# 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:** _____



**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**



**Dentist Initials _____** **Dental Hygienist Initials_____**