DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED
OMB Approval No. 0917–0009
Expiration Date:

DENTAL PRIVILEGES REQUEST FORM

INTRODUCTION

The Dental Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Most clinical privileges pertinent to the dental program of your assigned facility are listed below.

INSTRUCTIONS FOR COMPLETING THE FORM

Applicant: With a check mark in the appropriate location, indicate for each item whether you are requesting *limited* or *full* privileges. *Limited* means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding *full* privileges. *Full* means that the applicant is entitled to function independently, following standards consistent with the dental community at large. Be sure to sign the request as indicated on page 5.

Discipline-specific supervisor or consultant: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either *full, limited,* or *not recommended* (N.R.). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the governing body when granting or not granting privileges.

I. ENDODONTIC PROCEDURES

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Anterior root canal therapy	☐	☐	☐	☐	☐
B. Bicuspid root canal therapy	☐	☐	☐	☐	☐
C. Molar root canal therapy	☐	☐	☐	☐	☐
D. Endodontic surgery	☐	☐	☐	☐	☐

II. PERIODONTICS

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Mucogingival surgery	☐	☐	☐	☐	☐
B. Osseous surgery	☐	☐	☐	☐	☐
C. Osseous graft	☐	☐	☐	☐	☐
D. Free soft tissue grafts	☐	☐	☐	☐	☐
E. Splinting	☐	☐	☐	☐	☐
F. Occlussal adjustment—limited	☐	☐	☐	☐	☐
G. Occlussal adjustment—complete	☐	☐	☐	☐	☐
H. Special periodontal appliances (occlussal guard)					

III. REMOVABLE PROSTHODONTICS

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
A. Complete dentures	☐	☐	☐	☐	☐
B. Immediate dentures	☐	☐	☐	☐	☐
C. Partial dentures	☐	☐	☐	☐	☐
D. Obturator for cleft palate	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

III. REMOVABLE PROSTHODONTICS

	Applicant Requests Ltd.	Applicant Requests Full	Supervisor/ Consultant Recommends N.R.	Supervisor/ Consultant Recommends Ltd.	Supervisor/ Consultant Recommends Full
E. Overdenture—complete/partial					
F. Special appliances (specify): ________________________					

IV. ORAL SURGERY

	Applicant Requests Ltd.	Applicant Requests Full	Supervisor/ Consultant Recommends N.R.	Supervisor/ Consultant Recommends Ltd.	Supervisor/ Consultant Recommends Full
A. Routine tooth extractions					
B. Surgical extraction—erupted tooth					
C. Surgical extraction—tissue impaction					
D. Surgical extraction—bone impaction					
E. Surgical extraction—impaction requiring sectioning of tooth					
F. Residual root recovery by surgery					
G. Oral antral fistula closure					
H. Antral root recovery					
I. Tooth replantation					
J. Tooth transplantation					
K. Surgical exposure of impacted or unerupted tooth for orthodontic reasons					
L. Surgical exposure of impacted or unerupted tooth to aid eruption					
M. Biopsy of oral tissue (hard)					
N. Biopsy of oral tissue (soft)					
O. Alveoloplasty per quadrant in conjunction with extractions					
P. Alveoloplasty per quadrant not in conjunction with extractions					
Q. Stomatoplasty per arch—uncomplicated					
R. Stomatoplasty per arch—complicated					
S. Surgical excision					
T. Destruction of lesion by physical methods (electrosurgery)					
U. Removal of exostosis—maxilla/mandible					
V. Incision and drainage of abscess (intraoral)					
W. Incision and drainage of abscess (extraoral)					
X. Removal of foreign body, skin, or subcutaneous alveolar tissue					
Y. Maxilla closed reduction, teeth immobilized (if present)					
Z. Mandible open reduction (intraoral)					

IV. ORAL SURGERY

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd.	Full	N.R.	Ltd.	Full
AA. Mandible closed reduction	☐	☐	☐	☐	☐

IV. ORAL SURGERY

	Applicant Requests Ltd.	Applicant Requests Full	Supervisor/ Consultant Recommends N.R.	Supervisor/ Consultant Recommends Ltd.	Supervisor/ Consultant Recommends Full
BB. Malar/zygomatic arch closed reduction	☐	☐	☐	☐	☐
CC. Alveolus stabilization of teeth, open reduction, splinting	☐	☐	☐	☐	☐
DD. Closed reduction of TMJ dislocation	☐	☐	☐	☐	☐
EE. Frenulectomy	☐	☐	☐	☐	☐
FF. Emergency tracheotomy	☐	☐	☐	☐	☐
GG. Suturing of traumatic wounds (intraoral)	☐	☐	☐	☐	☐
HH. Suturing of traumatic wounds (extraoral)	☐	☐	☐	☐	☐

V. ORTHODONTICS

	Applicant Requests Ltd.	Applicant Requests Full	Supervisor/ Consultant Recommends N.R.	Supervisor/ Consultant Recommends Ltd.	Supervisor/ Consultant Recommends Full
A. Removable appliance—maxillary arch	☐	☐	☐	☐	☐
B. Removable appliance—mandibular arch	☐	☐	☐	☐	☐
C. Fixed appliances—maxillary arch (minor tooth movement)	☐	☐	☐	☐	☐
D. Fixed appliance—mandibular arch (minor tooth movement)	☐	☐	☐	☐	☐
E. Functional appliances	☐	☐	☐	☐	☐
F. Comprehensive orthodontic treatment	☐	☐	☐	☐	☐

VI. ADJUNCTIVE SERVICES

	Applicant Requests Ltd.	Applicant Requests Full	Supervisor/ Consultant Recommends N.R.	Supervisor/ Consultant Recommends Ltd.	Supervisor/ Consultant Recommends Full
A. N_2O analgesia	☐	☐	☐	☐	☐
B. IV sedation	☐	☐	☐	☐	☐
C. Therapeutic drug injection	☐	☐	☐	☐	☐
D. Oral sedation	☐	☐	☐	☐	☐

DENTAL PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

______________________________ ______________
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

______________________________ ______________
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (check one)

____ As noted.

____ With the following exceptions, deletions, additions, or conditions:

____

______________________________ ______________
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

______________________________ ______________
Service Unit Director Date

5. Privileges are hereby granted: (check one)

____ As noted.

____ With the following exceptions, deletions, additions, or conditions:

____

______________________________ ______________
Chairperson of the Governing Body Date

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 20 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: Reports Clearance Officer, Indian Health Service, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN: PRA (0917–0009). Please *do not send* this form to this address.