

# Mountain States Health Alliance

## Carter County

**NAME:** \_\_\_\_\_

**Privileges for:** SSH - Dentistry

	<u>Request</u>	<u>Granted</u>
<b>GENERAL DENTISTRY</b>		
Operative Dentistry	_____	_____
Crown & bridge preparation	_____	_____
Prosthetic replacement of teeth	_____	_____
Extraction of erupted teeth	_____	_____
Alveoplasty	_____	_____
Apicoectomy with or without root canal therapy and/or retrograde	_____	_____
Conservative root canal therapy	_____	_____
Frenectomy	_____	_____
Odontectomy of impacted teeth	_____	_____
Incision and drainage of dental infection	_____	_____
Treatment of traumatic injuries to teeth and associated periodontal and alveolar structures	_____	_____
Gingivectomy-gingivoplasty	_____	_____
Surgical curettage	_____	_____
Simple intra-oral biopsy	_____	_____
<b>PERIODONTICS</b>		
Mucogingival surgery	_____	_____
Osseous surgery (including flap entry and closure)	_____	_____
Free gingival grafts	_____	_____
Pedical grafts	_____	_____
Osseous grafts (one or multiple sites) in conjunction with periodontal surgery	_____	_____
Root resections, hemisections in conjunction with periodontal surgery	_____	_____
<b>ENDODONTIC</b>		
Apicoectomy with or without root canal therapy and or retrograde	_____	_____
Conservative root canal therapy	_____	_____
Hemisection	_____	_____
Dental (tooth) implant (e.g., vitreous carbon).	_____	_____
<b>PERIODONTICS</b>		
Inpatient and outpatient treatment of children with concurrent health problems, developmental problems or lack of psycho-physiological maturity requiring general anesthesia in hospital setting.	_____	_____
Frenectomies	_____	_____
Simple extractions	_____	_____
Removal of impacted supernumerary teeth and/or mesiodens	_____	_____
Restoration of primary and permanent teeth including s.s. crowns	_____	_____
Treatment and extirpation of affected pulp tissue	_____	_____
Placement of space maintainers to preserve tooth position	_____	_____
Preventive parental counseling	_____	_____
<b>ORAL AND MAXILLOFACIAL SURGERY</b>		

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Dental pathology, trauma and/or abnormalities	_____	_____
Diseases of the oral mucosa membranes	_____	_____
Oral and maxillofacial infections and/or inflammations	_____	_____
Facial pain	_____	_____
Atrophic and hypertrophic conditions of oral tissues	_____	_____
Cysts and tumors and the oral and maxillofacial regions	_____	_____
Craniofacial deformities of the jaw (congenital, developmental and acquired)	_____	_____
Anomalies of the oral and maxillofacial region	_____	_____
Cleft lip and/or palate and secondary repair of alveolar clefts	_____	_____
Maxillofacial fractures and soft tissue trauma	_____	_____
Maxillary sinus disease of odontogenic origin	_____	_____
Salivary gland disorders	_____	_____
Temporomandibular joint disease	_____	_____

**Other:**

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Recommendation of Department Chair

I have reviewed the requested privileges and supporting documentation as required for the above applicant and, based upon documentation of experience and demonstrated current competence, I recommend the same as requested unless otherwise stated.

Signed: \_\_\_\_\_  
(Department Chair)

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

*Approved:*

**Credentials Comittee:** \_\_\_\_\_

**Medical Exective Committee:** \_\_\_\_\_

**Community Board:** \_\_\_\_\_

**Board of Directors:** \_\_\_\_\_