

LOGBOOK FORMAT

PART 1: Implant Logbook Format - (Mandatory Submission)

Purpose

The implant logbook serves as a **primary screening and verification document**, ensuring that the candidate has genuine clinical experience.

Logbook instructions (to candidate)

The candidate must submit a complete logbook of implant procedures performed. The logbook must be:

- Chronologically arranged
- Signed by the candidate
- Digitally or physically verifiable
- Supported by records if audited

Candidate details

Name:

Registration Number:

Years of practice:

Implant procedure Log table

Case No	Date	Patient ID	Site	Procedure Type	Implant System	Immediate/Delayed	Augmentation	Prosthesis Type	Role (Primary/Assist)

Procedure type coding (Standardized)

- S = Single implant
- M = Multiple implants
- F = Full arch
- I = Immediate implant
- G = Guided surgery

Augmentation coding

- None
- GBR
- Sinus Augmentation - SA
- Soft tissue graft – STG
- Bone Grafting - BG

Prosthesis Coding

- SC = Single crown
- FPD = Fixed partial denture
- FA = Full arch
- OD = Overdenture

DECLARATION (LOGBOOK)

“I certify that the above entries are true and represent procedures performed by me. I understand that the Academy may audit any case.”

Signature

Date

PART 2: Case submission template (standardized format)

GENERAL INSTRUCTIONS

- Minimum **20 cases**
- Follow identical format
- Include **clinical photos + radiographs**
- Minimum **12-month follow-up preferable**

CASE TEMPLATE

1. Case Title - (Example: Immediate implant placement in maxillary central incisor with GBR)

2. Patient profile

- Age / Gender
- Chief complaint
- Medical history
- Risk factors (smoking, diabetes, etc.)

3. Diagnosis

- Clinical findings
- Radiographic findings
- CBCT interpretation
- Bone quality/quantity assessment

4. Treatment Planning

- Primary treatment plan
- Alternative options
- Justification of chosen plan
- Risk assessment

5. Surgical Phase

- Implant system and dimensions
- Surgical protocol
- Flap design / flapless

- Site preparation technique
- Augmentation procedure (if any)
- Intraoperative complications

6. Prosthetic phase

- Healing protocol
- Abutment selection
- Impression technique (digital/conventional)
- Prosthesis type
- Occlusal scheme

7. Outcome

- Immediate outcome
- Final prosthetic result
- Clinical photographs
- Radiographic evaluation

8. Follow-up (MANDATORY)

- Duration (minimum 12 months)
- Tissue response
- Bone stability
- Functional outcome

9. Complications

- Type of complication (if any)
- Time of occurrence

- Management performed
- Outcome

10. Reflective analysis (What went well?)

- What could have been improved?
- What would you do differently?
 - This section is **critical for Diplomate-level differentiation**

11. Case summary

- Key learning points
- Clinical significance