

COLLABORATIVE AGREEMENT – SOUTH DAKOTA

Agreement Between:

Supervising Dentist's Name: _____

Work Address: _____

Work Phone: _____ **Work Fax:** _____

E-mail: _____ **License #:** _____

Dental Hygienist's Name: _____

Work Address: _____

Work Phone: _____ **Work Fax:** _____

E-mail: _____ **License #:** _____

Location (s) Where Services Will Be Provided:

Practice settings are limited to schools, Head Start Programs, federally qualified health centers, mobile dental units, nursing homes, and programs administered through the South Dakota Department of Health, Department of Social Services, Department of Human Services and Department of Corrections.

Practice Setting (e.g. school, head start): _____

Clinic/Location Name or Service Site: _____

Address: _____

Phone: _____ **Fax:** _____

Practice Setting (e.g. school, head start): _____

Clinic/Location Name or Service Site: _____

Address: _____

Phone: _____ **Fax:** _____

(If necessary, attach a separate sheet listing any additional locations.)

Dentist Initials _____

Dental Hygienist Initials _____

Consultation Requirements

A dentist in a collaborative supervision agreement must be available to provide communication and consultation with the dental hygienist. A dental hygienist working under collaborative supervision must maintain contact and communication with his or her supervising dentist. Specify the type (e.g. in person, telephone), frequency, and other details regarding how communication and consultation will be maintained:

Dental Records

Specify the procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist:

Location of Records: _____

Patient Considerations

A dental hygienist working under collaborative supervision must practice according to age and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient.

Medical conditions that require a dental evaluation prior to hygiene services:

Considerations for medically-compromised patients:

In addition, for each patient the hygienist must:

- Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs.
- Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services.

Standing Orders

Procedure: Oral Prophylaxis Age Group: _____

Scaling and root planing are not allowed under collaborative supervision.

Standing Orders: _____

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Procedure: Oral Prophylaxis Age Group: _____

Scaling and root planing are not allowed under collaborative supervision.

Standing Orders: _____

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Procedure: Fluoride Varnish Age Group: _____

Standing Orders: _____

Fluoride varnish can continue to be provided if no dental exam has taken place. Yes No

Procedure: Sealants Age Group: _____

Standing Orders: _____

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Procedure: Sealants **Age Group:** _____

Standing Orders:

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Procedure: _____ **Age Group:** _____

Standing Orders:

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Procedure: _____ **Age Group:** _____

Standing Orders:

Period of time, no more than 13 months, in which a complete evaluation or an oral health review by a dentist must occur prior to providing this service to a patient again: _____

Continue on separate sheets as necessary for each procedure and age group.

Other Requirements

Indicate any other conditions or requirements for your supervision agreement here.

You must maintain a copy of this agreement at each practice location where collaborative supervision is provided. A copy must also be mailed to the South Dakota State Board of Dentistry, PO Box 1079 Pierre SD 57501.

If this agreement is modified, an updated agreement must be provided to the board and must be approved. If the agreement is terminated, the board must be notified in writing within 30 days.

I agree to provide collaborative supervision to the dental hygienist named herein according to the details specified in this collaborative agreement and the regulations of the South Dakota State Board of Dentistry. I will review this agreement at least annually.

I understand that if I violate any provisions of this collaborative agreement or any rule or statute pertaining to my profession, the Board may terminate this agreement.

Signature	Date
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Printed Name

I agree to provide dental hygiene services according to the details specified in this collaborative agreement and the regulations of the South Dakota State Board of Dentistry. I will review this agreement at least annually.

I understand that if I have rendered services under collaborative supervision I must complete a summary report at the completion of the program, or in the case of an ongoing program, at least annually. I understand that I must submit this information to the South Dakota State Board of Dentistry.

I understand that if I violate any provisions of this collaborative agreement or any rule or statute pertaining to my profession, the Board may terminate this agreement.

Signature	Date
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Printed Name

Dentist Initials _____

Dental Hygienist Initials _____