

Collaborative Practice Agreement

Collaborative Practice Dental Hygienist Information:

Sandra Smith, RDH BA RF

12345 Everywhere Street

Anytown MN 55555

Phone: 555.555.5555 Home

666.666.6666 Work

777.777.7777 Cell

Email: rdh1_hygienist@website.com

Minnesota Dental Hygiene License Number: H0000

Collaborative Practice Dentist Information:

Mary Jones Cabrera, DDS

54321 Always Street

Anytown MN 55555

Phone: 888.888.8888 Office

999.999.9999 Cell

Email: dds1_dentist@website.com

Minnesota Dentist License Number: D0000

Intended location of oral health care service delivery/program:

_____ name of center/facility _____

123 West Street

Anytown MN 55555

Intended population to be served:

Children enrolled in the Anytown Minnesota ___X___ Center, ages ___ to ___,
and their parents/guardians

or

Residents of Anytown Minnesota ___X___ Facility, ages _____ and up

**Name, title and credentials of person authorized to represent ____x____ center/facility;
(include address if different from above):**

Intended services to be provided:

Example for a Head Start or early childhood setting:

Medical history review; anticipatory guidance; oral health instruction; assessment/triage ;
dietary/nutritional assessment; fluoride varnish (~3 months); referral for further diagnosis
and/or treatment services as needed; recommended recall frequency

Example for a long-term care or residential setting:

Medical history review; hard and soft tissue assessment/triage; dental hygiene treatment plan,
health education/disease management, radiographs; anticipatory guidance on
dietary/nutritional and tobacco use factors; scaling and root planing utilizing local anesthesia
when necessary and/or appropriate; prophylaxis; removable prosthesis/denture cleansing;
fluoride varnish (~3 months); referral for further diagnosis and/or treatment services as needed;
recommendation of recall frequency

CPR for the Health Care Provider: (include copy of CPR card with Collaborative Agreement)

Date Taken: _____

Through Which Association (e.g. AHA, ARC) _____

Recertification Due Date: _____

Medical emergencies continuing education course: (include copy of CE course completion
certificate with Collaborative Agreement)

Date attended: _____

Program Sponsor: _____

Infection control continuing education course: (include copy of CE course completion certificate
with Collaborative Agreement)

Date attended: _____

Program Sponsor: _____

Dental Hygienist professional liability insurance coverage: (Include copy of recent policy renewal)

Name of Insurance Company: _____

Address of Insurance Company: _____

Policy Number: _____

Patient Records will be held at the following location:

Name of facility/office/home: _____

Address of facility/office/home: _____

Reimbursement for the services provided by the dental hygienist will be handled as follows:

(explain payment-for-services protocol to include insurance filing, sliding fee scale, co-payments, pro-bono, etc.):

MN Medicaid/National Provider Identifier (NPI) number:

Dental Hygienist _____ Dentist: _____

Acquisition of and payment for program supplies will be handled as follows: (include protocol for acquisition of items requiring a prescription, e.g. fluoride, anti-microbial rinses):

Attachments:

- * Consent to Care Form
- * Age and procedure-specific treatment protocols
- * Notice of time period for examination by a dentist, including the statement "Procedures provided by the collaborative practice dental hygienist DO NOT substitute for a comprehensive examination by a dentist."
- * Referral form, to include recall frequency
- * Protocol for treating medically compromised patients to include conditions when a dentist evaluation and treatment plan must occur prior to provision of services by the dental hygienist

Signature of Dental Hygienist: _____ **Date:** _____

Signature of Dentist: _____ **Date:** _____

Signature of person authorized to represent Anytown Minnesota Head Start Center:

_____ **Date:** _____

Registration of this collaborative agreement with the Minnesota Board of Dentistry occurred on:

Date: _____

Collaborative agreement annual renewal/review:

Dental Hygienist signature: _____

Date: _____

Dentist signature: _____

Date: _____

Additional notes:

(revised November 2009)