Name of Applicant: _____

(*Completed by the* Applicant) (*Completed by* Dental Director)

CORE PRIVILEGES FOR PEDIATRIC DENTISTS					
PRIVILEGE	**REQUESTED**	**NOT REQUESTED**	**APPROVED**	**DENIED**	**REMARKS**
Diagnostic services and oral medicine including, clinical examination and caries risk assessment, oral and maxillofacial radiography, diagnosis and management of oral and perioral lesions and anomalies	☐	☐	☐	☐	
Uncomplicated biopsies and adjunctive diagnostic tests	☐	☐	☐	☐	
Dental prophylaxis, dietary counseling, sealant application, fluoride therapies	☐	☐	☐	☐	
Comprehensive Restorative dentistry and oral rehabilitation for the primary, mixed, and permanent dentitions	☐	☐	☐	☐	
Management of the developing dentition - space maintenance/regaining, correction of dental crossbites and functional shifts	☐	☐	☐	☐	
Diagnosis and treatment of trauma to the primary, mixed, and permanent dentitions e.g., repositioning, replantation, and stabilization of intruded, extruded, luxated, and avulsed teeth	☐	☐	☐	☐	
Management of minor infections of the maxillofacial region by surgical or medical therapy	☐	☐	☐	☐	
Periodontal procedures. Gingival curettage, scaling, root planning	☐	☐	☐	☐	
Pulp capping, pulpotomy, pulpectomy and root filling of primary and permanent teeth	☐	☐	☐	☐	
Extractions of erupted teeth, incision and drainage	☐	☐	☐	☐	
Assessment and documentation of oral/dental neglect/abuse	☐	☐	☐	☐	
Provide out of our care to patients that they treat in the Facility	☐	☐	☐	☐	
Additional or special procedures – to be added	☐	☐	☐	☐	
Nomad – X-Ray	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

I realize that certification by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have checked above.

_____ _____

Applicant's Signature Date