وزارة الصحـــــة العامـــــة
Ministry of Public Health
State of Qatar • دولـــة قطـــر

Specialist Form: Pedodontics (Pediatric Dentistry)
Privilege Request

Applicant's Name: ……..…… Scope of Practice: …….

License No. (If Any): ……..…… Facility: ……..

Date: ……..……

Instructions

For applicant:

1. **Please note that you should sign next to each requested privilege.**
2. **Please use this sign (√) for the requested privilege.**
3. **Please leave any procedures you do not want to apply for blank and do not use (X) sign.**
4. **Please do not write additional privilege out of your scope of practice, as it will not be accepted.**
5. **Please do not write anything in the "for committee Use "section.**
6. **For additional privilege, do not choose the already granted privilege**
7. **Please attach the previous approval of the privilege when you apply for additional privilege.**
8. **Please note that you can apply for Appeal within one month of the date of Issuance of the Privilege.**
9. **You can only apply Once for Appeal per a single Privilege Application.**

For committee:

1. **Please note that the final decision must be signed by minimum 2 committee members.**
2. **Please use this sign (√) for recommended and not-recommended privilege.**
3. **Please specify the reasons for rejection (if applicable); for example (require experience, logbook is insufficient, need additional courses, etc.)**

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Privileges	For applicant use		For committee use		
	Request	*Signature*	*Recommended*	*Not Recommended*	*Reason for rejection (if any)*
1. Preventive Dental Care (Including Oral Hygiene, Injury Prevention, Dietary &Habit counseling)					
2. Behavior Management Techniques for Apprehensive Children (Including Voice Control, Non-verbal Communication, Tell-show-do, Positive Reinforcement, Distraction, Parental Presence /Absence, Hand Over Mouth & Physical Restraint)					
3. Aversive Behavioral Management (Including Digital & Non-nutritive Sucking Behavior, Tongue & Swallowing Habits)					
4. Management of Bruxism					
5. Pulpectomy					
6. Interceptive Orthodontic Treatment (Correction of Anterior & Posterior Cross Bite, Space Regainers, Maxillary Expansion with Removable Appliances)					
7. Serial Extraction					
8. Prosthodontic Procedures (Including Fabrication/ Insertion of Stainless Steel Crowns)					
9. Uncomplicated Extraction of Primary & Permanent Teeth, Full Management of All Types of Tooth Injuries (Traumas)					
10. Treatment of Medically Compromised Physically & Mentally Disables Children Under Local or General Anesthesia in Operating Room					

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Additional Privileges *(Specify if any)*:			

Note:

- You must submit along with this application all necessary document(s) to support your request. If documentation is incomplete, your request will not be accepted.
- By signing below, I acknowledge that I have read, understand, and agree to abide by DHP standards for privileging. I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and wish to exercise, and I understand that:

a) In exercising any clinical privileges granted, I am constrained by DHP's policies and rules applicable generally and any applicable to the particular situation.
b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the recognized policies and rules.

……. …….
Applicant's signature (Stamp if any) Date

……. ……
Medical Director (of the facility the applicant will perform surgeries in) Stamp & Signature Date

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Committee Decision:

Evaluation type:

By Interview ☐ virtual / personal

By documents only ☐

Or both ☐

Other comments:

……

Evaluation Committee Chairman:

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and I have made the above-noted recommendation(s).

…….. ……

Chairperson's Stamp & signature Date

Other Committee Members:

…….. ……

1) Name Date

…….. ……

2) Name Date

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PEDODONTIC CASE SUBMISSION GUIDELINES FOR SPECIALIST POST

1) All candidates are required to submit **6** cases on a USB drive.

2) All cases should be submitted officially through the Department of Healthcare Professions, Ministry of Public Health.

3) Without exception, excellent quality radiographs or digital images should be the standard.

4) Three of the submitted cases should be in operative dentistry including but not limited to fillings (occlusal and proximal fillings), crowns, nerve treatment (pulpotomies, pulpectomies etc) and extractions. **Each case should include full mouth treatment, should not be limited to a single tooth or a single quadrant**, **per patient** (i.e. each case should be full mouth treatment for single patient).

5) One case should involve the management of Dental trauma, either in the primary or permanent dentition.

6) The other two cases can be selected by the applicant himself/herself.

7) All cases should have complete documentation (copy of Patient's dental file) including the following:

a. Patient details
b. Medical & dental history
c. Pre-treatment radiographs
d. Diagnosis
e. Treatment plan
f. Post-treatment radiographs
g. Recall & follow-up radiographs