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My Goal Was To Be An Airplane Mechanic,

But I Wouldn't Change Becoming A Lab Technician

So how did I get involved in the dental lab business, since what I wanted was to be an airplane mechanic? Honestly, it just happened. I did not look for it. I did not even know what a dental laboratory was.

Around 1971, I was just a high school student in Irvington, N.J. working at a knitting factory from 11 p.m. to 7 a.m. and then attending school from 8:30 a.m. to 2:30 p.m. It wasn't easy keeping my eyes open during class, but I had no choice. I wanted to graduate from high school and not having a job was not an option for me.

One day, my brother asked me if I could go with him to this new place that opened half a block from his house. He was looking for a second job and asked me to help because of his language limitations. Leonard Greenberg owned Custom Cast Dental Lab and he told me that he didn't have a job for my brother, but he had a job for me after school until about 11 p.m. Well, at least by taking this job I could keep my eyes open during class. So, I took it. It was a big production lab and even though I had no plans to become a dental technician, I learned as much as I possibly could.

I graduated high school in 1973 and decided to take a small vacation with some friends to Miami, Fla., not knowing that I would soon call this place my home. Due to certain family circumstances, I had to get a job in South Florida and move my parents down here.

My first job here in Florida was with Lomax Dental Laboratory, where I was able to expand my knowledge without limits as a dental lab tech. Soon after, I became a CDT in 1976. And here I am today, 40 something years later.

The FDLA is a strong organization and offers its members many benefits. From educational opportunities through the Southern States Symposium & Expo, *focus* magazine and the various district workshops. Each one of these opportunities have helped me grow as a technician and lab owner.

I look forward to serving as your Florida Dental Laboratory Association president this year.

Lenny Herrera, CDT
FDLA president

FDLA Mission

Serving Florida's dental technology professionals as a valued part of the dental team enhancing oral health care.

FDLA Vision

Advancing the individual and collective success of Florida's dental technology professionals in a changing environment.

Values Statement

FDLA's board of directors and professional staff are guided by these principles:

- Integrity
- Leadership
- Recognition
- Safety
- Acceptance
- Innovation

Contents

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Published quarterly by the Florida Dental Laboratory Association. The FDLA is not engaged in legal, accounting, financial or other professional counseling and readers are cautioned to contact their professional advisors for advice. FDLA simply gathers information from various sources to keep the membership informed.

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6 Southern States Symposium & Expo A Success

10 Fixed or Removable? Why Not Both?

By Arian Deutsch, CDT, DTG

18 Case Design for Removable Prosthetics

By James T. Ellison, CDT

24 The Stone Verification Jig

By Alexander Wünsche, CDT

26 The Hub

FDLA news and recent happenings.

28 Zero-In

FDLA calendar and classifieds.

30 Focal Point

Welcome New Board Members

Advertisers Directory

The Argen Corporation . . . . . page 5
www.argen.com

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Southern States
SYMPOSIUM & EXPO
presented by FDLA

Southern States Symposium & Expo A Success

Nearly 800 dental laboratory technicians, dentists, dental team members, manufacturers and suppliers attended the 2017 Southern States Symposium & Expo in Orlando. There they had access to unparalleled continuing education, numerous networking opportunities and a tradeshow floor filled with some of the most innovative products where technicians saw some stellar technical demonstrations. A huge thank you to everyone who attended and the many who helped make the symposium and expo a success. We can't wait to see you all again next year!

Above: 2017 – 2018 FDLA Board of Directors installation ceremony

Above: Expo Hall buzz

Above: Friday Night Reception

Above: Fernando de Leon, FDLA president, with Outstanding Student Zhaojun Situ, McFatter Technical College

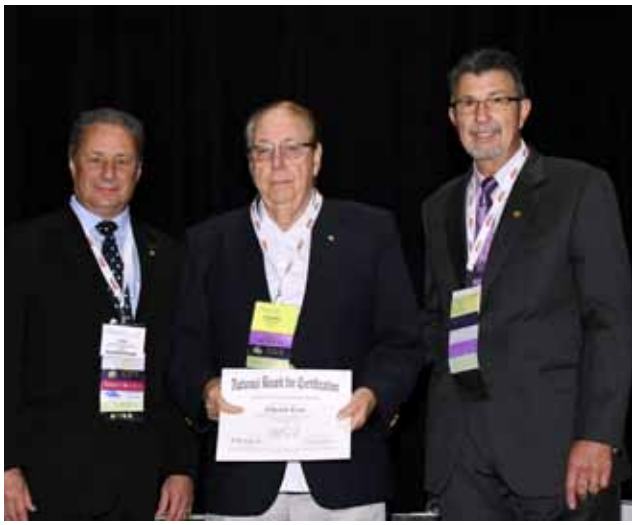
Above: Fernando de Leon, FDLA president, with Outstanding Student Asaf Yitzchak, McFatter Technical College

Above: Nancy Franceschi, CDT, outgoing FDLA board member, with Fernando de Leon, FDLA president

Above: Jerry Ulaszek, CDT, TE, NADL president, (left) and FDLA Past President and NBC Trustee Morris Fucarino, CDT, (right) present 25 year CDT milestones to Cathy Escott, CDT and Robert Young, CDT.

Above: Jerry Ulaszek, CDT, TE, NADL president, (left) and FDLA Past President and NBC Trustee Morris Fucarino, CDT, (right) present 30 year CDT milestone to Ned Lamarti, CDT.

Above: Jerry Ulaszek, CDT, TE, NADL president, (left) and FDLA Past President and NBC Trustee Morris Fucarino, CDT, (right) present 35 year CDT milestones to (from left to right) Gregory Johnson, CDT; Bruce Baker, CDT and Mark Armstrong, CDT.



Above: Jerry Ulaszek, CDT, TE, NADL president, (left) and FDLA Past President and NBC Trustee Morris Fucarino, CDT, (right) present 45 year CDT milestone to Ed Rietz, CDT.

Above: Fernando de Leon, FDLA President presents the FDLA President's Service Award to the Carbone family, in memory of Nate Carbone, CDT

Above: Nick Azzarra, FDLT Director at Large presents Fernando de Leon, FDLA president with a brick on behalf of the Foundation for Dental Technology

Above: Golf Tournament

Above: Straumann booth

Above: Dentsply Sirona booth

Above: Aspen Dental booth

Above: 2017 Best of Show – GC America, Inc.

Above: Casino at the Friday Night Reception

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By Arian Deutsch, CDT, DTG

FIXED or REMOVABLE? Why Not BOTH?

The terms fixed and removable are commonly used in the dental laboratory industry to denote a division that exists between removable prosthetics (such as dentures, partials, implant and tissue supported removable prosthetics), and fixed ceramic restorations (both tooth-borne and implant-borne).

Telescopic and conical solutions have been a well-proven, long-lasting staple in European dental prosthetics.

There is also a pronounced division regarding education among the two disciplines in the United States, whereas in Europe the approach to education is less fragmented and most technicians are trained to be competent in both fixed and removable dental laboratory disciplines. There is also a difference in the approach to partially dentate and implant cases in the European dental markets. It is from this environment that a solution combining some of the featured benefits of fixed and removable was developed. Telescopic and conical solutions have been a well-proven, long-lasting staple in European dental prosthetics.

The following article will highlight a brief history of the author's experiences with these types of solutions.

TELESCOPIC SOLUTIONS — PAST, PRESENT, FUTURE

In the past, telescopic cases consisted of the same three components as they do today. However, materials were different than today, and there were drawbacks to these materials. For example, when type IV gold alloys were used for both the primary and secondary telescopic components, wear would occur on both components, and thus, both components would need to be replaced when retention factors diminished.

The advent of CAD and CAM milling of titanium proved useful in that only the secondary telescope made from a high percentage gold via electroforming, would wear and the primary telescopic abutment of titanium would not wear (**Figure 1**). It is important to keep in mind that

Figure 1
Primary telescopes milled in wax and realized in titanium.

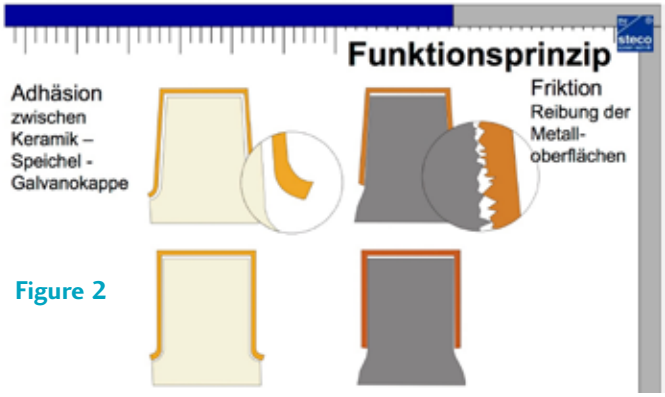

Figure 2

Figure 3 *(Above)*

hand milling of the parallel walls of the telescopic abutments was still necessary. However, with this advancement, it was now possible to fabricate an additional set of gold secondary telescopes for use in the future when retention levels diminished. Additionally, the auxiliary secondary gold telescopes could be easily luted into a telescopic prosthesis intra-orally, and the prosthesis retention was restored to normal immediately.

At present, a good number of telescopic solutions are being fabricated with a zirconia hybrid abutment as the primary telescope. This extends the life of retentive forces as highly polished zirconia does not abrade the secondary gold telescope as greatly as prior metal to metal interfaces (**Figure 2**).

Studies and experiments are flourishing using high-performance polymers, PEEK and PAEK for primary and secondary telescopic components. Many of these showing that they are viable and may become the chosen material for telescopic cases of the future (**Figures 3 and 4**).

Figure 4
(Above)

CONTEMPORARY TELESCOPIC SOLUTIONS

Presently, we are using highly polished zirconia as the primary telescope in most telescopic restorations. Today's telescopic prosthesis still utilizes three components: a primary, secondary and tertiary telescopic part. The primary telescopic abutment is a hybrid abutment, in other words, it is zirconia (**Figures 5a and 5b**) (GC Initial Zirconia)

Figure 5a
(Left) Deutsch Removable Bridge ZR ®

Figure 5b
(Left) Primary Telescopes - Zirconia Hybrid Abutments

Today's telescopic prosthesis still utilizes three components: a primary, secondary and tertiary telescopic part.

cemented to a titanium base, which serves as the implant interface. The secondary telescope is made from the electroforming of gold to the surface of the primary telescopic abutment. The third (tertiary structure) is designed by:

1. Scanning the first two telescopic components.
2. Digitally designing a support structure within the approved prosthetic volume.
3. Sending the STL file to either be selective laser melted in chromium cobalt or to be milled in a fiber interlaced high-performance polymer such as Trinia or Trilor.

This approach has proven to be successful and has streamlined the process for our laboratory because our turn around time between steps has been greatly reduced.

PRIMARY TELESCOPES

The primary telescope is designed in CAD, milled and sintered. It is then oriented on the titanium base correctly, and the titanium base is air abraded with AO at two bar pressure and primed using GC metal primer. The milled zirconia is air abraded on the inside of the interface to be cemented with AO at two bar pressure and primed with a zirconia priming agent. Once cemented, the hybrid abutments are placed into the handmill (Schick S3 Master) (**Figure 6**) at the insertion path. Next, the technician hand mills with a series of four to five, fine to ultra-fine diamonds to bring the perfectly parallel walls of the zirconia to a high glossy surface quality (**Figures 7a and 7b**).

Figure 6

Figures 7a, 7b
Deutsch Removable Bridge ZR ®

Figure 8
(Far Left)

Figure 9
(Left)

Figure 10
(Below)

SECONDARY TELESCOPES

The secondary telescopic component, the electroformed gold coping, is probably the most important component in a telescopic prosthesis due to the fit, which results from the electroforming process.

The secondary telescope is gold electroformed directly to the primary telescope yielding a typical fit of between 4-5 microns (**Figure 8**). A conductive silver lacquer is airbrushed onto the surface of the primary zirconia hybrid abutment (**Figure 9**), and an electrical lead is attached so that a low current runs over the entire surface of the telescope. During the electroforming process, a gold suspending solution is washed around the airbrushed abutments for five to six hours while the current is active. This causes the gold suspended in the solution to be pulled out of the solution and attracted to the surface of the abutment wherever the silver conductive lacquer is exposed to the solution.

The result is a very uniform gold telescopic coping. Typically, electroformers will give a choice of two layer thicknesses depending on the desired layer thickness of the final coping.

For many years, we have used, with great success, the Gramm Gammat Easy (**Figure 10**) and Gramm Gammat Freedom series of electroformers.

The entire abutments are disconnected from the electric leads, and any blocking resin used is removed carefully. Any gold which has formed around the margin, and is creating an undercut, is carefully removed with a rubber point until the gold coping releases from the primary abutment, typically with just hand pressure.

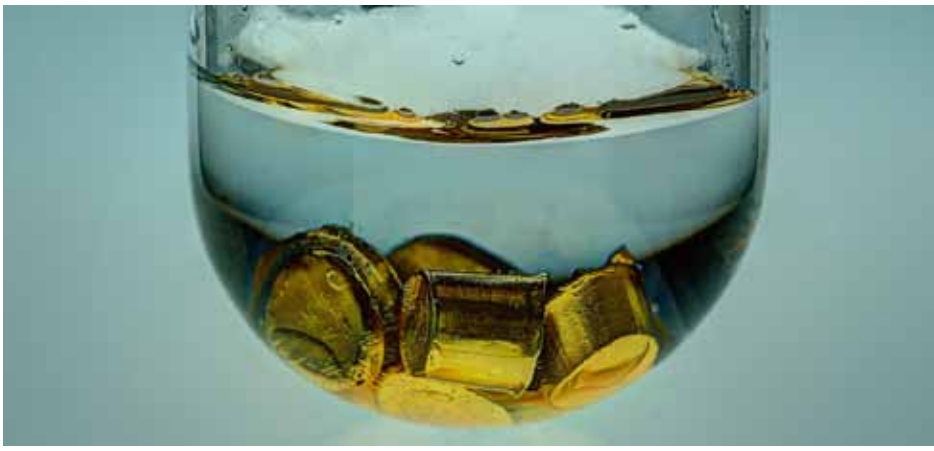

Figure 11
(Above)

Once released, the gold copings still retain some conductive silver lacquer on the inside where they interfaced with the conductive lacquer on the surface of the abutment. This layer needs to be removed as it can be hazardous to the patient. The gold copings are placed into a beaker which contains a 40 percent nitric acid and placed into an ultrasonic unit for approximately 20 minutes. The acid removes the silver conductive lacquer without harming the gold coping whatsoever (**Figure 11**).

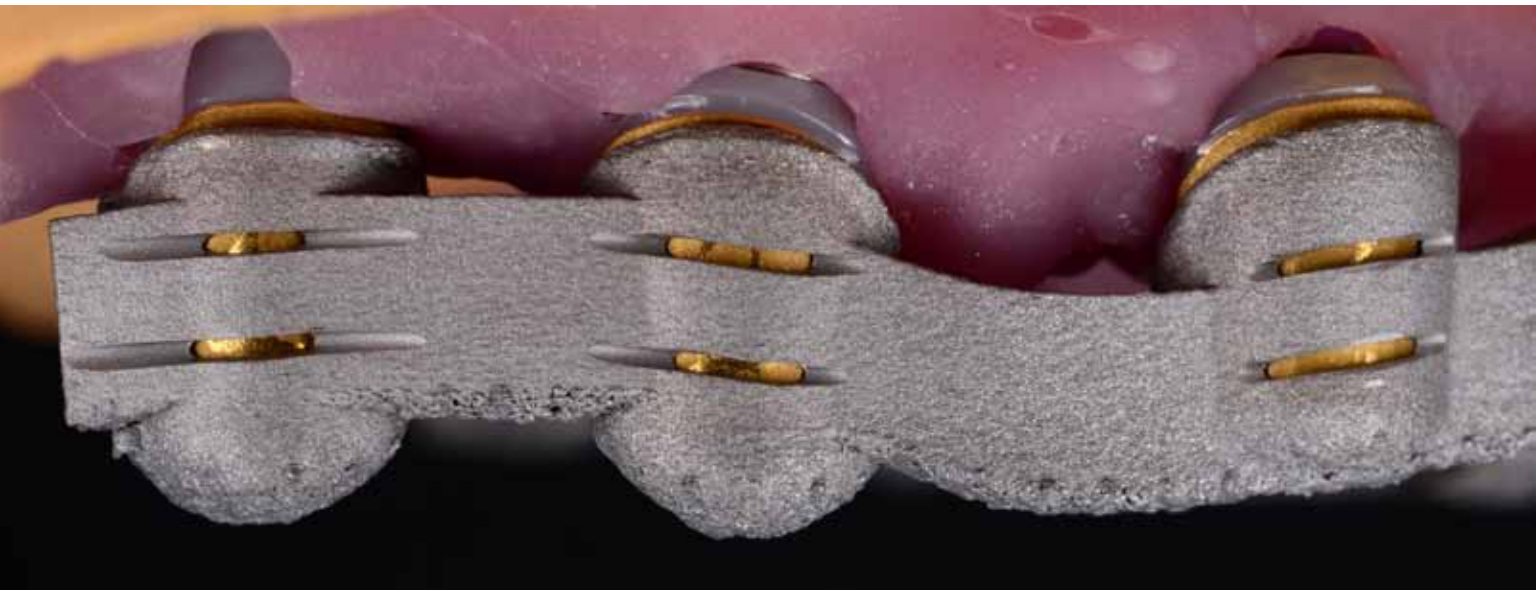

Figure 12
(Above) Tertiary

Nitric acid is a caustic chemical and must be handled with great care, including a fume hood and PPE to avoid chemical burn or injury. After use, the nitric acid solution must be neutralized before discarding, and all traces must be completely neutralized and removed from the gold secondary telescopes.

TERTIARY STRUCTURES

The tertiary structure binds all of the telescopic components together into a solid unit. They are designed with a cement gap around the gold secondary telescopes and slices are cut into the buccal portion to act as venting for the expression of excess cement (**Figure 12**).

One protocol which we use is to scan the master cast with abutments and gold copings in place, but with the soft tissue portion of the cast removed so that an accurate marginal fit can be made without obstructing the scan. Using the offset coping setting the thimble-like tertiary structure is designed with a cement gap around the gold secondary telescopes and connected with a bar between segments. Additionally, a pre-op scan of the outside of the approved wax try-in is made and stitched to the master cast. Two more scans are taken and stitched before designing the tertiary structure. A scan is made of the tissue so that it can be merged and the tertiary structure can be uniformly designed to be above the tissue (typically .5mm - 1mm to allow for wrapping the structure in GC Naturecryl acrylic) (**Figure 13**). The final scan is created by making a silicone putty matrix of the wax-up, removing the denture teeth from the wax-up, and placing the teeth into the matrix separately for scanning. Once scanned, this antagonist scan is stitched to the master digital model, and the tertiary structure can be designed underneath the basal portion of the denture teeth for an expedited combining step when the teeth are reattached to the structure after fabrication.

Figure 13
(Below)
Finished prosthesis with intrinsic gingival character

Once the tertiary is fabricated, the STL file can be sent for either SLM in the desired metal or milling in a variety of materials including Trinia, Pekkton or, most recently, Trilor.

BENEFIT OF TERTIARY CEMENT GAP

One of the great benefits of this cement gap is the ability to lute the gold secondary telescopes into the tertiary structure intra-orally to achieve a 100 percent passive fit, much like the CAL technique

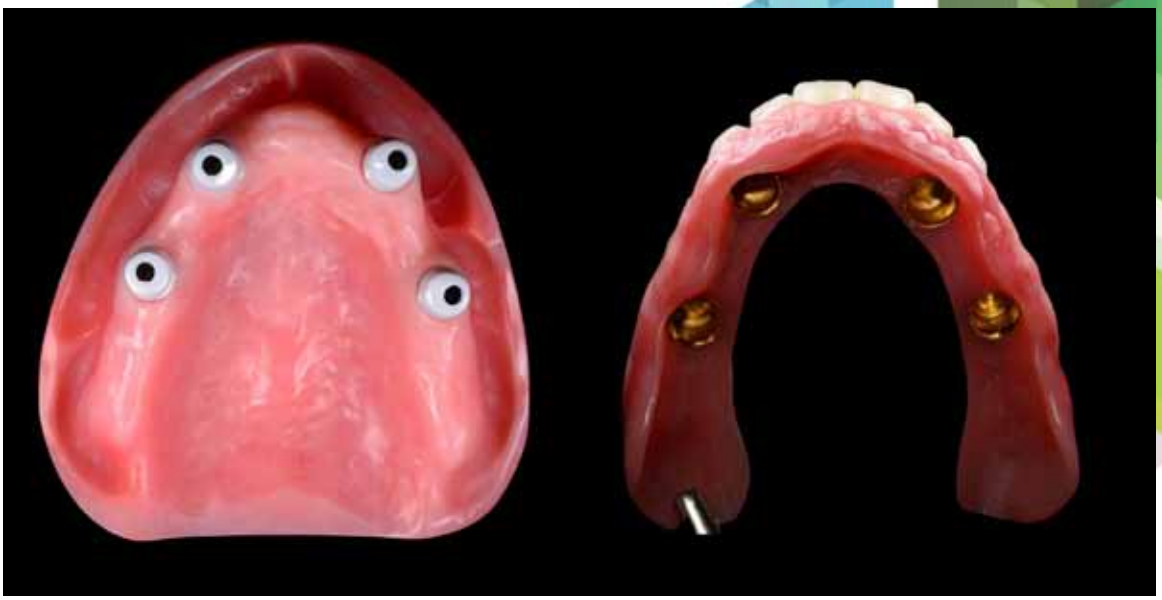

Figure 14
(Left)
Deutsch Removable Bridge ZR ®

demonstrated in the past. It's important to note that even with current and emerging technologies such as CAD/CAM milling of titanium bars directly to an implant or multi-unit abutment interface, a 100 percent passive reproduction is not possible when relying on master verified gypsum casts. So we have to ask, are the newer technologies achieving greater accuracy? Or do we need to take command of these technologies with our hands, and incorporate well-proven techniques to achieve a greater level of accuracy? In the author's opinion, it is only when we as technicians take control of the technology that we can create better fitting prosthetics. Otherwise, these technologies are simply achieving faster production with less required hand work.

We can provide a long-lasting prosthesis which exceeds patient expectations. More courses specific to incorporating this approach are just on the horizon, including courses about newer materials that will no doubt be incorporated into this trending solution.

ACKNOWLEDGMENTS:

It is important to me to give credit to some of the technicians who have made a great contribution to our efforts in developing the protocols for telescopic work along its evolution here in the United States, particularly when it comes to the tertiary structure aspects of this work. Some years ago I made a great friend, Alexander Wünsche, CDT, of Zahntechnique in Miami, Fla., who had already mastered SLM technology with his Miami Secondary Bridge Protocol. This protocol for utilizing SLM technology was then applied to our Deutsch Removable Bridge ZR® concept, and the merging of this technique into our protocol has made us more efficient and accurate across the entire process.

Another great friend, Sander Polanco, CDT, of OT Dental Laboratory in Staten Island, N.Y., shared with us his technique of using an antagonist scan to merge the basal surfaces of denture teeth into our final scan so that tertiary designs can be much more accurate.

ABOUT THE AUTHOR:

Arian Deutsch, CDT, DTG, is the owner of Deutsch Dental Arts in Surprise, Ariz., specializing in lifelike rehabilitation. He has trained with Daniel LeClerc, TD, Dr. Yvan Fortin and Frank Poerschke, MDT, and is a published author. He lectures nationally and serves as adjunct faculty at the Arizona School of Dentistry.

It is only when we as technicians take control of the technology that we can create better fitting prosthetics.

Figure 15
(Below)
Deutsch Removable Bridge ZR ®

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By James T. Ellison, CDT

Case Design for Removable Prosthetics

Although the case design criteria presented in this article can be applied to all removable prosthetics, the implant overdenture will be the primary focus.

There are several studies which indicate that patients restored with overdentures chew more efficiently.

Overdenture attachments are broken down basically into two subcategories. Bars are used to connect teeth, roots or implants. Bar joints are the resilient type of bar and bar units are the rigid style. Radicular studs are placed on top of roots or screwed into implants. Some have both a rigid and a resilient version. They feature either replaceable or adjustable parts.

There are a number of advantages that overdentures have over complete dentures. These are so dramatic that some dentists have suggested that the minimum standard of care for edentulous patients should be two implants and an overdenture. With some implant systems, the cost of an overdenture has become much more affordable, allowing treatment of many underserved patients. Wherever we have teeth, or the roots of teeth, or implants, we tend to retain the bone in those areas. There are several studies which indicate that patients restored with overdentures chew more efficiently. This ability tends to lead to more comfort, but also helps with proper nutrition. And there is often a psychological security in knowing that you can eat, speak and smile with a stable prosthesis, without the use of denture adhesive.

Once we add attachments into our case design, we gain additional advantages. You will be able to prescribe how the occlusal forces are handled. In other words, we have rigid and resilient attachments from which to choose. Therefore, we can decide if the overdenture will be supported more by the implants or if the ridge will handle more of the load.

And we gain superior esthetics. We are no longer relying on a closed palate and heavy extended flanges to hold the denture in place. In fact, an overdenture and a complete denture are not the same things. We must be sure that the flanges do not engage any tissue undercuts more than about 1mm. We must shorten the flanges so that they do not create a different path of insertion from that dictated by the attachments. It is best to begin each case by making a denture set up. You can make a putty matrix of the denture so that it can guide you when placing the attachments.

Drs. Rissin and House studied the masticatory performance of different patient groups (**Figure 1**). The natural dentition patients are the control group. As you would expect, they chew very effectively at 90 percent. The complete denture patients are on the other end of the spectrum

Figure 1

Chewing Efficiency

Rissin & House- JPD May 1978

MASTICATORY PERFORMANCE OF PATIENT GROUPS

GROUP	MASTICATORY PERFORMANCE*
Natural Dentition	90%
Complete Dentures	59%
Overdentures	79%

**measured the percentage of chewed food passing through a no. 12 sieve*

at only 59 percent. The overdenture patients, at 79 percent, are closer to the natural dentition patients than the complete denture patients.

The process of case design can be summed up as a process of elimination. We begin with all attachments, and by asking seven questions, we can narrow the choices down to one that will work well for the particular patient being treated.

You must first evaluate the condition of the periodontium. In other words, how much bone support does the patient have around the roots or implants? How well integrated are the implants? If the patient has good bone support, you could use either a rigid or a resilient attachment. However, if the support is limited, a resilient attachment would be most appropriate.

You must next consider the condition of the ridge. If it is highly resorbed, you will consider the use of a bar, although you would need several well-integrated implants for support. If the ridge is in reasonably good shape, free-standing resilient abutments provide a simpler, less costly, and biomechanically superior choice.

Next, consider what is in the opposing arch. Patients with two resilient arches often do not have a repeatable centric occlusion. This lack of repeatable centric occlusion can lead to problems with the temporomandibular joints. Therefore, in most cases, it is best to avoid this design. If the opposing dentition is rigid (natural teeth, rigid partial), then the attachment choice could be either a rigid or resilient design. However, if the opposing dentition is resilient (resilient partial, complete denture), it would be best to use a more stable design.

The abutments/implants would be considered next. There are fewer attachments made that will fit into or onto small implants or roots. The number of implants will affect the design. In general, in the maxilla, you would need a minimum of three implants, spread out in a triangular arrangement. Although, in both arches, the ideal situation is to have four implants nicely spread out into a four corners arrangement. Two implants would be the minimum in the mandible. There have been tens of thousands of successful overdentures retained only by two cuspid roots. Under the right conditions, two implants will also work.

The vertical space available from the implant/root to the opposing dentition is often the most important measurement. All manufacturers list the amount of vertical space needed for an attachment. You must have at least 1 mm of denture tooth thickness over the attachment, and that is for a patient with normal bite strength. Therefore, smaller attachments are often necessary to avoid a repair nightmare.

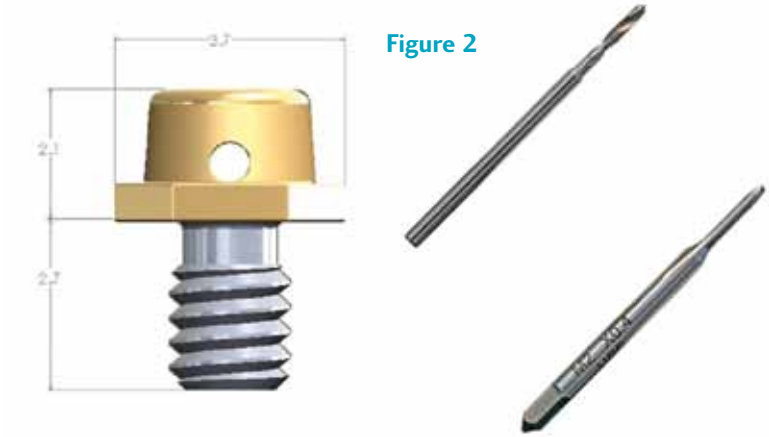


Figure 2

The last two design considerations are patient dexterity and the alloy you select for attachments that are cast or milled. Overdenture patients are often older and have limited manual dexterity. If you activate too many attachments, these patients will not be able to insert or remove their overdenture properly. When a patient has difficulty inserting their overdenture they will bite it into place, crushing, or wearing out quickly, the attachments. Patient education is important, but just as important is selecting an attachment system that will hold up under difficult conditions.

Patient education is important, but just as important is selecting an attachment system that will hold up under difficult conditions.

Answering these questions will help you to find an appropriate attachment system, but when does the patient become an overdenture candidate and stop being a partial denture candidate? Looking back are our design considerations (when a patient is exhibiting extensive bone loss, when they have four or fewer implants/abutments, and when they are having problems maintaining proper oral hygiene), you are looking at an overdenture candidate.

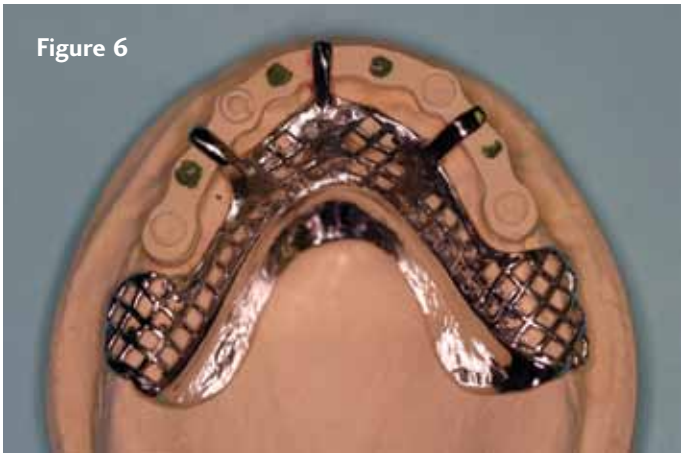
In this short article, I can only show one example of the innovative attachments systems that have become popular for retaining overdentures. Catch one of my lectures to learn more.

This attachment system can be used with milled or cast bar cases. It is the Micro ERA Drill & Tap (**Figure 2**). You merely drill holes into the bar, using the drill. Threads are created in the side of the holes using the tap.

This case was done by Dr. Gerald Middleton of Riverside, Calif. An implant level impression was made (**Figure 3**).

Soft tissue material was used around the impression copings and analogs (InstaGums®, Sterngold) (**Figure 4**).

The bar was milled with four holes drilled and tapped for the ERAs (**Figure 5**).



A framework was created for strength and stability. It is always a good idea to add a metal frame into open pallet overdentures. The Drill & Tap ERAs are screwed into the bar and torqued to 20 Ncm (**Figure 6**).

The micro ERA Metal Jackets are processed to the frame using EZ PickUp (Sterngold) (**Figure 7**).

The denture teeth are set (**Figure 8**).


Figure 9


Figure 10


Figure 11

The overdenture is processed. The black micro ERA Fabricating Males remain inside the metal jackets. At this point, the overdenture is not resilient (**Figure 9**).

To create resiliency (.4mm of vertical movement), the black males are cored out using the ERA Micro Core Cutter, and white final males are snapped in place using the ERA Micro Seating Tool (**Figures 10 and 11**).

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Figure 12

The bar is seated into the mouth. ORA Abutments (Sterngold) retain the lower overdenture (**Figures 12 and 13**).

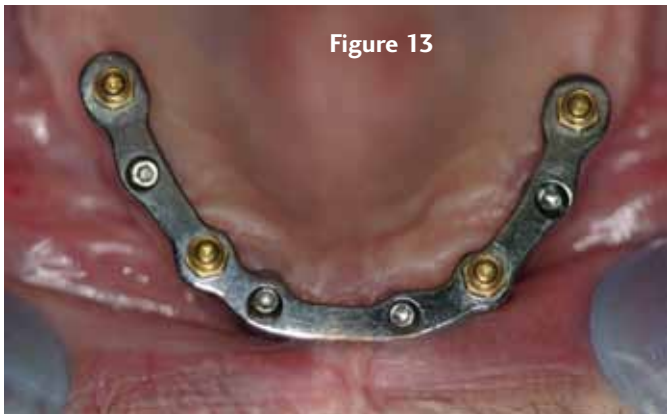

Figure 13

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The dentures are seated, and the occlusion is checked (**Figures 14 and 15**).

Figure 14

Figure 15

About the Author:

James T. Ellison, CDT, has a bachelor's degree in biology and an associate's degree in chemical technology. He earned the title of Certified Dental Technician 43 years ago and has experience in all phases of dental technology. He has spent the past 32 years with Sterngold as the head of the technical and educational departments. He has authored numerous articles on attachments, implants, milling, and the proper use of dental alloys. He is the author of the Sterngold Procedure Manual and is a contributing author to Dr. Hamid Shafie's book, Clinical and Laboratory Manual of Implant Overdentures. He has designed several attachments, including the ERA, and holds two patents on the ERA Implant. He has presented to both dental laboratory and dentist groups throughout the United States, Europe, Asia, and Central and South America. He has taught the popular attachment, implant and milling courses at Sterngold as well as advanced waxing courses.

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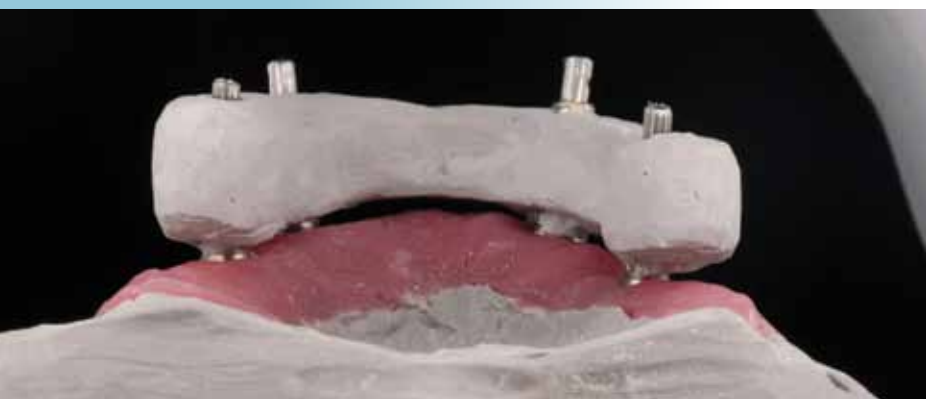
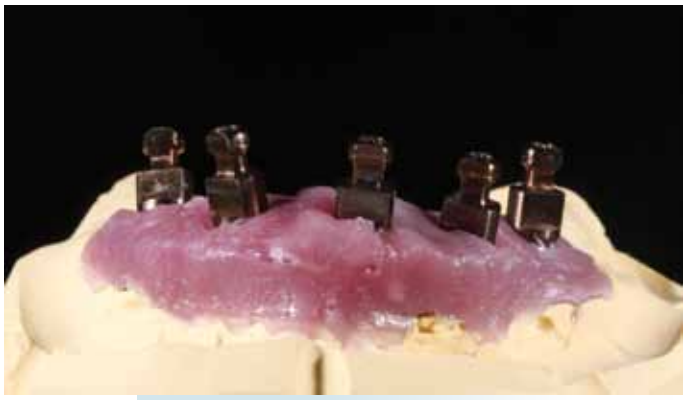
THE STONE VERIFICATION JIG

The big difference between individual unit implant restorations and connected multiple implant restorations is the critical role of the passive fit.

by Alexander Wünsche, CDT





So, how do we accomplish a passive fit? The answer to that is a verification jig so that we can verify our master cast to the implants in the mouth. This is so important because the accuracy of a master cast is affected by many influences, like the expansion of the stone, expansion or shrinkage of the impression material, as well as the temperature at the dental office and laboratory, and much more.

In the past, we have found many ways to verify our master casts, and there are verification jigs made out of resins, composites, metal burs, etc. However, I use stone.

The advantage of stone is that the jig will break immediately after screwing it into the implants if the fit isn't passive. This occurs because the stone is very brittle.

When the jig doesn't break, that means that the model is accurate and can be used without any changes. However, if the jig breaks that means that the crack can be stabilized with resin and a pickup impression should be taken over it. It's important to use a custom tray for the pickup because the stone verification jig is usually bigger in size and will not fit into a stock tray.

HOW TO MAKE A STONE VERIFICATION JIG

1. Use nonengaging temporary abutments or impression copings on the master cast.
2. Box the area with wax.
3. Pour low-expansion die stone into the boxed area.
4. After the stone is set and hard, the jig has to be thinned from the lingual to make sure it is not touching the soft tissue, so impression material can be floated underneath for accurate gingiva capturing in case the jig has to be picked up.

ABOUT THE AUTHOR:

Alexander Wünsche, CDT, is president of Zahntechnique Dental Laboratory, a premier high-end, full-service dental lab that specializes in implants and digital technology. Zahntechnique is an Amann Girrbach Live Lab, so they participate in alpha and beta tests of new materials and equipment.

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Above: At the 2017 Southern States Symposium & Expo, FDLA joined together with the Foundation for Dental Laboratory Technology (FDLT) to increase awareness of the opportunities for enhancing education in the industry. Members and vendors were encouraged to donate to the FDLT. Also, there was a Wine/Liquor Toss in the expo hall to help raise funds. A check was presented to the Foundation for Dental Laboratory Technology at the conclusion of the event.

FDLT Grant and Scholarship Opportunities

2017 might be half way over, but grants and scholarships offered through the Foundation for Dental Laboratory Technology are just getting started. Mark your calendars for these quickly approaching deadlines. Visit www.dentallabfoundation.org/scholarshipsgrants for more information.

JULY 15

NADL University Grant - Awards tuition to attend NADL University

Spear Education Grant - Awards a Spear Seminar seat

SEPT. 1

Education Access Grant - Awards qualifying faculty members funds to help cover the costs associated with attending an industry related educational event

SEPT. 15

Fall CDT Pillar Scholarship - Awards up to $935 for a candidate to take the CDT exams

Kois Center Education Grant - Awards a seat in the Biomechanics I & II course

OCT. 1

Keystone Grant - Awards funds to schools to develop and heighten dental laboratory technology awareness and education

OCT. 15

PTC John Ness Memorial Education Grant - Awards a PTC Ness Academy Hands on Course

NOV. 15

Fulcrum Grant - Awards up to $2,500 to supplement expenses related to an approved continuing education program

Legislative Update

As of September 2016, the Florida Dental Laboratory Association (FDLA) has a joint task force with the Florida Dental Association (FDA) reviewing market trends that impact both dental laboratory technicians and dentists. The Task Force primarily focused on ways to integrate language into the Florida Administrative Rules governing dentistry on chairside services, digital impressions and complex treatment planning.

On May 10, 2017, the Florida Dental Association approved the language drafted by the FDLA that would incorporate specific language into the Florida Administrative Rule governing dentistry.

What Comes Next?

- The Florida Board of Dentistry will review the submission.
- FDLA and FDA may need to testify before the Board in late summer 2017.
- If all goes well, the Board will approve the new language and it will be adopted into Florida Rules by fall 2017.

The new rules would authorize dental laboratory technicians to be chairside to assist with complex treatment planning. If these rules are adopted, Florida would be the first state to adopt language related to these activities.

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Welcome New Board Members

We're excited to introduce you to the newest members of the FDLA Board of Directors, who were sworn in during the Southern States Symposium & Expo.

Ramon Flores, with Amann Girrbach North America, LP. After serving in the military and obtaining a certification as a dental assistant, he trained as a technician in Germany before moving back to the U.S. and working in a laboratory. He's been with Amann Girrbach since 2007.

David Giompalo, II, CDT, is president of The American Dental Lab in Ft. Myers. He graduated from dental laboratory school in 1989 and became a CDT in removable prosthetics in 1996.

Rob Greeson, owns Rob Greeson Dental Studio in Bonita Springs. He is an accredited Dawson Academy lab technician and alumni, a Pankey alumni, a member of AACD and a member of ITI.

Doug Jackson, CDT, owns Touchstone Dental Laboratory, LLC, in Altamonte Springs.

Chris Peterson, CDT, owns Peterson Dental Laboratory in Delray Beach. After attending Walters State College and McFatter Technical Institute, he joined his father at the lab. He is Certified Dental Technician specializing in town and bridge and implants.

Recently, we caught up with three of the new board members to chat with them about their decision to be a part of the FDLA board.

Why did you decide to volunteer your time to serve as an FDLA board member?

Rob Greeson —
"I believe state associations are important to our industry and I wanted to volunteer my time to help the FDLA any way I can."

Doug Jackson, CDT —
"Initially, I was approached by a board member and the opportunity seemed to be interesting—a chance for me to give back to an industry that has been very good to me."

Chris Peterson, CDT —
"Our voice and livelihood as dental technicians, should not be left up to chance. I want to be proactive and do my part enhancing oral health."

What do you hope to accomplish as a board member?

Rob Greeson —
"I would hope that I can be a resource in both my background and my time—specifically in helping other technicians find and keep a passion for being successful lab technicians."

Doug Jackson, CDT —
"I want to help set the agenda for technicians by providing current and forward-looking programs in not only technical processes but also business issues that are being faced as the industry changes."

Chris Peterson, CDT —
"To grow professionally in my understanding of our industry and someday, God willing, utilize my assets when called upon by my peers."

What do you think is the best part about belonging to FDLA?

Rob Greeson —
"Meeting so many great people in a very positive environment."

Doug Jackson, CDT —
"The opportunity to help mold the future. Also, and all of the people I have met, friends I have made and will meet through my association with the FDLA."

Chris Peterson, CDT —
"The FDLA has my successes both a lab owner and as a technician at the core of its vision. On the personal side, the camaraderie and friendships I've made have been awesome."

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