Continuing Competency Record (CCR): May 1, 201_ to April 30, 201_ CDHM#_____

Dental Hygiene Practice Setting *(please check all that apply):*

☐ Clinical Therapy ☐ Health Promotion/Community Health ☐ Education ☐ Consultant/Presenter ☐ Research/Scientific Inquiry ☐ Administration/Management

Continuing Competency Goal #_____

SELF DIRECTED ASSESMENT

How did you determine your professional need? *(See pages 10 & 11 in **Section 2** of the CCP Package and optional **Self Directed Assessment Worksheet** online under 'FORMS')*

☐ Practice problems and reflection ☐ Using the CDHM Competencies/Practice Standards/Code of Ethics ☐ Questions, discussions or external feedback ☐ Evidence-based Practice

☐ Other: (Specify) _____

GOAL DEVELOPMENT AND ACTIVITY PLANNING

Please describe the professional need perceived: *(see pages 10 & 11 in **Section 2** of the CCP Package)*

CONTINUING COMPETENCY GOAL # _____ (1 or 2): *(see pages 12 & 13 in **Section 2** of the CCP Package)*

In one sentence define the CC Goal:

ACTIVITY IMPLEMENTATION & EVALUATION

CONTINUING COMPETENCY ACTIVITIES: What type of activities did you participate in to support the achievement of this goal?

*Check all that apply: (see pages 14 & 15 in **Section 2** of the CCP Package)*

☐ **Educational Courses/Seminars** ☐ **Online Courses** ☐ **Advanced Formal Education** ☐ **Professional Journals/Articles**

☐ **Study or Journal Clubs** ☐ **Videos or DVDs** ☐ **Other: (Specify) _____**

Date of Activity (course/read/met/viewed)	Continuing Competency Activity	Name of Course/Presenter; Title of Journal/DVD and Publication Dates	Number of hours

What was the <u>total</u> approximate time spent participating in these activities? *(for guideline hours, the CDHM recommends 10-15 hours per goal)*

1. Did these activities assist you in meeting your Continuing Competency Goal? ☐ **Met** ☐ **Not Met** ☐ **Partially Met**

Please Explain:

2. Please describe the new knowledge/skills gained from these activities:
(Summarize what you have learned from the CC activities related to this goal)

3. How will this new knowledge/skills enhance your area of dental hygiene practice?

4. Did you implement these enhancements/improvements into your dental hygiene practice? ☐ **Yes** ☐ **No** ☐ **In-process**
Briefly Describe:

5. Were there any constraints encountered in implementing these enhancement/improvements? ☐ **Yes** ☐ **No**
Briefly Describe:

6. Please list additional continuing competency activities that you participated in that did not directly relate to the Continuing Competency Goal (Optional):

Date	Continuing Competency Activity	Number of Hours