Privileges for: Dentistry

Request

ST. ELIZABETH - EDGEWOOD
ST. ELIZABETH - FLORENCE
ST. ELIZABETH - FT. THOMAS
ST. ELIZABETH - GRANT CO. (Surgical & other invasive procedures requiring general anesthetic are not offered)

Medical Executive Approval: August 27, 2009, Revised February 25, 2010, February 27, 2014

Board Approval: September 14, 2009, May 5, 2014

DEPARTMENT APPROVAL

_____Approved _____Disapproved

_____ _____
Department/Section Chair Signature **Date**

MINIMUM REQUIREMENTS

Degree required: DMD or DDS

Successful completion of an ADA approved residency training program in general dentistry or a dental specialty residency training program. Dentists who have not completed a residency training program must document competence to perform each Additional Privilege to the satisfaction of the Surgical Subspecialty Section Chair.

Note: For Practitoners (excluding AHPs) who apply for membership after March 2, 2009 be and remain (with a lapse of no longer than one year) board certified in their principal practice specialty, or become and remain (with a lapse of no longer than one year) board certified within six years of completion of their post-graduate medical training. Only those boards recognized by the American Board of Medical Specialties or the American Osteopathic Association are acceptable. This board certification requirement does not apply to applicants who on March 2, 2009 were members in good standing on the medical staff of the St. Luke Hospitals or St. Elizabeth Medical Center.

PRIVILEGES REQUESTED

Pursuant to Bylaws Section 6.1.4, practitioners may exercise the privileges requested and awarded below only at facilities where St. Elizabeth Healthcare offers those services.

I. Core Privileges: Core privileges in dentistry include the care, treatment or services listed immediately below. I specifically acknowledge that board certification alone does not necessarily qualify me to perform all core privileges or assure competence in all clinical areas. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below. Please line through and initial any specific privileges within a checked privilege group that you are NOT requesting.

DESCRIPTION OF CORE PRIVILEGES

_____ Co-admit patients in conjunction with a Member with oral/maxillofacial surgery privileges or other appropriately privileged Member, perform that portion of histories and physicals applicable to dentistry and evaluate total oral health needs; work up and provide comprehensive general dental diagnostic, preventative and therapeutic oral health care to patients of all ages to correct or treat various routine conditions of the oral cavity and dentition including treatment of oral and maxillofacial infections and/or inflammation, diseases of the oral mucous membranes and other dental pathology and abnormalities; manage fearful patients; provide inpatient consultative care; and refer patients to appropriate specialists while preserving continuity of care

_____ General dentistry, including endodontic therapy, fixed and removable prosthetic dentistry, isolated simple extractions of erupted teeth, periodontal therapy, restorative dentistry

_____ Frenectomy surgery

_____ Orthodontia (providing fixation for teeth fracture or broken)

_____ Periodontal surgery including removal of hyperplastic material

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_____ Incision and drainage of intra-oral lesions

II. Additional Privileges: In addition to the core privileges requested above, I am requesting the additional privileges below. In addition to meeting the minimum requirements for core privileges, applicants must provide documentation (fellowship completion, training course certification, letter from program director or department chair at primary hospital, etc.) demonstrating appropriate education, training, ability and current competence. Credentialing bodies or persons may request additional documentation or information. By signing this request, I believe that my specific training, experience and current competence qualifies me to perform each privilege that I have requested by checking in the spaces below.

DESCRIPTION OF ADDITIONAL PRIVILEGES

_____ Full mouth extraction of remaining teeth

_____ 3rd molar extractions

_____ Complex surgical extractions

_____ Pre-prosthetic surgical prep for dentures

_____ Alveoloplasty and torus palatinus surgery

_____ Cystectomy of the mouth

_____ General Orthodontia

_____ Placement of endosseous implants

_____ Moderate Sedation (requires proof of (a) board certification in Anesthesiology, Cardiology, Critical Care, Pulmonology or Emergency Medicine or (b) current ACLS Certification or (c) satisfactory completion of the ASA Moderate Sedation

Applicants Signature: _____ **Date:** _____