CHAPA-DE INDIAN HEALTH PROGRAM, INC.

Credentialing Requirements

The following items required for credentialing purposes. Return these items to Human Resources as soon as possible.

Statement of Understanding and Release (attached) _____

Request for Clinical Privileges (attached) _____

Adverse Action/Liability Claims Questionnaire (attached) _____

Financial Conflict of Interest Disclosure (attached) _____

Chapa-De Employment Application (attached) _____

Curriculum Vitae _____

Copy of Diploma from dental school _____

Copy of internship and residency certificates (if applicable) _____

Copy of current Dental License _____

Copy of Controlled Substance License (if applicable) _____

CPR Certification _____

Confidentiality form (attached) _____

Names and addresses of: (use attached sheet) _____
Dental School
Professional references (3)

Other:_____

_____

_____

DENTAL PRIVILEGES REQUEST FORM

DOCTORS OF DENTISTRY

NAME OF APPLICANT:_____DATE:_____

INTRODUCTION: The request for privileges must reflect the applicant, staff and the facility's ability to carry out or support the various functions. Request for privileges indicated with the ** must be accompanied by documentation of applicant's ability to perform that specific procedure (i.e. internship, residency, certificate or hands-on training).

INTSTRUCTIONS FOR COMPLETING THE FORM

Indicate by circling the letter in the appropriate column under the heading "Requested by Applicant" your decision to NOT request privileges, request LIMITED WITH SUPERVISION privileges, request LIMITED WITH CONSULTATION, or request FULL privileges to perform each specific dental procedure.

DEFINITIONS

F=FULL privilege. The applicant is entitled to function independently in this area, following community standards of care.

LC=LIMITED WITH CONSULTATION privileges. The applicant may function independently in this area after obtaining consultation from an appropriately trained specialist.

LS=LIMITED WITH SUPERVISION privileges. The applicant may function in this area only under the direct supervision of a provider holding FULL privileges.

N=Privileges NOT requested. The applicant is not privileged in this area.

Please circle the appropriate letter
F=FULL LC=LIMITED WITH CONSULTATION LS=LIMITED WITH SUPERVISION N=NOT

	APPLICANT REQUESTED	SUPERVISOR RECOMMENDATION
1) DIAGNOSTIC		
a) Oral examinations	**F LC LS N**	**F LC LS N**
b) Intraoral radiographs	**F LC LS N**	**F LC LS N**
c) Panoramic maxilla and mandible film	**F LC LS N**	**F LC LS N**
d) Pulp vitality tests	**F LC LS N**	**F LC LS N**
e) Diagnostic casts	**F LC LS N**	**F LC LS N**
f) Other (specify)	**F LC LS N**	**F LC LS N**

NAME: _____ DATE: _____

F=FULL LC=LIMITED WITH CONSULTATION LS=LIMITED WITH SUPERVISION N=NOT

	APPLICANT REQUESTED				SUPERVISOR RECOMMENDATION			
2) PREVENTIVE								
a) Oral prophylaxis	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Topical and systemic fluoride	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Oral hygiene instruction	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Sealants	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Space Maintenance	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
3) RESTORATIVE								
a) Operative restorations	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Full crowns	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Stainless steel crowns	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Sedative temporary filling	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Crown buildups	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Labial veneers	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
4) ENDODONTIC PROCEDURES								
a) Vital pulpotomy	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Pulpectomy/endo fill-primary tooth	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Anterior root canal therapy	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Bicuspid and molar root canal therapy	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Apexification	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Root resection**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Bleaching of discolored tooth	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
h) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
5) PERIOODONTIC PROCEDURES								
a) Periodontal exam (case workup)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Gingivectomy/Gingivoplasty	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Mucogingival surgery**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Osseous surgery**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Osseous graft**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Soft tissue grafts**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Provisional splinting	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
h) Root planing and curettage	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
i) Periodontal maintenance	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
j) Special periodontal appliances (occlusal guard)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
k) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
6) REMOVABLE PROSTHODONTICS								
a) Complete denture	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Immediate denture	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Removable partial denture	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Repairs to dentures	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Rebase/reline	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Tissue conditioning	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Overdentures	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
h) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**

NAME: _____ DATE: _____

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	APPLICANT REQUESTED				SUPERVISOR RECOMMENDATION			
7) FIXED PROSTHODONTICS								
a) Conventional cast fixed bridges	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Resin retained acid etched bridge	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Recement/repair fixed prosthetics	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Implant prostheses**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
8) ORAL SURGERY								
a) Routine tooth extraction	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Surgical extraction of erupted tooth	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Surgical extraction – tissue impaction **	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Surgical extraction – boney impaction**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Surgical extraction – sectioning of tooth**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Removal of residual roots, unexposed	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Closure of oral antral fistula**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
h) Reimplant/stabilize avulsed teeth	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
i) Surgical exposure of tooth**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
j) Biopsy of oral tissue (hard)**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
k) Biopsy of oral tissue (soft)**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
l) Alveoloplasty	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
m) Vestibuloplasty	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
n) Surgical excision of benign lesions (small)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
o) Surgical excision of benign lesions (large)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
p) Removal of destruction of small cysts	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
q) Removal of exostosis-maxilla or mandible**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
r) Incision and drainage of abscess–intraoral	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
s) Incision and drainage of abscess–extraoral**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
t) Removal of foreign/foreign reactive body**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
u) Suturing of traumatic wounds (intraoral)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
v) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
9) ORTHODONTICS								
a) Tooth guidance with removable appliances**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Minor tooth movement with fixed appliances**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Interceptive orthodontics fixed/removable appliances**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Serial extraction case management**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Habit control/functional appliances**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Comprehensive orthodontic procedures**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
10) ADJUNCTIVE SERVICES								
a) Oral premedication	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
b) Application of desensitizing medicaments	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
c) Prescriptions for drugs	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
d) Occlusal adjustment (limited)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
e) Oral sedation **	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
f) Therapeutic drug injection**	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
g) Administration of oral local anesthetic	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**
h) Other (specify)	**F**	**LC**	**LS**	**N**	**F**	**LC**	**LS**	**N**

I have not requested privileges for any procedures for which I am not qualified to perform. Furthermore, I realize that certification by a bond does not necessarily qualify me to perform certain procedures, and supervision/proctoring may be required.

_____	_____	_____
Name Typed or Printed	Signature of Applicant	Date

Privileges Recommendation:

☐ Recommend approval as indicated.

☐ Recommend approval with modification (Specify below)

☐ Recommend Disapproval (Specify below)

Specifications (if any):_____

_____

_____	_____
Dental Director/Dentist	Date
_____	_____
Chief Executive Officer	Date
_____	_____
Chairperson, Board of Directors	Date

STATEMENT OF UNDERSTANDING AND RELEASE

By receiving appointment to the Dental staff, I signify my willingness to appear for interviews in regard to my appointment and authorize Chapa–De Indian Health Program representatives to consult with administrators and members of Dental staffs of other institutions with which I have been associated and with others, including past and present Insurance carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the disclosure to this facility's professional staff and/or representatives of all personnel, professional and personal medical records and documents, including alcohol and drug abuse records at other institutions, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualification for staff membership. I further consent to the disclosure, by authorized Chapa–De representatives, of records of my professional service with Chapa–De relating to my personal character and professional qualifications and competence to carry out the clinical privileges granted to me by Chapa–De, to any subsequent practitioner(s), facility, state or country medical society or licensing board to whom or to which I may apply to clinical privileges, membership, or licensure. This may include information regarding drug and alcohol abuse or dependency.

I fully understand that a false statement, or the misrepresentation of information otherwise provided, may constitute cause for revocation of dental staff appointment and/or clinical privileges, and may be punishable by fine or imprisonment (U.S. Code, Title 18, and Section 1001).

I certify that the statement/documents I have provided for this appointment are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

I hereby release from liability all representatives of Chapa–De Indian Health Program for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character and other qualifications for the medical staff and any applicable clinical privileges.

I agree to abide by the bylaws, rules and regulations of the dental staff.

_____ _____

Signature Date

_____

Print Name

Chapa-De Indian Health Program, Inc.
Financial Conflict of Interest Disclosure

Name:_____ Department: Dental

Reporting Period:_____ Date:_____

1. Are you directly or indirectly involved in placing Chapa-De business with any person or entity in which you or your immediate family has a significant financial interest?
   - ☐ No
   - ☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

2. Have you accepted any gifts related to your position at Chapa-De from outside institutions, companies or individuals?
   - ☐ No
   - ☐ Yes (please explain) _____

   _____

3. Have you accepted or arranged for a gift or contribution from an outside entity in return for facilitation a business relationship with Chapa-De?
   - ☐ No
   - ☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

4. Do you have a significant financial interest in any entity that engages in a business relationship with Chapa-De?

☐ No

☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

5. Do you have any significant financial interest in any health care provider and/or entity to which Chapa-De health care practitioners refer patients?

☐ No

☐ Yes If yes, please provide the following:

Name of Business/Person/Entity _____ General Description of Business Activity _____

_____

Signature

CHAPA-DE INDIAN HEALTH PROGRAM, INC.

ADVERSE ACTION/LIABILITY CLAIMS QUESTIONNAIRE

Clinician Name: _____

1. **Have liability claims been filed against you, or against a hospital, other health care entity, corporation, or government, based on a case under your care?**
   Yes: _____ No: _____

2. **Have judgments or settlements been made involving you or against a hospital, corporation, or government based on a case under your care?**
   Yes: _ No: _____

3. **Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused for renewal?**
   Yes: _ No: _

4. **Has your professional license (certification or registration) to practice in any jurisdiction ever been limited, placed in probationary status, restricted, suspended, denied, revoked, voluntarily surrendered, or not renewed?**
   Yes: _ No: _

5. **Have you ever been censured or reprimanded by a licensing (certifying, etc) board, hospital medical staff, professional society, or other professional organization?**
   Yes: _ No: _

6. **Have any or all of your privileges at any health care facility ever been or are about to be limited, reduced, suspended, revoked, voluntarily surrendered in the course of an investigation, or not renewed? Have you resigned from a medical staff because of concern that your privileges might have been limited, suspended, or revoked? Have any other professional disciplinary actions been taken against you?**
   Yes: _ No: _

7. **Has your narcotics registration, federal or state, ever been denied, limited, suspended, voluntarily surrendered, not renewed, or revoked?**
   Yes: _ No: _

8. **Have you ever been denied membership, or renewal thereof, or been subject to disciplinary action in any professional society or organization?**
   Yes: _ No: _

9. **Have any civil or criminal charges ever been filed against you or are you under an investigation that might lead to such charges?**
   Yes: _ No: _

LIABILITY CLAIMS/ADVERSE ACTION QUESTIONNAIRE- page 2

10. Have you ever been sanctioned by Medicare or a Medicaid program, or by any other Federal agency?
Yes: _ No: _

11. Are you currently involved in or have knowledge of a pending investigation, review, or surveillance of your professional practice or conduct that could result in an adverse action concerning your ability to bill and collect from Medicare or Medicaid programs; your narcotics registration; your professional license registration or certification; or your medical staff membership or privileges?
Yes: _ No: _

Explain affirmative responses in detail:

_____

_____

_____

_____

_____

_____

_____

I agree to abide by all lawful standards, policies, and rules of Chapa-De Indian Health Program, Indian Health Service, and the Department of Health and Human Services as they apply to my responsibilities and practice as a member of this medical staff. I pledge to maintain an ethical practice and to provide for the continuous care of all my patients. I further agree to immediately disclose to the medical staff and/or administration more detailed information related to all "yes" responses if asked to do so. In addition, I agree to immediately report to the Clinical Administrator any new information concerning a "yes" response or concerning a response that becomes "yes" after filling out this questionnaire, either while medical staff privileges are pending or after they have been granted.

_____

Signature **Date**

CHAPA-DE INDIAN HEALTH PROGRAM, INC.

EMPLOYEE CONFIDENTIALITY

Each employee is responsible for safeguarding confidential information obtained in connection with his or her employment. In the course of your work, you may have access to confidential information regarding the company, its suppliers, its clients/patients or even fellow employees. It is your responsibility not to reveal or divulge any such information unless it is necessary for you to do so in the performance of your duties. Access to confidential information is on a "need to know" basis and must be authorized by your supervisor. Any breach of this policy will not be tolerated and corrective action will be taken.

Do not discuss the client/patient or any information regarding the client/patient with:

- Fellow workers/Board members (unless they are directly involved with caring for that client/patient)
- Another client/patient
- Concerned friends or visitors
- Client/patient relatives
- Any member of the news media
- Any member of your family
- Any person in the community

I understand and agree that in the performance of my duties as an employee of Chapa-De Indian Health Program, I must hold client/patient/employee information in confidence. I understand that any violation of the confidentiality of information may result in immediate termination.

_____ _____

Employee (Signature) Supervisor/Human Resources

_____

Print Name

_____

Date