

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

- A. Anterior root canal therapy
- B. Bicuspid root canal therapy
- C. Molar root canal therapy
- D. Endodontic surgery

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
| Ltd. | Full | N.R. | Ltd. | Full |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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II. PERIODONTICS

- A. Mucogingival surgery
- B. Osseous surgery
- C. Osseous graft
- D. Free soft tissue grafts
- E. Splinting
- F. Occlusal adjustment—limited
- G. Occlusal adjustment—complete
- H. Special periodontal appliances (occlusal guard)

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III. REMOVABLE PROSTHODONTICS

- A. Complete dentures
- B. Immediate dentures
- C. Partial dentures

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IV. ORAL SURGERY

Z. Mandible open reduction (intraoral)

| Applicant Requests | | Supervisor/ Consultant Recommends | | |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IV. ORAL SURGERY

- AA. Mandible closed reduction**
- 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)**

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V. ORTHODONTICS

- 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**

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|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|
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VI. ADJUNCTIVE SERVICES

- A. N₂O analgesia**
- B. IV sedation**
- C. Therapeutic drug injection**
- D. Oral sedation**

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