



MASTERSHIP APPLICATION FORM

Pre-Requisite Requirements: MUST HAVE FELLOWSHIP CERTIFICATION as well as completed 4 WCI courses including: 3 Day Implant Boot Camp, Guided Implant Surgery and Advanced Bone Grafting.

1 Please list sixty (60) completed implant cases.

Each case must have been completed a minimum of 12 months prior to application.

- Of those cases completed, use the WCAI Mastership Documentation form (see pg 3) to submit (10) surgical or restorative phase implant cases for review. Also include:

- Pre-Operative X-rays
- Treatment Plan
- Demonstrate Use Of WCI Implant Protocols Including LAD
- Post-Operative X-rays

- Do not use patient names on any documentation submitted. Use either an ID# or initials.

Please use the following coding system to describe your cases:

IP - Implant placement
RF - Fixed Restoration

RR - Removable Restoration
RA - Ridge Augmentation

SA - Sinus Augmentation
RS - Ridge Split

All materials must be submitted digitally (Keynote or PowerPoint) and uploaded at www.whitecapinstitute.com/WCAI

2 Submit proof of 75 CE hours in Implant Study over the preceding 3 years.

3 Provide a Curriculum Vitae.

4 Submit application with documentation with \$500 (USD) application fee.

5 Required attendance at WCI Annual Summit to receive certification and award.

Register at www.whitecapinstitute.com/summit. A separate registration and Summit fee will be required.

Maintenance Requirement: Earn 75 CE hours (min) in Implant CE over the next 3 years.

Payment by: CHECK (payable to WhiteCap Institute) VISA MASTERCARD AMERICAN EXPRESS

NAME _____

CARD NUMBER _____ EXP DATE ____/____/____ CV _____

SIGNATURE _____ DATE ____/____/____

Applications and documentation should be received eight weeks prior to the WCI Annual Summit if you wish your credentials to be presented. Please ensure that all records are sent through a carrier that will expedite, safely deliver and guarantee the delivery of your documentation.

**SEND APPLICATION FORMS TO:
WhiteCap Institute
Attention:WCAI
380 E 1500 S, ste 205
Heber City, UT 84032**

QUESTIONS? (435)754-7636

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MASTERSHIP APPLICATION FORM

NAME _____ DATE _____

PLEASE TYPE OR PRINT

DEGREES _____

OFFICE	ADDRESS		CITY	STATE	ZIP	COUNTRY
	PHONE		FAX			
	EMAIL ADDRESS		WWW. WEB ADDRESS			

HOME	ADDRESS		CITY	STATE	ZIP	COUNTRY
	PHONE	BIRTHDATE	PLACE OF BIRTH			

EDUCATION	PRE-DENTAL NAME OF COLLEGE/UNIVERSITY		GRADUATION DATE	DEGREE	
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	GRADUATE NAME OF COLLEGE/UNIVERSITY		GRADUATION DATE	DEGREE	

COUNTRY OF LICENSURE		LICENSE #
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SPECIALTY	AGD #
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MASTERSHIP DOCUMENTATION FORM

NAME _____ DATE _____

	Patient's ID# or Initials	Maxillary/ Mandibular Arch	Date Implant(s) Placed	Implant Brand	Type Of Procedure	Date of Uncovery	Date Restored	Type of Restoration	Dental Lab
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MASTERSHIP DOCUMENTATION FORM

NAME _____ DATE _____

	Patient's ID# or Initials	Maxillary/ Mandibular Arch	Date Implant(s) Placed	Implant Brand	Type Of Procedure	Date of Uncovery	Date Restored	Type of Restoration	Dental Lab
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MASTERSHIP DOCUMENTATION FORM

NAME _____ DATE _____

	Patient's ID# or Initials	Maxillary/ Mandibular Arch	Date Implant(s) Placed	Implant Brand	Type Of Procedure	Date of Uncovery	Date Restored	Type of Restoration	Dental Lab
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