Albuquerque Surgery Center
1720 Wyoming NE
Albuquerque, NM 87112

Delineation of Practice Prerogatives – Dental/Oral Assistant

Please indicate by a check in the requested column those practice prerogatives that are commensurate with your clinical ability, training and experience for which you are applying.

PRACTICE PREROGATIVES:	Requested	Not Requested	Approved	Denied	Independent	MD/DO Present
Set up instruments for dental/oral procedures						
Assist in setting up equipment for procedures						
Assist dentist/oral surgeon in completing procedures						
Expanded Function Dental Assistant (EFDA) functions						
Sealant Certificate functions						
Registered Dental Hygienist (RDH) functions						

Your initials as used in Medical Records - ________________________________.

Your signature as used in Medical Records - ________________________________.

I, ________________, hereby request practice prerogatives in the Allied Health specialty of **Dental/Oral Assistant** as indicated. I understand that practice prerogatives requested may differ from those approved. I further understand that this request does not preclude me from requesting additional practice prerogatives in the future.

________________________________ ________________
Dental Assistant Signature Date

________________________________ ________________
Sponsoring Physician Signature Date

APPROVAL:

Comments: ____

________________________________ ________________
Medical Director Date