**Dental Hygienist Public Health Supervision Agreement**

**Check one:**

 New agreement (no other agreement for this hygienist is on file)

 Additional agreement (this agreement will be in addition to an existing and still current agreement on file)

 New agreement (this agreement will replace an existing agreement on file)

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| **Dental Hygienist** | | | | | | | |
| Last Name: |  | | | License #: | |  | |
|  |  | | |  | |  | |
| First Name: |  | | | Work Phone: | |  | |
|  |  | | |  | |  | |
| Middle Name: |  | | | Personal Email: | |  | |
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| Work Address 1: |  | | | Work Email: | |  | |
|  |  | | |  | | | |
| Work Address 2: |  | | |  | | | |
|  |  | | | | | | |
| City: |  | State: |  | | Zip Code: | |  |
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| Years of Clinical Practice Experience: | |  |  | | | | |
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| **Supervising Dentist** | | | | | | | |
| Last Name: |  | | | License #: | |  | |
|  |  | | |  | |  | |
| First Name: |  | | | Work Phone: | |  | |
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| Middle Name: |  | | | Email: | |  | |
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| Work Address 1: |  | | |  | | | |
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| Work Address 2: |  | | |  | | | |
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| City: |  | State: |  | | Zip Code: | |  |
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| **Public Health Setting** | | | | | | |
|  | School |  | Child care centers (excluding home-based) | |  | Public health dental van |
|  | Head Start | | | |  | Free clinic |
|  | Federally qualified health center | | | |  | Nursing home |
|  | Federal, state, or local public health program | | | |  | Nonprofit community health center |
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| Clinic Location/Name or Service Site: | | | |  | | |
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| Clinic Location/Name or Service Site: | | | |  | | |
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| **Consultation Requirements** |
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| A dentist in a public health supervision agreement must be available to provide communication and consultation with the dental hygienist. A dental hygienist working under public health supervision must maintain contact and communication with their supervising dentist. |
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| Specify the type (e.g. in person, telephone), frequency, and other details regarding how communication and consultation will be maintained: |
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| **Dental Records** | |
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| Specify the procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist: | |
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| Location of records: |  |

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| **Patient Consideration** |
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| A dental hygienist working under public health supervision must practice according to age and procedure-specific standing orders as directed by the supervising dentist, unless otherwise directed by the dentist for a specific patient. |
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| Medical conditions that require a dental evaluation prior to hygiene services: |
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| Considerations for medically-compromised patients: |
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| In addition, for each patient the hygienist must: |
| * Have each patient sign a consent form that notifies the patient that the services that will be received do not take the place of regular dental checkups at a dental office and are meant for people who otherwise would not have access to services. |
| * Provide to the patient, parent, or guardian a written plan for referral to a dentist and assessment of further dental treatment needs. |
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**Standing Orders**

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|  | | | | | |
|  | Procedure: | Assessment/Screening | | |  |
| Age Group | | |  |
| Standing Orders: | | | |
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| Yes  No | | Assessment/Screening can continue to be provided if no dental exam has taken place. | |
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|  | Procedure: | Assessment/Screening to determine need for sealants | | |  |
| Age Group | | |  |
| Standing Orders: | | | |
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| Yes  No | | Assessment/Screening can continue to be provided if no dental exam has taken place. | |
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|  | Procedure: | Sealants | | | |  |
| Age Group | | | |  |
| Standing Orders: | | | | |
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| Hygienist can continue to provide this service up to | |  | months before an exam by a dentist must occur | |
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**Standing Orders Continued**

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|  | Procedure: | Fluoride Varnish | | |  |
| Age Group | | |  |
| Standing Orders: | | | |
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| Yes  No | | Fluoride varnish can continue to be provided if no dental exam has taken place. | |
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|  | Procedure: | Silver Diamine Fluoride | |  |
| Age Group | |  |
| Standing Orders: | | |
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| |  |  | | --- | --- | |  | | | Yes  No | Silver diamine fluoride can continue to be provided if no dental exam has taken place. | |  | | | | |
| |  |  | | --- | --- | | Date supervising dentist completed board-approved training for silver diamine fluoride: |  | | Date supervised dental hygienist completed board-approved training for silver diamine fluoride: |  | |  | | | | |

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|  | Procedure: | Oral Prophylaxis | | | |  |
| Age Group | | | |  |
| Standing Orders: | | | | |
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| Hygienist can continue to provide this service up to | |  | months before an exam by a dentist must occur | |
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**Standing Orders Continued**

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|  | Procedure: | Radiographs | | | |  |
| Age Group | | | |  |
| Standing Orders: | | | | |
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| Hygienist can continue to provide this service up to | |  | months before an exam by a dentist must occur | |
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|  | Procedure: |  | | | |  |
| Age Group | | | |  |
| Standing Orders: | | | | |
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| Hygienist can continue to provide this service up to | |  | months before an exam by a dentist must occur | |
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|  | Procedure: |  | | | |  |
| Age Group | | | |  |
| Standing Orders: | | | | |
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| Hygienist can continue to provide this service up to | |  | months before an exam by a dentist must occur | |
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**Other Requirements**

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| Indicate any other condition or requirements for your supervision agreement here. |
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| This public health supervision agreement must be reviewed at least biennially. A copy of the agreement must be mailed, emailed or faxed to the Bureau of Oral and Health Delivery Systems at the Iowa Department of Public Health and made available to the Iowa Dental Board upon request. |
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| A dental hygienist who has rendered services under public health supervision must complete a summary report at the completion of the program or in the case of an ongoing program, once per calendar year. The report shall be filed with the Bureau of Oral and Health Delivery Systems at the Iowa Department of Public Health on forms provided by the department. The department will email instructions and the form at the end of each calendar year. |
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| I agree to provide public health supervision to the dental hygienist named herein according to the details specified in this public health supervision agreement and the rules of the Iowa Dental Board. | | |
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| Dentist Signature |  | Date |
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| I agree to provide dental hygiene services according to the details specified in this public health supervision agreement and the rules of the Iowa Dental Board. | | |
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| Dental Hygienist Signature |  | Date |

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| To see the public health supervision rules for questions regarding public health supervision, please contact the Iowa Dental Board at (515) 281-5157 or visit the Board’s website at <https://www.dentalboard.iowa.gov/>. |
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| A copy of this agreement must be mailed or faxed to: |
|  |
| Iowa Department of Public Health  Bureau of Oral and Health Delivery Systems  321 E 12th Street  Des Moines, IA 50319  Toll Free: (866) 528-4020  Fax: (515) 242-6384 |