Arkansas Department of Health
Office of Oral Health

4815 West Markham, Slot 18
Little Rock, AR 72205
501-280-4111
rachel.sizemore@arkansas.gov

COLLABORATIVE CARE PERMIT FOR DENTISTS AND HYGIENISTS

APPLICANT INFORMATION (COLLABORATIVE DENTIST)		
Name:		Arkansas Dental License Number:
Office Address:		
City:	State:	ZIP Code:
Phone #:	Email:	Fax #:

Which Collaborative Care Permit are you and your hygienist(s) applying for (check one)? ☐ **Permit I** ☐ **Permit II**

APPLICANT INFORMATION (COLLABORATIVE HYGIENIST)		
Name:		Arkansas Dental Hygiene License Number:
Address:		
City:	State:	ZIP Code:
Phone #:	Email:	

Location of Care	
In what public setting are you planning to practice Collaborative Care?	
Address: Street	City

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Term of Practice

When do you anticipate beginning services?

If practicing in a school setting, in what tier does your school belong?

SIGNATURES

As a collaborative and consulting dentist, I agree to the following:

- To enter into a collaborative agreement with no more than three (3) collaborative dental hygienists.
- To be available to provide emergency communication and consultation with the dental hygienist(s) or appoint another dentist as a designee for those times when I (the consulting dentist) cannot be reached.
- To maintain records of patients treated, and to be responsible for the transfer of records if another dentist provides follow-up treatment.
- To maintain a copy of the Collaborative Agreement and Protocol on file with ASBDE
- To notify the ASBDE and the Office of Oral Health if the collaborative agreement between me and my hygienist(s) dissolves or contact information changes. Furthermore, I agree to notify ASBDE and the Office of Oral Health within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To submit an annual report by January 31st of each calendar year to the ASBDE office – see Article XIX (H)
- To report annually to the Office of Oral Health

Signature of dentist:	Date:

As a collaborative dental hygienist, I agree to the following:

- To enter into a collaborative agreement with no more than one (1) collaborative dentist.
- To maintain contact capabilities with the consulting dentist.
- To secure information consent from all patients or the parent/guardian of the patient before providing services.
- To provide to the patient, parent, or guardian a written plan for referral to a dentist for assessment of further dental treatment needs.
- To provide copy of collaborative care record of services to the institutional facility responsible for patient's care, when applicable.
- To secure release of information forms from the patient or parent/guardian of the patient if the care is provided in an institutional facility allowing me to access the patient's medical and dental records.
- To create and maintain all patient records and forward all records and radiographs or duplicates to the consulting dentist within seven (7) days of services rendered.
- To maintain a copy of the collaborative agreement and protocol on file.

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- To notify the ASBDE and the Office of Oral Health if the collaborative agreement between me and my consulting/collaborative dentist dissolves or contact information changes. Furthermore, I agree to notify ASBDE and the Office of Oral Health within thirty (30) days of the cessation of operation of any collaborative care agreement.
- To maintain a malpractice liability policy for the provision of services.
- To submit an annual report by January 31st of each calendar year to the ASBDE office – see Article XIX (H)
- To report annually to the Office of Oral Health

Signature of hygienist:	Date: