COLLABORATIVE SUPERVISION AGREEMENT
Silver Diamine Fluoride/ Nanosilver Fluoride Addendum

Addendum to the Collaborative Supervision Agreement Currently Held by the Following:

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 #:** _____

Standing Orders

Procedure: **Silver Diamine Fluoride** **Age Group:** _____

Only preventative application is 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: _____

Dentist Initials _____ **Dental Hygienist Initials**_____

Procedure: **Nanosilver Fluoride** **Age Group:** _____

Only preventative application is allowed under collaborative supervision.

Standing Orders: _____

_____

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_____

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:_____

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 (Dentist) **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 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 upon request.

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 (Dental Hygienist) **Date**

_____

Printed Name

Dentist Initials _____ **Dental Hygienist Initials**_____