

## DANB's Policy and Procedures for Appeal of Clinical Exam Results



Candidates who have taken the Oregon Clinical Radiologic Proficiency Exam may request an appeal of clinical exam results if:

- A) The candidate believes his/her clinical exam was not properly evaluated, or
- B) The candidate wishes to appeal a policy or procedure not related to scoring.

### Request for Reevaluation of Exam Radiographs

If a candidate believes that his or her clinical exam was not properly evaluated and would like to request a reevaluation, he or she must submit a *Request for Appeal of Clinical Exam Results* form along with a clinical appeal fee of \$50.00 so that it is received by DANB (via mail or fax) within 30 calendar days after the official score date printed on the exam results. A candidate may also request an appeal by sending an appeal letter and a clinical appeal fee of \$50.00 to DANB's Executive Director. In completing the request form or letter, the candidate should indicate that he or she is requesting a reevaluation of his or her clinical exam results. It is not necessary to send a copy of the exam radiographs.

Upon receipt of a request for reevaluation of exam radiographs, DANB will submit the exam radiographs on file for reevaluation.

Reevaluations are typically completed within 30 calendar days of receipt of the request for an appeal. DANB will notify the individual in writing of the results of the reevaluation. The pass/fail result of the reevaluation is final and is not subject to further appeal.

### Appeal Related to Irregular Circumstance

If a candidate wants to appeal a DANB clinical exam policy or procedure not related to scoring, he or she may submit an appeal using the *Request for Appeal of Clinical Exam Results* form, along with a clinical appeal fee of \$50.00. A candidate may also request an appeal by sending an appeal letter and a clinical appeal fee of \$50.00 to DANB's Executive Director. In completing the request form or letter, the candidate should indicate that he or she is requesting an appeal of a DANB clinical exam policy or procedure not related to scoring. In this event, DANB will not reevaluate the exam results, but will only investigate the situation described by the candidate submitting the appeal.

DANB shall notify the individual in writing of the action taken pursuant to the appeal, including the reasons therefor, within 30 calendar days after receipt of the request for reconsideration. The decision of DANB is final and is not subject to further appeal.

Dental Assisting National Board, Inc.

Request for Appeal of Clinical Exam Results

This form will be accepted through Dec. 31, 2017.

Contact DANB with any questions at 1-800-367-3262.



Measuring Dental Assisting Excellence®

Submit this form to:

DANB

Attn: Cynthia Durley, Executive Director

444 N. Michigan Ave., Suite 900

Chicago, IL 60611

Fax: 1-312-642-8507

Do NOT submit twice or you will be charged twice.

Request for Appeal

DANB ID Number: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Reason for appeal (check one):

- I am requesting a reevaluation of clinical exam results because I believe the exam radiographs submitted are of diagnostic quality.
I am appealing a DANB clinical exam policy or procedure not related to scoring.

Please briefly include rationale for your appeal here: \_\_\_\_\_

Attach any other supporting documentation that you would like DANB to consider to this completed form.

Candidate Information

Name (print or type) \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Last First MI

Email Address \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers: Office (\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

I hereby officially request an appeal of the results for a clinical exam administered by DANB. I understand a \$50 nonrefundable appeal fee is required. Supporting documentation of the appeal must accompany the request. I hereby affirm the information provided is true and correct.

Signature X \_\_\_\_\_ Date X \_\_\_\_\_

Payment

- Check/Money Order payable to DANB (must include the candidate's name and be in US dollars)
Credit Card Authorization (Visa, Mastercard, Discover & American Express accepted): Amount: \$ 50.00

Appeal Fee \$50 (3817)

Credit Card Number \_\_\_\_\_ CVV \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Cardholder's Name \_\_\_\_\_ Cardholder's Signature X \_\_\_\_\_

Cardholder's Billing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

By signing, the cardholder acknowledges purchase of the aforementioned services by DANB in the amount of the total shown hereon and agrees to perform the obligations set forth in the cardholder's agreement with the issuer. Furthermore, the cardholder understands that the signature obtained on this form shall be used to indicate receipt of purchase of the services by DANB.