

CLINICAL PRIVILEGES – DENTIST

AUTHORITY: Title 10, U.S.C. Chapter 55, Sections 1094 and 1102.

PRINCIPAL PURPOSE: To define the scope and limits of practice for individual providers. Privileges are based on evaluation of the individual's credentials and performance.

ROUTINE USE: Information on this form may be released to government boards or agencies, or to professional societies or organizations, if needed to license or monitor professional standards of health care providers. It may also be released to civilian medical institutions or organizations where the provider is applying for staff privileges during or after separating from the Air Force.

DISCLOSURE IS VOLUNTARY: However, failure to provide information may result in the limitation or termination of clinical privileges.

INSTRUCTIONS

APPLICANT: In Part I, enter Code 1, 2, or 4 in each REQUESTED block for every privilege listed. This is to reflect current capability and should not consider any known facility limitations. List training to justify award of non-core privileges in the space provided and use corresponding letter codes in the Justification Code column in section B. Sign and date the form. Forward the form to your Clinical Supervisor. *(Make all entries in ink.)*

CLINICAL SUPERVISOR: In Part I, using the facility master privileges list, enter Code 1, 2, 3, or 4 in each VERIFIED block in answer to each requested privilege. In Part II, check appropriate block either to recommend approval, to recommend approval with modification, or to recommend disapproval. Sign and date the form. Forward the form to the Credentials Function. *(Make all entries in ink.)*

- CODES:**
1. Fully competent within defined scope of practice. *(Clinical oversight of some allied health providers is required as defined in AFI 44-119.)*
 2. Supervision required. *(Unlicensed/uncertified or lacks current relevant clinical experience.)*
 3. Not approved due to lack of facility support. *(Reference facility master privileges list.)*
 4. Not requested/not approved due to lack of expertise or proficiency, or due to physical disability or limitation.

CHANGES: Any change to a verified/approved privileges list must be made in accordance with AFI 44-119.

NAME OF APPLICANT *(Last, First, Middle Initial)*

NAME OF MEDICAL FACILITY

I. LIST OF CLINICAL PRIVILEGES – DENTIST

	Request	Just. Code	Verified		Request	Just. Code	Verified
A. CORE PRIVILEGES <i>(*All dental AFSCs must request a Code 1 or a Code 2 for asterisked items)</i>				5. PERIODONTICS (continued)			
				b. Periodontal maintenance*			
				c. Minor gingival procedures <i>(Gingivoplasty, fibrotomy, mini-flap)*</i>			
1. ORAL DIAGNOSIS				6. PROSTHODONTICS			
a. Clinical oral evaluation*				a. Complete denture			
b. Oral cancer screening*				b. Removable partial denture			
c. Dental radiographs/diagnostic imaging*				c. Fixed partial denture			
d. Pulp vitality testing*				7. ORAL SURGERY			
e. Adjunctive medical laboratory studies*				a. Simple extraction*			
2. PREVENTIVE DENTISTRY				b. Pericoronitis treatment*			
a. Dental prophylaxis*				c. Intraoral incision and drainage*			
b. Topical fluoride treatment*				d. Treatment of avulsed tooth*			
c. Dental sealant*				e. Treatment of alveolar fracture/stabilization of tooth*			
d. Oral health counseling*				f. Suture intraoral wound*			
e. Enameloplasty/microabrasion				g. Soft tissue biopsy*			
f. Athletic mouthguard/fluoride carrier				h. Closed reduction of TMJ dislocation*			
g. Maintenance of dental implants				i. Alveoloplasty			
3. RESTORATIVE DENTISTRY				8. ORTHODONTICS			
a. Emergency temporary restoration*				a. Emergency treatment of fixed appliances <i>(Removal or replacement of bands, brackets, ligatures, elastics, or wires)*</i>			
b. Direct restorations <i>(amalgam/composite/glass ionomer)</i>				b. Repair or replacement of removable appliance			
c. Metal/ceramometal crown/inlay/onlay				9. PEDIATRIC DENTISTRY			
d. Post and core				a. Pulpotomy <i>(primary tooth)*</i>			
e. Stainless steel crown <i>(primary/permanent tooth)</i>				b. Space maintenance			
f. Vital bleaching procedure				10. ADJUNCTIVE GENERAL SERVICES			
4. ENDODONTICS <i>(permanent tooth)</i>				a. Palliative/emergency treatment of dental pain*			
a. Pulpectomy*				b. Local anesthesia*			
b. Endodontic therapy – permanent tooth				c. Regional block anesthesia*			
c. Internal bleaching				d. Occlusal guard			
5. PERIODONTICS							
a. Scaling and root planing*							

B. NON-CORE PRIVILEGES

Title of Training	Completion Date	Title of Training	Completion Date
a.		f.	
b.		g.	
c.		h.	
d.		i.	
e.		j.	

I. LIST OF CLINICAL PRIVILEGES – DENTIST (Continued)

	Request	Just. Code	Verified		Request	Just. Code	Verified
B. NON-CORE PRIVILEGES				7. MAXILLOFACIAL PROSTHODONTICS (continued)			
1. DIAGNOSIS				h. Obturator prosthesis			
a. Maxillofacial diagnostic radiograph				i. Surgical stent or splint			
b. Sialography				j. Radiotherapy prosthesis			
c. Temporomandibular joint film				k. Feeding aid			
d. Tomographic radiograph				l. Speech aid prosthesis			
e. Cephalometric radiograph analysis				8. ORAL SURGERY			
2. RESTORATIVE				a. Surgical removal of erupted tooth			
a. Gold foil restoration				b. Removal of impacted tooth			
b. Ceramic crown/inlay/onlay				c. Surgical removal of residual roots			
c. Ceramic labial veneer				d. Oroantral fistula procedure			
3. ENDODONTICS				e. Tooth transplantation			
a. Apexification/recalcification				f. Surgical exposure of unerupted tooth			
b. Periradicular surgery				g. Hard tissue biopsy			
c. Root amputation/hemisection				h. Surgical repositioning of tooth			
d. Intentional reimplantation				i. Vestibuloplasty			
e. Treatment of obstructed canal				j. Radical excision of reactive lesion			
f. Endodontic re-treatment				k. Removal of benign tumor, cyst, or neoplasm			
g. Repair of internal perforation				l. Removal of exostosis			
4. PERIODONTICS				m. Partial ostectomy			
a. Gingivectomy				n. Removal of foreign body			
b. Gingival flap procedure/apically positioned flap				o. Autogenous/non-autogenous graft			
c. Osseous surgery/crown lengthening				p. Repair soft/hard tissue defect			
d. Bone replacement graft				q. Frenectomy			
e. Guided tissue regeneration				r. Synthetic graft/implant			
f. Soft tissue graft				9. ORTHODONTICS			
g. Provisional splinting				a. Limited/adjunctive orthodontic treatment			
h. Localized delivery of therapeutic agents				b. Interceptive orthodontic treatment			
i. Guided bone regeneration				c. Comprehensive orthodontic treatment			
5. IMPLANT SERVICES				d. Habit therapy treatment			
a. Surgical placement of endosteal implant				e. Orthodontic retention			
b. Surgical placement of subperiosteal implant				10. PEDIATRIC DENTISTRY			
c. Surgical placement of transosteal implant				a. Aversive behavioral management			
d. Implant abutment placement				b. Operating room privileges – pediatric			
6. PROSTHODONTICS				c. Pulpectomy – primary tooth			
a. Occlusal analysis/pantographic tracing				d. Pediatric sedation/analolysis			
b. Overdentures				11. ORAL AND MAXILLOFACIAL PATHOLOGY** <i>(**Asterisked item may be requested by oral and maxillofacial pathologist only)</i>			
c. Immediate dentures				a. Postmortem examination/forensic identification			
d. Precision attachment denture				b. Histopathologic examination**			
e. Precision attachment fixed partial denture				12. ADJUNCTIVE MEDICAL SERVICES			
f. Implant restoration				a. Nitrous oxide analolysis			
g. Repair of dental implant prosthesis				b. Intravenous sedation			
h. Full-mouth reconstruction with alteration of vertical dimension				c. Clinical hypnosis			
i. Complete occlusal adjustment				d. Hospital admission			
7. MAXILLOFACIAL PROSTHODONTICS				e. Operating room privileges – adult			
a. Facial moulage				f. Hyperbaric monitoring			
b. Custom earpiece fabrication				g. Therapeutic drug injection			
c. Facial prosthesis (nasal/auricular/orbital etc.)				h. Obstructive sleep apnea appliance			
d. Facial implant prosthesis				i. Intraoral use of laser			
e. Ocular prosthesis							
f. Cranial prosthesis							
g. Nasal septal prosthesis							

CLINICAL PRIVILEGES – DENTIST (Continued)

DATE FORWARDED TO CREDENTIALS FUNCTION

DATE OF MDG/CC APPROVAL

IV. ADDITIONAL COMMENTS

V. BIENNIAL REVIEW

APPLICANT'S TYPED, PRINTED, OR STAMPED SIGNATURE BLOCK

SIGNATURE

DATE

SUPERVISOR'S TYPED, PRINTED, OR STAMPED SIGNATURE BLOCK

SIGNATURE

DATE

DENTAL COMMANDER/CHIEF OF DENTAL SERVICES' TYPED, PRINTED, OR STAMPED SIGNATURE BLOCK

SIGNATURE

DATE