

NATIONAL SCIENCE FOUNDATION
POLAR DENTAL EXAMINATION

NAME:	DATE OF BIRTH:	AGE:
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DAY TELEPHONE#:	EMAIL ADDRESS:
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YEAR OF PREVIOUS DEPLOYMENT:	CURRENT DEPLOYMENT DATES: FROM:	TO:
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AFFILIATION:

NSF
 S-Event or Group # _____
 ASC
 CH2MHILL
 Other _____

ANTARCTIC DEPLOYMENT STATION:

McMurdo
 South Pole
 Palmer
 Field Camp _____
 RVIB NB Palmer
 RVIB LM Gould

ARCTIC DEPLOYMENT STATION:

Summit
 Alaska
 Thule
 Other : _____

Chart existing restorations, missing teeth and endodontically treated teeth only:

PERIODONTAL EVALUATION

PROBINGS > 5 mm YES NO
 ACTIVE DISEASE NOTED YES NO

THIRD MOLAR EVALUATION

3rd MOLARS PRESENT YES NO
 POTENTIALLY SYMPTOMATIC YES NO

ALLERGIES:

Documentation of all treatment identified and rendered and original radiographs must accompany this form.

DATES	DIAGNOSES and TREATMENTS

Attach the following **ORIGINALS** to this exam:

PANO OR FULL MOUTH SERIES
 (Required first deployment and every 5 years after)

*Date of last Pano or Full Mouth Series: _____

BITEWING X-RAYS, SET OF 4 MOUNTED SHOWING ALL POSTERIOR TEETH
 (Required annually – within six months of deployment)

I have thoroughly examined this candidate for travel to the Polar Regions. All necessary treatment has been performed; all evaluations completed; and the appropriate diagnostic radiographs will accompany this completed form as requested by the "Dear Dentist" letter.

DENTIST'S NAME (PRINT)	DENTIST'S SIGNATURE	DATE
TELEPHONE NUMBER (include area code)	ADDRESS	

ATTENTION EXAMINING DENTIST:
Please forward completed form, all documentation of treatment and all **ORIGINAL X-rays** to:

UTMB Health Center for Polar Medical Operations Levin Hall
 5th Floor, Suite 5.527, Route 1004
 301 University Blvd., Galveston, TX 77555-1004
 Tel: 1-855-300-9704 Fax: 1-409 772-3600

CITY	STATE	ZIP
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MEDICAL STAFF USE ONLY:

PQ WINTER REVIEW

NPQ