HEALTH CENTER
DELINEATION OF PRIVILEGES (Dental Center - Dentists/Dental Hygienist)

APPLICANT'S NAME ______________________________ DATE __________

TITLE ______________________________

I understand that the completion of this form at the present time does not preclude me from requesting additional privileges at a later date.

Diagnostic	Current	Requested	Provisional	Recommended
Oral Examination				
Intraoral Radiographs				
Extraoral Radiographs				
Pulp Vitality Tests				
Diagnostic Casts				
Diagnostic Laboratory Tests				
Other (specify)				

Preventive				
Dental Sealants				
Oral Prophylaxis				
Oral Hygiene Instructions				
Space Maintainers				
Topical Fluoride Application				
Other (specify)				

Restorative				
Operative Restorations				
Stainless Steel Crowns				
Other (specify)				

Endodontic Procedures				
Anterior root canal therapy				
Bicuspid root canal therapy				
Molar root canal therapy				
Endodontic surgery				
Pulpotomy				
Pulpectomy				
Bleaching of discolored teeth				
Other (specify)				

Periodontics				
Mucogingival Surgery				
Osseous Surgery				
Osseous Graft				
Free Soft-Tissue Graft				
Splinting				
Occlusal Adjustment-Limited				
Occlusal Adjustment-Complete				
Special Periodontal Appliances				
Periodontal Scaling & Root Planning				
Gingival Curettage				
Gingival Flap Procedure				
Other (specify)				

Removable Prosthodonics				
Complete Dentures				
Immediate Dentures				
Partial Dentures				
Obturator for Fleft Palate				
Overdenture-complete/partial				
Relines & Repairs to Dentures				
Other (specify)				

Fixed Prosthodontics

Crowns				
Bridges				
Roots & Core				
Bridge Repairs				
Other (specify)				

Oral Surgery

Routine Tooth Extractions				
Surgical Extraction of Erupted Tooth				
Surgical Extraction-Tissue Impaction				
Surgical Extraction-Bone Impaction				
Surgical Extraction-Impaction Requiring				
(Sectioning of Tooth)				
Residual Root Recovery by Surgery				
Oral Antral Fistula Closure				
Tooth Replantaion				
Surgical Exposure of Impacted or Unerrupted				
(Tooth to aid eruption)				
Biopsy of oral tissues (hard)				
Biopsy of oral tissues (soft)				
Alveoloplasty per quadrant in conjunction w/ extractions				
Removal of lesion by physical methods				
Maxilla closed reduction, teeth immobilized				
Mandible closed reduction				
Alveolus stabilization of teeth, splinting				
Closed reduction of TMJ dislocation				
Frenulectomy				
Establish emergency airway				
Suturing of traumatic wounds (introral)				
Suturing of traumatic wounds (extraoral)				
Extraction of a permanent tooth for orthodontic treatment				
Other (specify)				

Orthodontics

Removable appliance (minor tooth movement)				
Fixed appliances (minor tooth movement)				
Functional appliances				
Comprehensive orthodontic treatment				
Other (specify)				

Adjunctive Services

Pharmacological anxiety control				
Conscious sedation				
Oral conscious sedation				
IM conscious sedation				
Rectal conscious sedation				
IV Conscious sedation				
Other (specify)				

***Applicant attests that clinical training provided adequate instruction and experience for requested privileges.**
*** Any restriction on clinical privileges granted is waived in an emergency situation.**
*** Clinical privileges expire and must be renewed after two years.**
*** Signatures of applicant and Dental Director affirm the ability of applicant to perform the mental and physical tasks necessary for the scope of practice required.**

Signature of applicant **Date**

Signature of Dental Director **Date**

Signature of Secretary, Board of Directors **Date**