Regions Hospital
Delineation of Privileges
Dental Assistant

Applicant's Name:_____ _____

Last First M Date

Instructions: Applicants must provide complete names and addresses for their references. <u>Please DO NOT SEND letters of recommendation along with your application</u>. These must be primary source verified by Regions Hospital. If documentation of cases or procedures is required, please attach case and/or procedural logs to your privilege delineation.

☐ CORE I- General Privileges Dental Assistant

Privileges	Basic Education & Minimal Formal Training	Required Documentation and Experience
Privileges are granted to dental assistants who under the direction of a licensed dentist or oral surgeon are qualified to perform the following functions: <u>With Indirect Supervision</u> – (means that the dentist is in the office, authorizes the procedures and remains in the office while the procedures are being performed) – includes: • Etch appropriate enamel surfaces, apply and adjust pit and fissure sealants • Monitor a patient who has been induced by a dentist into nitrous oxide-oxygen relative analgesia (see procedural sedation policy) • Perform restorative procedures limited to placing, contouring, and adjusting amalgam restorations, glass ionomers, and supragingival composite restorations (class I & V), and adapting and cementing stainless steel crowns • Perform mechanical polishing to clinical crowns not including instrumentation. Removal of calculus by instrumentation must be done by the dentist or dental hygienist before mechanical polishing • Take radiographs • Remove excess cement from inlays, crowns, bridges and orthodontic appliances with hand instruments only *Continued next page*	Graduate from a dental assistant school accredited by the Commission on Accreditation **<u>OR</u>** successfully passed the certification examination offered by the Dental Assistant National Board **<u>AND</u>** Must pass the MN registration exam within 5-years of applying for licensure **<u>AND</u>** Must pass the MN jurisprudence exam within 5-years of applying for licensure.	**<u>New Applicants</u>:** Name and address of a dentist or oral surgeon who we may contact to attest to your competency to perform requested privileges. _____ _____ _____ _____ _____ _____ **<u>Reappointment Applicants</u>:** Evaluation of current competency conducted by a dentist or oral surgeon of your choice. Please indicate name and address of the individual whom we may contact. _____ _____ _____

• Apply topical medications that are physiologically reversible, topical fluoride, bleaching agents, and cavity varnishes all of which must be prescribed by dentists • Take impressions for casts and appropriate bite registration • Place and remove rubber dam • Pre-select orthodontic bands • Place and remove elastic orthodontic separators • Remove and replace ligature ties and arch wires on orthodontic appliances • Remove sutures • Place and remove periodontal packs • Dry root canals with paper points • Place cotton pellets and temporary restorative materials into endodontic openings		
With Direct Supervision – (means that the dentist is in the office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient, evaluates the performance of the dental assistant) • Remove excess bond material from orthodontic appliances with hand instruments • Remove excess bond material from teeth with rotary instruments after removal of orthodontic appliances • Administrates nitrous oxide inhalation analgesia pursuant to the rule provisions • Place and remove matrix bands • Fabricate, cement, and adjust temporary restorations extraorally or intraorally • Remove temporary restorations with hand instruments only • Etch appropriate enamel surfaces before bonding of orthodontic appliances by a dentist		

TO BE COMPLETED BY APPLICANT:

I agree to supply Regions Hospital Credentialing Office (or designee) with all of the information that has been requested of me for the privileges that I have applied for listed above. I also understand that my application for privileges will not proceed until which time that the information is received.

_____ _____

Signature Date

TO BE COMPLETED BY SPONSORING PHYSICIAN:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____

Sponsoring Physician (PRINT NAME)

_____ _____

Sponsoring physician signature Date

TO BE COMPLETED BY REGIONS HOSPITAL DIVISION/SECTION HEAD AT TIME OF REVIEW AND APPROVAL:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

_____ _____

Regions Division/Section Head Signature Date