

DELINEATION OF PRIVILEGES FOR - GENERAL / PEDIATRIC / ORAL MAXILLOFACIAL DENTISTRY

General Dentistry privileges-the following minimum threshold criteria must be met:

- Licensed by the State of Iowa as D.D.S. or D.M.D.

Provide diagnostic, preventive, and therapeutic oral health care, inclusive of cleaning, fillings and simple extractions to patients of all ages to correct or treat various routine conditions of the oral cavity.

Requesting For:	Requested	Granted
	<input type="checkbox"/>	<input type="checkbox"/> Preventative Care for the teeth
	<input type="checkbox"/>	<input type="checkbox"/> Simple surgical extractions
	<input type="checkbox"/>	<input type="checkbox"/> Restorations / Fillings to the teeth
	<input type="checkbox"/>	<input type="checkbox"/> Administration of local anesthesia
	<input type="checkbox"/>	<input type="checkbox"/> Operation and interpretation of X-rays imaging
	<input type="checkbox"/>	<input type="checkbox"/> Supervision of Allied Health Practitioner/Residents/Students

Pediatric Dentistry privileges-the following minimum threshold criteria must be met:

- Licensed by the State of Iowa as D.D.S. or D.M.D., **And**
- Completion of an accredited ADA residency in pediatric dentistry

Restore, consult, work up, and provide diagnostic, preventive, and therapeutic oral health care of children from birth through adolescence to correct or treat various routine conditions of the oral cavity. It shall be construed to include care for special patients beyond the age of adolescence who demonstrate mental, physical or emotional problems.

Requesting For:	Requested	Granted
	<input type="checkbox"/>	<input type="checkbox"/> Preventative Care for the teeth
	<input type="checkbox"/>	<input type="checkbox"/> Simple surgical extractions
	<input type="checkbox"/>	<input type="checkbox"/> Restorations / Fillings to the teeth
	<input type="checkbox"/>	<input type="checkbox"/> Administration of local anesthesia
	<input type="checkbox"/>	<input type="checkbox"/> Operation and interpretation of X-rays imaging
	<input type="checkbox"/>	<input type="checkbox"/> Simple Frenotomy
	<input type="checkbox"/>	<input type="checkbox"/> Supervision of Allied Health Practitioner/Residents/Students

Oral Maxillofacial privileges-the following minimum threshold criteria must be met:

- Licensed by the State of Iowa as D.D.S. or D.M.D., **And**
- Completion of an accredited ADA residency in oral and maxillofacial

The ability to work up, and perform surgical procedures on patients of all ages presented with illnesses, injuries, and disorders of both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial regions. Inclusive of preventive, reconstructive or emergency care for the teeth, mouth, jaws and facial structure.

Requesting For:	Requested	Granted
	<input type="checkbox"/>	<input type="checkbox"/> Preventative / Reconstructive care for the teeth, mouth, jaws or facial structures
	<input type="checkbox"/>	<input type="checkbox"/> Exploration / Debridement / Excision / Biopsy / Drainage / Repair oral cavity lesions
	<input type="checkbox"/>	<input type="checkbox"/> Mandible bone grafting
	<input type="checkbox"/>	<input type="checkbox"/> Implant placement and removal
	<input type="checkbox"/>	<input type="checkbox"/> Administration of local anesthesia
	<input type="checkbox"/>	<input type="checkbox"/> Operation and interpretation of X-rays imaging
	<input type="checkbox"/>	<input type="checkbox"/> Supervision of Allied Health Practitioner/Residents/Students

SPECIAL PROCEDURES/TECHNIQUES

To be eligible to apply for a procedure listed below, you must meet the above threshold criteria and you **must also** demonstrate successful completion of an approved, recognized course, or acceptable supervised training residency, fellowship or other acceptable experience and provide documentation of competence in performing that procedure.

Requested	Granted
<input type="checkbox"/>	<input type="checkbox"/> Laser – CO2
<input type="checkbox"/>	<input type="checkbox"/> Laser – Diode

You are granted privileges to admit patients, perform histories and dental clinical examinations, order diagnostic tests, request consultations, provide consultations within the scope of your privileges, use all skills normally learned during dental school and residency and render any care in a life-threatening emergency or as requested by the Clinical Administration should there be a physician crisis in the facility. **Patients having dental surgery must have a History & Physical by a physician no more than 30 days prior to the day of surgery. If this H&P does not support the need for surgery, you will be required to complete a dental plan to document the need for surgery.**

You are expected to practice within the bounds of your training and competence and should not attempt to treat cases, which are not in your scope of practice. Newly developed treatment modalities are not included in this request and must be cleared by the Medical Executive Committee and Governing Board before their performance. Please become familiar with the capabilities and limitations of this facility.

I understand that in making this request I am bound by the applicable bylaws and/or policies of Lakeview Surgery Center and hereby stipulate that I meet the threshold criteria for this request and have provided supportive documentation. I also certify that I have knowledge to operate all the equipment necessary to carry out requested procedures.

Date : _____ Physician Signature : _____ Printed Name: _____

Privileges:
 Granted _____ Deferred _____ MEC Signature: _____ Date: _____

Granted _____ Deferred _____ GB Signature: _____ Date: _____

Modifications: _____