UNIVERSITY HOSPITALS AND HEALTH SYSTEM

2500 North State Street, Jackson MS 39216

PEDIATRIC DENTISTRY CLINICAL PRIVILEGES

Name: _____

☐ Initial Appointment
☐ Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: *4/3/2013.*

Applicant: Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in hospital and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR PEDIATRIC DENTISTRY

To be eligible to apply for core privileges in Pediatric Dentistry, the initial applicant must meet the following criteria:

Current certification in pediatric dentistry by the American Board of Pediatric Dentistry.

OR

Successful completion of an American Dental Association approved pediatric dentistry residency accredited by the Commission of Dental Accreditation or an approved foreign dental school and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to specialty certification in pediatric dentistry by the American Board of Pediatric Dentistry.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate the performance of a sufficient volume of pediatric dental inpatient, outpatient, emergency service, or consultative procedures, reflective of the scope of privileges requested, in the past 24 months or successful completion of specialty residency training in the past 12 months.

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Reappointment Requirements: To be eligible to renew core privileges in pediatric dentistry, the applicant must meet the following Maintenance of Privilege Criteria:

Current demonstrated competence and a sufficient volume of pediatric clinical dental procedures, with acceptable results, reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges. Medical Staff members whose board certificates in pediatric dentistry bear an expiration date shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

CORE PRIVILEGES

PEDIATRIC DENTISTRY CORE PRIVILEGES

☐ **Requested** Scope of practice includes primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence. Treatment also may be provided to patients beyond the age of majority who demonstrate physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment conditions that require specialized care. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. Includes the core privileges on the attached procedure list in concert with the following:

- Admissions, consultations, and dual management with physicians
- Diagnostic Services and Oral Medicine
- Preventive Procedures
- Restorative Dentistry and Oral Rehabilitation
- Management of the Developing Dentition and Occlusion/Orthodontic Procedures
- Trauma/Emergency Procedures
- Periodontal Procedures
- Endodontic Procedures
- Anesthesia and Pain Control
- Oral and Maxillofacial Surgery Procedures

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SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

If desired, Non-Core Privileges are requested individually in addition to requesting the Core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

USE OF LASER

☐ **Requested**

Criteria:

1) Completion of an acceptable laser safety course provided by the UMMC Laser Safety Officer
AND
2) Successful completion of an approved residency in a specialty or subspecialty which included training in lasers
OR
Successful completion of a hands-on CME course which included training in laser principles and observation and hands-on experience with lasers
OR
Evidence of sufficient volume of procedures performed utilizing lasers (with acceptable outcomes) within the past 24 months
AND
3) Practitioner agrees to limit practice to only the specific laser types for which they have documentation of training and/or experience

Maintenance of Privilege:

A practitioner must document that procedures have been performed over the past 24 months utilizing lasers (with acceptable outcomes) in order to maintain active privileges for laser use. In addition, completion of a laser safety refresher course provided by the Laser Safety Officer is required for maintenance of the privilege. Practitioner agrees to limit practice to only the specific laser types for which they have documentation of training and/or experience.

ADMINISTRATION OF SEDATION AND ANALGESIA

☐ **Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.

Section One--INITIAL REQUESTS ONLY:

☐ Completion of residency or fellowship in anesthesiology, emergency medicine or critical care **-OR-**

☐ Completion of residency or fellowship within the past year in a clinical subspecialty that provides training in procedural sedation training **-OR-**

☐ Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year (the estimate should include information about each type of procedure where

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Name: _____

sedation was administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

_____

_____

-OR-

☐ Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:

☐ Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**

Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

_____

_____

–AND-

☐ ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

–OR-

☐ Maintenance of board certification or eligibility in anesthesiology, emergency medicine, pediatric emergency medicine, cardiovascular disease, advanced heart failure and transplant cardiology, clinical cardiac electrophysiology, interventional cardiology, pediatric cardiology, critical care medicine, surgical critical care, neurocritical care or pediatric critical care, as well as active clinical practice in the provision of procedural sedation.

Section Three--PRIVILEGES FOR DEEP SEDATION:

☐ I am requesting privileges to administer/manage deep sedation as part of these procedural sedation privileges.
Deep Sedation/Anesthetic Agents used: _____

_____

APPLICABLE TO REQUESTS FOR DEEP SEDATION ONLY:
I have reviewed and approve the above requested privileges based on the provider's critical care, emergency medicine or anesthesia training and/or background.

_____ _____
Signature of Anesthesiology Chair Date

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CORE PROCEDURE LIST

To the applicant: If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, initial, and date.

- Inpatient and outpatient care including ward, operating room, and emergency department settings.
- Orofacial examination, oral and maxillofacial radiography, diagnosis and management of oral and perioral lesions and anomalies, treatment of common oral diseases, uncomplicated biopsies and adjunctive diagnostic tests (e.g., exfoliative cytology, microbial cultures, *mutans streptococcus* testing, other laboratory testing), caries risk assessment, assessment and documentation of oral/dental neglect/abuse
- Dental prophylaxis, dietary counseling, sealant application, fluoride therapies, mouthguards/occlusal guards, anticipatory guidance, tobacco cessation counseling.
- Comprehensive restorative care including fixed and removable prosthetic techniques for the primary, mixed, and permanent dentitions; cleft palate, maxillofacial, and speech prostheses; dental bleaching, micro abrasion, and esthetic, restorations
- Treatment of non-nutritive oral habits, space maintenance, space regaining, correction of dental crossbites and functional shifts, functional appliances, fixed appliance therapy, infant maxillary orthopedics, orthodontic treatment in conjunction with orthognathic surgery, occlusal adjustment.
- Evaluation, diagnosis, and treatment of trauma to the primary, mixed, and permanent dentitions (e.g., repositioning, replantation, and stabilization of intruded, extruded, luxated, and avulsed teeth; restoration of complicated and uncomplicated dental fractures), the pulpal, periodontal, and associated soft tissues, the dental alveolus, and orofacial soft tissues; treatment of infections of the maxillofacial region by surgical and medical therapy: thermal mouth burns.
- Gingival curettage, scaling, root planing, local or systemic chemotherapeutic therapy, dental splinting, frenectomy (including correction of ankyloglossia), gingivectomy, gingival grafts.
- Pulp capping, pulpotomy, pulpectomy and root filling of primary and permanent teeth; management of periradicular tissues.
- Local anesthesia of intraoral and perioral tissues; nitrous oxide/oxygen analgesia/anxiolysis; pain management by systemic chemotherapeutic agents.
- Extractions of erupted teeth, surgical exposure and/or removal of impacted or unerupted teeth, biopsy of lesions, incision and drainage, removal of minor cysts and foreign bodies.
- Order respiratory services
- Order rehab services
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Telehealth

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Name: _____

ACKNOWLEDGEMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at University Hospital and Health System University of Mississippi Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

☐ Recommend all requested privileges.
☐ Recommend privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

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_____

Division Chief Signature_____ ***Date***_____

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DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- ☐ Recommend all requested privileges.
- ☐ Recommend privileges with the following conditions/modifications:
- ☐ Do not recommend the following requested privileges:

Privilege	***Condition/Modification/Explanation***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

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_____

Department Chair Signature_____ ***Date***_____

Reviewed:

Revised:
2/3/2010, 6/2/2010, 10/5/2011, 11/2/2011, 12/16/2011, 1/4/2012, 11/07/2012, 4/3/2013