

**LAS CLINICAS DEL NORTE
DENTAL REQUEST FOR PRIVILEGES**

General, specialty, preventive, and emergency dental services in the following areas below. Place a check mark in the areas you are requesting privileges; in any sub-areas that you do not request privileges please cross out and initial. For example, if you did not want to write prescriptions, you would place a line through the word prescriptions in the "diagnostic/adjunctive procedures" area. If there is an area that you would like to request privileges, you have the training to accomplish them, they are not listed under a Procedure/Services category, write in the procedure in the "Other" area.

REQUESTED

PROCEDURE/SERVICES

- _____ **Diagnostic/adjunctive procedures:** To include oral exams, consultations, radiographics, local anesthesia, prescriptions. Post operative treatments, impressions, jaw relations records and mouth protectors.
Other: _____
- _____ **Emergency Dentistry:** To include, recementing fixed appliances, sedative restorations, pulpotomy/pulpectomy, endodontic interim treatment, gingival flap, reimplantation of traumatically avulsed teeth, provisional splints, periodontal scaling, tooth removal, repair of (simple) wounds, incision and drainage, reduction of dislocation, osteitis treatment and periocoronitis treatment.
Other: _____
- _____ **Preventive:** To include, prophylaxis, topical fluoride application and oral health counseling.
Other: _____
- _____ **Restorative:** To include, the placement of amalgam restorations, resin/composite restorations, inlays/onlays, post retention, enamelplasty.
Other: _____
- _____ **Endodontics:** To include, pulp treatments, root canal therapy, bleaching of discolored teeth (vital and nonvital), apexification.
Other: _____
- _____ **Periodontics:** To include, gingivectomy/gingivoplasty, gingival curettage, splints, occlusal adjustment, periodontal scaling, root planning, root desensitization, mucogingival flaps.
Other: _____
- _____ **Prosthodontics:** To include, over dentures, full and partial dentures made of resin or metal based, crowns and fixed appliances (bridges), laminates.
Other: _____
- _____ **Oral Surgery:** To include, tooth removal (simple), tooth removal (complicated), tooth removal impacted (soft tissue impaction), (hard tissue impaction), tooth exposure, excision of tumor, excision of cysts, removal of exostoses, removal of foreign body, frenectomy, biopsy.
Other: _____
- _____ **Orthodontics:** To include, space maintainers, habit breaker appliances, device repair, device removal, tooth uprighting.
Other: _____

Documentation of training and expertise to perform all practice procedures requested must be provided.

I hereby request the privileges identified above. Furthermore, I am physically and mentally capable to perform the above requested privileges.

Provider Signature

Date

Temporary Approval pending Medical/Dental Staff Committee Meeting

Denied

Signature Dental Director

Date