FIVE POINTS
SURGERY CENTER

Allied Health Professional

Dental Assistant

_____

_____

Practice

FIVE POINTS
SURGERY CENTER

Dear Assistant,

Five Points Surgery Center wishes to extend you the opportunity to apply for appointment to its Allied Health Professional staff.

Enclosed are a copy of the Allied Health Staff Application and a copy of the Medical Staff Bylaws.

In order to meet accreditation, Medicare certification requirements and Medical Staff Bylaws, please submit the following documents with your application:

1. Allied Health Staff Application
2. Copy of Malpractice Insurance Coverage
3. Obtain and forward two peer reference letters regarding competency/ professionalism (attached)
4. Curriculum Vitae or Resume
5. CDA Certificate (if applicable)
6. Copy of Government ID (Driver's License or Passport)
7. Delineation of Privileges
8. Copy of Immunization Records (TB, Hep B, MMR, Tdap, Varicella, Influenza, Covid 19)

Upon completion of the file, the Medical/Dental Director and members of the Clinical Review Committee will review all information, forward recommendations to the governing board, who will then determine final approval.

Your cooperation in submitting the application in the requested manner will insure that your privileges will be approved as soon as possible. Please return them to **credentialing@fivepointssurgerycenter.com**

We appreciate the opportunity to work with you. Please let me know if we can assist you in anyway possible.

Sincerely,

Five Points Surgery Center
Credentialing Team

FIVE POINTS SURGERY CENTER

Application for Privileges
Dental Assistant

Personal Data

Name _____
Last *First* *Middle*

Home Address _____
No. & Street *City* *State* *Zip*

Employer (must be active member of ASC medical staff) _____

Address _____
No. & Street *City/State* *Zip* *Phone*

Date of Birth _____ **Place of Birth** _____ **SSN** _____

Professional Training

_____
Institution/City/State *Degree* *From* *To*

_____
Institution/City/State *Degree* *From* *To*

Additional Education

_____
Institution/City/State *Degree* *From* *To*

List all hospitals or health care facilities where you have been employed.

_____
_____
_____
Institution/City/State *Position/Specialty* *From* *To*

License, Certification, and/or Registration in a Specialty Field

_____
_____
Number *Specialty* *Date of Expiration*

Memberships in Professional Organizations

_____
_____

Have any of your appointments or licenses ever been suspended, terminated or otherwise abridged? ___Yes ___No

To the best of your knowledge, are you mentally and physically capable of practicing your profession in a competent manner? __Yes ___No

Have there ever been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional medical practice? __Yes __No

Note: If the answer to question 1 or 3 is Yes, or question 2 is No, please provide facts and status on a separate sheet.

References

Please provide the names of three individuals who have personal knowledge of your current clinical ability, ethical character, health status, and ability to work cooperatively with others. One reference must be a peer.

_____
_____
_____

Name Address Phone Relationship

Affidavit

In making this application to **Five Points Surgery Center,** I agree to abide by the Surgery Center and Medical Staff's policies and Rules and Regulations. I understand that the privileges requested are dependent upon my employer maintaining current privileges on the Surgery Center Medical Staff.

By applying for appointment to the medical staff of the ***Five Points Surgery Center***, I hereby signify my willingness to appear for interviews in regard to my application. I hereby authorize the Surgical Center, its Medical Staff and their representatives to consult with prior associates and others who may have information bearing on my professional competence, character, ability to perform requested duties, ethical qualifications, and ability to work cooperatively with others and consent to the inspection by the Surgical Center, its Medical Staff, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for Staff appointment and clinical privileges, and I hereby consent to the release of such information.

The Surgical Center will treat this application and any information secured in connection therewith in strict confidence in accordance with the Medical Staff Bylaws, preserving with all reasonable safeguards the privacy of the applicant.

By my signature on this application, I also attest that:

- I have received an annual TB test
- I am immunized against communicable diseases as recommended by the CDC guideline for healthcare workers.

Signature: _____ Date _____

FIVE POINTS
SURGERY CENTER

Identification of Supervising Physician for Dental Assistant

_____, will be employed by or otherwise
Dental Assistant Name

affiliated with _____.
Dental Practice

This letter identifies the supervising physician as:

Physician Printed Name and Title: _____
Address: _____
Office Phone Number: _____

Specific duties to be performed by the Dental Assistant

named above are the following:

1. Preparation of dental materials for the dentist during operative dental procedures,
2. Organization of dental supplies during procedures to facilitate in the delivery of efficient patient care, and
3. Organization of dental supplies and materials following procedure to ready the dental chair for the next patient.
4. Document dental treatment during surgery.

I, _____, certify that the above-named
Physician Printed Name
Dental Assistant is competent in the 3 specific duties listed above and any other required duties, and that I could produce verification of competency within 24 hours upon request.

_____ _____
Physician Signature *Date*

Health & Drug Screen
Employer Attestation Statement

Employer listed below affirms that it has completed the following health screenings or documented health status in regard to _____as follows:
(Dental Assistant Name)

1. 2-step tuberculin skin test (1 test completed within the past 12 months), or documentation of a previous positive reactor including a chest x-ray completed with the past 5 years; if previous positive T Test a TB symptom screen completed within last 12 months and screen completed annually / every 12 months; or a TB Gold test; if TB Gold test completed a 2nd TB test would not be required *and*
2. Proof of Rubella and Rubeola and Mumps vaccination and/or proof of immunity by positive antibody titers, *and*
3. Proof of Varicella immunization and/or proof of Varicella immunity by positive titer *and*
4. Proof of Hepatitis B Immunization and/or proof of Hepatitis B immunity by positive titer or completion of a certification of declination of vaccine, if "clinical" patient contact is anticipated; *and*
5. Tdap vaccination documentation; *and*
6. Proof of Influenza vaccination or signed declination; *and*
7. Negative urine drug test results.

Employer acknowledges this information will be available to all Tenet affiliates within 24 hours (1 business day) of request.

Signature: _____
(Employer)
Printed Name: _____

Date: _____

Criminal Background Screen

Employer listed below submits a completed a background screen for:

_____

(Dental Assistant Name)

The background screen includes but is not limited to: Social Security Number trace, 7 year criminal record search, sex offender registry, OIG GSA search, and any other element required by Tenet facility to meet state law requirements:

_____ No record found

_____ Record found; reviewed with Surgery Center's HR Department

_____

Signature: _____
(Employer)
Printed Name: _____

Date: _____

FIVE POINTS
SURGERY CENTER

Uniform Size

Circle One

Scrub Shirt:	**XS**	**S**	**M**	**L**	**XL**	**XXL**	**XXXL**
Scrub Pants:	**XS**	**S**	**M**	**L**	**XL**	**XXL**	**XXXL**
Lab Coats:	**XS**	**S**	**M**	**L**	**XL**	**XXL**	**XXXL**

Surgical Glove Size: _____

□ Confidentiality
□ IT Policy

FIVE POINTS
SURGERY CENTER

Allied Health Staff
Management Information System Form

Practice Name: _____

Practice Manager: _____ Office Number: _____
Mark one: □ CDA □ DA □ Other _____

Date of Request: _____ □ Permanent □ Temporary – if temp, enter end date _____ / _____ / _____ (If no date, ID will expire in 90 days)
(MM / DD / YYYY)

Legal First Name	MI	Legal Last Name

Email Address: _____ Personal Number: _____

Security Questions:
1. Mother's Maiden Name: _____
2. City of Birth: _____

Temporary password will be provided during FPSC Orientation

Signature: _____

Office Use Only

Network ID: _____ Date Created: _____

Medical Staff: _____ Created by: _____

□ Logged Tracking Chart

Internet Acceptable Usage Policy Acknowledgment Form

As an employee or other authorized user of Five Points Surgery Center computer network, I have received and reviewed the VFive Points Surgery Center Internet Acceptable Usage Policy (the "Policy"). I understand that my use of the company's computer network is conditioned on my full compliance with the provisions of that Policy. I further understand that violations of the Policy may subject me to disciplinary action, up to and including termination of my relationship with Five Points Surgery Center.

I recognize and understand that I am being provided with access to the company's corporate internal network for the purpose of facilitating the internal business purposes of Five Points Surgery Center . I acknowledge that, to the extent permitted by applicable law, Five Points Surgery Center reserves and will exercise the right to monitor, review, audit, record, and publish reports and usage patterns regarding my Internet usage activities, at any time and for any purpose, with or without notice to me. I further acknowledge that I have no reasonable expectation of privacy as to my internet usage on the company's corporate internal network, including without limitation the identities and consent onetime sites visited, as well as the frequency and timing of such visits. I understand that I may not access or view internet sites containing offensive, pornographic, or otherwise objectionable or inappropriate materials. I also understand that I am responsible for my own internet activity using the company's corporate internal network and that Five Points Surgery Center cannot protect me from offensive or inaccurate information that I may access on the Internet.

By using the Five Points Surgery Center corporate internal network and accessing the internet through that network, I consent to the above terms and agree to abide by all terms of the Policy.

_____ _____

Signature of Employee Date

_____

Printed Name

CONFIDENTIALITY AND INFORMATION ACCESS AGREEMENT

IMPORTANT: *Please read the entire Agreement and accompanying policy. If you have any questions, please ask them before signing. You will receive a copy of your signed agreement for your records and* a *copy will be retained with your credentialing packet.*

This document is confirmation to Five Points Surgery Center (FPSC) that I am fully aware of the implications of misuse of any confidential and proprietary information pertaining to patients, caregivers, employees and surgery center operations.

GENERAL AGREEMENT: During my duties with FPSC, I may receive or have access to verbal, written or computer-generated information concerning patients, providers or institutionally proprietary data. I agree that, except as authorized or directed by FPSC or by legal process, I will not at any time during or after my tenure disclose any such information to any person, or permit any person to examine or make copies of any documents prepared by me, coming into my possession or control, or to which I have access unless as needed during my required activities. *I understand that unauthorized access or disclosure may result in disciplinary action and civil or criminal penalties; or both.* ·

I understand that all business activities of FPSC are considered confidential. I also understand that if I am exposed to FPSC business information that I am obligated not to discuss or disclose such information to persons outside FPSC unless as needed during my required activities. Additionally, within FPSC, such information will only be discussed with employees whose job requires such knowledge.

INFORMATION ACCESS AGREEMENT: I recognize and acknowledge that access to Health System information requires unique responsibilities for care and security. Therefore, I agree to the following:

- I will keep my computer access identifications and passwords confidential and not share them with anyone. Nor will I use another's identification and password.
- I understand that my computer login ID is the equivalent to my legal signature, and I will be accountable for all work done under my login ID.
- I will use my computer access solely to perform my duties with a clear need-to-know criterion.
- I will use my access to patient information (including myself, family members and friends) solely to perform my duties with a clear need-to-know criterion.
- I will not enter or attempt to enter false information into a live production environment.
- I will use designated sign-off procedures when leaving a computer workstation or terminal.
- I will not provide protected patient information (PHI) in writing, discussion or other manner to those who do not have a need to know.
- I will not remove PHI from the surgery center without authorization.
- I will discard materials containing PHI according to the surgery center policy.
- I know that patient confidentiality and privacy is a patient right and I will respect that right.

_____ _____

Signature Date

_____

Employee/Individual's Printed Name

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SURGERY CENTER

Professional Reference Questionnaire

Name of Applicant:

Area of Clinical Privileges Requested:

Name of Reference Practitioner:

Current Position of Reference Practitioner:_____

Time period of observations:_____

Location of observations:_____

Position at time of observation: _____

Type of clinical procedures observed: _____

Please indicate your evaluation of the practitioner based on your observations in comparison with those practicing similar specialties:

Criteria	Excellent	Above Average	Average	Below Average
Overall Ability				
Technical Skills				
Professional Judgement				
Compliance to Regulatory Requirements/Standards/ Staff Bylaws				
Professional Behavior/Interpersonal Skills				
Communication Skills				

Please describe any strengths or weaknesses observed:_____

To your knowledge, does the practitioner have any condition which could compromise his ability to perform any of the mental and physical functions related to the requested clinical privileges? _____ Yes ____ No If yes, please explain:_____
_____

To your knowledge, has the practitioner ever been denied membership or clinical privileges for any hospital system or medical staff? _____ Yes _____ No If yes, please explain: _____
_____.

Please review the attached copy of "Requested Delineation of Privileges". Do you concur that these privileges match the experience for this physician, and that he is qualified by training and experience to be approved for the requested privileges? _____Yes _____No If no, please explain: _____
_____
_____

Any additional information which may be relevant to the evaluation of the practitioner: _____
_____
_____

Signature/Title:_____Date:_____

FIVE POINTS SURGERY CENTER

PRIVILEGE REQUEST FORM | Dental Assistant | Delineation Of Privileges

I hereby request privileges in the specialty of **Dental Assistant** as shown on this form. I understand that the privileges grantedare subject to review coinciding with my application for medical staff membership. I routinely perform the below procedure(s) requested and these are consistent with my abilities, training and experience.

I also understand the application for additional or new procedures can be made at any time with proper documentation.

I realize that approval by a board does not necessarily qualify me to perform certain procedures. However, I believe that I am qualified to perform all procedures for which I have checked.

PROCEDURES	Requested	Not Requested	Granted	Denied
Preparation of dental materials for the dentist during operative dental procedures				
Organization of dental supplies during procedures to facilitate in the delivery of efficient patient care				
Organization of dental supplies and materials following procedure to ready the dental chair for the next patient				
Document dental treatment during surgery				
Take patient X rays by using Vatech EZ Ray P				
Assist in room turnover				

Applicant Signatures

Applicant's Signature	Print Name	Date

Approval Signatures

Governing Board Approval	Print Name	Date