Dear Dental Assistant,

Thank you for your interest in providing services at our facility. Specialty Surgery Center (SSC) is an Ambulatory Surgery Center that is certified by the Center for Medicare/Medicaid Services (CMS) as well as the Accreditation Association for Ambulatory Healthcare Facilities (AAAHC) as a premier provider of outpatient surgical care in middle Tennessee. The following application is required by state regulations and facility bylaws. This application is specifically for Practical Dental Assistants (PDA) and Registered Dental Assistants (RDA), as defined by the Tennessee Board of Dentistry, Chapter 0460-04: Rules Governing the Practice of Dental Assistants.

Please select which level you are applying for:

_____ Practical Dental Assistant - An auxiliary employee of a licensed dentist(s) who performs supportive chairside procedures under the direct supervision and full responsibility of that licensed dentist or who is a dental assistant student in an educational institution accredited by the Commission on Dental Accreditation of the American Dental Association, as defined by Rule 0460-4-.01.

_____ Registered Dental Assistant - An auxiliary employee of a licensed dentist(s) who has been issued a registration to practice intraoral dental assisting procedures in accordance with the statutes and rules of the Board, and is eligible to seek certification and training in advanced dental assisting areas, and who practices under the direct supervision and full responsibility of a licensed dentist.

In addition to this application, you will need to submit the following documentation before your application is considered complete:

_____ Copy of Recent photo ID (Driver’s License is acceptable)
_____ Copy of current Tennessee issued Registered Dental Assistant license (if applicable)
_____ Copy of current BLS/CPR certification,
_____ $75 application fee

The credentialing process will begin upon receipt of your complete Initial Credentialing Application as well as the initial application fee of $75. Temporary Privileges can be granted within 2 weeks, whereas your full appointment could take up to 6 weeks. Once full privileges are granted, they are active for a period of two (2) years.

If you have any questions or need assistance with this application, please feel free to contact me via email at cdavenport@ssctn.com or phone at (615) 321-6161 ext 1001. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Corporate Compliance, Specialty Surgery Center

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Initial Credentialing Application:  
Dental Assistant

Section I: Demographic Information

Last Name  First Name  Middle Initial  Gender

______  ____  ____  ____
Social Security Number  Date of Birth

Primary Practice Name  Office Manager/Contact

Primary Practice Address  City  State  Zip

(______) _____ - ______  (______) _____ - ______
Practice Telephone  Practice Fax  E-mail Address

Emergency Contact Person  Emergency Contact Phone  Emergency Contact Relation To You

Section II: Professional License/Certification Information
(Attach copies of all licenses and certifications if applicable)

License Number: ____________  Date Issued: ___/___/______  Expiration: ___/___/______

*Please specify if you hold any of the following certifications and attach proof of certification(s):

__________Monitoring of Nitrous Oxide  __________Restorative or Prosthetic Functions (Expanded Functions)

__________Coronal Polishing  __________Exposure of Radiographs Certification

__________Application of sealants

BLS (CPR) Certification Expiration Date: ___/___/______
Section III: Supervising Dentist Information

Name of Dentist currently on staff at Specialty Surgery Center who will be supervising you:

_________________________________________________________

Dentist Name (please print)

_________________________________________________________

Dentist Signature

Date

Section IV: Health Status

(If you answer “yes” to the following questions, please explain on separate sheet of paper)

1. Do you presently have any physical or mental condition, illness or injury (including use of or dependency on any chemical substance or alcohol) that in any way impairs or limits your ability to practice or perform procedures for the privileges you are requesting at Specialty Surgery Center with reasonable skill and safety? (with or without accommodation)?

   YES   NO

2. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?

   YES   NO

3. Are you currently engaged in illegal use of controlled dangerous substances?

   YES   NO

4. Have you received treatment or been advised to receive treatment for alcohol or substance dependency?

   YES   NO

5. Are you currently taking any medications that may affect either your clinical judgment or motor skills?

   YES   NO

Section V: Conditions of Application

I attest that the information contained in this profile and all enclosed/attached documents, which are agree to provide to support this profile, are complete and accurate. I agree to notify SSC of any change in the information contained in this profile and any attached documents within thirty (30) days of the date that I am aware of the change. Furthermore, I consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing review and decision.

A copy of this authorization and release has the same effect as the original.

___________________________________________

Printed name of Dental Assistant Applicant

Date

Signature of Dental Assistant Applicant
Privilege Delineation Form For:  
Dental Assistant

Name: __________________________________ Date: ____________________

I hereby request privileges to serve as a Registered Dental Assistant in the following areas*:

________ (Check here to request all below)

________ The processing of radiographs.  
________ Placement and removal of matrices for restoration

________ The application of topical fluorides.  
________ Removal of cement from restorations and bands.

________ The instruction of patients in dietary principles.  
________ The removal of sutures and staples.

________ The taking and recording of patient’s Med History  
________ The preparation of instrument trays.

________ Charting of oral conditions.  
________ The placement and removal of socket dressings

________ Fabrication, placement/removal of temporary restorations.

________ The maintenance of instruments and operatory infection control.

*Please refer to the Rules Governing the Practice of Dental Assistants: Chapter 0460-04, Section 08(3) for a complete list of approved procedures.

I understand that as an assistant, I will practice under the supervision of my sponsoring dentist during the intraoperative phase of the perioperative experience.

Applicant’s Signature ____________________________ Supervising Dentist Signature ____________________________

Compliance Officer Signature ____________________________ Date ____________________________ Approved? (YES or NO) ____________________________
Authorization for Dental Assistant

(To be filled out by sponsoring dentist)

This is to certify that I, _____________________________, a duly licensed Doctor of Medicine/Dentistry admitted to practice the art of medicine/dentistry or podiatry in the State of Tennessee do hereby apply for permission from the Credentialing/Medical Director to allow me to employ an assistant while practicing medicine/dentistry or podiatry at the Specialty Surgery Center.

I further certify and declare that I am admitted with full staff privileges to the Medical Staff of this facility.

I further certify and declare that the Assistant, whose name is _____________________________ shall at all times be my employee and shall never, for any reason, be considered to be an employee, agent or servant of the facility. I also declare that I shall, at all times, be personally responsible for any and all acts of aforementioned assistant while he/she is on the premises of the Specialty Surgery Center.

I further certify that the assistant is qualified and he/she will provide the Director of Nursing of Specialty Surgery Center acceptable proof of licensure, certification, or training.

I certify to all parties that I will always have direct supervision over and that I will be physically present to monitor his/her actions when necessary.

I further agree that I shall indemnify and hold the center and the partnership harmless from any and all claims relating to my assistant under the agreement and shall pay all expenses, including attorney’s fees relating to any such claims.

A photocopy of this shall serve as the original.

_________________________________  ______________________________________
Full Name of Sponsoring Dentist (Printed)  Date

_________________________________
Signature of Dentist

S:SSC\SSC Credentialing\Applications for Privileges\Initial Application (Dental Assistant).docx
By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Director of Nursing, or their designee, to make an inquiry of any of my references and institutions in which I have been enrolled or by whom I have been employed or extended privileges, as to my qualifications.

I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless from any action by me for their acts.

A photocopy of this shall serve as the original.

_________________________________  ____________________
Full Name (Printed)  

_________________________________  ____________________
Signature  Date
Right of Confidentiality

As a member of the Allied Health Staff of the Specialty Surgery Center, I recognize the patient’s right to confidentiality and agree to abide by the Patient’s Bill of Rights as posted within the Specialty Surgery Center. Additionally, I agree that information relating to a patient’s physical, mental, and/or emotional status will not be released except as set forth within the policies and procedures of the Specialty Surgery Center.

________________________________________
Full Name (Printed)

________________________________________
Signature

________________________________________
Date
Total Release of Liability

I, __________________________, an Allied Health Professional of the Specialty Surgery Center (SSC), understand that SSC’s first priority is to meet the needs of the patient. In meeting this goal, I understand that Specialty Surgery Center cannot be held responsible for any injury I may incur during my attending and/or assisting on surgeries while at their surgery center. In signing this form, I am relinquishing Specialty Surgery Center from any liability during my stay as an Allied Health Professional at Specialty Surgery Center.

_________________________________  ____________________
Full Name (Printed)

_________________________________  ____________________
Signature                           Date

_________________________________  ____________________
Witness Signature                  Date
Medical/Credentialing Director:

Please find my attached, completed, application for staff privileges as a Dental Assistant. I subsequently request temporary privileges for procedures delineated in my application, under the appropriate supervision, so that I may perform procedures at the Specialty Surgery Center for a period of ninety (90) days or until such time as my application has been approved by the governing board.

__________________________________________________________
Full Name (Printed)

__________________________________________________________
Signature Date

(Official Use Only Below Line)

Approved:_______  Denied:_______  Effective:_____/_____/_______ through ____/____/_______

__________________________________________________________
Signature of Compliance Officer Date
Full Approval of Appointment for:
Dental Assistant

________________________________________________________
Full Name (Printed)

(This Page Official Use Only)

Approved By Credentialing Staff:

________________________________________________________
Compliance Officer Signature  Date

Approved By Governing Body:

________________________________________________________
President, Specialty Surgery Center  Date
RDA sterilization training check-off list:

- Eliminating cross contamination with proper glove and gown use
- Covering of trays in high traffic areas (i.e. traveling from OR suites to the decontamination room)
- PPE that is required to be worn in the decontamination room (i.e. puncture resistant gloves)
- Proper way to remove instruments from cleaning solution
- Water and chemicals used to soak instruments
- Cleaning and processing instruments (i.e. opening scissors)
- Pre-sterilization preparation and packaging instruments
- Proper sterilizer loading and unloading techniques
- Cycles to be used for steam sterilizers
- How to correctly document cycles
- Applications for use of sterilization monitoring devices (i.e. chemical, biological indicators)
- Storing sterilized instruments safely

RDA signature: ______________________________________ Date: _____________________
Sterilization Trainer signature: __________________________ Date: _____________________
Compliance Officer signature: ___________________________ Date: _____________________