



ARIZONA STATE BOARD OF DENTAL EXAMINERS

4205 North 7th Avenue, Suite 300 • Phoenix, Arizona 85013

Telephone (602) 242-1492 • Fax (602) 242-1445

Dear Affiliated Practice Dental Hygienist:

Enclosed is an Affiliated Practice Relationship Notification Form. All areas of the form must be completed and submitted to the Board within thirty days after the effective date of the Agreement or amendment to the Agreement, in order for a valid Affiliated Practice Relationship to be in effect. Failure to submit a complete Notification Form, comply with all Statute and Rule related to Affiliated Practice Relationships, or to notify the Board within thirty days after the termination date from both the Affiliated Practice Dental Hygienist and Dentist are grounds for disciplinary action under Arizona Revised Statutes (A.R.S.) § 32-1263.

The following documents must be submitted (Please use this as a checklist to ensure all required documents are submitted):

- ___ Completed Dental Hygienist Notification Form which includes signed and notarized affidavit of eligibility
- ___ Affiliated Practice Agreement signed by both the Dental Hygienist and Dentist
- ___ Completed Dentist Notification Form
- ___ Photocopy of Procedures and Standing Orders
- ___ Photocopy of Referral and Reporting of Finding Form
- ___ Photocopy of Permission and Medical History Form (Patient Information)

Mail the Notification Form and other required documents to the address listed above. Upon receipt of these acceptable, completed forms and affidavit, the Board will issue a letter acknowledging the establishment of the Affiliated Practice Relationship.

It is your responsibility to keep the Board informed of any address changes or amendments to the Agreement.

For your convenience, templates are attached that can be used as guidelines for developing your Affiliated Practice Agreement and related documents. If you have any questions, contact Sherrie Biggs, Licensure Manager at 602.242.1492 x2007.

Enclosures:

- Dental Hygienist Notification Form
- Affiliated Practice Agreement
- Dental Notification Form
- Procedures and Standing Orders Template
- Referral Form and Report of Findings Template
- Permission and Medical History Form (Patient Information) Template
- Copy of the Statutes and Rules relating to Affiliated Practice Relationship



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DENTAL HYGIENE
Affiliated Practice Notification Form
Affidavit of Affiliated Practice Dental Hygienist Eligibility

Affiliated Practice (AP) Dental Hygienist Information A.R.S. 32-1289(E)(1)

Last Name _____ First _____ Middle _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Arizona License Number _____ Issue Date _____

AP Dentist Information A.R.S. 32-1289(E)(2)

Last Name _____ First _____ Middle _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Arizona License Number _____

Practice Information A.R.S. 32-1289(E)(3)

The dental hygienist has been actively engaged in dental hygiene practice for at least 2000 hours in the 5 years immediately preceding this Affiliated Practice Relationship as follows:

Name & Address of Practice/Employer	Dates of Practice/Employment	Total Number of Hours Worked
Total Hours:		

Affiliated Practice Agreement A.R.S. 32-1289(F)(1) – (8) and A.A.C. R4-11-609(E) & (F)

Attach a completed Affiliated Practice Agreement signed by the AP dental hygienist and dentist that includes the following:

1. ___ An identification of the affiliated practice setting in which the dental hygienist may engage in dental hygiene practice pursuant to this AP relationship.
2. ___ An identification of the procedures and standing orders that the dental hygienist must follow. The standing orders include the circumstances in which a patient may be seen by the dental hygienist.
3. ___ Acknowledgement that the dental hygienist must refer patients who have been assessed to the AP dentist for treatment or planning that is outside the dental hygienist's scope of practice and that the AP dentist may make any necessary referrals to other dentists.
4. ___ Acknowledgement that the patient be seen by a licensed dentist within 12 months of initial treatment by the dental hygienist and if the patient has not received an examination and treatment plan by a licensed dentist, the dental hygienist shall not provide further treatment.
5. ___ Acknowledgement that if the patient is 65 years of age or older be seen by a licensed dentist after treatment by the dental hygienist and if the patient has not received an examination and a treatment plan by a licensed dentist, the dental hygienist shall not provide further treatment
6. ___ Acknowledgement that if a patient presents with a complex medical history or medication regimen, the dental hygienist shall consult with the AP dentist prior to any treatment by the dental hygienist and that the patient shall be directed to the AP dentist. The AP dentist shall make any necessary referrals to other licensed dentists.
7. ___ Acknowledgement that the patient be informed that a licensed dental hygienist is providing the care and that the care does not take the place of a dental examination.
8. ___ Acknowledgement that the AP dentist is available telephonically or electronically during business hours of the AP dental hygienist to provide an appropriate level of contact, communication and consultation.
9. ___ A provision for a substitute dentist in the event of an extenuating circumstance that renders the AP dentist unavailable for contact, communication and consultation.

Continuing Education Information A.A.C. R4-11-609(A)(1)

The dental hygienist has completed 12 hours of continuing education. A minimum of 4 hours in medical emergencies and a minimum of 8 hours in at least two of the following: pediatric or other special health care needs, preventative dentistry or public health/community based dentistry.

Area	Title of Course	Course Sponsor	Date	Hours
Medical Emergencies				
Pediatric or Other Special Needs				
Preventative Dentistry				
Public Health Community Based Dentistry				
				Total hours:

Cardiopulmonary Resuscitation (CPR) A.A.C. R4-11-609(A)(2)

1. Hold a current certificate in basic cardiopulmonary resuscitation (CPR). Please attach a copy of your CPR certification.

Affiliated Practice Document Requirements

The following documents must be submitted with this notification:

- ___ Affiliated Practice Agreement

- ___ Standing Orders

- ___ Patient referral documents

- ___ Patient information documents (Permission and Medical History)

I, _____(your name), the Affiliated Practice Dental Hygienist, affirms that all information submitted by me in this Affiliated Practice Notification Form is true to the best of my knowledge and that I have met all the requirements of Arizona Revised Statutes § 32-1289 and Arizona Administrative Code R4-11-609.

I fully understand that any false statement in this Affiliated Practice Notification Form shall be grounds for disciplinary action authorized by A.R.S. 32-1263.

_____ Date _____ Signature of Dental Hygienist

STATE OF _____

County of _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20 _____.

Commission Expires:

_____ Notary Public

Affiliated Practice Agreement

_____ Dentist

And

_____ Dental Hygienist

agree to enter into an Affiliated Practice Relationship and to abide by all requirements of Affiliated Practice as stated in Arizona Revised Statutes (A.R.S.) § 32-1289 and Arizona Administrative Code (A.A.C.) Title 4, R4-11-609.

The effective date of this agreement is: _____

The termination date of this agreement is: _____

The dental hygienist and dentist shall notify the Arizona State Board of Dental Examiners within thirty days after the termination date of this agreement if the date is different than the contract termination date.

The affiliated practice setting in which the dental hygienist may engage in dental hygiene practice under this agreement is (Name, Address, Contact Information, etc):

This setting is a public health agency or institution, a public or private school authority or government sponsored program that provides dental services.

In this setting, the dental hygienist may perform dental hygiene procedures only on a person who is any of the following:

1. Enrolled in a federal, state, county or local health care program.
2. Participating in the national school meal program.
3. From a family with a household income that is less than two hundred per cent of the federal poverty guidelines.

The procedures and standing orders that the dental hygienist must follow under this agreement are stated in the attached Standing Orders document. The standing orders include the circumstances in which a patient may be seen by the dental hygienist.

The dental hygienist must refer patients who have been assessed to the affiliated practice dentist for treatment or planning that is outside the dental hygienist's scope of practice, and the affiliated practice dentist may make any necessary referrals to other dentists. If the patient has not received the treatment or planning for which the referral was made, the dental hygienist will not provide further treatment. A Referral Form that may be used is attached.

The patient must be seen by a licensed dentist within twelve months of initial treatment by the dental hygienist. If the patient has not received an examination and a treatment plan by a licensed dentist, the dental hygienist shall not provide further treatment.

If the patient is 65 years of age or older, they must be seen by a licensed dentist after treatment by a dental hygienist. If the patient has not received an examination and a treatment plan by a licensed dentist, the dental hygienist shall not provide further treatment.

If the patient has a complex medical history or medication regimen, the dental hygienist shall consult with the affiliated dentist prior to any treatment by the dental hygienist. The patient shall be directed to the affiliated dentist and the affiliated dentist and the affiliated dentist shall make any necessary referrals to other licensed dentists.

Patients will be informed that a licensed dental hygienist is providing the care and that the care does not take the place of a dental examination. A Patient Information Form that may be used is attached.

The dentist will be available telephonically or electronically during the business hours of the dental hygienist to provide an appropriate level of contact, communication and consultation. A substitute dentist will be available in the event of an extenuating circumstance that renders the Affiliated Dentist unavailable for contact, communication and consultation.

The dental hygienist will maintain an appropriate level of contact, communication and consultation with the affiliated dentist in the following manner (i.e. monthly meeting, weekly, conference call, etc.):

The dental hygienist will perform only those duties within the terms of this affiliated practice relationship and the Standing Orders attached. Root planing, administration of local anesthetics and nitrous oxide, and placement of sutures may not be performed. The dental hygienist is responsible and liable for all services rendered by the dental hygienist under this affiliated practice relationship.

The dental hygienist and dentist shall notify the Arizona State Board of Dental Examiners within thirty days after the termination date of this agreement.

Date Signature of Dental Hygienist

STATE OF _____

County of _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20 _____.

Commission Expires:

Notary Public

Date

Signature of Dentist

STATE OF _____

County of _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20 _____.

Commission Expires:

Notary Public



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**DENTIST
Affiliated Practice Notification Form**

Affiliated Practice (AP) Dentist Information A.R.S. 32-1289(D)

Last Name _____ First _____ Middle _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Arizona License Number _____

AP Dental Hygienist Information A.R.S. 32-1289(D)

Last Name _____ First _____ Middle _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Arizona License Number _____

I, the above cited Affiliated Practice Dentist, have entered into an Affiliated Practice agreement with the above cited Affiliated Practice Dental Hygienist.

A copy of the signed Affiliated Practice Agreement is attached to this Notification Form.

Date

Signature of Dentist

STATE OF _____

County of _____

SUBSCRIBED AND SWORN to before me this _____ day of _____, 20 _____.

Commission Expires:

Notary Public

*****This is a template and serves as a guideline of the required components*****

Procedures and Standing Orders For Dental Hygienist in an Affiliated Practice Relationship

Procedures allowed in this agreement

Assessment (any or all of the following may be provided):

- Medical and dental history review
- Blood pressure screening if indicated by medical condition
- Screen the oral cavity and surrounding structures to include any or all of the following assessments, as appropriate:
 - extraoral head and neck areas
 - intraoral hard and soft tissues
 - perform periodontal assessment
- Perform dental restorative charting and recording of clinical findings
- Expose and process dental radiographs according to ADA guidelines
- Perform a caries risk assessment

Dental Hygiene/Preventive Services (any or all of the following may be provided):

- Perform all procedures necessary for a complete prophylaxis, except root planing, the administration of local anesthetic, administration of nitrous oxide analgesia and placement of sutures.
- Apply dental sealants to teeth according to ADA and Centers for Disease Control and Prevention guidelines:
- Administer topical fluoride gels and varnishes as indicated according to ADA and Centers for Disease Control and Prevention guidelines:

Education:

- Discuss patient's homecare procedures and provide instruction when appropriate
- Provide tobacco cessation intervention and referral when appropriate.

General guidelines:

The dental hygienist should follow the standard of care for dental hygiene, and consult with the Affiliated Practice Dentist in questionable cases.

Other: _____

Circumstances in which a patient may be seen by the dental hygienist

The dental hygienist may provide treatment to the patient except in the following cases:

- Treatment should not be initiated if the intraoral screening indicates the following conditions:
 - Active herpetic lesions
 - Acute, symptomatic and/or painful dental infection
 - If the patient has not received the treatment or planning for which a previous referral was made by this dental hygienist, the dental hygienist shall not provide further treatment.
- Treatment should not be initiated if the patient does not meet the requirements of Arizona Revised Statutes (A.R.S.) § 32-1289(K).

- If the medical history review indicates any of the following conditions, consult with the Affiliated Practice Dentist before proceeding:
 - Tuberculosis (TB)
 - Diabetes
 - Seizures
 - Asthma or upper respiratory infection
 - Hemophilia
 - Leukemia
 - Non-compliance with premedication order when indicated, according to the ADA and the American Heart Association guidelines.

- If medical history indicates presence of systemic condition/disease (cardiovascular, uncontrolled thyroid, etc.), take and record patient's blood pressure. Consult with the Affiliated Practice Dentist if the blood pressure readings are not within standard guidelines for the age of the patient.

- Other: _____

Information to Patient; Referral

- Prior to treatment, parents or caregivers must be informed that "A licensed dental hygienist will be providing dental hygiene preventive services. This care does not take the place of a dental examination or complete dental care."

- After assessment and/or treatment, inform patient and parent/caretaker in writing of all conditions that should be called to the attention of a dentist. The form should include the statement, "A licensed dental hygienist provided dental hygiene preventive services. This care does not take the place of a dental examination or complete dental care."

- The form provided must include a written referral to the Affiliated Practice Dentist for treatment or planning that is outside of the dental hygienist's scope of practice (e.g., obvious, active caries). The Affiliated Practice Dentist may make necessary referrals to other dentists.

- Other: _____

*****This is a template and serves as a guideline of the required components*****

Referral Form and Report of Findings

Name of Program: _____

Affiliated Dental Hygienist: _____

Affiliated Dentist: _____

Today _____ (date), your child _____ (name) had a dental screening and/or dental hygiene prevention services provided by a **licensed dental hygienist**.

These are the findings and recommendations:

X	A. This is only a screening. This screening does not take the place of a dental examination. Your child should still have a regular dental check-up.
	B. Your child has a dental infection (abscess) and needs to see a dentist immediately.
	C. It appears your child has cavities! Cavities will not go away. Cavities spread to other teeth and can spread infection to the entire body. HURRY! Make an appointment with a dentist.
	D. No visible cavities: However, we did not take x-rays that would detect cavities between the teeth. It would be best for your child to see a dentist to be sure there are no cavities between the teeth.
	E. Cleaning: ____ Your child received a cleaning today. ____ Your child is in need of a dental cleaning and should visit a dental office soon.
	F. Sealants: ____ Your child received dental sealants today. ____ Your child is in need of sealants and should visit a dental office soon. ____ Your child's teeth cannot have dental sealants at this time because: ____ The molars appear to have decay. ____ The molars have fillings. ____ The molars already have sealants. ____ The permanent molars haven't come in yet. Please have them re-checked in 6 months.
	G. Fluoride: ____ Your child received a fluoride treatment today ____ Your child is in need of a fluoride treatment and should visit a dental office soon.
	H. Other findings and recommendations: _____ _____

Please call the dental office listed below for follow-up care. The dental hygienist may not provide further treatment to your child until any dental treatment outside the hygienist's scope of practice (such as fillings) is completed.

Affiliated Dentist _____ Phone (____) _____

Address _____

Dental Reminders

- Teeth should last a lifetime! Have your child brush his/her teeth everyday at home.
- Your child should have a complete checkup every year by a dentist to help prevent cavities, and to repair small cavities before they become large ones.

*****This is a template and serves as a guideline of the required components*****

Permission and Medical History Form (Patient Information)

Name of Program: _____

Affiliated Dental Hygienist: _____

Affiliated Dentist: _____

(Please print)

Child's Name: First _____ MI _____ Last _____

Address _____
Street City Zip Code

Home Phone (_____) _____ Date of Birth _____ Gender _____

Has your child ever visited a dentist before? Yes No

Does your child have or has your child had (please circle):

Asthma	Yes	No	Congenital Heart Disease	Yes	No
Heart Murmur	Yes	No	Rheumatic Heart Disease	Yes	No
Diabetes	Yes	No	Bleeding Problems	Yes	No
Seizures	Yes	No	Latex or Nickel Allergies	Yes	No
Tuberculosis (TB)	Yes	No			

Is your child taking any medications? Yes No

If yes, what medications? _____

Does your child have any allergies? Yes No

If yes, what allergies? _____

Has your child had any serious illness(es) or operation(s)? Yes No

If yes, what illness(es) or operation(s)? _____

Is there anything else we should know about the health of your child?

List _____

Who should we contact in the event of an emergency?

Name (print) _____ Daytime Phone (_____) _____

Address _____
Street City

I am the parent or guardian of the child named above. I give consent for my child to receive the dental screening and preventive oral health services provided by an Affiliated Practice Dental Hygienist. To the best of my knowledge, the medical history questions have been answered correctly and accurately. I allow my child to receive any x-rays, cleaning, sealants and/or fluoride that may be recommended.

I understand that the Affiliated Practice Dental Hygienist providing care is an Arizona licensed dental hygienist and that this care does not take the place of a complete dental examination or dental care. I understand that the hygienist will refer my child to a dentist for treatment outside the hygienist's scope of practice, and that if my child has not received the treatment, the dental hygienist may not provide further treatment.

Name of Parent/Guardian (Printed) _____

Signature _____ Date _____