



Non-core Privilege Form: Prosthodontics Privilege Request (Dentist)

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.)



Privileges	For applicant use		For committee use		
	Request	Signature	Recommended	Not Recommended	Reason for rejection (if any)
1. Denture Rebasing					
2. Immediate Denture Fabrication/ Insertion					
3. Over Denture Fabrication /Insertion					
4. Ceramic veneer preparation/ fabrication					
5. Multiple Unit Fixed Prosthesis Construction(More than one quadrant at a time)					
6. Implant Supported Restoration (single)					
7. Implant Supported Restoration (Multiple)					
8. Precision Attachment Denture Fabrication/Insertion					
9. Full-Mouth Reconstruction with Alteration of Vertical Dimension					
10. Complete Occlusal Adjustment					



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.

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Applicant's signature (Stamp if any)

Date

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Medical Director (of the facility the applicant

Date

will perform surgeries in) Stamp & Signature



For Committee use only

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).

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Chairperson's Stamp & signature

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Date

Other Committee Members:

.....

1) Name

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Date

.....

2) Name

.....

Date

PEDODONTIC CASE SUBMISSION GUIDELINES FOR GENERAL ANESTHESIA



GUIDELINES FOR NON-CORE PROSTHODONTICS PRIVILEGES REQUEST

1. Request letter from the employer requesting this privilege or mentioning your experience in the given privilege.
2. Copy of work experience in the requested privilege if have.
3. Copy of bachelor's degree & postgraduate degree certificates.
4. Copy of training certificate/courses attended in the requested privilege.
5. Updated Curriculum - Vitae (C. V).
6. Personal declaration of dental privileges.
7. Treated case (for Prosthodontics privilege).

Presentation Guidance Scheme for Non-core Prosthodontics privileges.

Case documentation should include Clinical photographs and radiographs as the below guideline:

1. **Photographs:** before surgery, photo during and after healing.
2. **Radiograph:** before and after procedure X-ray.
3. **Formats:** PowerPoint presentation or Similar Program
4. **Number of Cases:** Should not be less than 3 completed cases