



# Arkansas State Board of Dental Examiners

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## COLLABORATIVE CARE PERMIT FOR DENTISTS AND HYGIENISTS

### APPLICANT INFORMATION (COLLABORATIVE DENTIST) – Fee \$500

<b>Name:</b>		<b>Arkansas Dental License Number:</b>	
Office Address:			
City:	State:	ZIP Code:	
Phone #:	Fax #:	Email:	
Which Collaborative Care Permit are you and your hygienist(s) applying for (check one)? <input type="checkbox"/> <b>Permit I</b> <input type="checkbox"/> <b>Permit II</b>			

### APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #1

<b>Name:</b>	<b>Arkansas Dental Hygiene License Number:</b>
<b>For Collaborative Care Permit I (Hygienist) – Fee \$100</b>	1. Have you practiced as a dental hygienist for 1,200 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For Collaborative Care Permit II (Hygienist) – Fee \$150</b>	1. Have you practiced as a dental hygienist for 1,800 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No

### APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #2

<b>Name:</b>	<b>Arkansas Dental Hygiene License Number:</b>
<b>For Collaborative Care Permit I (Hygienist) – Fee \$100</b>	1. Have you practiced as a dental hygienist for 1,200 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For Collaborative Care Permit II (Hygienist) – Fee \$150</b>	1. Have you practiced as a dental hygienist for 1,800 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No

## APPLICANT INFORMATION (COLLABORATIVE HYGIENIST) - #3

<b>Name:</b>	<b>Arkansas Dental Hygiene License Number:</b>
<b>For Collaborative Care Permit I (Hygienist) – Fee \$100</b>	1. Have you practiced as a dental hygienist for 1,200 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For Collaborative Care Permit II (Hygienist) – Fee \$150</b>	1. Have you practiced as a dental hygienist for 1,800 clinical hours? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you taught for two (2) academic years over the course of the immediately preceding three (3) academic years at a dental hygiene school? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Have you completed a six (6) hour continuing education course in the subject of senior care and/or patients with developmental disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No

### ADDITIONAL DOCUMENTATION TO PROVIDE WITH THIS APPLICATION

- Please provide proof of the following:
- Proof of malpractice liability insurance
- Proof of a six (6) hour continuing education course in the subject of senior care/patients with developmental disabilities **(for Collaborative Care Permit II only)**
- A copy of your collaborative practice agreement protocol - see Article XIX (D)
- A copy of all consent forms – see Article XIX (E)
- A copy of all post care information that is given to patients – see Article XIX (F)

### SIGNATURES

As a collaborative and consulting dentist, I agree to the following:

- To enter into a collaborative agreement with no more than three (3) collaborative dental hygienists.
  - To be available to provide emergency communication and consultation with the dental hygienist(s) or appoint another dentist as a designee for those times when I (the consulting dentist) cannot be reached.
  - To maintain records of patients treated, and to be responsible for the transfer of records if another dentist provides follow-up treatment.
  - To maintain a copy of the Collaborative Agreement and Protocol on file.
  - To notify the Board if the collaborative agreement between me and my hygienist(s) dissolves or contact information changes.
- Furthermore, I agree to notify the Board within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To submit an annual report by January 31<sup>st</sup> of each calendar year to the ASBDE office – see Article XIX (H)

**Signature of dentist:**

**Date:**

As a collaborative dental hygienist, I agree to the following:

- To enter into a collaborative agreement with no more than one (1) collaborative dentist.
- To maintain contact capabilities with the consulting dentist.
- To secure information consent from all patients or the parent/guardian of the patient before providing services.
- To provide to the patient, parent, or guardian a written plan for referral to a dentist for assessment of further dental treatment needs.
- To provide copy of collaborative care record of services to the institutional facility responsible for patient's care, when applicable.
- To secure release of information forms from the patient or parent/guardian of the patient if the care is provided in an institutional facility allowing me to access the patient's medical and dental records.
- To create and maintain all patient records and forward all records and radiographs or duplicates to the consulting dentist within seven (7) days of services rendered.
- To maintain a copy of the collaborative agreement and protocol on file.
- To notify the Board if the collaborative agreement between me and my consulting/collaborative dentist dissolves or contact information changes. Furthermore, I agree to notify the Board within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To maintain a malpractice liability policy for the provision of services.
- To submit an annual report by January 31<sup>st</sup> of each calendar year to the ASBDE office – see Article XIX (H)

**Signature of hygienist #1:**

**Date:**

**Signature of hygienist #2:**

**Date:**

**Signature of hygienist #3:**

**Date:**