DELINEATION OF CLINICAL PRIVILEGES IN DENTISTY AND DENTAL HYGIENE
DUBAI HEALTH CARE CITY

Name: _____

GENERAL DENTISTRY

Requires a D.D.S./D.M.D. degree or equivalent from dental school, and a current and valid license to practice in a country on the list of accepted jurisdictions (attached to the application).

Requested		Granted		
Yes	No	Yes	No	
				DIAGNOSTIC PROCEDURES:
___	___	___	___	Clinical Oral Examination
___	___	___	___	Intraoral Radiograph Interpretation
___	___	___	___	Panoramic Radiograph Interpretation
___	___	___	___	Cephalometric Radiograph Interpretation
___	___	___	___	Request and Interpretation of Clinical Pathology Examinations
___	___	___	___	Diagnostic Casts
___	___	___	___	Other (specify): _____
___	___	___	___	_____
				PREVENTIVE PROCEDURES:
___	___	___	___	Dental Prophylaxis
___	___	___	___	Topical Fluoride Application
___	___	___	___	Fabrication of Custom Fluoride Trays
___	___	___	___	Application of Sealants to teeth
___	___	___	___	Oral Hygiene Instruction
___	___	___	___	Passive Space Maintenance Procedures
___	___	___	___	Other (specify): _____
___	___	___	___	_____
				RESTORATIVE PROCEDURES:
___	___	___	___	Conventional Restorative Dentistry Procedures
___	___	___	___	Indirect Pulp Capping
___	___	___	___	Direct Pulp Capping
___	___	___	___	Other (specify): _____
___	___	___	___	_____
				ENDODONTIC PROCEDURES:
___	___	___	___	Pulpotomy
___	___	___	___	Pulp Extirpation
___	___	___	___	Conventional Root Canal Therapy
___	___	___	___	Endodontic Apical Curettage
___	___	___	___	Apicoectomy
___	___	___	___	Retrograde Filling of Tooth
___	___	___	___	Apexification
___	___	___	___	Root Amputation
___	___	___	___	Hemisection
___	___	___	___	Bleaching of Discolored Teeth
___	___	___	___	Other (specify): _____
___	___	___	___	_____

Name:_____

GENERAL DENTISTRY (continued)

Requested		Granted		
Yes	No	Yes	No	
	____	____		PERIODONTAL PROCEDURES:
____	____	____	____	Gingivectomy
____	____	____	____	Scaling and Root Planing
____	____	____	____	Gingival curettage
____	____	____	____	Gingival Flap Curettage
____	____	____	____	Crown Lengthening
____	____	____	____	Osseous Grafting Procedures
____	____	____	____	Provisional Splinting of Teeth
____	____	____	____	Other (specify): _____
____	____	____	____	_____
				PROSTHODONTIC PROCEDURES:
____	____	____	____	Tooth Replacement with Conventional Removable Prosthodontic Procedures
____	____	____	____	Tooth Replacement with Conventional Fixed Prosthodontic Procedures
____	____	____	____	Construction of Precision Attachments for Retention of Prostheses
____	____	____	____	**Replacement of Teeth with Implant Retained/Supported Abutments**
____	____	____	____	Repairs to Removable Prosthodontic Appliances
____	____	____	____	Repairs to Fixed Prosthodontic Appliances
____	____	____	____	Denture Rebase Procedures
____	____	____	____	Denture Reline Procedures
____	____	____	____	Other (specify): _____
____	____	____	____	_____
				ORAL AND MAXILLOFACIAL SURGERY PROCEDURES:
____	____	____	____	Extraction of Erupted Teeth
____	____	____	____	Surgical Extraction of Erupted Teeth
____	____	____	____	Surgical Removal of periapical granuloma/cyst in conjunction with extraction
____	____	____	____	Routine Alveoloplasty
____	____	____	____	Removal of tori and exostoses
____	____	____	____	Intraoral Biopsy - Soft Tissue
____	____	____	____	Intraoral Biopsy - Hard Tissue
____	____	____	____	Closure of Oral Mucosal Lacerations
____	____	____	____	Management of Dentoalveolar Infection with Oral Antibiotics
____	____	____	____	Incision and Drainage of Intraoral Abscess
____	____	____	____	Excision of Hyperplastic Tissue
____	____	____	____	Frenectomy
____	____	____	____	Other (specify): _____
				OTHER PROCEDURES
____	____	____	____	Administration of Local Anesthesia
____	____	____	____	Diagnostic Local Anesthesia Procedures
____	____	____	____	Treatment of Geriatric Patients
____	____	____	____	Treatment of Medically Compromised Patients
____	____	____	____	**Surgical Placement of Endosseous Dental Implants**
____	____	____	____	Minor Tooth Movement Procedures
____	____	____	____	Diagnosis & Non-Surgical Treatment of TMJ Disorders

Name:_____

GENERAL DENTISTRY (continued)

Requires a D.D.S./D.M.D. degree from an ADA-accredited dental school or equivalent.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Occlusal Adjustment
____	____	____	____	Desensitization Procedures
____	____	____	____	Occlusal Guard Fabrication
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

ANESTHESIA

Requires documentation of appropriate training and experience for requested privileges.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Local Anesthesia
____	____	____	____	Diagnostic Blocks with Local Anesthesia
____	____	____	____	Nitrous Oxide/Oxygen Inhalation Conscious Sedation
____	____	____	____	Enteral Conscious Sedation
____	____	____	____	Intravenous Conscious Sedation (* requires proof of training and current competency)

ENDODONTIA

Restricted to individuals with advanced training in Endodontia. Requires educational qualification, board eligibility or board certification in Endodontia.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Direct Pulp Capping
____	____	____	____	Indirect Pulp Capping
____	____	____	____	Therapeutic Pulpotomy
____	____	____	____	Pulp Extirpation
____	____	____	____	Conventional Root Canal Therapy
____	____	____	____	Apexification
____	____	____	____	Apical Curettage
____	____	____	____	Root Amputation
____	____	____	____	Apicoectomy
____	____	____	____	Retrograde Filling
____	____	____	____	Hemisection
____	____	____	____	Recalcification Procedures
____	____	____	____	Bleaching of Discolored Teeth
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

Name:_____

ORAL AND MAXILLOFACIAL SURGERY

Restricted to individuals with advanced training in Oral and Maxillofacial Surgery. Requires educational qualification, board/college eligibility or board/college certification in Oral and Maxillofacial Surgery.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Extraction of Erupted Teeth
____	____	____	____	Extraction of Exposed Tooth Roots
____	____	____	____	Surgical Removal of Erupted Teeth
____	____	____	____	Surgical Removal of Impacted Teeth
____	____	____	____	Surgical Removal of Residual Tooth Roots
____	____	____	____	Surgical Repair of Oro-Antral Fistula
____	____	____	____	Surgical Exposure of Unerupted tooth to Aid in Eruption
____	____	____	____	Surgical Exposure of Unerupted Tooth and Placement of Orthodontic Appliance to aid eruption
____	____	____	____	Biopsy of Oral Hard Tissue
____	____	____	____	Biopsy of Oral Soft Tissue
____	____	____	____	Surgical Repositioning of Teeth
____	____	____	____	Alveoloplasty
____	____	____	____	Surgical Excision of Hyperplastic Tissue
____	____	____	____	Surgical Removal of Benign Tumors
____	____	____	____	Surgical Removal of Odontogenic or Non-odontogenic Cysts
____	____	____	____	Apicoectomy, Apical Curettage, and Retrograde Filling
____	____	____	____	Removal of Tori and Exostoses
____	____	____	____	Intraoral Incision and Drainage of Abscess
____	____	____	____	Extraoral Incision and Drainage of Abscess
____	____	____	____	Removal of Foreign Body
____	____	____	____	Sequestrectomy
____	____	____	____	Maxillary Sinusotomy for Retrieval of Tooth or Foreign Body
____	____	____	____	Closed Reduction of Facial Fractures
____	____	____	____	Closed Reduction of Mandibular Dislocation
____	____	____	____	TMJ Arthrocentesis
____	____	____	____	Nonsurgical Management of TMJ Disorders
____	____	____	____	Nonsurgical Management of Atypical Facial Pain
____	____	____	____	Closure of Intraoral Soft Tissue Lacerations
____	____	____	____	Closure of Extraoral Soft Tissue Lacerations
____	____	____	____	Oral Mucosal Grafts
____	____	____	____	Frenectomy
____	____	____	____	Chieloplasty
____	____	____	____	Excision of Pericoronal Gingiva

Name:_____

ORAL AND MAXILLOFACIAL SURGERY (continued)

Restricted to individuals with advanced training in Oral and Maxillofacial Surgery. Requires educational qualification, board/college eligibility or board/college certification in Oral and Maxillofacial Surgery.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Crown Lengthening Procedures
____	____	____	____	Sialolithotomy
____	____	____	____	Surgical Placement of Endosseous Implants
____	____	____	____	Surgical Placement of Subpereosteal Implants
____	____	____	____	Guided Tissue Regeneration
____	____	____	____	Autogenous Bone Graft
____	____	____	____	Maxillary Sinus Floor Grafting
____	____	____	____	Ridge Augmentation with Autogenous Bone Grafting
____	____	____	____	Nonsurgical Management of Trigeminal Neuralgia
____	____	____	____	Nonsurgical Management of Diseases of the Oral Region
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

Privileges for the following procedures require that the practitioner perform the procedures in a hospital or recognized outpatient surgical center:

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Vestibuloplasty
____	____	____	____	Vestibuloplasty with Skin or Mucosal Grafting
____	____	____	____	Surgical Removal of Malignant Tumors (Stage I & II)
____	____	____	____	Surgical Destruction of Lesion by Physical Methods
____	____	____	____	Open Reduction of Facial Fractures
____	____	____	____	TMJ Manipulation under Anesthesia
____	____	____	____	TMJ Arthroscopy
				Orthognathic Surgical Procedures – List procedures:
				_____
				_____
____	____	____	____	Surgical Rapid Palatal Expansion
____	____	____	____	Skin Grafts
____	____	____	____	Osteoplasty
____	____	____	____	Surgical Peripheral Nerve Repair Procedures
____	____	____	____	Peripheral Neurectomy
____	____	____	____	Ankylotomy
____	____	____	____	Sialodochoplasty
____	____	____	____	Coronoidectomy
____	____	____	____	Ridge Augmentation with Alloplastic Materials
				Management of Cleft Lip and Palate Deformities – List Procedures
				_____
				_____
____	____	____	____	Temporomandibular Joint Surgery – List Procedures
____	____	____	____	Maxillofacial Bone and Soft Tissue Reconstructive Surgery
____	____	____	____	Other_____

Name:_____

ORAL MEDICINE, ORAL RADIOLOGY, AND ORAL PATHOLOGY

Restricted to individuals with advanced training in Oral Medicine, Oral Radiology, or Oral Pathology. Requires educational qualification, board/college eligibility or board/college certification in the appropriate specialty.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Intraoral Biopsy - Soft Tissue
____	____	____	____	Intraoral Biopsy - Hard Tissue
____	____	____	____	Administration of Local Anesthesia for Diagnostic Purposes
____	____	____	____	Treatment Benign Tumors by Intralesional Injection
____	____	____	____	Treatment of Oral Mucosal Lesions by Intralesional Injection
____	____	____	____	Request and Interpretation of Clinical Laboratory Examinations
____	____	____	____	Diagnostic Microscopic Histopathology
____	____	____	____	Diagnostic Microscopic Cytology
____	____	____	____	Diagnostic Immunofluorescence Microscopy
____	____	____	____	Nonsurgical Management of Diseases of the Oral Region
____	____	____	____	Diagnosis and Nonsurgical Management of TMJ Disorders
____	____	____	____	Diagnosis and Nonsurgical Management of Atypical Facial Pain
____	____	____	____	Interpretation of Conventional Intraoral Radiographs
____	____	____	____	Interpretation of Panoramic Radiographs
____	____	____	____	Interpretation of Extraoral Diagnostic Radiographs, CT, MRI
____	____	____	____	Sialography
____	____	____	____	Tomography
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

ORTHODONTIA

Restricted to individuals with advanced training in Orthodontia. Requires educational qualification, board/college eligibility or board/college certification in Orthodontia.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Minor Tooth Movement with Removable Appliance
____	____	____	____	Minor Tooth Movement with Fixed Appliance
____	____	____	____	Minor Treatment to Control Harmful Habits
____	____	____	____	Interceptive Orthodontic Treatment
____	____	____	____	Comprehensive Orthodontic Treatment - Transitional Dentition
____	____	____	____	Comprehensive Orthodontic Treatment - Permanent Dentition
____	____	____	____	Comprehensive Orthodontic Treatment - Extended Skeletal Case
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

Name:_____

PEDIATRIC DENTISTRY

Restricted to individuals with advanced training in Pediatric Dentistry. Requires educational qualification, board/college eligibility or board/college certification in Pediatric Dentistry.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Dental Prophylaxis
____	____	____	____	Topical Fluoride Application
____	____	____	____	Passive Space Maintenance Procedures
____	____	____	____	Removal of Dental Caries
____	____	____	____	Conventional Restorative Dentistry Procedures
____	____	____	____	Pulpotomy
____	____	____	____	Root Canal Therapy of Primary Teeth
____	____	____	____	Conventional Root Canal Therapy
____	____	____	____	Prosthetic Tooth Replacement with Removable Prosthodontic Procedures
____	____	____	____	Prosthetic Tooth Replacement with Fixed Prosthodontic Procedures
____	____	____	____	Routine Dental Extraction
____	____	____	____	Intraoral Biopsy
____	____	____	____	Incision and Drainage of Intraoral Abscess
____	____	____	____	Minor Tooth Movement with Removable Appliance
____	____	____	____	Minor Tooth Movement with Fixed Appliance
____	____	____	____	Minor Treatment to Control Harmful Habits
____	____	____	____	Interceptive Orthodontic Treatment
____	____	____	____	Other (specify): _____

PERIODONTIA

Restricted to individuals with advanced training in Periodontia. Requires educational qualification, board/college eligibility or board/college certification in Periodontia.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Scaling and Root Planing
____	____	____	____	Gingivectomy
____	____	____	____	Gingival Curettage
____	____	____	____	Gingival Flap Curettage
____	____	____	____	Crown Lengthening Procedures
____	____	____	____	Mucogingival Surgery
____	____	____	____	Periodontal Osseous Surgery
____	____	____	____	Osseous Grafting Procedures
____	____	____	____	Pedicle Soft Tissue Graft Procedure
____	____	____	____	Free Soft Tissue Graft Procedure
____	____	____	____	Apically Positioned Flap Procedure
____	____	____	____	Guided Tissue Regeneration
____	____	____	____	**Surgical Placement of Endosseous Dental Implants**
____	____	____	____	Provisional Splinting of Teeth
____	____	____	____	Maxillary Sinus Floor Grafting
____	____	____	____	Other (specify): _____
____	____	____	____	_____

Name:_____

PROSTHODONTIA

Restricted to individuals with advanced training in Prosthetic Dentistry. Requires educational qualification, board/college eligibility or board/college certification in Prosthetic Dentistry.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Replacement of Teeth with Conventional Removable Prostheses
____	____	____	____	Replacement of Teeth with Conventional Fixed Prostheses
____	____	____	____	**Replacement of Teeth with Implant Retained/Supported Abutments**
____	____	____	____	Repairs to Complete Dentures
____	____	____	____	Repairs to Partial Dentures
____	____	____	____	Repairs to Fixed Prostheses
____	____	____	____	Denture Rebase Procedures
____	____	____	____	Denture Reline Procedures
____	____	____	____	Construction of Precision Attachments for retention of Prostheses
____	____	____	____	Maxillofacial Prosthetic Replacement for Intraoral Acquired or Congenital Defects
____	____	____	____	Maxillofacial prosthetic Replacement for Extraoral Acquired or Congenital Defects
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

DENTAL HYGIENE

Requires Certificate, Diploma, or degree in Dental Hygiene from an accredited school and a license to practice in a country on the list of accepted jurisdictions.

Requested		Granted		
Yes	No	Yes	No	
____	____	____	____	Obtain Medical History
____	____	____	____	Examination of Teeth and Oral Structures
____	____	____	____	Dental Prophylaxis and Polishing of Clinical Crowns of Teeth
____	____	____	____	Scaling and Root Planing
____	____	____	____	Application of Sealants to Teeth
____	____	____	____	Topical Fluoride Application to Teeth
____	____	____	____	Polishing of Dental Restorations
____	____	____	____	Patient Education in Oral Health Maintenance
____	____	____	____	Diet Counseling
____	____	____	____	Exposure of Dental Radiographs
____	____	____	____	Community Dental Health Program Implementation
____	____	____	____	Obtain Alginate Impressions
____	____	____	____	Placement of Temporary Dental Restorations
____	____	____	____	Other (specify): _____
____	____	____	____	_____
____	____	____	____	_____

I hereby request the specific privileges as indicated on this delineation of privileges listing.

Signature of Applicant _____ **Date** _____

APPROVED:

Medical Director/Dentist _____ **Date** _____