

Collaborative Practice Agreement

Template

Collaborative Practice Dental Hygienist Information:

Sandra Smith, RDH BA RF
12345 First Street
Anytown MN 55555
Phone: 555.555.5555 Home
666.666.6666 Work
777.777.7777 Cell
Email: rdh1_dental@yahoo.com

Minnesota Dental Hygiene License Number: H1234

Collaborative Practice Dentist Information:

Mary Jones, DDS
54321 Second Street
Anytown MN 55555
Phone: 888.888.8888 Office
999.999.9999 Cell
Email: dds1_dental@hotmail.com

Minnesota Dentist License Number: D4321

Intended location of oral health care service delivery/program:

*Anytown Minnesota Head Start Center
123 West Street
Anytown MN 55555*

Intended population to be served:

*Children enrolled in the Anytown Minnesota Head Start Center, ages 3 to 5,
and their parents/guardians*

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

Title/credentials of person authorized to represent Anytown Minnesota Head Start Center:

Intended services to be provided:

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

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 premium paid)

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 billing protocol to include insurance filing, sliding fee scale, co-payments, 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):

Attachments (to include but not be limited to):

- * 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:
