the correct referral of all patients, the specialty needs to broaden its horizons.

PMID: 17881191 [PubMed - indexed for MEDLINE]

Oral and maxillofacial surgery residency education.

Felsenfeld AL, Casagrande A. *J Calif Dent Assoc.* 2004 Oct;32(10):817-22.

Oral and maxillofacial surgery is the recognized specialty of dentistry that is responsible for the diagnosis and surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the bone and soft tissues of the oral and maxillofacial region. This article will present a review of the educational process for residents in oral and maxillofacial surgery as it has evolved and current training standards.

PMID: 15622705 [PubMed - indexed for MEDLINE]

Overview of facial cosmetic surgery.

Arcan SC. *J Calif Dent Assoc.* 2004 Oct;32(10):849-53.

Dentists routinely refer patients to oral and maxillofacial surgeons for dentoalveolar surgery, however few of these dentists are fully informed as to the full scope of surgical practice. Appropriately trained oral and maxillofacial surgeons may also offer cosmetic facial surgery to their patients under certain circumstances. This paper will provide an overview of cosmetic facial surgery.

PMID: 15622711 [PubMed - indexed for MEDLINE]

Non-surgical treatment modalities of facial photodamage: practical knowledge for the oral and maxillofacial professional.

Hegedus F, Diecidue R, Taub D, Nyirady J. *Int J Oral Maxillofac Surg.* 2006 May;35(5):389-98.

With the increasing interest in cosmetic procedures, oral and maxillofacial surgeons are being asked not only to improve oral health and aesthetics but to extend their expertise to provide advice on improving the overall appearance of the face. For the discerning patient, improving overall facial skin appearance is becoming an integral part of the process of surgical cosmetic procedures. Here, some of the non-surgical options available for the treatment of photodamaged skin are reviewed and an overview of the specific treatments in this category provided. Sun avoidance and protection from harmful rays with appropriate sunscreens are primary to maintaining healthy skin and appearance. Among treatment options, topical treatments with preparations such as retinoids, alpha-hydroxy acids and antioxidants have been shown to provide some benefit and are relatively easy to use albeit with appropriate precautions and professional guidance. As a second-level option, facial rejuvenation procedures such as botulinum toxin injection, soft tissue augmentation with collagen or hyaluronic acid gel, skin resurfacing, use of chemical peels, dermabrasion and laser resurfacing procedures can be used but require administration by qualified practitioners. Overall, these treatments may be used to complement rehabilitative, reconstructive, or cosmetic oral and maxillofacial surgery to further improve and complement surgical results.

PMID: 16352420 [PubMed - indexed for MEDLINE]

Comparison of the Education and Training of Physicians and Oral Surgeons

	DDS or DMD (Single-degree oral surgeon)	MD-Surgeon (Physician with medical degree)
Graduate Training	<p>4 Years Dental School</p> <p>Third Year: Restorative Dentistry, Pediatric Dentistry, Advanced Dental Surgery, and Outcomes of Treatment</p> <p>Fourth Year: 10 months required externships and clinical rotations in dentistry/oral health-related service</p> <p><i>Focus on oral health, not management of the whole patient</i></p>	<p>4 Years Medical School</p> <p>Third Year: Clinical Rotations in Medicine, Surgery, Pediatrics, Psychiatry, Obstetrics/Gynecology, Family Medicine</p> <p>Fourth Year: Acute Care, Ambulatory Care, Internal Medicine, and Neurology Clerkships; Clinical Electives; Advanced Cardiac Life Support</p> <p><i>24 months devoted to learning diagnosis and management of the whole patient</i></p>
Post-Graduate/Residency Training	<p>Oral Surgery Residents:</p> <p>4-year program, only</p> <p>18 months medical/surgical rotations</p> <p>30 months clinical oral health</p> <p><i>Oral Surgeons' total post-graduate residency experience is less than a medical student earns before obtaining their MD</i></p> <p><i>Senior OMS residents are required to complete only 10 total aesthetic and reconstructive surgical cases</i></p> <p>American Society of Plastic Surgeons, 2003</p>	<p>Physician Surgical Specialists:</p> <p>5-6 years of clinical surgical education: (general surgery, otolaryngology-head and neck surgery, plastic surgery, neurosurgery, critical care medicine, ophthalmology, trauma management...)</p> <p><i>Training Includes:</i></p> <ul style="list-style-type: none"> •Advanced surgical planning and diagnosis, surgical physiology and pharmacology, wound healing, surgical pathology, management of surgical complications... •Progressive responsibility in an accredited program recognized by the Accreditation Council on Graduate Medical Education

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Alabama	90 (as of 5/2007)**	No.	Completion of a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation required. (Code of Ala. § 34-9-19)	Must be eligible to sit for the specialty exam or possess diplomate status required to advertise as specialist. (Code of Ala. § 34-9-19)	Must be eligible to sit for the specialty exam or possess diplomate status required to advertise as specialist. (Code of Ala. § 34-9-19)	Yes. (Code of Ala. § 34-9-10)	Required. 20 hours annually. (Ala. Admin. Code r. 270-X-4-.04)
Alaska	N/A*	Yes. (Alaska Stat. § 08.36.244)	Complete as many academic years of advanced education in the specialty as are required by the appropriate specialty board in a program accredited by the Commission on Accreditation of the American Dental Association or its successor agency. (Alaska Stat. § 08.36.246)	Pass a specialty examination given by the Central Regional Examining Board OR be board certified. (Alaska Stat. § 08.36.246)	Pass exam OR be board certified by a specialty certification board recognized by the American Dental Association. (Alaska Stat. § 08.36.246)	Yes. (Alaska Stat. § 08.36.234)	Required. 28 contact hours and CPR certification. (12 Alaska Admin. Code 28.400)
Arizona	N/A*	No.	Completion of educational program of two or more years in a specialty area accredited by the Commission on Dental Accreditation of the American Dental Association required for advertising specialty services OR Board eligible OR Board certified. (A.A.C. § R4-11-1102)	No./Optional. (A.A.C. § R4-11-1102)	State statute allows for specialty practice by Board eligible/Board certified specialists, but also allows educationally qualified specialists to advertise as specialists. (A.A.C. § R4-11-1102)	Yes. (A.A.C. § R4-11-202)	Required. 72 hours per renewal period. (A.A.C. R4-11-1203)
Arkansas	N/A*	No. Board issues certificates to specialists who meet requirements. (A.C.A. § 17-82-305)	Complied with requirements as specified by the American Dental Association Council on Dental Education in a specialty branch of dentistry. (A.C.A. § 17-82-305)	Specialty Examinations may be oral or written, or both, and the applicant may be required to demonstrate his knowledge and proficiency in the specialty in which he desires to be certified. Not required if certified. (A.C.A. § 17-82-305)	Required for advertising as specialist. (A.C.A. § 17-82-305)	Yes. (A.C.A. § 17-82-308)	Required. 50 credit units every two years. (038 00 CARR 001, ARTICLE XIV)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
California	1010 (as of 5/2007)	No. Board issues permits to individuals who meet requirements. (Cal Bus & Prof Code § 1638)	Requires individual to be certified in the specialty by specialty board of ADA. (Cal Bus & Prof Code § 1638). A qualified oral surgeon shall be a dentist who meets the requirements of (1) and either (2) or (3). (1) Confines his practice to the specialty of oral surgery; (2) Has successfully completed a course of advanced study in oral surgery of three years or more in programs recognized by the Council on Dental Education of the ADA; (3) Has completed advanced training in oral surgery and meets both of the following requirements: (A) Has had advanced study and hospital experience in performing oral surgery in maxillofacial deformities and temporo-mandibular joint dysfunction. (B) Is listed in the Directory of the ADA with the Specialty Code of 10. (22 CCR 51223)		State requires individual to be certified in the specialty by specialty board of ADA or to be eligible to sit for specialty certification exam. (Cal Bus & Prof Code §§ 1638, 1640)	Yes. (Cal Bus & Prof Code § 1638; 16 CCR 1040)	Required. 50 hours per renewal period. Effective Jan. 1, 2006, licensees are required to complete cue units on infection control and the California Dental Practice Act. (16 CCR 1017)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Colorado	47 (as of 2005)**	No. A licensed dentist has the legal authority to practice in any and all areas of dentistry and also the authority to confine the areas in which he or she chooses to practice. (3 CCR 709-1, Rule XXVI)	Practitioners who have successfully completed an ADA accredited specialty program may advertise the practice of that specialty. (3 CCR 709-1, Rule XXVI)	Silent.	Silent.	Yes. (C.R.S. 12-35-120; 3 CCR 709-1, Rule IV)	Silent.
Connecticut	N/A*	No.	Completed two years of advanced or postgraduate education in the area of such specialty. (Conn. Gen. Stat. § 20-106a)	Silent.	Silent.	Yes. (Conn. Gen. Stat. § 20-110)	Required. 25 contact hours every 2 years. (Conn. Gen. Stat. § 20-126c)
Delaware	N/A*	No.	Silent.	Silent.	Silent.	Yes. (24 Del. C. § 1124)	Required. 50 hours every 2 years as well as a CPR course. (CDR 24-1100, Section 6)
D.C.	N/A*	No.	Silent.	Silent.	Silent.	Yes. (C.D.C.R. 17-4209.1)	Required. 25 hours every 2 years, which includes CPR and infection control. (C.D.C.R. 17-4206.4)
Florida	270 (as of 5/2007)	No.	Completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation. (Fla. Stat. § 466.0282)	Individual must be eligible for examination OR already be a diplomate. (Fla. Stat. § 466.0282)	Be a diplomate of a national specialty board recognized by the American Dental Association. (Fla. Stat. § 466.0282)	No.	Required. 30 hours biennially. (Fla. Stat. § 466.0135)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Georgia	110 (as of 5/2007)	No.	Complete the educational requirements stated in the American Dental Association's specialty practice guidelines. (Ga. Comp. R. & Regs. r. 150-11-.01)	Silent.	Silent.	Yes. (O.C.G.A. 43-11-41, O.C.G.A. 43-11-42, Ga. Comp. R. & Regs. r. 150-7-.04)	Required. 40 hours per biennium. (O.C.G.A. § 43-11-46.1)
Hawaii	N/A*	No.	Silent.	Silent.	Silent.	No.	Required. 32 hours every two years and basic life support. (WCHR § 16-79-144)
Idaho	N/A*	License as Dental Specialist required. (Idaho Code § 54-916)	Must be a graduate of and hold a certificate from both a dental school and a Graduate Training Program that are accredited by the Commission on Dental Accreditation of the American Dental Association. (IDAPA 19.01.01.045)	An examination covering the applicant's chosen field may be required and, if so, will be given by the Idaho State Board of Dentistry or its agent. Individuals practicing specialty prior to 1992 may not be required to take exam. (IDAPA 19.01.01.045)	Candidates who are certified by the American Board of that particular specialty, and who meet the qualifications set forth in the Board's Rules, may be granted specialty licensure by Board approval. (IDAPA 19.01.01.045)	Yes. (Idaho Code § 54-916B)	Required. 30 hours per each biennial renewal period. All dentists must hold current CPR card. (IDAPA 19.01.01.050)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Illinois	30 (as of 5/2007)	Required. (225 ILCS 25/11)	Successful completion of a 4 year (48 months) period of training in oral and maxillofacial surgery in a school and/or hospital approved by the Department. A minimum of 30 months shall be in clinical oral and maxillofacial surgery. The schedule shall include 24 months of full-time hospital training in an acceptable oral and maxillofacial surgery residency program. Not less than 4 months of this period must be devoted to training in anesthesiology. (68 Ill. Adm. Code 1220.310)	Examination as a specialist in Oral and Maxillofacial Surgery. (68 Ill. Adm. Code 1220.320)	Individual who is certified as an American Board Diplomate in the specialty for which application for licensure is made shall not be required to take the examination for dental specialist licensure. (68 Ill. Adm. Code 1220.335)	Yes. (225 ILCS 25/19).	Required. 48 hours per three year licensing period. (225 ILCS 25/16.1)
Indiana	210 (as of 5/2007)	No.	Graduation from an accredited advanced dental educational program. (828 IAC 1-1-18)	Silent.	Silent.	Yes. (Burns Ind. Code Ann. § 25-14-1-16)	Required. 20 credit hours every two years. (Burns Ind. Code Ann. § 25-14-3-8)
Iowa	100 (as of 5/2007)	No.	Successfully completed a formal graduate or residency training program in oral surgery accredited by the Commission on Dental Accreditation of the American Dental Association OR have limited practice to this area prior to January 1, 1965, and have been permitted to continue to do so pursuant to resolution of the ADA House of Delegates. (650 IAC 28.5(153))	Silent.	Silent.	Yes. (650 IAC 11.2 (147,153))	Required. 30 hours every 2 years. (650 IAC 25.2(153))

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Kansas	50 (as of 5/2007)	No. Board certifies specialists. (K.A.R. § 71-2-5)	Each applicant shall have successfully completed a graduate program in the specialty for which certification is sought in a dental school, college, or other dental specialty training program that is approved by the board and that the board determines has standards of education not less than those required for accreditation by the Commission on Dental Accreditation of the American Dental Association equivalent, applicable for the year in which the training was completed. (K.A.R. § 71-2-5)	Kansas specialty examination. (K.A.R. § 71-2-7); Waiver of examination (K.A.R. § 71-2-5).	Each applicant for a specialist certificate shall meet the following requirements: (a) Submit a transcript of all graduate-level dental education completed and a letter of reference from a practicing dentist who has personal knowledge of the applicant's experience and qualifications in the specialty for which a specialist certificate is sought; and (b) pass a board-approved specialist examination for the specialty sought. (K.A.R. § 71-2-7)	Yes. (K.S.A. § 65-1434)	Required. 60 hours every 2 years. Specialist dentist is required to take 40 of the 60 hours on cue courses relevant to the specialty. (K.A.R. § 71-4-1)
Kentucky	N/A*	Required. (KRS § 313.410)	Education of not less than two (2) years study in graduate or postgraduate courses, after graduation from a dental school. (201 KAR 8:345)	State specialty examination required. (201 KAR 8:340) The passing grade shall be seventy-five (75) percent. Failure to attain this passing mark shall disqualify the candidate for licensure in a dental specialty. (201 KAR 8:350)	Silent.	Yes. (KRS § 313.420)	Required. 30 hours every 2 years.

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Louisiana	N/A*	State recognizes specialists. (LAC 46:XXXIII.122)	The licensed dentist seeking specialty recognition must have successfully completed an ADA accredited post-doctoral program for each specialty. (LAC 46:XXXIII.122)	Silent.	Silent.	Yes for licensure by credentials. Licensure by reciprocity is prohibited. (La. R.S. 37:768)	Required. 40 hours per renewal period. (LAC 46:XXXIII.1611)
Maine	N/A*	No.	Silent.	Silent.	Silent.	Yes. (32 M.R.S. § 1085, CMR 02-313-012)	Required. 40 hours every 2 years with CPR certification required. (32 M.R.S. § 1084-A, CMR 02-313-013)
Maryland	90 (as of 5/2007)	Board will identify specialists. (Md. HEALTH OCCUPATIONS Code Ann. § 4-504)	Qualifications may include: requirements established by various specialty certifying boards of the American Dental Association; education and experience. (Md. HEALTH OCCUPATIONS Code Ann. § 4-504)	Qualifications may include: requirements established by various specialty certifying boards of the American Dental Association; education and experience. (Md. HEALTH OCCUPATIONS Code Ann. § 4-504)	Qualifications may include: requirements established by various specialty certifying boards of the American Dental Association; education and experience. (Md. HEALTH OCCUPATIONS Code Ann. § 4-504)	Yes. (Md. HEALTH OCCUPATIONS Code Ann. § 4-306)	Required. 30 hours per renewal period, including 2 hours of infection control and CPR certification. (COMAR 10.44.22.04)
Massachusetts	230 (as of 5/2007)	No.	Silent.	Yes. (234 CMR 2.02)	Silent.	Yes. (ALM GL ch. 112, § 48)	Required. 40 hours biennially. (234 CMR 5.01)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Michigan	40 (as of 5/2007)	Yes. (MCL § 333.16608)	Graduation from an accredited program in the specific specialty. (R 338.11267)	Specialty exam required. (MICH. ADMIN. CODE R 338.11267, MICH. ADMIN. CODE R 338.11513)	No. For purposes of the administration of the general rules of the board of dentistry in the Michigan administrative code, a reference to specialty certification is a reference to a health profession specialty field license. (MCL § 333.16608)	Yes. (R 338.11267)	Required. 60 hours every 3 years. Dental specialists shall have completed 20 hours of the 60 required board-approved continuing education hours in the dental specialty field in which they are certified. At least 1 cue credit in pain and symptom management (R 338.11701)
Minnesota	190 (as of 5/2007)	No. In the case of oral and maxillofacial surgeons only, have a Minnesota medical license in good standing. (Minn. Stat. § 150A.06, Subd. 1c)	Successfully completed a postdoctoral course approved by the Commission on Accreditation in one of the specialty areas OR approval of specialty examining board. (Minn. R. 3100.7000)	Approval by one of the specialty examining boards OR educationally qualified. (Minn. R. 3100.7000)	Approval by one of the specialty examining boards OR educationally qualified. (Minn. R. 3100.7000)	Yes. (Minn. Stat. § 150A.06, Subd. 4)	Required. 50 credit hours every biennial cycle. CPR certification required. (Minn. R. 3100.5100)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Mississippi	50 (as of 5/2007)	Board certifies specialists. (Miss. Code Ann. § 73-9-29)	Individual must comply with the requirements specified by the Council on Dental Education of the American Dental Association in a specialty branch of dentistry OR be certified as a diplomate of a specialty Board. (Miss. Code Ann. § 73-9-29)	Mississippi State Board of Dental Examiners specialty examination. (Miss. Code Ann. § 73-9-29)	A diplomate of a specialty board approved by the American Dental Association may announce specialty. (Miss. Code Ann. § 73-9-29)	Yes. (Miss. Code Ann. § 73-9-24)	Required. 40 hours every 2 years. (CMSR 50-010-001, Board Rule No. 41)
Missouri	70 (as of 5/2007)	Yes. (§ 332.171 R.S.Mo)	Completed a dental specialty program accredited by the Council on Dental Accreditation. (§ 332.171 R.S.Mo.)	Silent.	Recognized in the state, but not required. (§ 332.171 R.S.Mo)	Yes. (§ 332.171 R.S.Mo.)	Required. 50 hours per renewal period. (20 CSR 110-2.240)
Montana	N/A*	No.	Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or be diplomates of a nationally-recognized certifying board. (MONT. ADMIN. R. 24.138.3101)	Silent.	Dentists who announce as specialists must have successfully completed an educational program accredited by the commission on dental accreditation, two or more years in length, as specified by the council on dental education or be diplomates of a nationally-recognized certifying board. (MONT. ADMIN. R. 24.138.3101)	Yes. (MONT. ADMIN. R. 24.138.507)	Required. 60 credit hours every 3 years. (MONT. ADMIN. R. 24.138.2104)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Nebraska	50 (as of 5/2007)	No.	Individual must have current certification from, or eligibility for current certification from, a specialty board, recognized by the American Dental Association appropriate to that area of dental practice to advertise as a specialist. (Nebraska Admin. Code Title 172, Ch. 54)	Silent.	Individual must have current certification from, or eligibility for current certification from, a specialty board, recognized by the American Dental Association appropriate to that area of dental practice to advertise as a specialist. (Nebraska Admin. Code Title 172, Ch. 54)	Yes. (R.R.S. Neb. § 71-144)	Required. 30 hours every 2 years. (Nebraska Admin. Code Title 172, Ch. 56-004.01)
Nevada	N/A*	Required. (Nev. Rev. Stat. Ann. § 631.250)	Successfully completed the educational requirements currently specified for qualification in the special area by the certifying board. (NRS 631.250)	Examination not required for specialty licensure. (Nev. Rev. Stat. Ann. § 631.250)	Certification not required for specialty licensure. (Nev. Rev. Stat. Ann. § 631.250)	Yes. (Nev. Rev. Stat. Ann. § 631.255)	Required. 20 hours per year. CPR certification must be current. (NAC 631.173)
New Hampshire	N/A*	No.	Dentists announcing specialization and limitation of practice shall adhere to section 5-H of the 2005 edition of the American Dental Association Code of Ethics, as provided in Den 500. (N.H. Admin. Rules, Den 302.04)	Dentists announcing specialization and limitation of practice shall adhere to section 5-H of the 2005 edition of the American Dental Association Code of Ethics, as provided in Den 500. (N.H. Admin. Rules, Den 302.04)	Dentists may announce diplomate status granted by a bona fide national organization. (N.H. Admin. Rules, Den 302.04)	Yes. (RSA 317-A:24)	Required. 40 hours per biennium, including a basic life support course. (N.H. Admin. Rules, Den 403.03)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
New Jersey	360 (as of 5/2007)	Board issues specialty permits. (N.J.A.C. 13:30-6.1)	Successfully completed a post-doctoral education, accredited by the American Dental Association Council on Dental Education, of two or more years in duration in one or more of the specialty areas OR have certification to advertise as specialist. (N.J.A.C. 13:30-6.1)	Silent.	A licensed dentist who is certified or eligible for certification by a specialty board recognized by the American Dental Association appropriate to that area of dental practice listed OR educationally qualified required to advertise as specialist. (N.J.A.C. 13:30-6.1)	Yes. (N.J. Stat. § 45:6-6)	Required. 40 hours every 2 years. (N.J. Stat. § 45:6-10.1)
New Mexico	N/A*	Yes. (N.M. Stat. Ann. § 61-5A-12)	Applicant shall have a postgraduate degree or certificate from an accredited dental college, school of dentistry of a university or other residency program. (N.M. Stat. Ann. § 61-5A-12)	Clinical and written examination given by the board or its examining agents that covers the applicant's specialty. (N.M. Stat. Ann. § 61-5A-12)	Successfully completed an examination for diplomat status or a specialty licensure examination comparable to the specialty exam. (16.5.8.9 NMAC)	Yes. (N.M. Stat. Ann. § 61-5A-12)	Required. 60 hours every triennial cycle. (16.5.8.9 NMAC)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
New York	360 (as of 5/2007)	No.	Completion of a graduate level program in oral and maxillofacial surgery acceptable to the department. Required for dental anesthesia certificate. (8 NYCRR §61.10)	Silent.	Silent.	Yes. (8 NYCRR §61.4)	Required. 60 hours per triennial registration period. (8 NYCRR § 61.15) Beginning January 1, 2009, each dentist shall become certified in CPR by a provider approved by the department. Coursework will be included in the mandatory hours of continuing education. (8 NYCRR § 61.19)
North Carolina	220 (as of 5/2007)	No.	Completion of a postdoctoral course approved by the ADA Commission on Accreditation in a specialty or approved by one of the specialty examining Boards required for advertisement as specialist. (21 N.C.A.C. 16P.0105)	Silent.	Silent.	Yes. (N.C. Gen. Stat. § 90-36)	Required. The Board shall determine the number of hours of study within a particular period and the nature of course work required. (N.C. Gen. Stat. § 90-31.1, 21 N.C.A.C. 16R.0103)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
North Dakota	N/A*	Yes. A dentist shall practice within the scope of that dentist's education, advanced training as recognized by the board, and any specialty practice recognized by the American dental association or other professional entity recognized by the board. (N.D. Cent. Code, § 43-28-10)	Successfully completed an educational program accredited by the Commission on Accreditation of Dental and Dental Auxiliary Educational Programs, two or more years in length, as specified by the Commission on Dental Accreditation of the American Dental Association required OR may have certification to advertise as a specialist. (N.D. Admin. Code 20-02-01-01)	Silent.	Individual must be a diplomate of a nationally recognized certifying board OR educationally qualified to advertise as specialist. (N.D. Admin. Code 20-02-01-01)	Yes. (N.D. Cent. Code, § 43-28-15)	Required. 32 hours every two years. The infection control cue requirement is 2 hours. CPR certification must be current. (N.D. Cent. Code, § 43-28-12.2, N.D. Admin. Code 20-02-01-06)
Ohio	180 (as of 5/2007)	State Board "recognizes" specialists. (OAC Ann. 4715-5-04)	Successfully completed a post-doctoral education program for the specialty which is accredited by the American Dental Association Commission on Dental Accreditation OR certification. (OAC Ann. 4715-5-04)	Silent.	Be a diplomate of the national certifying board of a specialty recognized by the American dental association OR educationally qualified. (OAC Ann. 4715-5-04)	Yes. (ORC Ann. 4715.10)	Required. 40 hours biennially. (ORC Ann. 4715.141)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Oklahoma	N/A*	Board recognizes specialists. (O.A.C. § 195:10-9-2)	Certificate of satisfactory completion of advanced training program in Oral Surgery approved by the Commission on Dental Accreditation of the American Dental Association and in a hospital approved by the Council on Hospital and Institutional Dental Service of the American Dental Association. (O.A.C. § 195:10-9-2)	Specialty Examination required. (O.A.C. § 195:10-11-10)	Silent.	Yes. (O.A.C. § 195:10-5-2)	Required. 60 hours every 3 years. CPR certification required. (O.A.C. § 195:25-1-2, O.A.C. § 195:25-1-3)
Oregon	N/A*	Board certifies specialists. (Or. Admin. R. 818-021-0015)	Completion of a post-graduate program approved by the Commission on Dental Accreditation of the American Dental Association OR certified. (Or. Admin. R. 818-021-0015)	Specialty examination administered by examiners appointed by the Board who are specialists in the same specialty as the applicant and passing the state jurisprudence exam. (Or. Admin. R. 818-021-0017)	A diplomate of or a fellow in a specialty board accredited or recognized by the American Dental Association OR educationally qualified. (Or. Admin. R. 818-021-0015)	Yes. (Or. Admin. R. 818-021-0011)	Required. 40 hours every 2 years. (Or. Admin. R. 818-021-0060)
Pennsylvania	110 (as of 5/2007)	No.	Successfully complete a specialty training program approved by the ADA's Commission on Dental Accreditation. (49 Pa. Code § 33.203)	Silent.	Silent.	Yes. (49 Pa. Code § 33.107)	Required. 30 hours per biennial period. (49 Pa. Code § 33.401)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Rhode Island	N/A*	No.	Completion of a post graduate program approved by the Commission on Dental Accreditation of the American Dental Association OR certification required to advertise as specialist. (CRIR 14-140-007, Section 27.0)	Silent.	Individual must be a diplomate of or a fellow in a specialty board accredited or recognized by the American Dental Association OR educationally qualified to advertise as a specialist. (CRIR 14-140-007, Section 27.0)	Yes. (CRIR 14-140-007, Section 5.0)	Required. 40 hours every 2 years. (CRIR 14-140-007, Section 5.0)
South Carolina	N/A*	Required. (S.C. Code Ann. § 40-15-220)	Applicant must meet current educational requirements as set forth by the American Dental Association for ethical announcement of a practice limited to that specialty. (S.C. Code Ann. § 40-15-260)	Theoretical and practical specialty examination OR certified. (S.C. Code Ann. § 40-15-250)	A diplomate of a national certifying board recognized by the American Dental Association may be granted a specialty license without examination by the Board. (S.C. Code Ann. § 40-15-250)	Yes. (S.C. Code Ann. § 40-15-270) The board may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state if the applicant complies with the provisions of Reg. 39-1 B. (S.C. Code Ann. § 40-15-275)	Required. 14 hours per year. (S.C. Code Regs. 39-5)
South Dakota	N/A*	No.	Completion of postdoctoral training which is recognized and approved by the American Dental Association Commission on Dental Accreditation. (ARSD 20:43:04:01)	Silent.	Silent.	Yes. (S.D. Codified Laws § 36-6A-47)	Required. 100 hours every 5 years. CPR certification required. (ARSD 20:43:03:07)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Tennessee	N/A*	State Board "certifies" specialists. (Tenn. Comp. R. & Regs. R. 0460-2-.06)	Successful completion of advanced study in Oral and Maxillofacial Surgery of 4 years or more in a graduate school or hospital accredited by the CODA or the ADA and the Board. Has also successfully completed a residency and a clinical fellowship, of at least one (1) continuous year in duration, in esthetic (cosmetic) surgery accredited by the American Association of Oral and Maxillofacial Surgeons or by the American Dental Association Commission on Dental Accreditation OR certification required. (R.0460-2-.06).	All specialty applicants shall submit to an oral examination even if certification from an American Board in a specialty is accepted in lieu of submitting proof of successful completion of a residency program in a specialty. (Tenn. Comp. R. & Regs. R. 0460-2-.06)	Holds privileges issued by a credentialing committee of a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (Tenn. Comp. R. & Regs. R. 0460-2-.06)	Yes. (Tenn. Comp. R. & Regs. R. 0460-2-.01)	Required. 40 hours every 2 years. (Tenn. Comp. R. & Regs. R. 0460-1-.05). Two out of the 40 hours must consist of a course pertaining to chemical dependency education and/or shall be a course designed specifically to address prescribing practices.
Texas	260 (as of 5/2007)	Board issues "license by specialty exam." (22 TAC § 101.2)	Successfully complete training in an American Dental Association approved specialty in an education program that is accredited by the Commission on Dental Accreditation of the American Dental Association OR certified. (Tex. Occ. Code § 256.002)	Successful completion of a specialty examination administered by a regional examining board designated by the State Board of Dental Examiners. (22 TAC § 101.2)	Been currently or previously certified as "Board Eligible" by an American Dental Association-approved specialty board or educationally qualified. (Tex. Occ. Code § 256.002)	Yes. (Tex. Occ. Code § 256.101)	Required. 12 hours per year. (Tex. Occ. Code § 257.005)
Utah	N/A*	No.	Completed an ADA accredited educational program beyond the dental degree required for advertisement as specialist. (U.A.C. R156-69-502)	Silent.	Silent.	Yes. (Utah Code Ann. § 58-69-302)	Required. 30 hours every 2 years. (U.A.C. R156-69-304a)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
Vermont	N/A*	No.	Individual must meet the educational standards set by the Commission on Accreditation of Dental and Dental Auxiliary Programs of the American Dental Association OR be certified to advertise as specialist. (26 V.S.A. § 809)	Silent.	Eligibility to take the A.D.A. approved certifying board in that specialty OR educationally qualified in order to advertise as specialist. (26 V.S.A. § 809)	Yes. (26 V.S.A. § 805)	Required. 800 hours every 5 years. (CVR 04-030-080, Section 4.11)
Virginia	160 (as of 5/2007)	Board certifies specialists. (18 VAC 60-20-310)	Complete an oral and maxillofacial residency program accredited by the Commission on Dental Accreditation or a clinical fellowship. (18 VAC 60-20-310)	Silent.	Hold board certification by the American Board of Oral and Maxillofacial Surgery (ABOMS) or board eligibility as defined by ABOMS. (18 VAC 60-20-310)	Yes. (18 VAC 60-20-310)	Required. 15 hours every year. CPR certification also required. (18 VAC 60-20-50)
Washington	140 (as of 5/2007)	No.	Must be entitled to such specialty designation under the guidelines or requirements for specialties approved by the Commission on Dental Accreditation and the Council on Dental Education of the American Dental Association. (WAC § 246-817-420)	Must be entitled to such specialty designation under the guidelines or requirements for specialties approved by the Commission on Dental Accreditation and the Council on Dental Education of the American Dental Association (WAC § 246-817-420)	Silent.	Yes. (WAC § 246-817-130)	Required. 21 hours every year. (WAC § 246-817-440)

Figure 1. State licensure requirements for oral and maxillofacial surgeons

State	Workforce	License as a specialist required	Specialty education required	Specialty examination required	Certification	Reciprocity/ licensure by credentials	Continuing education
West Virginia	N/A*	Board issues certificates of qualification in a specialty of dentistry. (W. Va. CSR § 5-1-5)	In order to qualify for certification in this specialty, the licensee shall have a minimum of three full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency approved by the Council on Dental Education of the American Dental Association. (W. Va. CSR § 5-1-5)	Silent.	Silent.	Yes. (W. Va. Code § 30-4-9)	Required. 35 hours biennially. (W. Va. CSR § 5-1-10)
Wisconsin	50 (as of 5/2007)	No.	Successfully completed a post doctorate course approved by the Commission on Dental Accreditation of the American Dental Association in a specialty recognized by the American Dental Association required for practice as a specialist. (Wis. Adm. Code DE 6.02)	Silent.	Silent.	Yes. (Wis. Stat. § 447.04)	Required. 30 credit hours every 2 years. (Wis. Stat. § 447.056)
Wyoming	N/A*	No.	Dentists who announce as specialists must have successfully completed an educational program accredited by the Commission on Dental Accreditation, two (2) or more years in length, or be certified. (WCWR 024-034-006)	Silent.	Silent.	Yes. (WCWR 024-034-003, Sec. 2)	Continuing education required to renew basic life support. (WCWR 024-034-004, Sec. 2)

All information gathered from state statutes and codes, italicized text denotes information taken from board websites, or conversations with the Board. State Workforce numbers all retrieved July 7, 2008 from U.S. Department of Labor - Bureau of Labor Statistics. *N/A data cannot be published because of federal data privacy standards. ** Indicates information from state specific available labor and market information for the occupation.

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
Alabama	Code of Ala. § 34-9-6	No
Alaska	Alaska Stat. § 08.36.360	No
Arizona	A.R.S. § 32-1202	No
Arkansas	A.C.A. § 17-82-102	No
California	Cal Bus & Prof Code § 1625	"Oral and maxillofacial surgery" means the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects which involve both functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (Cal Bus & Prof Code § 1638)
Colorado	C.R.S. 12-35-103	No
Connecticut	Conn. Gen. Stat. § 20-123	A person who is licensed to practice dentistry under this chapter, who has successfully completed a postdoctoral training program that is accredited by the Commission on Dental Accreditation or its successor organization, in the specialty area of dentistry in which such person practices may: (1) Diagnose, evaluate, prevent or treat by surgical or other means, injuries, deformities, diseases or conditions of the hard and soft tissues of the oral and maxillofacial area, or its adjacent or associated structures; and (2) perform any of the following procedures, provided the dentist has been granted hospital privileges to perform such procedures: (A) Surgical treatment of sleep apnea involving the jaws; (B) salivary gland surgery; (C) the harvesting of donor tissue; (D) frontal and orbital surgery and nasoethmoidal procedures to the extent that such surgery or procedures are associated with trauma. (Conn. Gen. Stat. § 20-123)
Delaware	24 Del. C. § 1101	No
D.C.	D.C. Code § 3-1201.02	No
Florida	Fla. Stat. § 466.003	"Oral and maxillofacial surgery" means the specialty of dentistry involving diagnosis, surgery, and adjunctive treatment of diseases, injuries, and defects involving the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. (Fla. Stat. § 466.003)

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
Georgia	O.C.G.A. § 43-11-17	Oral and maxillofacial surgery is the specialty of dentistry that includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. A dentist who represents himself or herself as an "oral and/or maxillofacial surgeon," "specialist in oral and/or maxillofacial surgery" or similar term has completed the educational requirements stated in the American Dental Association's specialty practice guidelines in existence at the time the representation is made. (Ga. Comp. R. & Regs. r. 150-11-.01)
Hawaii	HRS § 448-	No
Idaho	Idaho Code § 54-901	No
Illinois	225 ILCS 25/17	No
Indiana	Burns Ind. Code Ann. § 25-14-1-23	No
Iowa	Iowa Code § 153.13	Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (650 IAC 28.5(153))
Kansas	K.S.A. § 65-1422	Oral and maxillofacial surgery means that branch of dentistry concerning the diagnosis and the surgical and adjunctive treatment of disease, injuries, and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (K.A.R. § 71-2-2)
Kentucky	KRS § 313.010	No
Louisiana	La. R.S. 37:751	Oral and Maxillofacial Surgery--the specialty of dentistry which includes the diagnosis, surgical, and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (LAC 46:XXXIII.301)
Maine	32 M.R.S. § 1081	No
Maryland	Md. HEALTH OCCUPATIONS Code Ann. § 4-101	No
Massachusetts	ALM GL ch. 112, § 50	No

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
Michigan	MCL § 333.16601	The practice of oral (maxillofacial) surgery includes the diagnosis and surgical and adjunctive treatment of the diseases, injuries, and deformities of the human mouth, jaws, and associated maxillofacial structures. The specialty of oral (maxillofacial) surgery shall include all of the following: (a) The preliminary performance of a history and physical examination for the purpose of assessing medical, dental, and anesthetic risks for contemplated oral and maxillofacial surgery. (b) The appropriate radiological and laboratory diagnosis. (c) The anesthetic, surgical, and adjunctive management for diseases, injuries, and deformities of the human mouth, jaws, and associated maxillofacial structures. (Mich. Admin. Code. R. 338.11513)
Minnesota	Minn. Stat. § 150A.05	No
Mississippi	Miss. Code Ann. § 73-9-3	Oral and maxillofacial surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (CMSR 50-010-001)
Missouri	§ 332.071 R.S.Mo	The specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (20 CSR 2110-2.085)
Montana	Mont. Code Anno., § 37-4-101	No
Nebraska	R.R.S. Neb. § 71-183	No
Nevada	Nev. Rev. Stat. Ann. § 631.215	No
New Hampshire	RSA 317-A:20	No
New Jersey	N.J. Stat. § 45:6-19	A licensed dentist whose credentials have been approved and who has been granted privileges by the medical staff of a public or private licensed hospital or other public or private institution in this state and who has been approved by the governing board of the hospital or institution may: a. Diagnose and treat patients admitted for acute or chronic illness, injury or deformity within the province of the human jaw and associated structures and complete and authenticate medical records of patients admitted or treated for dental or oral and maxillofacial surgical problems; and b. Prescribe medication and treatment for patients admitted for dental or oral and maxillofacial surgical problems. (N.J. Stat. § 45:6-19.5)
New Mexico	N.M. Stat. Ann. § 61-5A-4	No

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
New York	NY CLS Educ § 6601	No
North Carolina	N.C. Gen. Stat. § 90-29	A graduate of a medical college approved by the Liaison Commission on Medical Education or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency Program approved by the Board before completion of medical school. (N.C. Gen. Stat. § 90-9)
North Dakota	N.D.C.C. N.D. Cent. Code, § 43-28-01	No
Ohio	ORC Ann. 4715.01	No
Oklahoma	59 Okl. St. § 328.19	The diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (O.A.C. § 195:10-9-2)
Oregon	ORS § 679.010	Oral and Maxillofacial Surgery is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (Or. Admin. R. 818-001-0002)
Pennsylvania	63 P.S. § 121	Oral and maxillofacial surgeon is a dentist who limits his practice to the part of dental care which deals with the diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region. (55 Pa. Code § 1149.2)
Rhode Island	R.I. Gen. Laws § 5-31.1-1	No
South Carolina	S.C. Code Ann. § 40-15-70	No
South Dakota	S.D. Codified Laws § 36-6A-32	No

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
Tennessee	Tenn. Code Ann. § 63-5-108	That specialty branch of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Oral and Maxillofacial Surgery includes the treatment of the oral cavity and maxillofacial area or adjacent or associated structures and their impact on the human body that includes the performance of the following areas of Oral and Maxillofacial Surgery, as described in the most recent version of the Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery of the American Association of Oral and Maxillofacial Surgeons: (a) Patient assessment; (b) Anesthesia in outpatient facilities, as provided in T.C.A. § § 63-5-105 (6) and 63-5-108 (g); (c) Dentoalveolar surgery; (d) Oral and craniomaxillofacial implant surgery; (e) Surgical correction of maxillofacial skeletal deformities; (f) Cleft and craniofacial surgery; (g) Trauma surgery; (h) Temporomandibular joint surgery; (i) Diagnosis and management of pathologic conditions; (j) Reconstructive surgery including the harvesting of extra oral/distal tissues for grafting to the oral and maxillofacial region; and (k) Cosmetic maxillofacial surgery. (Tenn. Comp. R. & Regs. R. 0460-1-.01)
Texas	Tex. Occ. Code § 251.003	The practice of the dental specialty of oral and maxillofacial surgery includes the diagnosis of and the surgical and adjunctive treatment of diseases, injuries, and defects involving the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial region. (Tex. Occ. Code § 251.003)
Utah	Utah Code Ann. § 58-69-102	No
Vermont	26 V.S.A. § 721	No
Virginia	Va. Code Ann. § 54.1-2711	Certification is required for an oral and maxillofacial surgeon to perform aesthetic or cosmetic procedures. Such certification shall only entitle the licensee to perform procedures above the clavicle or within the head and neck region of the body. Based on the applicant's education, training and experience, certification may be granted to perform one or more of these or similar procedures: Rhinoplasty; Blepharoplasty; Rhytidectomy; Submental liposuction; Laser resurfacing or dermabrasion; Browlift (either open or endoscopic technique); Platysmal muscle plication; and Otoplasty. (18 VAC 60-20-290) Certification shall not be required for performance of the following: 1. Treatment of facial diseases and injuries, including maxillofacial structures; 2. Facial fractures, deformity and wound treatment; 3. Repair of cleft lip and palate deformity; 4. Facial augmentation procedures; and 5. Genioplasty. (18 VAC 60-20-300). "Maxillofacial" means pertaining to the jaws and face, particularly with reference to specialized surgery of this region. § 54.1-2700. "Oral and maxillofacial surgeon" means a person who has successfully completed an oral and maxillofacial residency program, approved by the Commission on Dental Accreditation of the American Dental Association, and who holds a valid license from the Board. § 54.1-2700.

Figure 2. State scope of practice regulations for oral and maxillofacial surgeons

State	Citation for dentist scope of practice	Separate definition for scope of practice of oral and maxillofacial surgeons
Washington	Rev. Code Wash. (ARCW) § 18.32.020	Oral and maxillofacial surgery means the specialty of dentistry that includes the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects of the hard and soft tissues of the oral and maxillofacial region. (Rev. Code Wash. (ARCW) § 18.32.020)
West Virginia	W. Va. Code § 30-4-15	"Oral and maxillofacial surgery" is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries, and defects involving both the functional and aesthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. (W. Va. CSR § 5-1-2)
Wisconsin	Wis. Stat. § 447.01	No
Wyoming	Wyo. Stat. § 33-15-114	No

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
Alabama	Board of Dental Examiners	Code of Ala. § 34-9-43	6 members: 5 licensed dentists, 1 licensed dental hygienist	Dentist members are nominated by dentists and elected by an election conducted by the Board of Dental Examiners. Dental hygienist is nominated by dental hygienists and elected by an election conducted by the Board of Dental Examiners. Five year terms.	Board members receive compensation in addition to per diem expenses set for government employees. (Code Ala. § 34-9-41)
Alaska	Board of Dental Examiners	Alaska Stat. § 08.36.070	9 Members: 6 licensed dentists; 2 licensed dental hygienists; 1 public member	Appointment by the Governor.	Not applicable.
Arizona	Board of Dental Examiners	Ariz. Rev. Stat. § 32-1207	11 members: 6 licensed dentists; 2 licensed dental hygienists; 3 public members	Appointment by the Governor. Four year terms.	Not applicable.
Arkansas	Board of Dental Examiners	Ark. Code Ann. § 17-82-208	9 Members: 6 licensed practicing dentists; 1 licensed practicing dental hygienist, 1 consumer representative, 1 elderly representative	Appointment by the Governor. Five year terms.	The Board fixes the salary of the Secretary-treasurer of the Arkansas State Board of Dental Examiners. (Ark. Code Ann. §17-82-209)
California	Dental Board of California	Cal. Bus. & Prof. Code § 1611.5	14 Members: 8 practicing dentists, 1 of which is a member of a faculty of any California dental college, 1 of which practices in a nonprofit community clinic; 1 registered dental hygienist; 1 registered dental assistant; 4 public members	Appointment by the Governor, except for 2 public members. Senate Rules Committee and Speaker of the Assembly each appoint a public member. Four year terms.	The current statute will become inoperative on July 1, 2008. (Cal. Bus. & Prof. Code § 1611.5)
Colorado	Board of Dental Examiners	Colo. Rev. Stat. § 12-35-107	10 Members: 5 dentists; 2 dental hygienists; 3 public members	Appointment by the Governor. Four year terms.	Not applicable.
Connecticut	State Dental Commission	Conn. Gen. Stat. § 20-103a, 20-107, 20-114	9 Members: 6 dental practitioners; 3 public members	Appointment by the Governor. Terms coincide with term of appointing Governor.	Not applicable.
Delaware	Board of Dental Examiners	24 Del. Code § Ann. 1106	9 Members: 5 licensed dentists; 1 dental hygienist; 3 public members	Appointment by the Governor. Three year terms.	Not applicable.

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
D.C.	Board of Dentistry	D.C. Code § 3-1204.08	7 members: 5 licensed dentists; 1 licensed dental hygienist; 1 consumer member	Appointment by the Mayor, subject to the consent of the council. Three year terms.	Members of the Board receive compensation in addition to reimbursement for expenses. (D.C. Code § 3-1204.06)
Florida	Board of Dentistry	Fla. Stat. § 466.004	11 Members: 7 dentists; 2 dental hygienists; 2 public members	Appointment by the Governor, subject to confirmation by the Senate. Four year terms.	Not applicable.
Georgia	Board of Dentistry	O.C.G.A. § 43-11-7	11 Members: 9 dentists; 1 practicing resident dental hygienist; 1 consumer member	Appointment by the Governor. Five year terms.	Not applicable.
Hawaii	Board of Dental Examiners	Haw. Rev. Stat. § 448-6	12 Members: 8 practicing dentists; 2 licensed dental hygienists; 2 public members	Appointment by the Governor, subject to confirmation by the Senate. Four year terms.	Not applicable.
Idaho	Board of Dentistry	Idaho Code § 54-912	8 Members: 5 dentists; 2 dental hygienists; 1 consumer member	Appointment by the Governor. Five year terms.	Not applicable.
Illinois	Board of Dentistry	225 ILCS 25/6	11 Members: 8 dentists; 2 dental hygienists; 1 public member	Appointment by the Director of Professional Regulation. Four year terms.	Not applicable.
Indiana	Board of Dentistry	Ind. Code Ann. § 25-14-1-2	11 Members: 9 practicing dentists; 1 practicing dental hygienist; 1 public member	Appointment by the Governor. Three year terms.	Not applicable.
Iowa	Board of Dental Examiners	Iowa Code Ann. § 153.33	9 Members: 5 members licensed to practice dentistry; 2 members licensed to practice dental hygiene; 2 public members	Appointment by the Governor, subject to confirmation by the Senate. Three year terms.	Not applicable.
Kansas	Dental Board	Kan. Stat. Ann. § 74-1406	9 Members: 6 dentists; 2 dental hygienists; 1 public member	Appointment by the Governor. Four year terms.	Not applicable.
Kentucky	Board of Dentistry	K.R.S. § 313.220	9 Members: 7 licensed dentists; 1 public member; 1 licensed dental hygienist	Appointment by the Governor. Four year terms.	Not applicable.
Louisiana	Board of Dentistry	La. Rev. Stat. 37:760	14 Members: 13 licensed dentists; 1 licensed dental hygienist	Appointment by the Governor, subject to confirmation by the Senate. Five year terms.	Not applicable.

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
Maine	Board of Dental Examiners	32 M.R.S. § 1073	9 Members: 5 members of the dental profession; 2 dental hygienists; 1 denturist; 1 public member	Appointment by the Governor. Five year terms.	Not applicable.
Maryland	Board of Dental Examiners	Md. HEALTH "OCCUPATIONS" Code § 4-205	16 Members: 9 dentists; 4 dental hygienists; 3 consumer members	Appointment by the Governor. Four year terms.	Not applicable.
Massachusetts	Board of Registration in Dentistry	ALM GL ch. 112, § 43	9 Members: 6 dentists; 2 public members; 1 dental hygienist; 2 dental assistant advisory members	Appointment by the Governor. Five year terms.	Not applicable.
Michigan	Board of Dentistry	Mich. Comp. Laws § 333.16101 - 333.16349	19 Members: 8 dentists; 2 dental specialists; 4 hygienists; 2 registered dental assistants; 3 public members	Appointment by Governor, subject to confirmation by the Senate. Four year terms.	Specialty Task Force advises the Board in specialty areas. The Task Force consists of 9 members: 1 non-specialty dentist; 1 prosthodontist, 1 endodontist, 1 oral and maxillofacial surgeon, 1 orthodontist, 1 pediatric dentist, 1 periodontist, 1 oral pathologist, and 1 public member. (Mich. Comp. Laws § 333.16624)
Minnesota	Board of Dentistry	Minn. Stat. § 150A.04	9 Members: 2 public members; 5 dentists; 1 registered dental assistant; 1 registered dental hygienist	Appointment by the Governor. Four year terms.	Not applicable.
Mississippi	Board of Dental Examiners	Miss. Code Ann. § 73-9-13	8 Members: 7 actively practicing dentists; 1 actively practicing dental hygienist	Appointment by the Governor, subject to confirmation by the Senate. Six year terms.	Not applicable.
Missouri	Dental Board	R. S. Mo. § 332.031	7 Members: 5 dentists; 1 dental hygienist; 1 public member	Appointment by the Governor subject to confirmation by the Senate. Five year terms.	Not applicable.
Montana	Board of Dentistry	Mont. Code Ann. § 37-1-307	10 Members: 5 dentists; 1 denturist; 2 dental hygienists; 2 public members	Appointment by the Governor subject to confirmation by the Senate. Five year terms.	Not applicable.

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
Nebraska	Board of Dentistry	Neb. Rev. Stat. § 71-112.03	10 Members: 6 dentists, 2 of which are involved in teaching; 2 dental hygienists; 2 public members	Appointment by the State Board of Health. Five year terms.	Not applicable.
Nevada	Board of Dental Examiners	Nev. Rev. Stat. Ann. § 631.190	11 Members: 6 licensed dentists; 3 licensed dental hygienists; 1 public member; 1 member representing disadvantaged dental patients	Appointment by the Governor. Three year staggered terms.	Not applicable.
New Hampshire	Board of Dental Examiners	N.H. Rev. Stat. Ann. § 317-A:4	9 Members: 6 dentists; 2 dental hygienists; 1 public member	Appointment by the Governor with approval of the council. Five year terms.	Not applicable.
New Jersey	Board of Dentistry	N.J. Stat. § 45:6-3	11 Members: 8 dentists; 1 dental hygienist; 2 public members	Appointment by the Governor. Four year terms.	Board members receive additional compensation for participating in examinations. (N.J. Stat. § 45:6-1.1)
New Mexico	Board of Dental Health Care	N.M. Stat. Ann. § 61-5A-10	9 Members: 5 dentists; 2 dental hygienists; 2 public members	Appointment by the Governor. Five year terms.	Not applicable.
New York	Board of Dentistry	N.Y. Educ. Law § 6603	17 Members: 13 licensed dentists; 3 licensed dental hygienists; 1 certified dental assistant	Appointment by the Board of Regents. Five year terms.	Not applicable.
North Carolina	Board of Dental Examiners	N.C. Gen. Stat. § 90-22	8 Members: 6 licensed dentists; 1 licensed dental hygienist; 1 non-voting public member	Elected by North Carolina dentists. Three year terms.	Not applicable.
North Dakota	Board of Dental Examiners	N.D. Cent. Code, § 43-28-06	7 Members: 5 dentists; 1 dental hygienist; 1 consumer member	Appointment by the Governor. Five year terms.	Not applicable.
Ohio	Dental Board	Ohio Rev. Code Ann. § 4715.03	13 Members: 9 licensed dentists, 2 of which are specialists; 3 dental hygienists; 1 public member	Appointment by the Governor, subject to consent of the Senate. Four year terms.	Not applicable.
Oklahoma	Board of Dentistry	59 Okl. St. § 328.15	11 Members: 8 dentists; 1 dental hygienist; 2 public members	Public members are appointed by the Governor while the dentists and dental hygienists are elected. Three year terms.	Not applicable.
Oregon	Board of Dentistry	Or. Rev. Stat. § 679.250	9 Members: 6 licensed dentists, 1 of which is a specialist; 2 licensed dental hygienists; 1 public member	Appointment by the Governor subject to confirmation by the Senate. Four year terms.	Not applicable.

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
Pennsylvania	Board of Dentistry	63 P.S. § 122	13 Members: Secretary of Health; Director of the Bureau of Consumer Protection; Commissioner of Professional and Occupational Affairs; 7 licensed dentists; 1 licensed dental hygienist; 2 public members	Appointment by the Governor with the consent of the Senate. Six year terms.	Not applicable.
Rhode Island	Board of Examiners in Dentistry	R.I. Gen. Laws § 5-31.1-4	12 Members: 6 dentists; 2 dental hygienists; 4 public members	Appointment by the Governor. Three year terms.	Not applicable.
South Carolina	Board of Dentistry	S.C. Code Laws § 40-1-70	9 Members: 7 dentists; 1 dental hygienist; 1 public member	One dentist and the public member shall be appointed by the Governor, 6 dentists are elected by South Carolina dentists. Six year terms.	Not applicable.
South Dakota	Board of Dentistry	S.D. Codified Laws § 36-6A-14	7 Members: 5 dentists; 1 dental hygienists; 1 resident public member	Appointment by the Governor. Three year terms.	Not applicable.
Tennessee	Board of Dentistry	Tenn. Code Ann. § 63-5-105	11 Members: 7 practicing dentists; 2 practicing dental hygienists; 1 practicing registered dental assistant; 1 public member	Appointment by the Governor. Three year terms.	Not applicable.
Texas	Board of Dental Examiners	Tex. Occ. Code § 254.001	15 Members: 8 dentists; 2 dental hygienists; 5 public members	Appointment by the Governor subject to consent of the Senate. Six year terms.	Not applicable.
Utah	Dentist and Dental Hygienist Licensing Board	Utah Code § 58-1-202	9 Members: 6 licensed dentists; 2 licensed dental hygienists; 1 public member	Appointment by the director of the Division of Occupational and Professional Licensing subject to approval by the Governor. Four year terms.	Not applicable.
Vermont	Board of Dental Examiners	Vt. Stat. Ann. tit. 36 § 767	9 Members: 5 dentists; 2 dental hygienists; 2 public members	Appointment by the Governor. Five year terms.	Not applicable.
Virginia	Board of Dentistry	Va. Code Ann. § 54.1-2400	10 Members: 7 dentists; 2 dental hygienists; 1 public member	Appointment by the Governor. Four year terms.	Not applicable.
Washington	Dental Quality Assurance Commission	Wash. Rev. Code § 18.32.0357	14 Members: 12 licensed dentists; 2 public members	Appointment by the Governor. Four year terms.	Not applicable.

Figure 3. State board operating information for oral and maxillofacial surgeons

State	Regulatory body	Authority	Composition	Appointment procedure	Special procedures
West Virginia	Board of Dental Examiners	W. Va. Code § 30-4-5	9 Members: 6 licensed dentists; 1 licensed dental hygienist; 1 certified dental assistant; 1 public member	Appointment by the Governor with the consent of the Senate. Five year terms.	Not applicable.
Wisconsin	Dentistry Examining Board	Wis. Stat. § 447.02	11 Members: 6 dentists; 3 dental hygienists; 2 public members	Appointment by the Governor, subject to Senate confirmation.	Not applicable.
Wyoming	Board of Dental Examiners	Wyo. Stat. § 33-15-101	6 Members: 5 dentists; 1 dental hygienist	Appointment by the Governor subject to the consent of the Senate. Four year terms.	Not applicable.

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