Initial Credentialing Application:
Dental Assistant

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 pitts@tnosi.com or at (615) 321-6162. We look forward to receiving your completed application and working with you.

Sincerely,

Adam S. Pitts, M.D., D.D.S.
Credentialing Director, Specialty Surgery Center
# Initial Credentialing Application:
**Dental Assistant**

## Section I: Demographic Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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Social Security Number: __________

Date of Birth: ___/___/______

Preferred Contact Method:
E-mail: ________
Phone: ________
Fax: ________

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

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: ___/___/______

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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 V: 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 VIII: 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 __________________________

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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.

________ The application of topical fluorides.

________ The instruction of patients in dietary principles.

________ The taking and recording of patient’s Med History

________ Charting of oral conditions.

________ Fabrication, placement/removal of temporary restorations.

________ The maintenance of instruments and operatory infection control.

________ Placement and removal of matrices for restoration

________ Removal of cement from restorations and bands.

________ The removal of sutures and staples.

________ The preparation of instrument trays.

________ The placement and removal of socket dressings

*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

__________________________
Credentialing/Medical Director 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)

__________________________  __________________________
Signature of Dentist  Date
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
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

Right of Confidentiality
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
Temporary Staff Privileges for:
Dental Assistant

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 Credentialing Director

______________________________________________________________________________________________

Date
Full Approval of Appointment for:
Dental Assistant

_________________________________
Full Name (Printed)

(This Page Official Use Only)

Approved By Medical/Credentialing Staff:

_________________________________
Medical/Credentialing Director Signature

Date

Approved By Governing Body:

_________________________________
President, Specialty Surgery Center

Date