FIVE POINTS
SURGERY CENTER

Allied Health Professional

Dental Assistant

_____

Practice Name

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. Current BLS/CPR Certification
7. Copy of Government ID (Driver's License or Passport)
8. Delineation of Privileges (attached)
9. Copy of Immunization Records (TB - skin or QuantiFERON results, Hep B, MMR, Tdap, Varicella, Influenza, Covid19). Titers are acceptable proof of immunity. If needed, approved declinations are attached.

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*

Other Names _____
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*

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 Five 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

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

FIVE POINTS
SURGERY CENTER

Dental Assistant Rights and Responsibilities Acknowledgment Form

To align with AAAHC Standards, a dental assistant's rights and responsibilities focus on maintaining clinical excellence, patient safety, and professional accountability within the surgery center. The Dental Assistant provides high-level clinical and surgical support within an outpatient surgery environment. Responsible for maintaining a clean and/or sterile surgical field, assisting in complex procedures, and ensuring adherence to AAAHC infection control and patient safety standards. By applying for privileges at FPSC, you are contracted to maintain your skills, job duties, and credentials, according to your profession and outlined below:

Credential Maintenance: Maintaining current licensure, certifications (e.g., DANB, X-ray, BLS/CPR), and malpractice insurance as required by the Governing Board.

Clinical Competence: Providing care solely within your granted privileges and under the appropriate level of supervision by a licensed dentist or physician.

Patient Safety & Advocacy: Verifying patient identity and participating in "Time Out" procedures before treatments. Upholding patient rights, including maintaining visual, auditory, and electronic privacy. Reporting any concerns regarding patient abuse, neglect, or safety hazards immediately.

Infection Control: Adhering strictly to AAAHC, OSHA, and CDC guidelines for the sterilization of instruments, operatory breakdown/setup, and hazardous waste management.

Quality Improvement: Participating in the facility's Quality Management program if asked, which may include peer reviews, clinical record charting, and incident reporting.

Professional Conduct: Treating all patients, families, and team members with respect, courtesy, and dignity, regardless of background.

By signing below, you are acknowledging that you understand the job duties of an assistant in an ASC and that you are certified to perform the tasks requested on the delineation of privileges form.

_____ _____

Signature of Employee Date

_____

Printed Name

FIVE POINTS
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

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:_____

DECLINATION FORM FOR COVID VACCINE

My employer (or affiliated health facility) recommends that I receive COVID-19 vaccination to protect myself, patients, staff, and others in the healthcare facility.

I DO NOT WANT A COVID VACCINE.

I acknowledge that I am aware of the following facts:

- COVID-19 is a serious contagious virus that can easily spread from person to person. Some infected people may have severe disease and die. No one knows how COVID-19 will affect them.
- COVID-19 vaccination is recommended for me and for all other healthcare workers to help prevent spreading the disease to friends, family, and staff and to protect me from getting COVID-19, or from serious illness if I do get infected.
- I understand that, if I contract COVID then, I am potentially contagious for 2 days before any symptoms appear. During this time, and for 10-14 days after infection, I can potentially transmit COVID-19 to patients and staff in this facility and to my family.
- I understand that if I become infected with COVID-19 then, even if my symptoms are mild or non-existent, I can spread the virus to others. Symptoms that are mild or non- existent in me can still cause serious illness and death in others.
- I understand that if I get COVID-19 then, I will be required to isolate away from others and will not be able to work for a minimum of 5 days after symptoms appear or 5 days from the date, I test positive if I have no symptoms.
- I understand that I cannot get COVID-19 from the vaccine and getting the vaccine is a safer way to build up immunity.
- I understand that side effects usually go away on their own within a week and are a sign that the immune system is working.
- The consequences of my refusal to be vaccinated could be life threatening for me and the health of everyone with whom I have contact, including my co-workers and all patients in this healthcare facility.

Despite all these facts, I choose to decline COVID-19 vaccination at this time. I may change my mind and accept vaccination later if vaccine is available and will provide proof at that time. I have read and fully understand the information on this declination form.

(Optional) I am declining due to the following reason:

_____

_____

Signature: _____ Date: _____

Name (print): _____

Practice name (if applicable): _____

FIVE POINTS SURGERY CENTER

DECLINATION FORM HEPATITIS B VACCINE

Select the appropriate box:

- ☐ Hepatitis B vaccination series documentation and positive titer. Records attached.
- ☐ Never received a vaccination. Vaccine series and a follow-up titer offered.
- ☐ Official documentation of vaccination, but no documented titer. Hepatitis B titer offered.
- ☐ History of vaccination or incomplete vaccination series, but no official documentation:
  - ☐ Attempt to obtain official records by contacting previous employers, healthcare provider or the employee working with the health department to access records.
  - ☐ If records reveal an incomplete series, the missing doses will be provided, and a titer performed.
  - ☐ If records are not located, the worker is considered unvaccinated and will be offered vaccination series with titer.

Workers can accept or decline the vaccination(s) or a titer by signing one of the boxes below.

HEPATITIS B VACCINE CONSENT (No vaccination series or lack of documentation)

I consent to move forward with Hepatitis B Virus (HBV) vaccine and titer. I understand the injections are given over a period of several months before it is effective in preventing the disease.

The titer will provide documentation of immunity. If a titer reveals inadequate immunity, based on public health guidance, workers will be provided additional doses of the vaccine, not to exceed six (6) doses to obtain immunity.

Signature: _____ Date: _____

TITER CONSENT (Documentation of Hepatitis B vaccine series but no titer obtained)

I consent to move forward with Hepatitis B Virus (HBV) and titer. The titer will provide documentation of immunity. If a titer reveals inadequate immunity, based on public health guidance, workers will be provided additional doses of the vaccine, not to exceed six (6) doses to obtain immunity.

Signature: _____ Date: _____

TITER DECLINED

Signature: _____ Date:_____

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring a Hepatitis B Virus infection. I have been given the opportunity to be vaccinated at no charge to myself. I understand that by declining this vaccine I continue to have occupational exposure to blood or be at risk of acquiring Hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Signature: _____ Date: _____

Healthcare Professional Name (print): _____

Reference:
Hepatitis B and the Healthcare Personnel: CDC Answers Frequently Asked Questions
Centers for Disease Control and Prevention. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management. MMWR 2013;62(No.10)

DECLINATION FORM FOR FLU VACCINE

This facility has recommended that I receive influenza vaccination to protect myself and the patients I serve.

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that the influenza vaccine cannot transmit influenza, and it does not prevent all disease.
- I have declined to receive the influenza vaccine. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later if vaccine is available. I have read and fully understand the information on this declination form.

I am declining due to the following reasons (check all that apply):

- □ I believe I will get influenza if I get the vaccine.
- □ I do not like needles.
- □ My philosophical or religious beliefs prohibit vaccination.
- □ I have an allergy or medical contraindication to receiving the vaccine.
- □ Other reason – (Optional) please tell us_____

I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.

I understand that I may change my mind at any time and accept influenza vaccination if vaccine is available.

I have read and fully understand the information on this declination form.

Signature:_____Date:_____

Name (print):_____