



**University of Michigan
Hospitals and Health Centers**

**Delineation of Privileges
Department of Hospital Dentistry**

Name: _____
Please print or type

LEVEL I CORE PRIVILEGES (All Dental – General and Specialty)

Minimum Training and Experience

All New and Current Faculty: DDS or DMD, or equivalent. Completion of an ADA-accredited program in dentistry or foreign equivalent. Continued experience is documented by having participated in the care of a minimum of 10 patient cases within the previous privileging period.

Scope of Privileges

Examine, consult, diagnose, and provide preventive and therapeutic oral healthcare to patients of all ages

Intraoral and extraoral radiology and imaging, includes exposing and interpreting

Local anesthesia, pain and anxiety control utilizing behavioral and pharmacological techniques, including use of nitrous oxide

Palliative dental treatment

Splinting of mobile teeth, temporary

- Requested (Applicant)** **Not Requested (Applicant)**
 Recommended approval (Service Chief/Chair)

LEVEL II PRIVILEGES General Dentistry Core Privileges (Specialists may choose these privileges but are not required to do so.)

Minimum Training and Experience

All Faculty: All must be Dental School graduates; Level I minimum training and experience.

New Faculty: Successful completion of 1a, b, c, or d: **AND 2**

1a. Successful completion of an American Dental Association (ADA) approved hospital-based GPR program or foreign equivalent and a letter of reference from the institution at which the applicant trained documenting successful completion of the program or a copy of certification indicating successful completion of the program.

1b. Successful completion of a hospital-based postgraduate dentistry training program, at least one

year in duration, and a letter of reference from the institution at which the applicant trained documenting successful completion of the program or a copy of certification indicating successful completion of the program.

- 1c. A minimum of 5 years of experience in general dental practice.
- 1d. Certification by the American board of a dentistry specialty program, or on track for Board Certification
- 2. A minimum of one-year experience in a hospital dentistry program and a letter of reference from the applicant's most recent service chief documenting hospital dentistry experience.

Current Faculty: Continued experience is documented by having participated in the care of a minimum of 5 patient cases within the previous privileging period.

Scope of Practice/Privileges

General dental and oral surgical care of medically, physically, and behaviorally compromised patients, includes:

Operative Dentistry

- Direct fillings with amalgam, composite resin, or other approved material
- Bonded or Cemented restorations fabricated in a laboratory
- Bleaching or other esthetic procedures

Fixed and Removable Prosthodontics

- Cemented or bonded crowns and bridges
- Complete and partial dentures

Endodontic therapy, nonsurgical

General periodontics

- Scaling and root planning
- Gingivectomy/gingivoplasty

Geriatric dentistry

Oral Surgery

- Erupted teeth, removal of
- Root recovery
- Alveoloplasty
- Minor pre-prosthetic surgery, soft and hard tissue
- Soft tissue intraoral biopsy (less than 1 cm)
- Emergency oral & maxillofacial care

Minor tooth movement with removable appliances

Fabrication of oral appliances for management of temporomandibular joint disorder or myofascial pain

Fabrication of oral appliances for management of sleep disordered breathing including snoring and sleep apnea

Oral pathology and oral medicine

Pediatric dentistry

Emergency treatment of infected teeth

Emergency treatment of traumatized teeth

Requested (Applicant) **Not Requested (Applicant)**

Recommended approval (Service Chief/Chair)

LEVEL III Advanced/Specialty Procedures

Based on either advanced training, or education and experience above and beyond that obtained in dental school.

Evidence would include any of the following:

Advanced training: Certificate of completion of a n advanced program or specialty program in the relevant area

Continuing education: Certificate of completion of a continuing education program in the relevant subject area. Would require direct observation before approval

Experience: Documentation of experience in the relevant subject area, to include records of three patients with identifiable information removed. Would require direct observation before approval.

Scope of Services/Privileges

Advanced endodontics including re-treatment apicoectomy, apexification, apexogenesis, and treatment of calcified canals.

Requested (Applicant) Not Requested (Applicant) Recommended approval

Advanced implant prosthodontics for fixed and/or removable implant-borne prostheses

Requested (Applicant) Not Requested (Applicant) Recommended approval

Advanced periodontics including flap surgery, bone and/or mucocutaneous grafts/surgery, and guided tissue regeneration

Requested (Applicant) Not Requested (Applicant) Recommended approval

Advanced orthodontics for dentoalveolar, orthognathic, or congenital/acquired craniofacial anomalies, including use of fixed appliances

Requested (Applicant) Not Requested (Applicant) Recommended approval

Advanced prosthodontics for oral and/or maxillofacial prostheses for malformations of face, jaws, and mouth

Requested (Applicant) Not Requested (Applicant) Recommended approval

Impacted teeth, removal of

Requested (Applicant) Not Requested (Applicant) Recommended approval

Implant surgery, dental

Requested (Applicant) Not Requested (Applicant) Recommended approval

Advanced intraoral surgical treatment of infection, abscess, hematoma, or cyst, including biopsy of hard tissue and soft tissue greater than 1 cm.

Requested (Applicant) Not Requested (Applicant) Recommended approval

Full mouth restorative and surgical rehabilitation under general anesthesia.

Requested (Applicant) Not Requested (Applicant) Recommended approval

SPECIAL PRIVILEGES

A separate application is required to APPLY or REAPPLY for the following Special Privileges:
▶ FLUOROSCOPY

- ▶ LASER
- ▶ ROBOTIC SURGICAL PLATFORM
- ▶ SEDATION PRIVILEGES FOR A NON-ANESTHESIOLOGIST

PLEASE go to URL: www.med.umich.edu/i/oca for instructions, or contact your Clinical Department Representative.

TO BE COMPLETED BY APPLICANT:

I meet the previously stated criteria and request that my application be considered for the privileges as outlined above. I authorize and release from liability, any hospital, licensing board, certification board, individual or institution who in good faith and without malice, provides necessary information for the verification of my professional credentials for membership to the Medical Staff of The University of Michigan Health System.

Applicant Signature: _____ Date: _____

DEPARTMENT ACTION

Approval: _____ As Requested _____ As Modified

Explain any modifications:

I have reviewed and/or discussed the privileges requested and find them to be commensurate with his/her training and experience, and recommend that his/her application proceed.

Justification for approval is based on careful review of the applicant's education, postgraduate clinical training, demonstrated clinical proficiency and Board Certification or qualifications to sit for the Boards.

Department Chair: _____ Date: _____

Service Chief: _____ Date: _____

CREDENTIALS COMMITTEE ACTION

Approval: _____ As Requested _____ As Modified

Explanation for any modification:

EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS ACTION

Approval: _____ As Requested _____ As Modified.

Explanation for any modification:
