QUALIFICATIONS: To be eligible for core privileges in dentistry, the practitioner must meet the following qualifications:

BASIC EDUCATION: D.D.S. or D.M.D.

MINIMAL FORMAL TRAINING: Completion of an approved school of dentistry program and successful completion of a post-graduate program of at least one (1) year approved by the American Dental Association - or - Current certification or active participation in the examination process leading to certification by the relevant American Dental Board.

EXPERIENCE: Applicants for initial appointment must provide documentation of active practice or training during the previous two years.

REAPPOINTMENT REQUIREMENTS: Current demonstrated competence and an adequate volume of current experience (as specified in the ADMINISTRATION Medical Staff Credentialing Process) with acceptable results in the privileges requested for the past 24 months based on results of quality assessment/improvement activities and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

Note: If any privileges are covered by an exclusive contractual arrangement, physicians who are not party to the contract are not eligible to request the privilege(s) regardless of education, training and experience.

Requested CORE PRIVILEGES

Consultation, diagnosis, prevention and treatment of any injuries, diseases, or deformities of the teeth, jaw, and those related structures generally involved in trauma or in infection of dental origin. It includes oral diagnosis and operative (restorative) dentistry as well as oral surgery, oral pathology, orthodontics, pedodontics, periodontics, prosthodontics, and endodontics.

- Patients admitted for dental services shall be admitted by a member of the active medical staff, either the attending physician or family physician. Dental patients shall be the joint responsibility of the dentist and staff physician.

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 that I wish to exercise at Decatur County Memorial Hospital.

Signed: ________________________________ Date: ____________________

☐ Found qualified for privileges requested.

☐ Modifications recommended as follows: ________________________________

_________________________________________       __________________
Department Chair                              Date

Core Privilege Form Approved:

Department Committee       Date: 11-07-14
Medical Staff              Date: 02-20-15
Board of Trustees          Date: 02-26-15