



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

Re-Credentialing Application: General Dentist

Dear General Dentist,

Thank you for your continued interest in providing services at our facility. We have enjoyed participating in the care of your patients undergoing treatment at Specialty Surgery Center (SSC). In an effort to comply with State and Federal guidelines governing Ambulatory Surgery Centers, our Governing Board requires that all providers submit a re-credentialing application every two (2) years. Much of this application is an attestation and update of your Initial Application for Privileges. A copy of your Initial Application for Privileges can be provided upon request. In addition to the following application, you will need to submit the following documentation before your application is considered complete:

- _____ Updated copy of current Tennessee issued Professional License (Dental License)
- _____ Updated copy of current Professional Liability Insurance (Malpractice Insurance)
- _____ Updated copy of Loss History Report related to your Professional Liability Insurance
- _____ Copy of current BLS/CPR certification, ACLS &/or PALS (if applicable)
- _____ Copy of Current DEA (if applicable)
- _____ Updated list of facilities where you currently hold active privileges (if applicable)
- _____ \$100 Re-credentialing application fee

The re-credentialing process will begin upon receipt of your complete Re-Credentialing Application as well as the Re-Credentialing Application fee of \$100. This application should be submitted prior to expiration of your previously granted privileges. Once this application has been processed, privileges are again 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

**Re-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: Additional Education & Employment Information
(Attach current Curriculum Vitae)

Since submitting your Initial Application for Privileges have you completed additional training recognized by an Accrediting Body (ie ACGME, CODA)

YES NO

Training Program

Dates attended

To _____

Training Program

Dates attended

To _____

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

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 two years, please explain:

<p>Section V: Health Status & Personal/Professional Information (If you answer “yes” to the following questions, please explain on separate sheet of paper)</p>
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Since your initial appointment, or last reappointment to Specialty Surgery Center, have any of the following been, or are actions pending or are any in the process of being: denied, revoked, suspended, reduced, limited, placed on probation, modified, not renewed, voluntarily or involuntarily relinquished?

- | | | |
|--|-----|----|
| 1. State medical/dental license (any state) | YES | NO |
| 2. Any other professional registration | YES | NO |
| 3. DEA Registration | YES | NO |
| 4. Membership on Active Staff (any facility) | YES | NO |
| 5. Clinical Privileges (any facility) | YES | NO |
| 6. Rights on any Medical Staff | YES | NO |
| 7. Other institutional affiliations or status | YES | NO |
| 8. Professional society membership | YES | NO |
| 9. Fellowship/Board certification or eligibility | YES | NO |
| 10. Professional liability insurance (malpractice insurance) * | YES | NO |
| 11. Driver’s License | YES | NO |

**-Any liability claim information should include names, dates, parties, clinical Summary, of events, disposition, current status and/or settlement amounts.*

Since your initial appointment, or last re-appointment to Specialty Surgery Center:

- | | | |
|---|-----|----|
| 1. Have you been involved in any liability judgments, awards, or out of court settlements, or is any malpractice action currently pending? If “yes,” answer how many below, if “No”, skip to next question. | YES | NO |
| How Many in last two (2) years? _____ | | |
| 2. Have you been convicted of any crime, other than a minor traffic violation? | YES | NO |

Section VI: 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 VII: 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 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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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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**Full Approval of Re-Appointment for:
General Dentist**

(This Page Official Use Only)

Full Name (Printed)

Re-Appointment Begins

Re-Appointment Expires

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 _____