Arkansas State Board of Dental Examiners

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COLLABORATIVE CARE PERMIT FOR DENTISTS AND HYGIENISTS

APPLICANT INFORMATION (COLLABORATIVE DENTIST) – Fee $25

Name:		**Arkansas Dental License Number:**
Office Address:		
City:	State:	ZIP Code:
Phone #:	Fax #:	Email:
Which Collaborative Care Permit are you and your hygienist(s) applying for (check one)? ☐ **Permit I** ☐ **Permit II**		

APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #1

Name:	**Arkansas Dental Hygiene License Number:**
For Collaborative Care Permit I (Hygienist) – Fee $5	1. Have you practiced as a dental hygienist for 1,200 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No
For Collaborative Care Permit II (Hygienist) – Fee $8	1. Have you practiced as a dental hygienist for 1,800 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? ☐ Yes ☐ No

APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #2

Name:	**Arkansas Dental Hygiene License Number:**
For Collaborative Care Permit I (Hygienist) – Fee $5	1. Have you practiced as a dental hygienist for 1,200 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No
For Collaborative Care Permit II (Hygienist) – Fee $8	1. Have you practiced as a dental hygienist for 1,800 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? ☐ Yes ☐ No

APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #3	
Name:	**Arkansas Dental Hygiene License Number:**
For Collaborative Care Permit I (Hygienist) – Fee $5	1. Have you practiced as a dental hygienist for 1,200 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No
For Collaborative Care Permit II (Hygienist) – Fee $8	1. Have you practiced as a dental hygienist for 1,800 clinical hours? ☐ Yes ☐ No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? ☐ Yes ☐ No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? ☐ Yes ☐ No

ADDITIONAL DOCUMENTATION TO PROVIDE WITH THIS APPLICATION

- Please provide proof of the following:
- Proof of malpractice liability insurance
- Proof of a six (6) hour continuing education course in the subject of senior care/patients with developmental disabilities **(for Collaborative Care Permit II only)**
- A copy of your collaborative practice agreement protocol - see Article XIX (D)
- A copy of all consent forms – see Article XIX (E)
- A copy of all post care information that is given to patients – see Article XIX (F)

SIGNATURES

As a collaborative and consulting dentist, I agree to the following:

- To enter into a collaborative agreement with no more than three (3) collaborative dental hygienists.
- To be available to provide emergency communication and consultation with the dental hygienist(s) or appoint another dentist as a designee for those times when I (the consulting dentist) cannot be reached.
- To maintain records of patients treated, and to be responsible for the transfer of records if another dentist provides follow-up treatment.
- To maintain a copy of the Collaborative Agreement and Protocol on file.
- To notify the Board if the collaborative agreement between me and my hygienist(s) dissolves or contact information changes. Furthermore, I agree to notify the Board within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To submit an annual report by January 31st of each calendar year to the ASBDE office – see Article XIX (H)

Signature of dentist:	**Date:**

As a collaborative dental hygienist, I agree to the following:

- To enter into a collaborative agreement with no more than one (1) collaborative dentist.
- To maintain contact capabilities with the consulting dentist.
- To secure information consent from all patients or the parent/guardian of the patient before providing services.
- To provide to the patient, parent, or guardian a written plan for referral to a dentist for assessment of further dental treatment needs.
- To provide copy of collaborative care record of services to the institutional facility responsible for patient's care, when applicable.
- To secure release of information forms from the patient or parent/guardian of the patient if the care is provided in an institutional facility allowing me to access the patient's medical and dental records.
- To create and maintain all patient records and forward all records and radiographs or duplicates to the consulting dentist within seven (7) days of services rendered.
- To maintain a copy of the collaborative agreement and protocol on file.
- To notify the Board if the collaborative agreement between me and my consulting/collaborative dentist dissolves or contact information changes. Furthermore, I agree to notify the Board within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To maintain a malpractice liability policy for the provision of services.
- To submit an annual report by January 31st of each calendar year to the ASBDE office – see Article XIX (H)

Signature of hygienist #1:	**Date:**
Signature of hygienist #2:	**Date:**
Signature of hygienist #3:	**Date:**