Specialty Surgery Center
322 22nd Avenue North | Nashville, TN 37203
(615) 321-6161 | fax (615) 645-9870 | www.ssctn.com

Initial Credentialing Application: Pediatric Dentist

Dear Pediatric Dentist,

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. 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 Professional License (Dental License)
_____Copy of current Professional Liability Insurance (Malpractice Insurance)
_____Copy of Loss History Report related to your Professional Liability Insurance
_____Copy of current BLS/CPR certification, ACLS &/or PALS (if applicable)
_____Copy of Dental School Diploma
_____Copy of Residency Completion Certificate
_____ Copy of DEA (if applicable)
_____List of facilities where you currently hold active privileges (if applicable)
_____$150 application fee

The credentialing process will begin upon receipt of your complete Initial Credentialing Application as well as the initial application fee of $150. 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) 340-8510. We look forward to receiving your completed application and to working with you.

Sincerely,

Christina Davenport
Specialty Surgery Center

Initial Credentialing Application:
Pediatric Dentist

Section I: Demographic Information

_____ _____ _____ _____
Last Name First Name Middle Initial Gender

_____-_____-_____ ____/____/_____ Preferred Contact Method: E-mail Phone Fax
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)

License Number: _____Type:_____Date Issued: ____/____/_____ Expiration: ____/____/_____

License Number: _____Type:_____Date Issued: ____/____/_____ Expiration: ____/____/_____

DEA/Controlled Substance Number: _____ Expiration Date: ____/____/_____

BLS Certification Expiration Date: ____/____/_____ ACLS Certification Expiration Date: ____/____/_____

PALS Certification Expiration Date: ____/____/_____

Specialty Board(s) by which you are certified: _____ Date certified: ___/____/_____

Date Certification Expires: ____/____/_____ Have you ever taken & failed a professional certification examination? YES NO

If yes, please provide details: _____

Section III: Professional Liability Information
(Attach proof of liability insurance and loss history if applicable)

_____ _____
Current Liability Carrier Name Policy Number

____/____/_____ ____/____/_____ _____ _____
Policy Effective Date Expiration Date Per Occurrence Amount ($) Aggregate Amount ($)

Section IV: Education, Training, & Employment Information

_____ _____To_____
Dental School Dates attended

_____ _____To_____
Pediatric Residency (Graduate Program) Dates attended

Please list your employment history for the previous five years, including your current employer:

Employer: _____ City/State: _____

Position: _____ Dates employed: _____ to _____

Employer: _____ City/State: _____

Position: _____ Dates employed: _____ to _____

Employer: _____ City/State: _____

Position: _____ Dates employed: _____ to _____

If there has been any lapse in employment (>6 months) during the past five years, please explain:

_____

_____

_____

_____

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 VI: Professional Information

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

1.	Has your license, DEA, or certification to practice in this state or any other state ever been suspended, revoked, voluntarily relinquished, or put on probation status; or, are any of these actions pending with respect to your license, DEA, registration or certification	YES	NO
2.	Have your hospital or surgical facility privileges ever been revoked, suspended, limited reduced, non-renewed; or, have disciplinary proceedings ever been instituted against you by a hospital or surgical facility; or, are any of these actions now pending with respect to your hospital or surgical facility privileges?	YES	NO
3.	Have any complaints or adverse action reports been filed against you with a local, state, or national professional society or licensure board?	YES	NO
4.	Are you now or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation; or have you ever received any notice of any claim or complaint against you?	YES	NO
5.	Has your professional liability insurance ever been cancelled, non-renewed or have you ever been denied professional liability insurance?	YES	NO
6.	Have you ever been sanctioned or disciplined by Medicare/Medicaid?	YES	NO
7.	Have you ever been prosecuted for, convicted of or charged with a felony or misdemeanor (other than minor traffic violations)?	YES	NO

Section VII: Professional Reference Information

Please list the name, address, phone number, and title or relationship of two (2) professional peer references and one (1) personal reference who have observed you during your practice of procedures who can attest to your current clinical abilities, ethical character and health status.

_____ _____
Peer Reference #1 Name Title

_____ _____ _____ _____
Address City State Zip Code

(_____) _____ - _____ _____
Phone E-mail (if available)

_____ _____
Peer Reference #2 Name Title

_____ _____ _____ _____
Address City State Zip Code

(_____) _____ - _____ _____
Phone E-mail (if available)

_____ _____
Personal Reference Name Title

_____ _____ _____ _____
Address City State Zip Code

(_____) _____ - _____ _____
Phone E-mail (if available)

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 Pediatric Dentist Applicant Date

_____
Signature of Pediatric Dentist Applicant

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Privilege Delineation Form For: General Dentistry

Name:_____ Date:_____

Please check the requested privileges below:

	Official Use Only	
	Accept	**Denied**
_____Extraction of teeth, simple and surgical		
_____Treatment of infections of dental origin or arising from the oral cavity or associated structures		
_____General restorative dentistry, operative dentistry, and fixed/ removable partial dentures		
_____Treatment of caries and replacement of teeth		
_____Basic gingival curettage, splinting, occlusal adjustment, scaling, and root planning		
_____Basic, non-surgical, pulp capping, pulpotomy, root filling (root canal)		
_____Reimplantation and stabilization of avulsed teeth		
_____*Dental Implants **Subject to review and approval of the Governing Body based upon documentation of Previous experience and/or course certification*		

_____ _____
Applicant's Signature Date

_____ _____ _____
Governing Board Signature Date Approved? (YES or NO)

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Privilege Delineation Form For: Pediatric Dentistry

Name: _____ Date:_____

Please check the requested privileges below:

Official Use Only	
Accept	**Denied**

_____Fulfillment of general dentistry (reference General Dentistry Privilege Delineation Form)

_____Dental treatment of handicapped children and adults

_____Dental trauma, excluding the treatment or manipulation of fractures to the maxillofacial region

_____Dental treatment of medically compromised children, including evaluation and treatment of Hematology/Oncology patients, including treatment and prevention of microstomia, therapy to increase oro-motor function and dental preventive care

_____ _____
Applicant's Signature Date

_____ _____ _____
Governing Board Signature Date Approved? (YES or NO)

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Informed Consents

I recognize that it is my responsibility as the attending Dentist, to explain the procedures, alternative treatment(s), possible complications, and expected outcome(s) to all of my patients being admitted to Specialty Surgery Center

A photocopy of this shall serve as the original.

_____
Full Name (Printed)

_____ _____
Signature Date

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Release of Information

By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the Corporate Compliance Officer, 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

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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

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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

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Acknowledgement of Notification

Notice to Physicians/Dentists: **"Medicare payment to ambulatory surgery centers is based on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending Physician/Dentist by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal and State Laws."**

I hereby acknowledge receipt of the above notice provided to me by Specialty Surgery Center acting in accordance with 42 CFR Part 405, #405.472.

_____
Full Name (Printed)

_____ _____
Signature Date

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Dictation Authorization

I, _____, an Allied Health Professional, authorize the Specialty Surgery Center to automatically sign my dictation by typing "electronic signature on file" at the end of my reports. I will review copies of my transcribed reports and will provide corrected, dated and initialed copies whenever errors are found. The Specialty Surgery Center will file the corrected report on the record together with original marked "Addended." If I wish to personally review any dictation, I will dictate "to be personally reviewed prior to signing" at the end of my dictation and the Specialty Surgery Center will flag the transcribed report for my signature.

_____
Full Name (Printed)

_____ _____
Signature Date

_____ _____
Witness Signature Date

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Temporary Staff Privileges for: Pediatric Dentist

Compliance Officer:

Please find my attached, completed, application for staff privileges as a Pediatric Dentist. I subsequently request temporary privileges for dental/surgical procedures delineated in my application 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

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Full Approval of Appointment for:
Pediatric Dentist

_____
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

SPECIALTY SURGERY CENTER

PROVIDER/CRNA HEALTH SCREENING

Name: _____ SS#: _____
Address: _____

Phone: _____ DOB: _____

Family
Doctor:_____Address:_____
_____ Phone: _____

HEALTH HISTORY:
Allergies: _____ Current Medications: _____
_____

Do you have or have you ever had the following: (yes or no)

Heart disease	**_____**	**Liver disease**	**_____**
Lung disease	**_____**	**Mental illness**	**_____**
Diabetes	**_____**	**Depression**	**_____**
Epilepsy	**_____**	**Musculoskeletal**	**_____**
Seizures	**_____**	**disease or injury**	**_____**
Cancer	**_____**	**Stomach or bowel**	**_____**
Tuberculosis	**_____**	**Renal disease**	**_____**
Hypertension	**_____**	**Fever/night sweats**	**_____**

What are your current immunizations? _____

List any major hospitalizations and any previous surgeries including year. Exclude childbirth._____
_____
_____

PHYSICAL EXAM:
HT: _____ WT: _____ BP: _____ P: _____ R: _____ Temp: _____ Sat: _____

Any recent illness? _____
Recent exposure to communicable diseases? _____
Recent unexplained weight loss? _____ lbs _____over _____ months
Hepatitis B Series: Yes _____ No _____ Hep Titer results: _____ Date: _____
T.B. skin test date: _____ Site: _____ Result: _____
Influenza vaccine: Yes _____ No _____ Date _____
Comments:

Examiners Signature: _____Date_____

Employee Signature: _____Date_____