Case History Portfolio Examination Guidelines

Updated December 8, 2025

Dear Candidates,

The *Case History Portfolio Examination Guidelines* give you a complete road map to follow while you are creating your digitally-submitted Portfolio. These *Guidelines* contain updates from the preceding May 2025 version of the document, as well as the current December 2025 update.

Review this version of the *Guidelines* in their entirety, as some noteworthy changes have occurred. This version will help explain, clarify, or better define expectations for submitted Portfolios.

Portfolio changes:

Latest Updates (beginning with the December 2025 version of the Guidelines and applicable beginning with the May 2026 exam):

-Starting with the May 1, 2026 submission cycle, the deadline **date** will remain as May 1, however the deadline **time** for the portfolio submission will change to **2 PM Central Daylight Time (CDT).** The deadline is no longer by midnight. The 2 PM Central Daylight Time deadline will be strictly enforced, and any Portfolio that has not been submitted in its entirety by that deadline will automatically be assigned for the next cycle for grading. See Page 6 of these *Guidelines*.

- After careful research conducted in association with Data Recognition Corporation (DRC), an organization that is expert in the field of high stakes exam development and statistical analysis, the ABE elected to incorporate a new rating scale rubric to begin with the May 1, 2026 exam cycle.

- As of the May 1, 2026 exam, each case will be evaluated in ten categories. Examiners will assign one grade per each of these categories. Each case will receive a total of twenty scores (Ten per each examiner). Please refer to the new rating scale rubric on Pages 30 – 33 of these *Guidelines.*

- For Case 5, “Periradicular Surgery”, re-surgery (revision of previous periradicular surgery) is no longer acceptable for any cases completed after May 1, 2026.

Updates from the prior version of the Guidelines (May 2025) and still applicable for current exam:

For Case 5, “Periradicular Surgery”, the inclusion of a biopsy and accompanying pathology report is now an absolute requirement. Failure to submit this case with these required elements will result in a “First-Review Failure” and the entire Portfolio will not be graded. If, during the surgical procedure, a suitable tissue specimen for biopsy is not available, for whatever reason, a different surgical case should be chosen for your Portfolio. See Pages 6 and 9 of these *Guidelines*.

- The completion date for Case 5, “Periradicular Surgery,” will now be the date that the root-end resection, preparation, and filling are performed. With many providers placing resorbable sutures, this will be a standard completion point for this case, and the one-year post-treatment evaluation will need to occur from that date, rather than a suture removal date. See Page 8 of these *Guidelines*.

As of the May 2024 submission cyle, portfolios will only be graded once a year. Candidates will have access to the website to upload their Portfolio at any time during the year. However, the recurring submission deadline will be on May 1st.

- Expansion of Case 4 to permit submission of a greater selection of case types for this category. With previous Portfolios consisting of only molar teeth, it was decided that some non-molar teeth may carry adequate complexity to demonstrate the clinical skills required of a board-certified specialist. Rather than “Retreatment”, this case will now be designated as “Other Treatment.” See Page 8 of these *Guidelines.*

- As each Portfolio consists of just 5 total cases, a limited number of conditions will be permitted for inclusion in this current expansion of the Case 4. See Page 8 of these *Guidelines* for specific permissible inclusion criteria for this case category.

- While allowing more cases to be included with this category, this limitation in acceptable case types is necessary to minimize variability in the evaluation process and subsequent statistical analysis. This will ensure the Board’s history of high examination reliability will be maintained.

- Previously, Case 4 consisted of retreatment of a maxillary or mandibular molar. That type of case will still be permitted for Case 4, thus this change will not affect anyone who already has that type of case within their existing Portfolio case compilation.

- With more case types being permitted for Case 4, the hope is to encourage more Candidates to challenge the ABE Case History Portfolio Examination.

- There are new guidelines for the use of a table for reporting pre-operative diagnostic test findings. A table will still be utilized, but there are now symbols to utilize when reporting the results of various commonly-performed tests. This guidance will simplify this portion of the Case History Report, providing a consistent set of reporting options. This eases the overall process and will enhance grading by examiners. See Pages 21-22 of these *Guidelines.*

- To provide clarity for examiners, any exceptions to this guidance for the diagnostic table, or for additional testing conducted, should be explained by the Candidate using the narrative field within the intraoral exam section of the Case History Report (using the Addendum page, if needed). See Page 22 of these *Guidelines*.

- The "Cover Sheet" and "List of Abbreviations" documents are optional; there is no requirement for the inclusion of either in a Portfolio. The length of each of these documents, if utilized, is limited to ONE page each. See Page 29 of these *Guidelines*.

- While not an absolute requirement, as a help to demonstrate complexity of the medical components of a case and their proper management, it is suggested that each case history report include the ASA (American Society of Anesthesiologists) Physical Status Classification for each patient. See Page 20 of these *Guidelines*.

- The requirement for a one-year post-treatment evaluation remains for all five cases; this is consistent with the necessity to show acceptable outcomes associated with the treatment rendered.

The requirement for all cases completed after May 1, 2024 will be the evaluation must occur one year or later after case completion. See pages 7 and 28 of these *Guidelines*.

- Note: Prior instructions indicated that an evaluation conducted within the 12th-month or later following case completion was acceptable. That will now only apply for cases completed prior to May 1, 2024.

- Working length verification must be provided for each non-surgical case, using a radiographic image with a file or obturation cone. Prior guidelines indicated that a cone fit with sealer in place would not be acceptable.

- A cone-fit image with sealer in place can now be acceptable, especially if the extent of the cone in each canal is discernible to the Portfolio evaluators. See page 11 of these *Guidelines*.

- For "Patient Sex," an "Other" choice is included in the associated drop-down box within the most recent version of the Case History Report form. See Page 19 of these *Guidelines*.

Reminders of emphasis:

- Pre-operative, intra-operative, immediate post-treatment, and one-year post-treatment evaluation images are still required to be intraoral digital images. Submission of CBCT images as the sole modality of radiographic evaluation is not acceptable.

- There is no capability to submit complete CBCT image volumes. Screenshots of CBCT images are acceptable and may be included to supplement required intraoral images. Only the planar views that supply the needed information should be submitted.

- If CBCT imaging is used to validate the presence of pre-operative disease, images submitted for post-treatment evaluation should be of similar position and orientation to validate conditions at the one-year (or more) point.

- As in the past, the ABE may need to limit the number of submissions accepted for review in any given cycle. Any such limitation on submissions would be dynamic and based exclusively on available examiner resources. Any Portfolio that meets the scheduled deadline that cannot be reviewed, would be automatically held, and reviewed the following cycle. Candidates would be notified of this situation by ABE staff. With only a single grading cycle each year, Candidates are highly encouraged to not wait until near the deadline for their final submission.

- We urge every Candidate to read this updated version of the *Case History Portfolio Guidelines* document cover- to-cover before you begin. After that continue to use it as a reference as you collect cases, record treatment information, write narratives, and when you double-check your work before submitting.

- The instructions need to be followed very closely, as you are graded for the accuracy as well as the content of your Portfolio. To ensure compliance, Candidates are reminded to make sure they are using the most recent Case History Report form.

- Another must-read document is the *Case History Exam Submission Instructions* which will guide you through each step of the process from registering for the exam to the final uploading of your Portfolio. These instructions can be found at: www.amboardendo.org/home/instructions.

- An additional resource is a series of case history exam tutorial videos that can be found here on the ABE case history webpage: https://www.aae.org/board/get-board-certified/examinations/case-history-examination/.
These videos are designed to show you, step-by-step, how to register, complete a Case History Report form, and upload your Portfolio onto the Case History Portfolio website. If you have any questions regarding the technical aspects of submitting a Portfolio, our Chief Operating Officer, Ivana Bevacqua can be reached via e-mail at: ivana@amboardendo.org.

The Directors and Staff of the American Board of Endodontics collectively wish you success in achieving Board Certification.

Case History Portfolio Committee
American Board of Endodontics
December 2025

Table of Contents

Starting your Portfolio

- These *Guidelines* were created to give you a roadmap to follow while creating your Portfolio.

- You should read this document cover-to-cover before you begin, and then use it as a reference as you treat patients, record treatment information, collect cases, write narratives, and double-check your work before submitting.

Case Submission Dates

- Portfolios are accepted at any time during the year but are only examined once each year.

- The deadline for each annual grading cycle is **2 PM Central Daylight Time (CDT) on May 1st of each year.**

- Portfolios must be submitted by uploading to the designated ABE site before this deadline.

- Portfolios submitted after the deadline will be included in the next cycle, providing eligibility is still current.

- While you have until 2 PM Central Daylight Time (CDT) on May 1st for the final submission, you are urged not to wait until the last few days to begin uploading your Portfolio.

- Give yourself plenty of time and be sure you understand the digital process and upload instructions.

"First-Review"

- Before the full grading process begins, each submitted Portfolio will undergo a "First Review", where several major items are checked.

- If a Portfolio contains any of the errors mentioned below, **it will be recorded as a failed exam.**

- Once one of these errors is observed (the first detection of a first-review issue), no further grading will occur.

- The Candidate will be notified via email by ABE staff that their Portfolio has failed in "First Review," and advised:
  - Which error caused the first-review failure.
  - That other Portfolio cases were not evaluated for first-review issues and those need to be carefully checked.
  - To check the entire Portfolio for any errors (those for first-review and others) prior to resubmitting their Portfolio in a subsequent cycle.

"First-Review" components:

Required case categories
- If any of the required cases have not been submitted, or are not in the correct order, the entire Portfolio will fail.

Photograph masking
- If this has not been completely or properly done (as described later in this document) for any photograph, the entire Portfolio will fail.

Document and image masking
- If this has not been completely or properly done (as described later in this document) for any included document or radiographic image, the entire Portfolio will fail.

Biopsy with pathology report
- For Case 5, Periradicular Surgery, if a biopsy specimen was not obtained and a pathology report (adequately masked) is not included, the entire Portfolio will fail.

One-year post-treatment evaluation

- If the one-year post-treatment evaluation requirement was not met for any case, the entire Portfolio will fail (see Page 28 of these *Guidelines* for the only exception to this).

English Translation

- If the Case History Report, or any included supplemental documents, are written in any language other than English, a translation into English must accompany each report.

- Any translation must be notarized as a true copy of the original material.

- These notarized verification documents must be saved as PDF files and uploaded under Reports for each affected case.

Required Cases for Submission

- Candidates are required to submit documentation of five specific cases (as explained below) that they have selected from their specialty practice of endodontics.

- An ideal Portfolio will contain cases that demonstrate a broad spectrum of diagnostic and treatment procedures, demonstrating the ability to manage complex clinical situations at a specialist's level.

- The variety and complexity of the cases must thoroughly demonstrate exceptional knowledge, judgment, skill, and expertise in the specialty of endodontics.

- Only cases treated since the start of your endodontic program may be included.

- All cases must be those that you have personally treated.

- More than one tooth for the same patient may be submitted as part of a Portfolio, however, each tooth needs to have been treated during a separate treatment visit.

- Completing care on more than one tooth at the same visit cannot be reported as two separate cases, even though they might meet other required case parameters.

- It is essential that examiners are able to evaluate all the elements for managing each case in its entirety, from start to finish. This cannot occur if treatment for two cases occurs during the same patient care visit.

- Each specific type of required case will coincide with a number that will be consistently referred to throughout this process.

- A list of the case numbers and specifics for each type are shown on the following page.

Continued

Case Numbers and Types

Case 1 Nonsurgical Root Canal Treatment - Maxillary Molar

- Nonsurgical root canal treatment. This case must be a maxillary molar.
- This case should have high complexity (cases with calcified canals, curved or long canals, unusual anatomy, etc.).

Case 2 Nonsurgical Root Canal Treatment - Mandibular Molar

- Nonsurgical root canal treatment. This case must be a mandibular molar.
- This case should have high complexity (cases with calcified canals, curved or long canals, unusual anatomy, etc.).

Case 3 Nonsurgical Retreatment - Maxillary or Mandibular Molar

- This case may be either a maxillary or a mandibular molar.
- This case requires removal of previous obturating materials from the canals of the tooth.

Case 4 Other Treatment

- A case submitted in this category may be any one of these type cases:
  - Same as Case 1, 2, or 3:
    Nonsurgical Root Canal Treatment — maxillary or mandibular molar.
    Nonsurgical Retreatment — maxillary or mandibular molar.
  - Or:
    Nonsurgical Root Canal Treatment — non-molar tooth with significant complexity (see below).
    Nonsurgical Retreatment — non-molar tooth with significant complexity (see below).

- Any tooth submitted for this category must have sufficient complexity that elevates the case difficulty to a level clearly requiring treatment by an endodontist and must include completion of the case demonstrated by obturation and appropriate follow-up.

- Sufficient complexity for this category comprises:
  - treatment requiring canal obturation combined with management of at least one of the following characteristics:
  - complicated anatomic features such as (but not limited to):
    - extremely atypical, difficult morphologic aspects.
    - extra canals or extra roots.
    - extreme canal curvature or length.
    - canal obstructions (calcified canals, separated instruments, etc.).
    - significant resorption or perforation: repaired non-surgically or surgically (in conjunction with canal obturation).
    - complex developmental anomaly (dens invaginatus, dens evaginatus, gemination or fusion, etc.).

- The intent of this category is to offer the opportunity to submit a molar or a non-molar case (to include such cases that require management of other atypical situations) that can demonstrate the highly technical skills of diagnosis, canal preparation, and obturation possessed by an endodontic specialist.

- For this category, osseo-integrated implants, extractions, or endodontic procedures not listed above, are not acceptable.

Case 5 Periradicular Surgery - Maxillary or Mandibular Molar

- This case may be either a maxillary or a mandibular molar.
- Root-end resection, root-end preparation, and root-end filling of at least one root of the tooth is required.
- A specimen for biopsy is required and must be submitted for histologic examination.
- An original pathology report (adequately masked) is required.
- Note: the root-end resection, preparation, and filling will be considered the completion or “finished” date for surgical case. The one-year post-treatment evaluation will need to occur from that date.
- Intentional replantation cases are not acceptable for this category. Re-surgery (revision of previous periradicular surgery) is not acceptable for this category.

Biopsy and Pathology Report

- For Case 5 (Periradicular Surgery - Maxillary or Mandibular Molar), a biopsy is required, coupled with histopathologic examination of the specimen by a pathologist.
- An original pathology report is also required, which must be scanned into the Portfolio as a supplemental document; the pathology report must be properly and thoroughly masked, as specifically described elsewhere in these *Guidelines*.
- The histopathologic diagnosis from that report must be entered into the appropriate field within Section H on Page 2 of the Case History Report form.
- If, during the surgical procedure, a suitable tissue specimen for biopsy is not available, for whatever reason, a different surgical case should be chosen for your case portfolio.

Protected Health Information (PHI)

- A serious error in the submission of Portfolios is incomplete masking within any document or image submitted.

- The inadvertent disclosure of PHI can be prevented by "masking" of that information contained in a:
    - Pathology report.
    - Medical Consultation.
    - Laboratory Report.
    - Copy of any other report.
    - CBCT screenshot or other radiographic images.
    - Clinical photograph of a patient.

- All identifying information must be thoroughly masked.
- This includes, but is not limited to:
    - All names:
        - Candidate, patient, physician, referring dentist, pathologist, radiologist, consultant, etc.
        - School, practice name, clinic, facility, institution, military installation, logos, etc.
    - Addresses (the entire address must be masked).
    - Geographic locations.
    - Phone and fax numbers.
    - Social security or other patient identification numbers (chart, Medicaid/Medicare or other insurance, etc.).
    - Signatures.
    - Any specific identifying features in an image:
        - A name or patient ID number.
        - A physical feature (eyes, tattoos, etc.).

- After you have completed the masking, read the documentation again, from the top of the page to the bottom, to ensure you have masked all identifying text or other content.

- Be certain that the entirety of the masking still provides complete coverage after you have scanned your document or radiographic image (such as a screen shot of portion of a CBCT or other image) and saved it as an acceptable file for upload.
    - To minimize any inadvertent disclosure of PHI, it is mandatory that you mask a hard copy of your original document or image, and then scan in the hard copy as a new, unique PDF document for upload.
    - Simply drawing a box over the text intended for masking (in Adobe Acrobat or other software) may allow for brief or intermittent views of the masked data due to a lag time between the appearance of the drawn box above the text. This method should not be used when masking PHI.

- Failure to adequately or properly mask any PHI, or other identifying information, in any document or image will result in a "First Review Failure."

Radiographic and Photographic Images

Each case of a Portfolio attempts to demonstrate the highest specialty-level abilities, as demonstrated through evaluation, diagnosis, treatment, and outcomes. The Case History Report form describes case elements through narrative sections, which are supported by the submission of various images. This section provides instruction and guidance on this important Portfolio component.

Image quality

- Only high-quality images should be submitted.

- Unacceptable features include radiographs or photographic images that are too dark, too light, not clear, or too small. Avoid the creation of distortions produced by improper angulations or poor digital sensor placement.

- Intraoral radiographs should be presented in their entirety and should NOT be cropped.

- Portions of CBCT images, and other extraoral images (such as panoramic images), may be cropped to best demonstrate essential elements. A portion of one of the three CBCT planar views (coronal, sagittal, axial) may be presented without the others. Choose images and submit views that best display the diagnostic information you are trying to demonstrate. The CBCT images may be augmented with arrows or other labeling for clarification purposes.

- Size and File Types

  - Minimum image size: 200 KB ---------- AND---------- 540 x 360 pixels.

  - For better image resolution, image size: 300 KB and higher --- AND---------- 800 x 600 pixels and higher.

  - Individual image files should not exceed 4 MB.

  - Only JPEG, JPG, GIF, and PNG radiographic or image files are acceptable.

- Prior to uploading the images to the case history website, it is up to the Candidate to determine that the images:
  - are clear and of high quality.
  - do not blur or pixelate (even when zooming in).
  - clearly illustrate what needs to be communicated diagnostically, during treatment, and post-treatment evaluation.

- After uploading your cases, and prior to clicking on the “submit” button, review all images for:
  - quality and resolution.
  - proper chronologic sequence.
  - proper labeling.

- ALL radiographs and images MUST be referenced at the proper, corresponding location within the Case History Report.

Image type and quantity

- A sufficient number of radiographs is essential so that the reviewing examiner can clearly understand and verify the information presented by the Candidate. This includes diagnostic, intra-operative, immediate post-treatment, and post-treatment one-year evaluations.
- Images should collectively demonstrate everything that is described in the Case History Report narratives.
- More guidance regarding images is contained on the next pages.

Continued

Pre-operative images

- For all cases, pre-operative intraoral radiographic images are required. This typically consists mostly of periapical images. Bitewing or other intraoral images may be included to provide additional supportive information.
- Due to the complexity of the cases required for a Portfolio, in most instances, a single pre-operative intraoral radiograph is not sufficient.
    - To be considered acceptable, a pre-operative radiographic assessment of a molar tooth should demonstrate the clear extent of all roots and associated pathosis.
    - Rationale:
        - A single view of structures with a preoperative periapical image of a multi-rooted tooth will rarely show the full depiction of anatomy for all roots.
        - The use of multiple images with varied angulations can permit optimum visualization of superimposed structures; images should maximize visualization of all roots, canals, and their apical terminations.
        - If the revelation of roots and other endodontically-important structures is deficient, it will negatively affect the scoring. This is applicable to pre-operative, intra-operative, and post-treatment evaluation images.
- There is no capability to submit complete CBCT volumes.
- CBCT screen shots, or other extraoral images (such as panoramic), may be included and utilized as supplementary images, as appropriate.
    - CBCT screen shots supplementing a single preoperative PA, which add to the adequate assessment of the anatomy, could be acceptable.
    - The use of CBCT as the sole imaging modality for Portfolio cases is not acceptable; this applies to all pre-, intra-, and post-treatment imaging requirements.
    - For CBCT images, it is not necessary to show all three planar axes, unless a more global view is essential to exhibit an important case aspect; a cropped and labeled view of one or more axes is acceptable to demonstrate a particular observation.
    - For any component of a CBCT image volume, all protected information visible in the images (even if only a cropped partial image) must be masked.

Length verification images

- Working length verification with intra-oral images must be provided for each canal in non-surgical cases, using one of several radiographic image choices:
    - A file in each canal.
    - A gutta-percha cone in each canal, without sealer.
    - A gutta-percha cone in each canal, with sealer in place but prior to the completion of obturation procedures.
        - Although the sealer may partially obscure the location of the cone within the canal, a cone-fit image with sealer in place can be acceptable if the extent of the cone in each canal is adequately discernible to the Portfolio evaluators.

- Electronic Apex Locater use is an acceptable substitute for file measurement radiographs although the anatomy of each canal must then be demonstrated with a cone fit image (with or without sealer) following the parameters described above.
- The use of CBCT as the sole mode for length determination and subsequent verification is not acceptable.

Periradicular lesion

- If present, it is important that radiographic images collectively show the entire periradicular lesion.

Post-treatment images

- For all cases, immediate post-treatment intraoral radiographic images are required.
- All treated canals must be visible in their entirety; an adequate number and type of images must be submitted to allow full evaluation by the examiners.
- Follow the same parameters as described above for pre-operative images.

Continued

One-year post-treatment evaluation images

- For all cases, intraoral radiographic images are required for this evaluation.
- For thorough depiction of case outcomes and healing progress, providers should follow the parameters mentioned above regarding pre- and post-treatment imaging.
- Clinical examinations and radiographic images for the required one-year post-treatment evaluation may be completed by another provider, but sufficient clinical findings of that individual should be thoroughly reported and the interpretation of all images submitted should be done by the Candidate.
- CBCT imaging should also follow the related instructions shown previously in these *Guidelines*.
- If a screen shot is used for a portion of the information acquired for pre-treatment information and again as a component of follow-up evaluation, it should be in the same planar axis and similar location within the image volume as the pre-operative CBCT screen shot.

Image Descriptions

- When describing a radiographic image in the Case History Report, include observations from the entire image, not just the tooth that is being reported on and treated.

Image Reporting

- All images (radiographic and photographic) submitted must be referenced in the corresponding narrative section:
    - The Case History Report form must state that a radiograph (mentioning the type of image) or photograph was obtained.
    - This image reporting must be in the proper location within the report form.
    - The dates listed with the images must match those stated in the report form which correspond with when the images were obtained.

Image Dates and Descriptions

- Dates and descriptions associated with images need to be entered as you upload each one.
- For Dates: you will enter in the MM-DD-YYYY format.
    - Example: November 18, 2000 will be entered as 11-18-2000.
- For image descriptions you will enter something to easily identify the purpose of the images; if there are more than one for a similar purpose, add a number after the descriptor.
    - Examples: Pre-op PA 1, Pre-op PA 2, Pre-op BW, WL, Cone-fit, Post-op PA 1, Post-op PA 2, etc., or whatever best describes the images you are uploading. Labels should be easy for the examiners to follow. It can be helpful to include each label description with each corresponding image when it is referenced in the Case History Report narrative sections.
    - There is a limit of 50 characters for each image description; being as succinct as possible helps ease the grading process.
    - The interpretation of the image (or rationale for its acquisition) will be included in the appropriate section of the Case History Report (clinical evaluation, radiographic interpretation, clinical procedures, or post-treatment evaluations).

Image Placement

- All digital radiographic and photographic images need to be arranged in chronological order in your Portfolio.
- This can be managed prior to final submission.
- While preparing the Portfolio, place the images in chronological sequence on your screen, from left to right.
- If you accidentally upload your images out of sequential order, you may use the “drag and drop” feature to place your images in the correct order.
- Please be certain that your date and description for each image is still accurate.
- You can learn more about this process in the *Case History Exam Submission Instructions* and from the library of *Case History Exam Training Videos*.

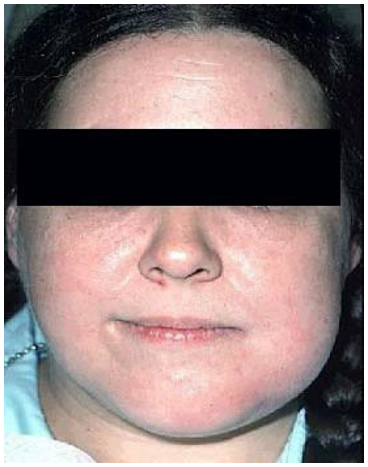
Continued

Photographs

Photographs can amplify information and should be included only if they help “tell the story” or demonstrate key aspects of the case (where a picture can be more effective than, or augment, a description).

All photographs with potentially identifying features visible (such as eyes), must be properly masked to prevent patient identification. See below for further information on this.

Shown here is an example of a correctly masked patient photograph:



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Creating Your Case History Portfolio

- Each of the five cases mentioned previously will be submitted using a separate Case History Report form.
- This form will be downloaded from the ABE's case history website. Make sure you are using the most current version of the form.

Downloading the Case History Report Form

- NOTE: You must use Adobe Acrobat Reader to open and complete each of your case history forms.
- Using an alternate PDF Reader with the Case History Report form will corrupt the file, and it will not function properly for you, nor will it render properly for examiners when uploaded onto the site for final submission.
- If you do not have Adobe Acrobat Reader software on your computer, you can download a free version for either a Mac or PC via the case history website at: http://www.amboardendo.org.

- To download a Case History Report form, go to: http://www.amboardendo.org.
- You will save a separate form on your computer for each case, naming them accordingly (Case 1, Case 2, etc.).
- You will then completely fill out the Case History Report form for each case.
- You will not upload your cases to the Digital Case History server until they have been completed and thoroughly proofread.
- All five completed Case History Report forms should be saved on your computer, with all supporting images and documents.
- You will eventually submit (upload) each of your Case History Report forms and other components only when they have been completed (all instructions have been followed) and are ready for grading.
- The file must remain in a PDF format; do NOT save the completed, ready-to-upload form as any other file type.

- You do not need to register for the Case History Exam to download the Case History Report PDF form and begin constructing your Portfolio.
- You DO need to be registered for the exam to upload your finalized Portfolio, consisting of all completed forms for your five cases. Instructions for the final submission of the Portfolio are found later in these *Guidelines*.

Portfolio Composition

- Your Case History Portfolio will encompass:
  - The Case History Report for each of your five cases.
  - All supporting images for each case.
  - All required and optional supporting documents.
- The Case History Report contains multiple sections, each with specific instructions for completion (shown on subsequent pages in these *Guidelines*).
- Every section of each Case History Report must be complete and prepared according to these *Guidelines*.
- Not following instructions is a frequent reason for Portfolio failure.

- Understandably, a submitted Board Case Portfolio comes with an expectation that all components will involve only the HIGHEST QUALITY.
- Narrative portions of each Case History Report Form must guide examiners through the Candidate's thought process from evaluation to diagnosis to treatment to re-evaluation.
- Throughout each report, use proper and consistent terminology, acceptable grammar, and correct spelling.
- With only five cases, the narrative sections should contain clear, concise explanations for the examiners, avoiding excessive or lengthy descriptions or unusual abbreviations.

Sample of a Case History Report Form

- On the next three pages, you will find screen-shots of the Case History Report form.

- You will not be submitting a printed form; this serves only as an example.
- Review this sample form, to familiarize yourself with all the required information.
- The PDF form for your Digital Exam Submission will be downloaded from: http://www.amboardendo.org.

Continued

AMERICAN BOARD OF ENDODONTICS CASE HISTORY REPORT

For this form to function correctly and be formatted properly for examiner viewing, you must **only use Adobe Acrobat Reader** to open and fill out the form.

Case Report Number:
Candidate Number:
Patient Age:
Date Case Started:
Patient Sex:
Date Case Finished:
Date of Post-treatment Evaluation:

A. Tooth # (1 - 32):

B. Procedure Category:
OTHER subcategory

CHIEF COMPLAINT:

C. MEDICAL HISTORY:

D. DENTAL HISTORY AND HISTORY OF PRESENT CONDITION:

E. CLINICAL EVALUATION: (Diagnostic Procedures)
Exam:

Tests:

Radiographic Interpretation:

F. PRE-TREATMENT DIAGNOSIS:
Pulpal:
Apical:

G. TREATMENT PLAN:
Recommended: **Emergency**:
Definitive:
Alternative:
Restorative:

PROGNOSIS:

H. CLINICAL PROCEDURES: Treatment Record

DIAGNOSIS (If different post-treatment)

Pulpal:

Apical:

HISTOPATHOLOGIC DIAGNOSIS (If biopsy)

CANAL (M,D,B,L, etc)	APICAL SIZE*	OBTURATION MATERIALS AND TECHNIQUES

***Size of the largest instrument used at the apex**

I. POST-TREATMENT EVALUATIONS: (Last post-treatment evaluation recorded must be 1 year minimum.)

Date:

Date:

Date:

AMERICAN BOARD OF ENDODONTICS
CASE HISTORY REPORT

ADDENDUM

Case History Report Form Navigation

Tab Button

- The “tab” button allows navigation from one section to the next.

Select Buttons

- There are drop-down boxes associated with the “Patient Sex,” “Procedure Category,” “Pre-Treatment Diagnosis: Pulpal and Apical,” and “Prognosis” fields in the Case History Report form.
- Clicking on the related select button allows the Candidate to make their choice for each section from the drop-down menu.
- Text boxes are located under the “Procedure Category” and adjacent to the “Pre-Treatment Diagnosis: Pulpal and Apical” drop-down boxes; these accommodate the entry of additional information to expand understanding of the procedure to be reported on (for Case type 4) or to clarify the diagnoses selected.

Spell Check

- The Case History Report Form does not provide the functionality of “spell check”.
- A work-around solution is to create your report in a Word (or similar) document, copy the text, then paste the content into the appropriate section in the form. However, if you do this, please ensure that your font and font size remain the same as the pre-formatted settings on the Case History Report Form.
- Please remember that while “spell check” is a useful tool, it is the responsibility of the Candidate to present an error-free report; proofread your report for content and then re-proofread your report strictly for spelling errors.

Allowed Space

- While entering text on the Case History Report form, you will be restricted to the allowed space for each section of the form.
- If you exceed the limits of the space, you can click on the “More...” button at the beginning of each field and you will automatically be transferred to the “Addendum” page where you can enter additional content for a specific section (which you will label accordingly).
- There is only one addendum page for each case; all information for each case must fit in the primary fields plus the area of the single addendum page; if there is additional material to enter, the report will need to be edited to condense the total content.

Changes

- Prior to uploading a case, changes can be made within the Case History Report form and saved to your computer as often as you like.
- However, if you have uploaded a case, and then make any changes, that updated case will need to be uploaded again.
- This re-uploading can be done repeatedly PRIOR to submitting the entire exam.
- Once the entire exam is submitted, the Portfolio can no longer be accessed and no further changes to cases, images, documentation, etc., can be made; this applies even if the final submission occurred prior to the deadline.

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Case History Report Form - Guidance for Each Section

Case Report Number

- This number must coincide with one of the five case type numbers described earlier (1, 2, 3, 4, or 5).
- This number must be consistent with the number you will enter when you upload your form and log it onto your Portfolio Submission Main Screen (see the *Case History Exam Submission Instructions or Case History Portfolio Submission Tutorial Videos*).

Patient Age

- This must indicate the patient's age when treatment was started.

Patient Sex

- From the drop-down box, select Male, Female, or Other. These selections are present with the most recent version of the Case History Report form.

Candidate Number

- Use the number assigned to you by the Board.
- Names must never be used.

Date Case Started

- This date indicates the first appointment with the patient (consult or treatment).
- Enter date in this format: MM-DD-YYYY (Example: 11-18-2020).

Date Case Finished

- This date indicates the last appointment where active treatment was provided.
- For Case 5 (Periradicular Surgery - Maxillary or Mandibular Molar), the "case finished" date is considered the date of the root-end resection, preparation, and filling.
- If Case 4 involves a surgical component, the "case finished" date is considered the last date where you saw the patient for any component of definitive treatment (not including any post-treatment evaluations).
- Enter date in this format: MM-DD-YYYY (Example: 11-18-2020).

Date of post-treatment evaluation

- This date indicates the final post-treatment evaluation.
- This has a one-year requirement after the case was finished (to ensure compliance with this requirement, see the associated sections previously in this document).
- Enter date in this format: MM-DD-YYYY (Example: 11-22-2021).

Tooth Number (Section "A" of the Case History Report form)

- Use the numbering system of "1 to 32" to designate the tooth from your case.
    - Tooth # 1 is the maxillary right third molar, tooth # 16 is the maxillary left third molar, tooth # 17 is the mandibular left third molar, and tooth # 32 is the mandibular right third molar.
- The tooth number entered on each Case History Report form must be consistent with the number entered when logging it onto your Portfolio Submission Main Screen (see the *Case History Exam Submission Instructions*).

Continued

Procedure Category (Section "B" of the Case History Report form)

- For all cases, select the correct procedure from the drop-down box (NS RCT, RETX, or S-RCT). This entry must be consistent with the list of the required case types and order of placement in the Portfolio.
- For Case 4 ("Other Treatment"), you will choose either NS RCT or RETX, as that case has a requirement that the case involve obturation (either as initial or retreatment); you also have the option to use the field below the drop-down box (labeled OTHER subcategory) to type in specific information related to that case (Examples: perforation repair, resorption repair, dens evaginatus, extreme canal length, etc.). Make sure your entry is succinct enough to be totally visible in the field.

Chief Complaint

This is frequently stated in the patient's own words, but can be clarified with additional information, if helpful.

Medical History (Section "C" of the Case History Report form)

- Each case must provide a thorough synopsis of the patient's medical history; there should be sufficient reporting of what systems were reviewed.
- Include previous and current medical conditions and diseases, and pertinent surgical history (especially include information that could impact your care of the patient).
- Include any allergies or adverse drug reactions.
- Although many medical issues might not impact care, adequate information should be included to validate that an appropriate, thorough review of the patient's medical history has occurred.

- While not an absolute requirement, as a help to demonstrate complexity of the medical components of a case and their proper management, it is suggested that each case history report include the ASA (American Society of Anesthesiologists) Physical Status Classification for each patient; for most, their classification will be ASA I, II, III, or IV. As is found on the AAE Case Difficulty Assessment Form these categories have overall definitions of:
  Class I: Healthy patient with no systemic illness.
  Class II: Patient with mild degree of systemic illness, but without functional restrictions.
  Class III: Patient with severe degree of systemic illness which limits activities but is not immobilizing.
  Class IV: Patient with severe systemic illness that may be immobilizing and may sometimes be life threatening.
- It is understood that this classification system is not being utilized in this context for general anesthesia assessment. For further guidance and definitions/examples for each category, see the American Society of Anesthesiologist's website.

If appropriate, or required for proper case management, document that medical consultations were obtained; (copies of those can be fully masked, scanned, and uploaded as part of the case submission).
- Alterations in your normal treatment regimen due to medical issues or conditions should be explained and justified in the clinical procedures section of the Case History Report.

- Medications

  - All medications must be documented, both prescribed and recommended (over-the-counter substances).
    - Include dosages, frequency of dosing, the condition for which the drug was prescribed, or the reason for use for non-prescription items.

- Vital Signs

  - Vital signs should include blood pressure and pulse.
  - Vital signs should also include respiratory rate (if indicated by patient conditions), temperature (if indicated by patient conditions, such as swelling), and weight (if any local anesthesia or medication recommendations could be affected by this, such as with pediatric patients or others of low body weight).
  - Vital signs must be recorded during the initial visit and at subsequent appointments.
  - Maintain a consistent location for reporting vital signs within your submissions:
    - Include the first set of vitals within Section C of the report and subsequently within Section H for visits after the initial appointment.
    - or -
    - List the vitals within all visits reported in Section H, to include the initial evaluation visit.
  - Appropriate vital signs should also be reported for each post-treatment evaluation visit.

Dental History and History of Present Condition (Section “D” of the Case History Report form)

- A thorough synopsis of the patient’s dental history should be stated.
- Include patient reports of symptoms pertinent to the reason for referral or for the requested endodontic treatment.
    - If you have included a radiographic or other image from the referring dentist, indicate that in this section. The interpretation of those images will be reported in the “Radiographic Findings” section.
- Alterations in your normal treatment regimen due to information revealed in the dental history should be explained and justified in the clinical procedures section of the Case History Report.

Clinical Evaluation: Diagnostic Procedures (Section “E” of the Case History Report form)

- Exam

    - Report all pertinent or impactful findings from thorough extra-oral and intra-oral examinations.
        - Include: presence of swelling, sinus tract, restorations and their condition, soft-tissue and hard-tissue observations, etc.

- Tests

    - Report all diagnostic tests performed on suspect teeth, as well as adjacent teeth or those within the same or opposing sextant. Testing only the suspect tooth or that which subsequently undergoes treatment is not acceptable.
    - Typical endodontic and periodontal diagnostic testing information is reported in a table format.
        - Using the table, and following instructions for completing the table, will provide ease, consistency, and clarity in reporting these test results, enhancing the Portfolio evaluation process.
    - For information that cannot be accommodated in the table, use the Addendum page to add content.
    - Creating and inserting tables into the Case History Report form:
        - In the “Clinical Evaluations: Tests” section a table will be used for reporting tests, the teeth tested, and results for each.
        - The size of the table will depend on the number of teeth tested and tests conducted.
        - The number of rows and columns can be adjusted by entering the number for each in the corresponding fields, as required.
        - Click on the button named “Insert Table” and a table will appear.
            - If the table requires more than 6 columns or 6 rows, you can insert it into the Addendum page by defining the necessary number of rows and columns, checking the box next to “Check to insert table in addendum,” and then clicking the “More” button.
            - After clicking on the “More” button, you will be taken to the “Addendum” page, where you will see the text “E. CLINICAL EVALUATION (continued) Tests” has been auto-populated as a place-holder field for your table.
            - Navigate back to the “Tests” section on Page 1 and click on “Insert Table”. Your extended table will now appear when you navigate back to the “Addendum” page. The table can now be populated with the desired information.

    - The table will be used to report common endodontic diagnostic tests that are routinely performed.
    - Each case will use a battery of tests that apply to the situation for the tooth being reported on. Examples:
        - Cold test, heat test, EPT, percussion, palpation, periodontal probing, mobility.
    - Once the table for test results has been created, list the numbers on one axis and the tests performed on the other. The results for each tooth and test will be entered in the corresponding fields.

    - See the following page for guidance on filling out the results fields within the table.

Continued

You will report your diagnostic findings (within the table) using the symbols (with accompanying clinical findings for each) shown below.
- In your table, you will enter the symbol shown in the blue highlighted areas that corresponds to your observed results for each test.

Cold test	**0**	**+**	**++**	**+++**	**L**
	non-responsive	responsive	exaggerated response	severely exaggerated response	add to ++ or +++ to indicate lingering
Heat test	**0**	**+**	**++**	**+++**	**L**
	non-responsive	responsive	exaggerated response	severely exaggerated response	add to ++ or +++ to indicate lingering
EPT	**0**	**+**			
	non-responsive	responsive			
Percussion	**0**	**+**	**++**		
	non-tender	tender	very tender		
Palpation	**0**	**+**	**++**		
	non-tender	tender	very tender		
Perio probing	**Enter probing depths**				
	MB, B, DB, ML, L, DL				
Mobility	**0 - 1 - 2 - 3 *** **				
	Enter classification				
Bite test	**0**	**+**	**++**		
	non-tender	tender	very tender		

*** Note: Suggested mobility numbers follow this definition:
0: no movement distinguishable.
1: physiologic (< 1 mm) horizontal movement.
2: > 1 mm horizontal movement.
3: > 1 mm horizontal movement + vertical movement.

- Any exceptions to this diagnostic table guidance should be explained by the Candidate within the intraoral exam section narrative field, (using the “Addendum” page, if needed) to provide clarity for examiners.

- In addition, other diagnostic testing or procedures conducted (not included in the table) should be explained by the Candidate within the intraoral exam section narrative field (using the “Addendum” page, if needed).

Examples:
- Testing of any kind that might reproduce the patient’s Chief Complaint.
- Transillumination, staining, evaluation for fremitus or other occlusion issues, etc.
- Other periodontal observations (general perio status, bleeding or exudate on probing, recession, attached gingiva levels, etc.).

- Radiographic Interpretation

  - List all pre-treatment images acquired.
  - List the radiographic findings, interpretations, or observations from each image.
  - Include (but not limited to):
    - Restorations and their apparent condition.
    - Bony structure and condition.
    - Pathosis (with location, size and extent, and characteristics).
  - Report on the suspect tooth or teeth, along with all other areas and structures visible for each image.
  - Any description of findings or image interpretation should allow examiners to understand your thought process.

  - For extensive guidance and instructions on radiographs and photographs, see previous pages in these *Guidelines*.

<u>Pretreatment Diagnosis</u> (Section "F" of the Case History Report form)

- Select a pre-operative pulpal and apical diagnosis for each case from the drop-down box.
  - Ensure that your chosen diagnoses are consistent with reported signs and symptoms and with findings from your examination and testing.
  - A text field is located next to the drop-down box for Pulpal and Apical diagnoses; use this area to enter a diagnosis not included in the drop-down lists, or other clarifying information.

- Pulpal and Apical Diagnostic Terminology

  - In February 2010 the ABE unanimously voted to support the adoption of the diagnostic terminology proposed by the Consensus Conference on Diagnostic Terminology, published in the December 2009 special issue of the Journal of Endodontics.

  - This terminology is to be used by Candidates to document their cases in the Portfolio.
  - The Case History Report form has drop-down boxes, with the accepted terminology, included in the Pre-treatment Diagnosis section.
  - It is essential that you ensure your chosen diagnoses fit the facts of the case.
  - An incorrect diagnosis will result in an unacceptable score for this portion of the report.

    - On the following page, the accepted terminology (for both Pulpal and Apical diagnoses) for your Portfolio can be seen, with descriptions for each (from the publication mentioned earlier).
  - If you feel the need to "qualify," or further explain and justify your choice of diagnoses, this can be accomplished in the text field adjacent to the drop-down boxes or in the appropriate narrative section of the report.

Continued

Pulpal Diagnosis	
Normal Pulp	A clinical diagnostic category in which the pulp is symptom-free and normally responsive to pulp testing.
Reversible Pulpitis	A clinical diagnosis based upon subjective and objective findings indicating that the inflammation should resolve and the pulp return to normal.
Symptomatic Irreversible Pulpitis	A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. *Additional descriptors:* Lingering thermal pain, spontaneous pain, referred pain.
Asymptomatic Irreversible Pulpitis	A clinical diagnosis based on subjective and objective findings indicating that the vital inflamed pulp is incapable of healing. *Additional descriptors:* No clinical symptoms but inflammation produced by caries, caries excavation, trauma.
Pulp necrosis	A clinical diagnostic category indicating death of the dental pulp. The pulp is usually non-responsive to pulp testing.
Previously Treated	A clinical diagnostic category indicating that the tooth has been endodontically treated and the canals are obturated with various filling materials other than intracanal medicaments.
Previously Initiated Therapy	A clinical diagnostic category indicating that the tooth has been previously treated by partial endodontic therapy (e.g. pulpotomy, pulpectomy).

Apical Diagnosis	
Normal Apical Tissues	Teeth with normal periradicular tissues that are not sensitive to percussion or palpation testing. The lamina dura surrounding the root is intact and the periodontal ligament space is uniform.
Symptomatic Apical Periodontitis	Inflammation, usually of the apical periodontium, producing clinical symptoms including a painful response to biting and/or percussion or palpation. It may or may not be associated with an apical radiolucent area.
Asymptomatic Apical Periodontitis	Inflammation and destruction of apical periodontium that is of pulpal origin, appears as an apical radiolucent area, and does not produce clinical symptoms.
Acute Apical Abscess	An inflammatory reaction to pulpal infection and necrosis characterized by rapid onset, spontaneous pain, tenderness of the tooth to pressure, pus formation and swelling of associated tissues.
Chronic Apical Abscess	An inflammatory reaction to pulpal infection and necrosis characterized by gradual onset, little or no discomfort, and the intermittent discharge of pus through an associated sinus tract.
Condensing Osteitis	Diffuse radiopaque lesion representing a localized bony reaction to a low-grade inflammatory stimulus, usually seen at apex of tooth.

Treatment Plan (Section “G” of the Case History Report form)

Recommended: enter information, as appropriate, for the categories listed on the report form (emergency, definitive, or both).

- Emergency:
  - Suggested treatment for conditions that warrant urgent management and could be sufficient to provisionally reduce or eliminate existing symptoms.
  - This will typically be treatment that is short of definitive care, such as full or partial pulpotomy, pulpectomy, incision for drainage, etc.
- Definitive: Enter a recommended, definitive endodontic procedure, based on selected pre-operative diagnoses.

- Alternative:

  - Considering the involved tooth and its associated conditions, enter any suitable alternative endodontic treatment; you can also offer any appropriate recommendation for additional endodontic treatment following the primary recommended treatment choice.
  - For most endodontic situations, “no treatment” is typically not recommended as an acceptable treatment option, since it can result in an unhealthy situation for the patient; however, patients have the right to choose this option, thus “no treatment” as an alternative treatment choice should be listed.

- Restorative:

  - List reasonable restorative procedures than you would suggest, given the tooth and associated conditions.
  - Keep in mind the comprehensive dental treatment plan that might be in place for this patient.
    - List procedures you might perform, such as post (if needed) and core placement; this might occur at the time of endodontic treatment completion, at a subsequent appointment with you, or with their primary care dentist.
    - List procedures you would suggest after that (such as a cuspal-coverage direct restoration, full-coverage crown, replacement of an existing restoration or crown, other suitable suggestion for the situation, etc.)

Prognosis

From the drop-down box, choose the prognosis you anticipate with this case, either:

- FAVORABLE
- QUESTIONABLE
- UNFAVORABLE.

Clinical Procedures (Section “H” of the Case History Report form)

- Treatment Record

  - List all appointment dates, and narrative reports of those, in chronological order.
  - List each date the patient was seen as well as those when there was no treatment, but there was communication with the patient (such as follow-up phone calls or messages, both to and from the patient).

- Informed Consent

  - Indicate that informed consent was obtained.
  - Indicate what treatment was consented, and whether the consent was written, verbal, or both.

Continued

- Procedures

  - Describe and justify (where necessary):
    - All clinical procedures performed:
      - Any emergency care rendered.
      - Any non-emergent care rendered.

  - Reporting on specific treatment procedures and processes:
    - Local anesthesia:
      - State the name and amount (in mg) of local anesthetics and vasoconstrictors administered.
    - Isolation methods:
      - State any complexities encountered and how they were overcome.
      - If a rubber dam clamp is not visible on working length verification radiographs, explain your technique of rubber dam application.
    - Canal contents and conditions encountered.
    - Canal shaping and instrumentation sequence and techniques.
    - Irrigants:
      - Include chemicals, concentrations, and methods of delivery.
      - If a specialized, non-traditional, or recently introduced adjunct such as an irrigation or disinfection device (such as a laser, GentleWave, or other) is used, explain the rationale for its use and the methodology employed.
    - Intracanal medicaments and methods of placement (if utilized).
    - Canal obturation materials:
      - Include all components utilized (core material and sealers) and techniques used.
    - Access restoration (interim or definitive):
      - Include choice of materials and any special techniques utilized.
    - Medications, prescribed or recommended, for post-operative use:
      - Include names, dosages, frequency, and duration of dosing; state rationale for use in this situation.
      - Any method of administration other than “P.O.” must be annotated.
      - Provide justification for prescribing antibiotics and for prescribing or recommending analgesic drugs.
    - Patient disposition (what should occur next) and how appointment will be arranged.
    - State any specific or specialized post-op instructions given to the patient.
    - Describe any difficulties or complications encountered with any treatment component and their management.

  - Additional considerations when reporting procedures:
    - Describe any intra-operative imaging that was obtained, including any special interpretive observations (working length verification, check films for any reason, CBCT, etc.).
    - For extensive guidance and instructions on radiographs and photographs, see previous Pages 10-13 in these *Guidelines*.
    - If any portion of treatment was modified due to information collected with the medical and dental histories, this should be indicated in the clinical procedures section of the Case History Report.
    - Application of biologic principles should be demonstrated within the narrative. State your reasoning with any aspect of a procedure or choices that were made with the delivery of treatment. Help the examiners understand your rationale for treatment decisions.
    - Include content that specifically helps demonstrate the complexity of the case.
      - Include anything else that helps reveal your thought process and helps “tell the story” of a particular case or case element; especially include justification that the case is of “Board quality.”
    - Post-surgery appointments soon after treatment procedures (for healing checks, suture removal, etc.) should be entered in this “Clinical Procedures” section and not within the “Post-treatment Evaluations” section.
    - Include in the narrative if a follow-up was done later the same day as treatment or the next day.
      - Include a short summary of any post-treatment follow-up communications (checking on progress of signs and symptoms, post-procedure care calls, reports of biopsy findings, etc.).
      - These should be entered in this “Clinical Procedures” section and not within the “Post-treatment Evaluations” section.

Continued

- For surgical treatment, other than the relevant details listed previously, include a description of the surgical steps with adequate detail, such as (but not limited to):
    - Type and extent of the flap.
    - Presence or absence of bony dehiscence.
    - Steps taken to ensure hemostasis.
    - Root-end resection and preparation parameters.
    - Inspection of the resected root surface, with any findings.
    - Identification of etiology.
    - Root-end filling, choice of material, and placement technique.
    - Any other treatment or procedural component to help the examiners assess the complexities of the case and the Candidate's ability to manage them appropriately.

- Diagnosis (if different post-treatment)

    - Use this section if findings during your treatment would alter your decision about the pre-operative diagnoses.
    - Include pulpal, apical, or both, as applicable.

- Histopathologic Diagnosis (if biopsy)

    - Enter the diagnosis indicated on the pathology report following the periradicular surgery case procedures.

- Procedure Table

    - Record:
        - Canal designation.
        - Apical size (size of the largest instrument used at the apex).
        - Obturation materials (core material and sealer) and techniques used.

Continued

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- Post-Treatment Evaluations (Section "I" of the Case History Report form)

  - For each case, a post-treatment evaluation must be conducted after a minimum of **one full year** from the date that definitive endodontics or root-end surgery was completed.
    - Examples:
      - Initial non-surgical endodontics or retreatment, or root-end resection, preparation, and filling for periradicular surgery occurs on August 20th; the re-evaluation occurs on August 25th of the following year; this is after a minimum of one full year; this is acceptable.
      - Initial non-surgical endodontics or retreatment, or root-end resection, preparation, and filling for periradicular surgery occurs on August 20th; the re-evaluation occurs on August 5th of the following year; **this is not after a minimum of one full year; this is not acceptable**.

    - Note: **To accommodate cases with completion dates prior to May 1, 2024** (when prior guidelines instructions were in effect), a post-treatment evaluation performed in the 12th month after completion of treatment will be considered acceptable.
      - Example: Initial non-surgical endodontics or retreatment, or root-end resection, preparation, and filling for periradicular surgery occurred on July 28th; the re-evaluation occurs on July 11th of the following year; this is not a full year, but is within the 12th month from the prior procedure completion; this is acceptable (based on previous guidelines).
    - This exception to the one-year post-treatment evaluation only applies to cases with a completion date prior to May 1, 2024. **Cases with completion dates after May 1, 2024 must comply with the one-year requirement as stated above in these current *Guidelines*.**

    - This section of the Case History Report is not for any post-treatment interactions with patients soon after treatment procedures were completed (those typically occur within a few weeks).
    - More than a single post-treatment evaluation can occur and be reported in chronologic order in the Case History Report form.
  - The final post-treatment evaluation will appear last in the report and must meet the "one-year" requirement parameters as described previously in these *Guidelines*.

  - The post-treatment evaluation should:
    - Provide a summary of the pertinent treatment and/or restorative procedures that followed endodontic treatment.
      - Consist of reporting signs and symptoms at that time, along with typical components of a thorough endodontic evaluation, to include periodontal probings.
    - Consist of adequate intraoral radiographic imaging to document conditions and outcomes.
    - Follow the same parameters, criteria, and suggestions as described earlier for pre-operative imaging.
      - Imaging must collectively demonstrate the entire extent of all roots and treated canals, along with adequate surrounding periradicular tissues.
      - CBCT screen shots can be utilized as supplemental imaging, along with their interpretation.
      - If CBCT imaging was used to validate the presence of pre-operative disease, images submitted for the post-treatment evaluation should be of similar position and orientation to validate conditions at the one-year (or more) point.
    - Provide adequate and thorough image interpretation.
    - Include comments on any changes (clinical and radiographic) from the original conditions reported for the treatment tooth and other teeth visible on the radiographs.
    - For extensive guidance and instructions on radiographs and photographs, see previous Pages 10-13 in these *Guidelines*.

    - Include a clear statement of the criteria (clinical and radiographic) used to consider an outcome successful.
      - Include a definitive statement about the outcome of the case (at the time of the last post-treatment evaluation).

Cover Sheet and List of Abbreviations

-The "Cover Sheet" and "List of Abbreviations" documents are optional; there is no requirement for their inclusion in a Portfolio.
- The length of each of these documents, if utilized, is limited to ONE page each. With this limitation to a single page, the text font size must be no smaller than size 10.

- For the Cover Sheet:
  - The intended use of the cover sheet is to describe various aspects of case management that are routinely employed or utilized (particularly with two or more cases). If included on the cover sheet, these items do not then need to be repeated for multiple reports. It carries less utility with only five cases but can still serve a purpose.
  - If a component of a case is only performed for one case, it likely does not warrant inclusion on the cover sheet.
  - Common items included with the cover sheet (these are merely illustrative, and should not be considered mandatory):
    - Anything that would likely be repetitively reported with all or most cases. Examples:
      - Synopsis of general areas explored during medical history review.
      - Components of endodontic procedures routinely accomplished for multiple cases being reported.
        - Protocols of canal shaping, irrigation, obturation, etc.
        - Temporization or other restorative aspects.
        - Synopsis of patient instructions (post-op, medications, follow-up, etc.).
        - Information gathered during post-treatment evaluations and definitions of reported outcomes.
        - Etc.
  - Specific technique descriptions should be succinct.
    - The cover sheet should not be used as an additional addendum page for the Case History Report form. It is for inclusion of information employed within multiple Case History Reports.

- For the list of abbreviations:
  - Include only abbreviations that would likely be repetitively utilized with all or most cases.
  - Include the abbreviation used in the Case History Reports, along with its definition.
    - Universally accepted dental or medical terms do not need to be included, as it is highly likely that examiner experience and the context when the abbreviation is used would not result in confusion. Examples:
    - Tooth surfaces (M, D, MOD, B, L, etc.); canals within a tooth (D, L, M, P, MB, MB2, etc.).
    - Blood pressure (BP); "as needed for" (prn), and others used with prescriptions.
    - Periodontal ligament (PDL); Nickel-titanium (NiTi).
    - As stated elsewhere in these *Guidelines*, use of the abbreviation "WNL" (within normal limits) is highly discouraged.

    - If a Candidate chooses to use any abbreviation (especially if to be used repetitively) that would not likely be understood by examiners, those should be listed on the "Abbreviations List" supplemental document.
    - Candidates are highly encouraged to spell out words that are used once or infrequently within their Portfolio, as opposed to using an abbreviation. This especially relates to terms or words that are atypical or very specialized, where spelling the term out reduces confusion and can enhance the grading process.
    - If an abbreviation is only utilized once in a single case, it likely does not warrant inclusion on the abbreviation list; Candidates should simply spell that single word (or words) out in the Case History Report. The bottom line is that more emphasis should be placed on making the case report "easy for the examiners to read" rather than making the case report "easy for the Candidate to write."

- Each of these supplemental documents should be saved in PDF format for upload onto the website as part of the Portfolio. They are uploaded as supplemental documents, separate from the Case History Report form.

Portfolio Grading – New Grading Rubric

- The first evaluation of Portfolios occurs via a "First Review" process (explained previously).
- Each Portfolio (that is found acceptable during that initial review) is then examined independently by two examiners.
- After careful research conducted in association with Data Recognition Corporation (DRC), an organization that is expert in the field of high stakes exam development and statistical analysis, the ABE elected to incorporate a new rating scale rubric to begin with the May 1, 2026 exam cycle.
- As of the May 1, 2026 exam, each case will be evaluated in ten categories. Examiners will assign one grade per each of these categories. Each case will receive a total of twenty scores (Ten per each examiner).
- Therefore, each portfolio will receive 50 scores per examiner, and 100 total scores per portfolio.
- This thorough process gives the examining Directors ample knowledge and insight into the level of the Candidate's diagnostic and clinical skills.
- During the grading process, the Candidate's identity is always strictly protected.

Categories for evaluation:

A score is given for each of the categories below. Each category corresponds to sections of the Case History Report Form. Candidates will also be evaluated on "Documentation Quality" and "Overall Case Complexity".

Medical History
Dental History and History of Present Condition
Clinical Evaluation and Diagnostic Procedures
Radiographic Findings
Pretreatment Diagnosis: Pulpal and Apical Diagnostic Terminology
Treatment Plan: Recommended, Alternative, and Restorative; Prognosis
Clinical Procedures: Treatment Record of Visits and Procedures
Post-Treatment Evaluation
Documentation Quality: Precision, accuracy, completeness, and appropriate use of language
Overall Case Complexity

Each of the above-listed categories, except for the Pretreatment Diagnosis category receives a score according to the following scale:

Excellent	3
Acceptable	2
Deficient	1
Unacceptable	0

The Pretreatment Diagnosis category receives a score according to the following scale:

Acceptable	1
Unacceptable.	0

- Once grading has been completed, a specialized firm independently evaluates all aspects of the ABE Board examination process
- For Case History Portfolios, a multi-faceted analysis is performed; the impact of all components of the examination are accounted for, including rater severity, case difficulty, and demonstrated diagnostic and treatment skills. This provides examination results that are reliable and confirms that the evaluations and grading are dependable, without bias.
- On the following pages, updated charts are shown that represent some key scoring criteria used by the Directors; this helps demonstrate how the categories and scores apply to each section of the Case History Report form.
- These are the same charts that Board examiners use as a guideline in determining how to grade each Case History Portfolio. Please read them over carefully to help understand what differentiates between a grade of Excellent, Acceptable, Deficient, and Unacceptable.

SKILL	0 UNACCEPTABLE	1 DEFICIENT	2 ACCEPTABLE	3 EXCELLENT
Medical History	Medical history was not provided or lacked crucial information (e.g., vital signs, consults if needed, medication). The missing information jeopardized the treatment plan and execution or possibly placed the patient at risk for harm.	Medical history was provided without information that would influence the treatment plan and execution.	Medical history was provided without information that might not influence the treatment plan and execution.	Medical history was provided with adequate details that supported the treatment plan, execution, and patient safety.
Dental History and History of Present Condition	Dental history and/or history of present condition is missing.	Either dental history or history of present condition is incomplete and/or missing relevant details; they are not in chronological order.	Relevant dental history and a complete history of present condition are provided, but they are not in chronological order.	A concise, relevant dental history and a complete history of present condition are provided; histories are in chronological order.
Clinical Evaluation and Diagnostic Procedures	Clinical examinations, findings, and/or relevant diagnostic tests and their results are not provided.	Clinical examinations, findings, and/or relevant diagnostic tests are incomplete. The missing information will significantly affect diagnosis, treatment, and prognosis.	Clinical examinations, findings, and/or relevant diagnostic tests may be incomplete, but the missing information will not significantly affect diagnosis, treatment, and prognosis.	Clinical examinations, findings, and relevant diagnostic tests and their results are complete and concisely support the diagnosis, treatment, and prognosis.
Radiographic Findings	Radiographic images are missing and/or are not diagnostic. OR The interpretation of radiographic images is missing or incorrect.	Radiographic images lack sufficient detail, or the number of radiographic images is insufficient. OR The interpretation of radiographic images contains omissions that affect the diagnosis, treatment, and prognosis.	The number and quality of radiographic images is appropriate. AND The interpretation of radiographic images is correct but has minor omissions. The missing information does not affect the diagnosis, treatment, and prognosis.	The number and quality of radiographic images is appropriate. AND The interpretation of radiographic images is correct and complete.

SKILL	0 UNACCEPTABLE	1 ACCEPTABLE
Pretreatment Diagnosis: Pulpal and Apical Diagnostic Terminology	Pulpal and/or apical diagnoses are incorrectly identified. OR Pupal or apical diagnosis is missing.	Pulpal and apical diagnoses are correctly identified.

SKILL	0 UNACCEPTABLE	1 DEFICIENT	2 ACCEPTABLE	3 EXCELLENT
Treatment Plan: Recommended, Alternative, and Restorative; Prognosis	Recommended treatment plan, restorative plan, prognosis and/or alternative treatment is inappropriate and/or missing.	Recommended treatment plan is appropriate and restorative plan is complete. Prognosis and/or alternative treatment plan is inappropriate.	Recommended treatment plan is appropriate, restorative plan is complete, and prognosis is appropriate. Alternative treatment plans are incomplete.	Recommended treatment plan is appropriate, restorative plan is complete, prognosis is appropriate, and alternative treatment plans are complete.
Clinical Procedures: Treatment Record of Visits and Procedures	Informed consent was not obtained. OR Clinical procedures were performed incorrectly and/or performed in an inappropriate sequence. OR Clinical procedures were not documented. OR Pharmacological management was missing or potentially harmful. OR Treatment was not modified in accordance with the medical and dental history, if required.	Informed consent was obtained. AND Clinical procedures were performed with procedural errors that may affect prognosis and/or may have been performed in an inappropriate sequence. OR Clinicalprocedures were documented with major omissions. OR Pharmacological management was unjustified. OR Treatment was not modified in accordance with the medical and dental history, if required.	Informed consent was obtained. AND Clinical procedures were performed with procedural errors that did not affect prognosis and in an appropriate sequence. AND Clinical procedures were documented with minor omissions. AND Pharmacological management was acceptable but may be unnecessary. AND Treatment was modified in accordance with the medical and dental history, if required.	Informed consent was obtained. AND All clinical procedures were performed without procedural errors and in an appropriate sequence. AND Clinical procedures were documented thoroughly. AND Pharmacological management was appropriate and justified. AND Treatment was modified in accordance with the medical and dental history, if required.

SKILL	0 UNACCEPTABLE	1 DEFICIENT	2 ACCEPTABLE	3 EXCELLENT
Post-Treatment Evaluation	Clinical exam is missing. OR Post-treatment radiograph(s) are non-diagnostic. OR Restoration is missing. OR New or enlarged apical lucency is present and may be stated, with major inconsistencies between the interpretation of healing and the description of radiographic findings.	Clinical exam is incomplete (may include IOE and/or EOE but is missing clinical testing). OR Post-treatment radiographs do not demonstrate the area of interest adequately. OR Temporary restoration is present. OR Uncertain apical healing or unchanged apical lucency may be stated, with major inconsistencies between the interpretation of healing and the description of radiographic findings.	Clinical exam is limited (missing IOE or EOE but includes clinical testing). OR Post-treatment radiographs are diagnostic, but do not demonstrate all obturated canals. OR Core restoration is intact but is missing full coverage. OR Definitive apical healing or healed is stated, with minor inconsistencies between the interpretation of healing and the description of radiographic findings.	Detailed clinical exam is complete (includes clinical testing, IOE, EOE). AND Post-treatment radiographs are diagnostic and show all obturated canals. AND Core restoration is intact with full coverage. AND Definitive apical healing or healed is stated, and the interpretation of healing is consistent with the description of radiographic findings.
Documentation Quality: Precision, accuracy, completeness, and appropriate use of language	Documentation is incomplete, uses incorrect terminology, or has spelling and grammatical errors that detract from the narrative.	Documentation is incomplete but uses correct terminology or has multiple spelling and grammatical errors that may detract from the narrative.	Documentation is complete, uses correct terminology, and has minimal spelling and grammatical errors that do not detract from the narrative.	Documentation is complete, uses correct terminology, and has no spelling or grammatical errors.
Overall Case Complexity	The case requires a level of knowledge and skill within the scope of a general dentist.	The case requires a routine level of knowledge and technical skill. OR The case requires a routine level of patient management.	The case requires a moderate level of knowledge and technical skill. OR The case requires a high level of patient management.	The case requires the highest level of knowledge and technical skill. OR The case requires the highest level of patient management.

Portfolio Improvement Suggestions and Comments from Examiners

- This section contains observations and prior issues noted by ABE examiners, along with suggestions and advice.
- These can be useful reminders of areas where Portfolios have exhibited problems in the past and reviewing these might help strengthen your Portfolio submission.

Radiographic images

- Radiographs should substantiate the information in the write-up.
- All radiographs and images must be presented in the same order as their occurrence during your diagnostic, treatment, and re-evaluation procedures.
- All radiographs and images must be referenced with interpretation (or rationale for acquisition) in the write-up.
- Radiographic description should be consistent with the image. Avoid cases where the final radiographic outcome appears ambiguous, yet the write-up assures that "everything turned out great."

Documentation errors

- Spelling errors! Check spelling ... then check spelling again ... perhaps even have a non-dentist check the spelling.
- Review for sentences that do not make sense.

"WNL"

- Use of the term "WNL" or "within normal limits" is highly discouraged throughout the entire case report.
- One provider's "normal" might not carry the same definition as that of another. This can create an imprecise understanding about what is taking place clinically.

Anesthetics

- Make it clear when local anesthetic was not used and why.
- Inappropriate dosages of anesthetics for patient weight or medical condition.

Case Complexity

- Avoid submitting cases that could be done by a general practitioner. This has been mentioned historically as a common and significant error.

Complex anatomy

- If atypical, complicated anatomy or additional canals are encountered, make sure that images demonstrate the full extent of the complexity (with pre-, intra, and post-treatment images as well as any subsequent evaluations).

Medical management issues

- Include recommendations to patient(s) about elevated blood pressure.
- Not evaluating blood pressure intra- or post-operatively or not checking the blood pressure at subsequent appointments (especially when indicated by medical condition or by initial measurement during a visit) can be a significant error.
- Inadequate monitoring of a patient using sedation medication.
- Inadequate evaluation of a patient prior to discharge.
- Recommending inappropriate medications or dosages for patient's medical history.

Continued

Other errors

- Presence of errors that are clearly described in the *Case History Portfolio Guidelines* as deficient or unacceptable.

- Not making appropriate recommendations to referring dentist for restoration.

- Inadequate or incomplete dental history.

- Use of vague terminology. Example: “copious irrigation.” What does that mean?

- Prescribing analgesics and antibiotics without justification.

- Textbook, lengthy or overly complex descriptions of techniques.

- Failure to confirm that original signs and symptoms are no longer present during subsequent treatment visits or the post-treatment evaluation visit. Examples:
    - Patient is percussion sensitive at original visit and this evaluation is never performed again, thus there is no demonstration that symptoms improved or resolved.
    - There is no report that previous swelling or sinus tract has completely resolved.

- Cases with very little to no diagnostic or treatment information in the Case History Report; there should be adequate information provided to support diagnoses and procedural decisions; this is balanced with the amount of material provided on the one-page “Cover Sheet” (if submitted).
- Conversely, if every case needs an addendum sheet, then your entries are too lengthy and can be condensed.

- The purpose of the case report narrative is to guide the examiner through your cases from start to finish.
- Your descriptions can help them understand your thought process, rationale, and decisions; don’t make them guess or wonder about things -- clear, concise explanations can make your submission easy to follow and understand.

Candidate Review Document

- On the following pages is the “Candidate Review Document”, which is comprised of two documents:
    - Portfolio Self-Assessment Review Document 1
    - Portfolio Self-Assessment Review Document 2
- These will assist Candidates with a self-assessment of their Portfolio prior to submission.

- Be certain to review this form (and print them out) as you begin your case history exam process; this will help you with proper Portfolio completion by knowing in advance of especially-emphasized Portfolio aspects.
- Refer to this document throughout your compilation of Portfolio elements; it highlights errors that result in a failed Portfolio and will help you avoid many other common mistakes.
- Use these documents to guide a thorough self-check of the suggested items for each of your completed cases. Use the blocks to the right of the form to check off that your review has been accomplished for each corresponding case. Make any needed corrections that are discovered. This allows you to be certain that each case in your Portfolio contains none of these major problem areas.

- The Board encourages all Candidates to also utilize a trusted, experienced mentor to review each case meticulously. It can also be beneficial to have a non-dental person read over the cases, to assess spelling and grammar errors.

- Prior to your final Portfolio submission, you will be asked (on the website) to verify that you have used the “Candidate Review Document” (which consists of the two Portfolio review pages) to complete a self-assessment of each review item for each case.

Continued

		Case Number				
		1	2	3	4	5
"First-Review" Errors That Result in a Failed Portfolio						
Proper Case Category **The entire Portfolio will fail if any of the cases below have not been submitted or are not in the correct order**						
Case 1 NS RCT	Maxillary Molar					
Case 2 NS RCT	Mandibular Molar					
Case 3 NS RETX	Maxillary or Mandibular Molar (must involve removing canal obturation materials)					
Case 4 OTHER	Other Treatment (must involve canal obturation)					
Case 5 Periapical Surgery	Maxillary or Mandibular Molar (with root-end resection and root-end filling)					
Case 5 Biopsy submission with pathology report **The entire Portfolio will fail if this has not been done.**						
Image Masking All photographs of patients must have their eyes or other identifying features adequately masked. Any identifying information on radiographs (such as with CBCT screenshots) must be adequately masked. **The entire Portfolio will fail if this has not been done.**						
Document Masking The Case History Report and all supplemental reports and documents must be completely masked. This includes, but is not limited to: - All names (Candidate, patient, physician, referring dentist, pathologist, radiologist, consultant, school, practice name, clinic, facility, institution, military installation, logos, etc.) - Addresses (the entire address must be masked) and geographic locations - Phone numbers, fax numbers, and signatures - Social security or other ID numbers (chart, any insurance #s, etc). **The entire Portfolio will fail is this has not been done.**						
One-Year Post-Treatment Evaluation Clinical evaluations and post-treatment evaluation radiographs, one year from the date treatment is completed, are required for all cases. The only exception to this requirement (for cases with a completion date prior to May 1, 2024) is shown on Page 28 of these *Guidelines*. **The entire Portfolio will fail if this has not been done.**						

Continued

Portfolio Self-Assessment Review Document 2					
	Case Number				
	1	2	3	4	5
Significant Errors Committing the following errors once will NOT automatically fail the entire Portfolio, but check your Portfolio thoroughly for these issues.					
Radiographs and Digital Images Dates must match the dates as shown in the Case History Report form.					
Radiographs and images must be presented in chronologic order.					
The quality of all radiographs and images must be excellent. Poor quality radiographs include those that are too dark, too light, or not clear; digital images that are too small are not acceptable.					
All images submitted (radiographic and photographic) are referenced in the treatment narrative sections.					
Radiographs and Image Size Begin with high quality images. Image files should not exceed 4 MB.					
For better resolution, image size: 300 KB and higher-----AND ---- 800 x 600 pixels and higher. Only JPEG, JPG, GIF and PNG image files will be accepted. The ABE provides criteria for size and quality of images; ultimately it is up to the Candidate to determine (prior to uploading the images on to the case history website) that the images are clear, of high quality, do not blur or pixelate when zoomed in, and clearly illustrate what needs to be communicated diagnostically or procedurally.					
Cone Beam Computed Tomography Only CBCT screen shots are permitted (all must be adequately masked). There is no capability to submit complete CBCT volumes.					

Portfolio Submission

- For in-depth instructions on how to register for the exam, and how to upload your Portfolio, please go to https://www.amboardendo.org/Home/Instructions and download the *Case History Exam Submission Instructions*. You may also view the ABE's library of videos that demonstrate how to download and use the Case History Report form, register for the exam, and submit your Portfolio. The link to these videos can be found at https://www.aae.org/board/get-board-certified/examinations/case-history-examination/.

- As you walk through the process of registering for and submitting your Case History Portfolio online, this section will review the Portfolio components and the steps to be followed when the Candidate is ready for final submission.

- You DO need to be registered for the exam prior to final submission (uploading your Portfolio).

Candidate Pledge

- When you register for Case History Exam, you will be prompted to sign the "Candidate Pledge."
-This pledge affirms that all the cases in your Portfolio were for patients that you treated during your practice, and images collected, case history forms created and supporting documentation provided for each case are valid, created/collected by you, and are original documents pertaining to each case. The pledge also affirms that you agree to adhere to all requirements detailed in the *ABE Policy and Procedures Manual*.

Payment of Examination Fee

- To register for the Case History Exam, you will need to pay the examination fee via PayPal; when paying via PayPal, you may enter a major credit card as your form of payment.
- You will not be able to register or upload your Portfolio until the exam fee is paid.

- Each Portfolio ready for submission will consist of finalized and double-checked Case History Report forms for the five cases and all supporting images and documentation (required and optional).

Portfolio Components

- For the final submission, you will upload:
  - The five separate Case History Report forms:
    - Each of the five forms properly coincide with the five required case type categories
    - All forms have been double-checked using the Candidate Review Document (see below in this section).
    - All forms must be saved as a PDF document for upload to the Portfolio submission site.

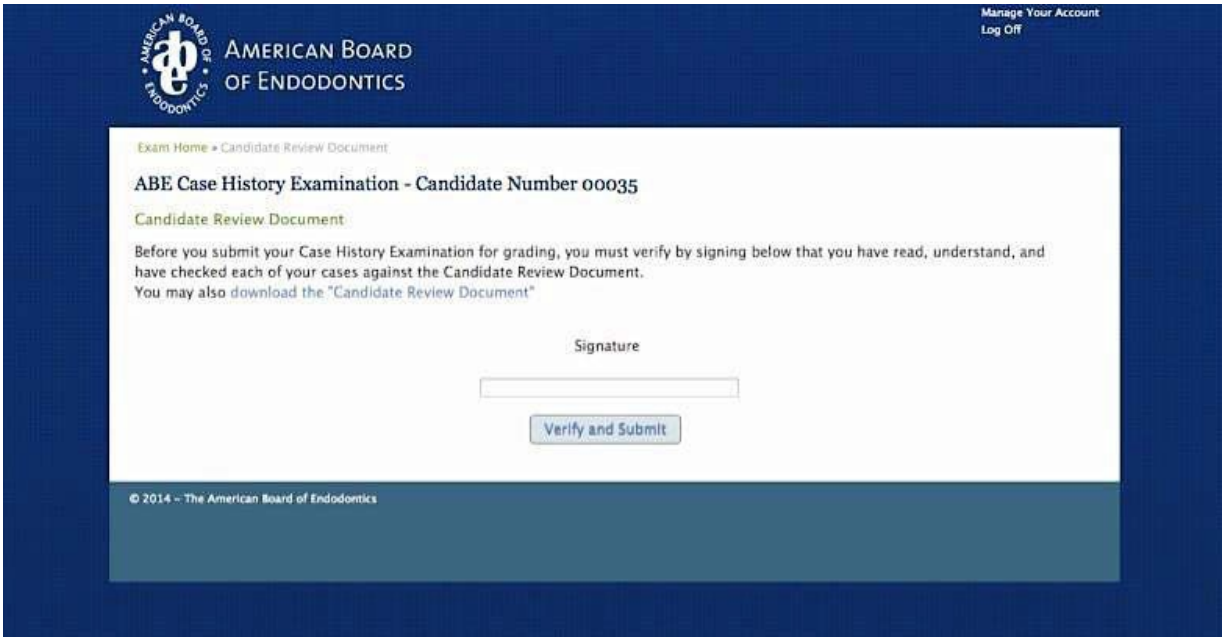
  - All necessary digital images to fully document and support each of the five cases.
    - Submit only high-quality radiographs and images, as described earlier in these *Guidelines*.
    - Reminder: ALL intraoral radiographs, extraoral radiographs, CBCT screenshots, and photographs MUST be properly referenced in all applicable sections of the Case History Report write-up.
    - ALL submitted images must be properly masked.

  - Any additional required or optional supplemental documents and reports
    - Required:
      - Oral Pathology Report (received after the required biopsy for Case 5).
      - Notarized certification for translation of all Portfolio documents into English (if applicable).
      - Medical consultation or laboratory report (if applicable).
    - Optional:
      - Cover Sheet.
      - List of Abbreviations.
      - Any others to support a particular case, etc.
    - All supportive or supplemental materials (both required and optional) must be properly and thoroughly masked; this process is described in detail on Page 9 of these *Guidelines.*
    - All supportive or supplemental materials must be saved as a PDF document for upload to the Portfolio submission site.

Continued

Candidate Pledge and Review Document (Verification of Use)

- Just prior to uploading your completed Portfolio, you will be asked (on the website) to confirm that you have checked your entire Portfolio and that it complies with all the criteria listed in the Candidate Review Document.
- An explanation of the Candidate Review Document (comprised of two Portfolio Self-Assessment Review Documents**)** appears on Pages 35-37 in these *Guidelines*.
- The screen you will encounter appears as:



- You will confirm that you have performed this careful review of all your cases before their submission.
- Typing your name in the “Signature” field will serve as your official signature.

Uploading the Cases

- Uploaded Portfolios must be received online at http://www.amboardendo.org on or before the submission deadline of 2 PM (Central Daylight Time) on May 1st.

- Do not wait until the last minute to register and upload your Portfolio.

- Although every effort has been made to make the process simple and straightforward, there are many steps to be followed and technical difficulties can always occur, especially if you are using outdated web browsers.
    - You should work with the most current version of your web browser.
    - If you are having compatibility issues with one browser, try switching to an alternate one.
- Give yourself adequate time for the task of uploading your Portfolio.
- Be certain that you retain the final version of your completed Portfolio on your computer.

- NOTE: Due to an ever-increasing number of Portfolios submitted, the ABE may need to limit the number of submissions accepted for review in any given cycle.
    - Any such limitation on submissions would be dynamic and based exclusively on available examiner resources.
    - Any Portfolio that meets the advertised deadline but cannot be reviewed, will be automatically held, and reviewed the following cycle. Candidates will be notified of this circumstance by ABE staff.
- DO NOT wait until minutes before the deadline to submit your Portfolio; the sooner you register and upload your Portfolio, the more likely you are to be included in the cycle for which you are submitting.

Continued

Candidate Notification

- After grading and statistical analysis are completed, the Secretary of the Board will notify the Candidate by e-mail whether the Case History Portfolio is acceptable or unacceptable.
- Actual scores will not be released, although the Board Secretary may provide feedback in general terms.

Appeal Policy

- No appeal is permitted based on an individual's receipt of a failing grade on the Case History Portfolio Examination.
- Please refer to the *ABE Policy and Procedures Manual* for all current policies.

Final Reminder

It is extremely important that each Candidate carefully review and follow all policies and instructions in these *Guidelines*.

All American Board of Endodontics Directors and ABE Staff members understand the effort that goes into creating your individual Portfolio. We wish you success with this Case History component of the Board Certification process.

American Board of Endodontics
750 W. Lake Cook Road, Suite 137
Buffalo Grove, IL 60089
staff@amboardendo.org
847.947.8619