

**REHOBOTH MCKINLEY CHRISTIAN HOSPITAL (RMCH)  
CLINICAL PRIVILEGES APPLICATION  
DENTISTRY CLINICAL PRIVILEGES**

APPLICANT NAME: \_\_\_\_\_

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**CORE INPATIENT PRIVILEGES:**

\*Co-admit, consult, evaluate, diagnose and provide diagnostic, preventive, and therapeutic oral health care to patients, to correct or treat various routine conditions of the oral cavity. Therapeutic oral health care to children to correct or treat various and other presenting conditions affecting the oral cavity. Dentition, its investing structures (gingiva and alveolar processes). Age specific criteria for admission must be adhered to based on specific facility requirements.

The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

\*Co-admit is to be done in conjunction with a member of the Active Medical Staff of an appropriate specialty.

**These privileges do not include any of the privileges listed under Special Privileges. In cases of pre-existing medical conditions, a medical consultation is required.**

**NOTE: In the case of an emergency, to the degree permitted by license and regardless of department, staff status or clinical privileges, shall be permitted and shall be assisted by hospital personnel to do everything possible to save a patient from serious harm.**

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**QUALIFICATIONS FOR CORE PRIVILEGES:** (Check only the first one which applies to you)

\_\_\_ **DDS or DMD: Successful completion of an approved school of dentistry and successful completion of an approved post-graduate program of at least one (1) year approved by the Commission on Dental Accreditation.**

Or

\_\_\_ **Dentists wishing to identify themselves as specialists in endodontics, orthodontics, oral pathology, pediatric dentistry, periodontics or prosthodontics, and proclaim limitation of their practices to these clinical areas must complete their training in programs approved by the Commission on Dental Accreditation**

And

\_\_\_ **New Applicants may be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.**

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NAME: \_\_\_\_\_

**STANDARD PRIVILEGES:**

| REQUESTED                              |     | RECOMMENDED |     |
|--|-----|-------------|-----|
| Yes                                    | No  | Yes         | No  |
| ___                                    | ___ | ___         | ___ |
| Dentistry core privileges (see page 1) |     |             |     |

**SPECIAL PRIVILEGES:** Eligibility to apply for a special procedure listed below requires successful completion of an approved recognized course -- when such exists -- or acceptable supervised training in residency, fellowship or other acceptable experience. Documentation of competence in performing that procedure, consistent with the criteria set forth in medical staff policies governing the exercise of specific privileges must be provided.

For each special request, you must state the training and number of procedures during training; or number of procedures performed in the last 12 months. If any one or all-special privileges are not needed, YOU MUST CHECK "NO" UNDER "PRIVILEGES REQUESTED".

| REQUESTED                     |     | RECOMMENDED |     |
|-------------------------------|-----|-------------|-----|
| Yes                           | No  | Yes         | No  |
| ___                           | ___ | ___         | ___ |
| Procedural treatment/sedation |     |             |     |

Training/Experience: \_\_\_\_\_

NOTE: A PRACTITIONER GRANTED IV SEDATION PRIVILEGES MUST ABIDE BY PATIENT CARE SERVICES POLICY # 02-35

|                           |     |     |     |
|---------------------------|-----|-----|-----|
| ___                       | ___ | ___ | ___ |
| Use of laser**            |     |     |     |
| ___                       | ___ | ___ | ___ |
| Training/Education: _____ |     |     |     |

|                           |     |     |     |
|---------------------------|-----|-----|-----|
| ___                       | ___ | ___ | ___ |
| Dental implant surgery    |     |     |     |
| ___                       | ___ | ___ | ___ |
| Training/Education: _____ |     |     |     |

|                            |     |     |     |
|----------------------------|-----|-----|-----|
| ___                        | ___ | ___ | ___ |
| Removal of impacted teeth  |     |     |     |
| ___                        | ___ | ___ | ___ |
| Training/Experience: _____ |     |     |     |

|                            |     |     |     |
|----------------------------|-----|-----|-----|
| ___                        | ___ | ___ | ___ |
| Periodontal surgery        |     |     |     |
| ___                        | ___ | ___ | ___ |
| Training/Experience: _____ |     |     |     |

**\*\* Laser/requirements:** Completion of an approved eight hour minimum CME course which includes training in laser principles and safety, basic laser physics, laser tissue interaction, discussions of the clinical specialty field and hands-on experience with lasers. A letter outlining the content and successful completion of the course must be submitted, or documentation of successful completion of an approved residency in a specialty or subspecialty, which included laser, and a minimum of eight hours observation and hands-on experience with lasers.

**ADDITIONAL PRIVILEGES (Specify training/experience/number of procedures):**

| REQUESTED | RECOMMENDED |     |
|-----------|-------------|-----|
|           | YES         | NO  |
| _____     | ___         | ___ |
| _____     | ___         | ___ |
| _____     | ___         | ___ |
| _____     | ___         | ___ |
| _____     | ___         | ___ |

DENTISTRY CLINICAL PRIVILEGES APPLICATION

NAME: \_\_\_\_\_

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

- (a) in exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation
- (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

INPATIENT DEPARTMENT REVIEW:

Comments/Recommendations/Suggestions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proctoring Arrangement: I have discussed the need for proctoring of this applicant. The following practitioner(s) who is/are member(s) of the Active Staff of the Medical Staff has/have been assigned:

\_\_\_\_\_

Signed: \_\_\_\_\_  
Medical Staff Surgery Department Chairperson

\_\_\_\_\_  
Date of Review

## GENERAL DENTISTRY PROCEDURE LIST

- \_\_\_\_\_ Restorative dental procedures, to include operative dentistry, crown, and bridge
- \_\_\_\_\_ Placement of removable dental prosthesis to include partial and complete dentures
- \_\_\_\_\_ Exodontia, to include simple non-surgical removal of teeth, alveoplasty, cystectomy  
minor osseous surgery and intra-oral biopsy
- \_\_\_\_\_ The prosthetic phase of implants
- \_\_\_\_\_ Oral prophylaxis, not to include mucogingival surgery or periodontal surgery (unless a recognized  
specialist in periodontics)
- \_\_\_\_\_ Repair of mucosal lacerations

Attachment to Dentistry Privilege Form

Approved: August 2006