Regions Hospital
Delineation of Privileges
Dentistry

Applicant's Name: ____________________________________________________________

Last   First         M.

Instructions:  
• Place a check-mark where indicated for each core group you are requesting.  
• Review education and basic formal training requirements to make sure you meet them.  
• Review documentation and experience requirements and be prepared to prove them. Where documentation of cases or procedures is required, attach said case/procedure logs to this privileges-request form.  
• Provide complete and accurate names and addresses where requested -- it will greatly assist how quickly our credentialing-specialist can process your requests.

Overview
Core I   – General privileges in dentistry
Core II – General privileges in pediatric dentistry
Moderate sedation
Core procedure list
Signature page
Core I — General privileges in Dentistry

<table>
<thead>
<tr>
<th>Privileges</th>
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</thead>
<tbody>
<tr>
<td>Privileges include admission, work up, diagnosis, and provision of non-surgical and surgical care to all patients of all ages presenting with illnesses, injuries and disorders of the dental anatomy. These privileges include periodontics, endodontics, restorative dentistry, prosthetics, preventive diagnostic care and dentoalveolar surgery.</td>
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<table>
<thead>
<tr>
<th>Basic education and minimal formal training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DDS or DMD</td>
</tr>
<tr>
<td>2. Successful completion of an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation and (a) a hospital-based residency in general dentistry or (b) a dental specialty residency training program or (c) equivalent experience as a dentist on another hospital medical staff.</td>
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<table>
<thead>
<tr>
<th>Required documentation and experience</th>
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<tbody>
<tr>
<td>NEW APPLICANTS:</td>
</tr>
<tr>
<td>1. Provide documentation of dental services for at least 25 patients during the past 12-months in areas such as periodontics, endodontics, pedodontics, restorative dentistry and simple oral surgery;</td>
</tr>
<tr>
<td>2. Provide contact information for a dentist peer (not oral surgeon) whom the credentialing specialist may contact to provide an evaluation of your clinical competency.</td>
</tr>
</tbody>
</table>

Name: ________________________________
Name of Facility: _______________________
Address: ______________________________
Phone: ___________________ Fax: __________
Email: ________________________________

REAPPOINTMENT APPLICANTS: |
1. Provide contact information for a dentist peer (not oral surgeon) whom the credentialing specialist may contact to provide an evaluation of your clinical competency. |

Name: ________________________________
Name of Facility: _______________________
Address: ______________________________
Phone: ___________________ Fax: __________
Email: ________________________________
### Core II — General privileges in pediatric dentistry

<table>
<thead>
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<tbody>
<tr>
<td>Admit, work-up, diagnosis and provide non-surgical and surgical care to all pediatric patients to 15 years of age, including management of fractures and displacements of primary and permanent incisors, suturing of gingival injuries, management of abscessed primary and permanent teeth, restoration of carious teeth under general anesthesia provided by the Anesthesiology Section, endodontic procedures on primary and permanent teeth, and extraction of primary and permanent teeth.</td>
</tr>
<tr>
<td>In certain situations, an oral surgeon may be called upon to provide treatment for the difficult procedures and also in those cases where the injuries may involve the face or jaw.</td>
</tr>
</tbody>
</table>

### Basic education and minimal formal training
1. DDS or DMD
2. Successful completion of a 2-year accredited post-doctoral residency in Pediatric Dentistry;
3. Current board certification or active participation in the examination process with achievement of certification in Pediatric Dentistry within 5 years.

### Required documentation and experience

#### NEW APPLICANTS:
1. Provide contact information for a dentist peer (not oral surgeon) whom the credentialing specialist may contact to provide an evaluation of your clinical competency.
   - Name: ____________________________
   - Name of Facility: ______________________
   - Address: ______________________________
   - Phone: ___________ Fax: ________________
   - Email: ________________________________

#### REAPPOINTMENT APPLICANTS:
1. Provide contact information for a dentist peer (not oral surgeon) whom the credentialing specialist may contact to provide an evaluation of your clinical competency.
   - Name: ____________________________
   - Name of Facility: ______________________
   - Address: ______________________________
   - Phone: ___________ Fax: ________________
   - Email: ________________________________
Core Procedure List — Dentistry

**Applicant**: Strike though procedures you do not want to request.

This list is a sampling of procedures included in the core. This is not intended to be all encompassing but rather reflective of the categories/types of procedures included in the core.

1. Performance of history and physical exam
2. Crown and bridge preparation
3. Management of extremely fearful patients
4. Minor soft tissue surgery and repair with the oral cavity, including frenectomy and suturing of lacerations
5. Operative restorations
6. Prosthetic replacement of teeth
7. Simple extractions
8. Space maintenance
9. Splinting (fixed)
ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which – by education training, current experience and demonstrated performance – I am qualified to perform and that I wish to exercise at Regions Hospital. I understand that:

1. In exercising any clinical privilege granted, I am governed by Regions Hospital and Regions Medical Staff policies and rules applicable generally and any applicable to the particular situation.
2. In an emergent situation I may perform a procedure for which I am not privileged when no practitioner holding the applicable procedure is available to respond to the emergency.

I agree to supply Regions Hospital Medical Staff Services (or designee) with all the information that has been requested of me for the privileges that I have applied for. I also understand that my application for privileges will not proceed until the information is received.

__________________________________________________ ___________________________________
Signature       Date

DIVISION / SECTION HEAD RECOMMENDATION

I have reviewed and/or discussed the clinical privileges requested and supporting documentation for the above-named applicant and make the following recommendation/s:

☐ Recommend all requested privileges

☐ Recommend privileges with the following conditions/modifications

☐ Do not recommend the following requested privileges

<table>
<thead>
<tr>
<th>Privilege</th>
<th>Condition / Modification / Explanation</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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Notes:

__________________________________________________ ___________________________________
Signature       Date
### Regions Hospital
**Delineation of Privileges -- Moderate Sedation**

<table>
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<tr>
<td>☐ Administer and manage moderate sedation/analgesia, a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accomplished by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is always maintained.</td>
</tr>
</tbody>
</table>

### Basic education and minimal formal training

1. MD, DO, MBBS, MB BCH, DPM, DMD, DDS,
2. Successful completion of an ACGME or AOA or Royal College of Physicians and Surgeons of Canada, approved residency training program.
3. Current ACLS, ATLS or PALS certification.

### Required documentation and experience

#### NEW APPLICANTS:

1. Provide documentation of successful completion of an examination provided by the Regions medical staff services

   **Or**

   Document experience by providing one of the following:
   - Evidence of successful completion of a moderate sedation test with passing score from another hospital;
   - Governing board letter from another hospital indicating the applicant has moderate sedation privileges;
   - Letter from Medical Staff Office at another hospital indicating specifically that the practitioner has moderate sedation privileges and the date they were granted;
   - If a recent graduate, attestation of competency from program director.

2. Provide documentation of current ACLS, ATLS or PALS certification.

#### REAPPOINTMENT APPLICANTS:

1. Provide documentation of performing moderate sedation for at least ten (10) patients within the past 24 months;

   **Or**

   Provide documentation from Division/Section Head that attests to ongoing current competence.

2. Provide documentation of current ACLS, ATLS or PALS certification.

#### TO BE COMPLETED BY APPLICANT: I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information being requested of me for the privileges I am applying for. I understand my application for privileges will not proceed until the information is received.

---

Signature
Date

#### TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL: I have reviewed and/or discussed the privileges requested and find them to be commensurate with this applicant’s training and experience. I recommend this application proceed.

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Signature
Date

12.2014