

Radiology Clinical Competency Evaluation

Dental Auxiliary _____ Signatures when completed
 Period of Evaluation (dates) _____ Chief _____
 Successful completion of written evaluation: Yes ___ No ___ Date _____ Dental Auxiliary _____

| Total of Ten Patients Must include a combination of BWX series, PAs and Panos | Clinical Evaluation Areas See criteria attached for each area to be evaluated | Evaluation (check appropriate box) | | Remarks |
|--|---|---------------------------------------|--------------------------|---------------------------------|
| | | Pass | No Pass | |
| Patient's Chart # /Date 1. _____ / _____ Type of radiographs _____ BWX Series _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | <input type="checkbox"/> | <input type="checkbox"/> | 1. _____ DDS Signature _____ |
| Patient's Chart # /Date 2. _____ / _____ Type of radiographs _____ BWX Series _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | <input type="checkbox"/> | <input type="checkbox"/> | 2. _____ DDS Signature _____ |
| Patient's Chart # /Date 3. _____ / _____ Type of radiographs _____ BWX Series _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | <input type="checkbox"/> | <input type="checkbox"/> | 3. _____ DDS Signature _____ |
| Patient's Chart # /Date 4. _____ / _____ Type of radiographs _____ BWX Series _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | <input type="checkbox"/> | <input type="checkbox"/> | 4. _____ DDS Signature _____ |
| Patient's Chart # /Date 5. _____ / _____ Type of radiographs _____ PA _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | <input type="checkbox"/> | <input type="checkbox"/> | 5. _____ DDS Signature _____ |

| Total of Ten Patients Must include a combination of BWV series, PAs and Panos | Clinical Evaluation Areas See criteria attached for each area to be evaluated | Evaluation (check appropriate box) | | Remarks |
|---|---|---------------------------------------|---------|----------------------------------|
| | | Pass | No Pass | |
| Patient's Chart # /Date 6. _____ / _____ Type of radiographs _____ PA _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | | | 6. _____ DDS Signature _____ |
| Patient's Chart # /Date 7. _____ / _____ Type of radiographs _____ PA _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | | | 7. _____ DDS Signature _____ |
| Patient's Chart # /Date 8. _____ / _____ Type of radiographs _____ PA _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | | | 8. _____ DDS Signature _____ |
| Patient's Chart # /Date 9. _____ / _____ Type of radiographs _____ Pano _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | | | 9. _____ DDS Signature _____ |
| Patient's Chart # /Date 10. _____ / _____ Type of radiographs _____ Pano _____ | Infection Control Radiological protection Quality of radiographs Presentation of radiographs | | | 10. _____ DDS Signature _____ |

