South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

Collaborative Agreement

Please attach a $20.00 fee if submitting an initial collaborative agreement.

Supervising Dentist's Name: _____

Address: _____

_____

Phone: _____ **License #:** _____

E-mail: _____

Dental Hygienist's Name: _____

Address: _____

_____

Phone: _____ **License #:** _____

E-mail: _____

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: _____

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

Clinic/Location Name or Service Site: _____

Address: _____

_____

Phone: _____

If necessary, please attach a separate sheet that lists additional location

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: _____

_____

_____

Dentist Initials _____ **Dental Hygienist Initials**_____

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.

Dentist Initials _____ **Dental Hygienist Initials**_____

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**

_____

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

_____

Signature **Date**

_____

Printed Name

Mail completed agreement to:
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

Include $20.00 fee for initial collaborative agreements only.

For Office Use Only:
Check # _____
Amount _____
Date _____

Dentist Initials _____ **Dental Hygienist Initials_____**