BP-A0603 **REQUEST FOR DENTAL PRIVILEGES** CDFRM
JUN 10

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

DENTIST'S NAME	INSTITUTION LOCATION	TYPE OF APPLICATION ___ INITIAL ___ RENEWAL

Privileges to practice dentistry in the Bureau of Prisons are requested by category in concurrence with level of training and experience. The capability of an institution to support requested procedures is also taken into consideration by the Chief Dental Officer and the BOP Governing Body. In all instances, procedures or treatments not specifically delineated are not precluded when:

1. The procedure or treatment is closely related to a delineated privilege of the provider.

2. The provider has training and current proficiency allowing reasonable competence for the procedure.

Dentists will be granted privileges on initial appointment and no less than every two years after initial appointment.

___ CATEGORY I

Practice is limited to General Dentistry and non-complicated procedures. The dentist will request consultation in the local community or at a BOP referral center for any complicated procedures and in all cases in which doubt exists as to the outcome of the procedure.

___ CATEGORY II

Dentists with these privileges are expected to have training/experience and competency commensurate with that provided by additional training and experience.

___ CATEGORY III

Dentists with these privileges are expected to have formal training and Board Certification in a recognized dental specialty and competency is at a level to perform complicated procedures and act as consultant to those dentists classified as Category 1 or Category 2.

LOCAL REPRODUCTION AUTHORIZED

DELINEATION OF DENTAL PRIVILEGES DESIRED

REHABILITATION OF DENTAL ARCHES	YES	NO
Operative Restorations		
Crown and Bridge Preparation		
Prosthetic Replacement of Teeth		
Endodontic Treatment of Teeth		
Periodontal Treatment of Teeth		
Minor Tooth Movement		

EXTRACTION OF TEETH	YES	NO
Routine, Uncomplicated Extractions (Single and Multiple)		
Surgical Removal of Non-Impacted Teeth		
Surgical Removal of Impacted Teeth		

INTRA-ORAL SURGERY	YES	NO
Alveolectomy		
Alveoloplasty		
Apicoectomy		
Biopsy, Incisional and Excisional		
Caldwell-luc Procedure		
Cleft Palate Repair		
Excision, Benign Tumor		
Excision, Malignant Tumor		
Excision, Minor Cyst		
Excision, Extensive Cyst		
Incision and Drainage		
Infection, Minor		
Infection, Major		
Laceration, Minor		
Laceration, Severe		
Mucosal/Gingival Flap Procedures		
Periodontal Surgery		
Ranula		
Salivary Gland Surgery		
Tongue Surgery		
Torus Mandibularis/Palatinus		

EXTRA-ORAL SURGERY	Yes	No
Excision, Minor Cyst		
Excision, Extensive Cyst		
Excision, Benign Tumor		
Excision, Malignant Tumor		

Incision and Drainage	☐	☐
Infection, Minor	☐	☐
Infection, Major	☐	☐
Laceration, Major	☐	☐
Lip Surgery	☐	☐
Traumatic	☐	☐
Congenital Defect	☐	☐
Pathological	☐	☐
Salivary Gland Surgery	☐	☐

FRACTURES OF FACIAL BONES	YES	NO
Mandible, Closed Reduction	☐	☐
Mandible, Open Reduction	☐	☐
Maxilla, Closed Reduction	☐	☐
Maxilla, Open Reduction	☐	☐
Zygoma, Closed Reduction	☐	☐
Zygoma, Open Reduction	☐	☐

OTHER	YES	NO
IV Sedation	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

List any other procedures with appropriate category you are requesting privileges to be granted.

INSTITUTION RECOMMENDATION

- ☐ Recommended for privileges as requested
- ☐ Recommended for privileges with attached modifications
- ☐ Recommendation deferred at this time

Chief, Dental Officer/Institution — Date

Clinical Director — Date

Warden/Governing Body Representative — Date

GOVERNING BODY DISPENSATION

- ☐ Privileges are granted for a term of two years
- ☐ Privileges granted with attached modifications
- ☐ Temporary privileges granted for _____ Days
- ☐ Privilege request deferred at this time
- ☐ Privilege request denied

Explanation for privilege deferment or denial:

Governing Body / Chief Dental Officer / BOP — Date

NOTE: The Chief Dental Officer, BOP, grants privileges for institution Chief Dental Officers who in turn grant privileges to staff dental officers and other dental staff who perform patient care.

Washington, DC 20534

AUTHORIZATION FOR RELEASE OF INFORMATION

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the medical staff. All information submitted by me in this application is true to my best knowledge and belief.

I hereby signify my willingness to authorize the BOP, its medical staff and their authorized contractor to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others (including past and present malpractice carriers) who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by the BOP, its medical staff and its representatives of all records and documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release from liability all representatives of the BOP and its medical staff for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I further hereby release from liability any and all individuals and organizations who provide information to the BOP or its medical staff, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by the BOP or its medical staff to other hospitals, medical associations and other interested persons on request regarding any information the BOP and the medical staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the BOP and its staff for so doing.

I understand and agree that I, as an applicant for medical staff membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I believe I am in good health with no physical or mental limitations that would adversely affect the execution of privileges I have requested or the performance of my clinical duties and responsibilities.

Signature of Applicant _____ Date _____

Social Security Number _____