UNIVERSITY OF MICHIGAN
SCHOOL OF DENTISTRY

Office of Patient Services (02/03/15)

MEMORANDUM

TO: Dental Postgraduate Students requesting clinic privileges.

FROM: Stephen J. Stefanac, DDS, MS
Associate Dean, Patient Services

SUBJECT: Credentials Program at the School of Dentistry

Students participating in Dental Postgraduate programs that involve patients at the School of Dentistry are required to complete the attached credentialing forms to facilitate risk management and to maintain accurate and complete records for compliance purposes. The Department Chair and the Dean for Patient Services will approve what procedures may be performed for patients.

THIS FORM SHOULD NOT BE USED FOR GRADUATE STUDENTS

Please include copies of the following with this completed form:

- Letter from the Department Chair to the Associate Dean for Patient Services outlining the length and content of the postgraduate experience and the level of supervision that will be provided to the candidate during patient care. The Chair should also indicate a full-time faculty member who can be contacted if questions arise.
- A current curriculum vita and photograph.
- A certified copy of transcripts, in English, for all professional education.
- Current (< 2 years old) TOEFL scores for writing and speaking if English is a second language. A request for a waiver of this requirement can be discussed in the Chair's letter.
- Copy of U.S. visa application (if applicable).
- Proof of Basic Cardiac Life Support training
- Verification of hepatitis B immunization.
- Verification of a tuberculin skin test within the past year.
- Completed privileges form.

<u>If applicable</u>, include copies of your current:

- Michigan Dental License
- Michigan Specialty Certificate
- Federal DEA (Controlled Substance) License
- Michigan DEA (Controlled Substance) License

You must have a National Provider Identifier (NPI) number if you will be signing prescriptions. If you do not have a NPI number please go to the following website to apply. NOTE: You must have a U.S. Social Security Number to apply.

https://intranet.dent.umich.edu/patientservices/NPI.html

All credentialing information is held in the strictest confidence and is monitored on a periodic basis. When your applicable credentials approach their expiration date you will be notified to send a copy of your renewed credentials to your department administrator, who will then inform the Office of Patient Services. Failure to renew your license and credentials in a timely fashion will result in loss of practice/clinical privileges which may make it impossible for you to complete your program.

Complete the attached forms; attach copies of the appropriate documents, and return to your department's administrator.

The University of Michigan
School of Dentistry
Dental Postgraduate Student Credentials Form

PREAMBLE

The faculty, staff, and students of the School of Dentistry are responsible for the quality of care rendered to patients. Standard of care is a reflection of professional competence and goals established to obtain optimal dental health. Several criteria are accepted as evidence of competence, including those required by State laws and those established by the School of Dentistry. The criteria include education, licensure, experience, certification, service, appointments and health of the applicant. All dentists and associated health professionals who are actively engaged in the treatment of, or who are responsible for supervising the treatment of patients in teaching clinics, in clinical research or various kinds of service clinics, are required to furnish the School of Dentistry with the credentials information requested. Competence must correspond to the health service provided.

Name in full: _____
Last First Middle

Anticipated date of program completion: _____

Predoctoral Education: Dental School _____

Degree _____ Date of graduation _____

Graduate Dental Education: 1. School _____

Degree _____ Field _____ Date _____

Certificate _____ Date _____

2. School _____

Degree _____ Field _____ Date _____

Certificate _____ Date _____

Prior Teaching Appointment: _____ Date _____
Rank/Title

Prior Teaching Appointment: _____ Date _____
Rank/Title

Private Practice Experience:

Practice Name	Address	Inclusive Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Hospital Appointments:

Hospital	Address	Inclusive Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Military Dentist Experience: _____ Inclusive Dates: _____

Licensure: (If applicable, please attach copies)

Michigan Dentist Lisc. # _____ Issue Date _____ Exp. Date _____

Michigan Specialty Lisc. # _____ Issue Date _____ Exp. Date _____

MI Controlled Substance Lisc. # _____ Issue Date _____ Exp. Date _____

National Practitioner Identifier (NPI) _____

Federal DEA License # _____ Expiration Date _____

Additional Information:

Basic Life Support (BLS) Certification: Expiration Date _____

Advanced Cardiac Life Support (ACLS) Certification: Expiration Date _____

Hepatitis B Date of Inoculation _____

Last Tuberculin Skin Test Date _____

If the answer to any of the following questions is Yes, please give full details below.

Has your license to practice dentistry in any jurisdiction or your DEA license ever been limited, suspended or revoked? _____ Yes _____ No

Have your privileges at any practice or teaching site ever been suspended, diminished, revoked, or not renewed? _____ Yes _____ No

Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any organization of dentistry? _____ Yes _____ No

Has a malpractice notice of intent or case even been filed against you? _____Yes _____No
(If yes please provide details)

Has a malpractice judgment been made against you or settled out of court, or is a malpractice claim pending? (If yes please provide details) _____Yes _____ No

Have you been the subject of any completed or ongoing peer review investigations?
_____ Yes _____ No

Do you have any significant physical, mental, or medical problems which could interfere with your ability to perform duties for which you are appointed? _____ Yes _____ No

Do you have any contagious or communicable disease which will endanger others?
_____ Yes _____ No

Explain any "Yes" answers below:

Carefully read below, and sign

Should there, during my training, be reasonable cause to believe that I am unable to discharge my clinical and educational responsibilities due to a mental, physical, alcohol or other drug problem, I understand that I may be required to undergo medical and/or psychiatric evaluation and that during evaluation and treatment I may not be able to treat patients or teach students at the School of Dentistry.

I fully understand that any misstatements or purposeful omissions from this application; or failure to maintain my credentials will affect my ability to treat patients and could lead to my dismissal from my program. The School will require that I obtain information and demonstrate competency regarding patient privacy, infection control, risk management or other topics to maintain my credentials.

I authorize the Dean of the School of Dentistry, or his designate, to consult with references that I provide in support of my credentials or with others who may have information bearing on my competence, character or ethical qualifications.

I agree to provide for continuous quality care and supervision of patients, and to report to the Office of Patient Services any change in my health status that would affect my ability to practice dentistry.

Signature – Applicant _____ Date _____

Program Director _____ Date:_____

Department Chair _____ Date _____

Associate Dean for Patient Services _____Date _____

THE OFFICE OF PATIENT SERVICES MUST BE INFORMED OF ANY CHANGE IN THE INFORMATION SUBMITTED OR IN THE STATUS OF THE APPLICANT WITHIN 30 DAYS.

Request for Privileges

Privileges	**Requested** *(Program Director's Initials)*	**Approval** *(Associate Dean for Patient Services Initials)*
Patient examination		
Interpret cone beam CT		
Direct restoration (amalgam, resin, etc)		
Indirect restorations (crowns, onlay, etc)		
Implant restoration		
Endodontic therapy		
Non-surgical periodontal therapy		
Surgical periodontal therapy (not implant related)		
Placement of implants		
Implant related surgery – (bone grafting, sinus lift, etc.)		
Removable prosthodontics		
Fixed prosthodontics		
Erupted tooth extraction		
Surgical tooth extraction		
Conscious sedation		
Soft tissue surgery including biopsy		
Hard tissue surgery including biopsy		
Orthodontic tooth movement		

UNIVERSITY OF MICHIGAN
School of Dentistry

Hepatitis B Virus Vaccine Information Sheet and Consent Form

_____ _____ _____ _____
Name *Faculty* *Staff* *Date*

The following information describes the risk of acquiring hepatitis B and the side effects of the vaccine.

Hepatitis B:
Hepatitis B virus causes a systemic infection with major effect on the liver. Symptoms may include nausea, loss of appetite, fatigue and weakness. Some persons may develop chronic hepatitis, liver cancer or die of the acute illness. Transmission is by exposure to blood or blood-contaminated body fluids of an infected person through breaks in the skin or mucous membrane surfaces of a non-immune person. The incubation period ranges from 40-180 days.

Immunization:
Hepatitis B vaccine is a non-infectious, sub-unit viral vaccine produced by recombinant DNA techniques. One cannot develop hepatitis, AIDS or any other viral illness from receiving the vaccine. After a typical series of three (3) doses of the vaccine over six months, an average of over 90% of healthy adults develop antibodies, which protect against development of hepatitis B. The duration of protection is at least three years. Hepatitis B vaccine is recommended for all persons who are at increased risk of infection with hepatitis B virus, including some health care workers. The vaccine is neither helpful nor harmful in hepatitis B virus carriers or persons with existing antibodies to hepatitis B.

Special Considerations:
Because it is unnecessary, the vaccine is not recommended for persons with immunity to hepatitis B.

1. Do you believe you are immune to hepatitis B either through natural infection or previous vaccination? (If "yes", documentation must be submitted)

   yes _____ no _____

Explain: _____
_____

Procedure:
After signing this consent, if you have not already begun receiving the hepatitis B virus vaccine, you should make arrangements to do so. The immunization is received in three doses (dose 1, now, dose 2, one month from now and dose 3, six months from now). The immunization injections are done at minimal cost to you. Once the immunization series is completed, you may request a blood test for antibody to hepatitis B virus. If the antibody test indicates you are not yet immune, additional doses may be recommended and provided at cost to you. Some people do not seroconvert. It is in your best interest to get your titer checked for presence of antibody. University students can be tested for antibody determination at University Health Service during a period of 3-12 months after completing the third inoculation. A positive hepatitis B titer is usually good for 7-12 years.

Consent:
I have read the above statements about hepatitis B virus vaccine and have received satisfactory answers to all my questions. I understand that in my training at the School of Dentistry I may be at increased risk of contracting hepatitis B virus, and that immunization has been recommended to prevent my becoming infected or ill.

I consent to receive injections of hepatitis B virus vaccine and to have blood drawn following the series.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

OR

I consent to have blood drawn for hepatitis B antibody level determination.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

OR

I refuse the blood tests and immunizations for hepatitis B virus that have been offered to me.*

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

*Failure to be tested or immunized will not jeopardize your student status.

OR

It has been explained to me why I do not need to be vaccinated at this time and I agree to that.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Return Completed Form To:

Office of Patient Services
University of Michigan School of Dentistry
1011 N. University, Room 1301
Ann Arbor, Michigan 48109-1078

UNIVERISTY OF MICHIGAN
SCHOOL OF DENTISTRY

MANTOUX SKIN TEST INFORMATION SHEET AND CONSENT FORM

It shall be the policy of the University Of Michigan School Of Dentistry to maintain a Tuberculosis Screening Program to protect faculty, staff and students. TB skin testing is available at no charge to employees and at a minimal charge to students through University Health Services. The following information describes the skin test procedure.

TB Screening: Includes skin testing to detect TB infection. When a skin test is applied, screening is considered complete after the test has been checked 48-72 hours after application and subsequent evaluation completed if indicated, as specified by University Health Services (UHS) protocols. When a chest x-ray has been ordered by UHS, screening is considered complete after the x-ray has been taken and subsequent appointments kept as specified in protocols.

Reactive Skin Test: Response of ten (10) or more millimeters of induration 48 hours following a Mantoux intradermal injection of 5TU of Tuberculin Purified Protein Derivative.

Procedure: After signing the consent below, you will be scheduled to receive the skin test. The skin test must be read by University Health Services within 48-72 hours. It is your responsibility to return to UHS in this time frame for interpretation.

Consent: I have read the above statements about the Mantoux skin test and have received satisfactory answers to all my questions.

I consent to receive the Mantoux skin test.

_____ _____
Signature Date

_____ _____
Witness Date

UNIVERSITY OF MICHIGAN
SCHOOL OF DENTISTRY

AUTHORIZATION FOR
UNIVERSITY HEALTH SERVICE INOCULATIONS

This is to certify that _____ is a student at the School of Dentistry and is authorized to receive the following inoculation(s):

- ☐ TB Skin Test (Mantoux)
  TB Skin Test NOT administered on Thursdays.
- ☐ HBV Vaccination
- ☐ Other (Please Specify) _____
  _____

University Health Service bills all inoculations and other specified services to the School of Dentistry Office of Patient Services account. Authorization for this employee to receive the indicated services has been approved by:

Department Name: _____

Supervisor Name: _____

Contact Phone No. _____

Department Administrator:
A copy of this form must be forwarded to Gary Sweier, room 1303, Office of Patient Services, with the appropriate account number to re-charge services to.

UHS Allergy and Immunization Clinic
To schedule an appointment
Contact the clinic
764-8304

Hours of Operation
Please note Health Services is closed between noon – 1 p.m. everyday.

Fall/Winter – September to April

Monday	8:00-5:00 p.m.
Tuesday	8:00-5:00 p.m.
Wednesday	8:30-5:00 p.m.
Thursday	9:00-5:00 p.m.(Reading of tests only)
Friday	8:00-4:30 p.m.

Spring/Summer May to August

Monday	8:30-4:30 p.m.
Tuesday	8:30-4:30 p.m.
Wednesday	8:30-4:30 p.m.
Thursday	9:00-4:30 p.m. (Reading of tests only)
Friday	8:30-4:30 p.m.

This Form Must Accompany the Student To University Health Services.