

POLK MEDICAL CENTER  
*Medical Staff Privilege Checklist*

PEDIATRIC and GENERAL DENTISTRY PRIVILEGES

Pediatric Dentistry Training Requirements:

To be eligible for core privileges the pediatric dentistry, the applicant must meet the following qualifications:

1. Successful completion of an American Dental Association accredited school of dentistry with a DDS or DMD.
2. Successful completion of a post graduate residency program in Pediatric Dentistry accredited by the Commission on Dental Accreditation or its equivalent.
3. Attain Board Certification in Pediatric Dentistry by the American Board of Pediatric Dentistry no later than five (5) years after the date on which his residency training was completed or within two (2) years after first being granted clinical privileges, whichever comes later.
4. Documentation of the performance of at least 10 inpatient/outpatient procedures while in training in a hospital setting in the past two years, or the performance of at least 10 inpatient/outpatient procedures within the last two years while in practice.

**Core privileges defined:**

Privileges to co-admit, consult, evaluate, diagnose and provide diagnostic, preventive and therapeutic oral healthcare, including surgical care to **pediatric patients of all ages** - except as specifically excluded from practice and except for those special procedure privileges listed below, if applicable – to correct or treat various routine conditions of the oral cavity. Co- admission must be in conjunction with a staff Pediatrician with admitting privileges or a staff Family Medicine physician with admitting privileges in Pediatrics.

**Privileges requested in Pediatric Dentistry ( )                      Approved ( )**

General Dentistry Training Requirements

To be eligible for core privileges in general dentistry, the applicant must meet the following qualifications:

1. Successful completion of an American Dental Association accredited school of dentistry with a DDS or DMD.
2. Successful completion of an approved postgraduate program of at least one year accredited by the Commission on Dental Accreditation or its equivalent.
3. Documentation of the performance of at least 10 inpatient/outpatient procedures while in training in a hospital setting in the past two years, or the performance of at least 10 inpatient/outpatient procedures within the last two years while in practice.

**Core privileges defined:**

Privileges to co-admit, consult, evaluate, diagnose and provide diagnostic, preventive and therapeutic oral healthcare, including surgical care, **to patients age 18 and over** - except as specifically excluded from practice and except for those special procedure privileges listed below, if applicable – to correct or treat various routine conditions of the oral cavity. Co- admission must

be in conjunction with a staff general Internal Medicine or staff Family Medicine physician with admitting privileges.

**Privileges requested in General Dentistry ( )      Approved ( )**

**Acknowledgement of practitioner**

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform, and that I wish to exercise at Polk Medical Center, and I understand that:

1. 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.
2. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.
3. All members of the medical staff are required to treat patients, their families, hospital staff, and colleagues in a respectful and professional manner at all times. Each member of the medical is expected to comply with hospital and medical staff code of conduct policies. Failure to do so may be the basis for dismissal.

Applicant's Signature \_\_\_\_\_

Date: \_\_\_\_\_

APPROVED:

\_\_\_\_\_  
Credentials Committee Chairman

\_\_\_\_\_  
Date

**MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION**

\_\_\_\_\_ Concur with Credential Committee's recommendation and forward to governing body

\_\_\_\_\_ Return to Credential Committee for clarification of the following:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

**BOARD APPROVAL**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

\_\_\_\_\_  
Date