



**Fixed Prosthodontics Laboratory  
 Quality Assurance**

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

1. Correct restoration(s):

- |                  |   |   |
|------------------|---|---|
| a. Type          | Y | N |
| b. Margin(s)     | Y | N |
| c. Materials     | Y | N |
| d. Pontic Design | Y | N |

Comments: \_\_\_\_\_

2. Restoration(s) duplicate the supplied provisional cast: Y N NA

Comments: \_\_\_\_\_

3. Restoration(s) seats completely on both solid and removable dies: Y N

4. Proximal contacts: Adequate Tight Light Open

Comments: \_\_\_\_\_

5. Adequate Anterior Guidance (when indicated): Y N

Comments: \_\_\_\_\_

6. Proper MI contacts: Y N

Comments: \_\_\_\_\_

7. Restoration(s) contour: Good \_\_\_\_\_

Over contoured \_\_\_\_\_

Under contoured \_\_\_\_\_

8. Other defects/flaws: Y N

Comments: \_\_\_\_\_

9. Suggested action: \_\_\_\_\_

Accepted for Placement

\_\_\_\_\_ (Student Name)

\_\_\_\_\_ (Faculty Name)

Rejected for Placement

\_\_\_\_\_ (Student Name)

\_\_\_\_\_ (Faculty Name)