ATRIUM HEALTH ANSON
DELINEATION OF PRIVILEGES
SPECIALTY OF DENTISTRY

I have reviewed the DOP/Roster provided to me by MSS and confirm as indicated below:

☐My DOP is accurate and reflects privileges relevant to my current practice

☐I have listed privileges that should be removed:

Printed Name: _____

Signature: _____

Date: _____

If your roster indicates that you hold any of the privileges listed below, you must provide the maintenance criteria as described, in order to maintain the privilege. Your maintenance criteria and attestation must be returned together.

N/A - NO MAINTENANCE CRITERIA

STOP:

UNLESS YOU ARE REQUESTING NEW PRIVILEGES, YOU DO NOT NEED TO GO BEYOND THIS POINT.

Select records where Specialty equals Dentistry

Carolinas HealthCare System Anson

Name: _____

Anson Community Hospital

Privilege/Procedure Application Form

PR9 **12/04/14**

Sort By: **Department, Specialty, Category, Procedure**

Department of: Medicine
Specialty: Dentistry

Category: Not applicable

SubCategory: Not applicable

	Privilege/Procedure
	NA
_____	General Dental Treatment (including but not limited to): Composite Restorations, Deep Root Scaling, Dental Arches, Dental Intra Oral Radiography, Suture Removal, Teeth Extractions

Applicant:_____

Date: _____

Select records where Specialty equals Dentistry