DELINEATION OF CLINICAL PRIVILEGES - DENTISTRY

For use of this form, see AR 40-68; the proponent agency is OTSG.

1. NAME OF PROVIDER	2. RANK/GRADE	3. AOC	4. PRIVILEGING PERIOD *(YYYYMMDD)* FROM TO

5. MEDICAL/FACILITY *(Name and Address: City/State/ZIP Code)*

6. DATE BOARD ELIGIBLE *(YYYYMMDD)*	7. BOARD EXAM TAKEN Total ☐ Partial ☐	8. DATE OF BOARD CERTIFICATION *(YYYYMMDD)*

INSTRUCTIONS

GENERAL: The scope of privileges for each AOC will be identified using procedure codes and definitions that are consistent with current nomenclature. Providers will be given a list of the procedures corresponding to the AOC for which they request privileges.

PROVIDER: Enter the appropriate provider code in the column marked "REQUESTED" of Section I indicating the dental AOC for which you are requesting privileges. Requests for additional privileges may be entered in the remarks section or by separate attachment. Documents verifying training and competency may be required for additional privileges and/or those that require special certification.

ADMINISTRATIVE SUPERVISOR: This individual is normally the Officer in Charge (OIC) of the primary facility to which the provider will be assigned, or the OIC's designee. Review the requested privileges and complete Section II. This serves as a recommendation to the Credentials Committee and the commander who is the approval authority.

CREDENTIALS COMMITTEE CHAIRPERSON: Review the requested privileges and complete Section III. This serves as the Credentials Committee's recommendation to the commander who is the approval authority.

PROVIDER CODES

1 - Fully competent to perform
2 - Modification requested *(Justification attached)*
3 - Supervision requested
4 - Not requested

SECTION I - CLINICAL PRIVILEGE

Requested		Requested	
	General Dentistry (63A)		Dental Public Health (63H)
	Comprehensive Dentistry (63B)		Pediatric Dentistry (63K)
	Periodontics (63D)		Orthodontics (63M)
	Endodontics (63E)		Oral & Maxillofacial Surgery (63N)
	Prosthodontics (63F)		Oral Pathology (63P)

REMARKS *(Use attachment if necessary.)*

SIGNATURE OF PROVIDER	DATE *(YYYYMMDD)*

SECTION II - ADMINISTRATIVE SUPERVISOR RECOMMENDATION

	Approve as requested		Clinical supervision required *(Justify below)*
	Approve with Modification *(Specify below)*		Disapprove *(Justify below)*

REMARKS *(Use attachment if necessary.)*

SUPERVISOR *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*

SECTION III - CREDENTIALS COMMITTEE/FUNCTION RECOMMENDATION

	Approve as requested		Clinical supervision required *(Justify below)*
	Approve with Modification *(Specify below)*		Disapprove *(Justify below)*

REMARKS *(Use attachment if necessary.)*

COMMITTEE CHAIRPERSON *(Name and rank)*	SIGNATURE	DATE *(YYYYMMDD)*