



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

Initial Credentialing Application: General Dentist

Dear General 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 Current 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:
General Dentist**

Section I: Demographic Information

Last Name	First Name	Middle Initial	Gender
_____ - _____ - _____ 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

(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
(Attach current Curriculum Vitae)

Dental School

Dates attended To _____

Graduate School (if applicable)

Dates attended To _____

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 General Dentist Applicant Date

Signature of General Dentist Applicant



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**Privilege Delineation Form For:
 General Dentist**

Name: _____

Date: _____

Please check the requested privileges below:

_____ 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*

Official Use Only	
Accept	Denied

 Applicant's Signature

 Date

 Governing Board Signature

 Date

 Approved? (YES or NO)



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Release of Information

By making application to the Specialty Surgery Center as an Allied Health Professional, I hereby authorize the 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:
 General Dentist**

Medical/Credentialing Director:

Please find my attached, completed, application for staff privileges as a General 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 Compliance Officer

 Date



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**Full Approval of Appointment for:
General 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 _____