

MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 200 • 715 S. Pear Orchard Road • Ridgeland, MS • 39157 • 601-944-9622 • www.dentalboard.ms.gov

TO: MISSISSIPPI LICENSED DENTISTS

FROM: Denny Hydrick, Executive Director

SUBJECT: Application to Authorize General Supervision

Authorization to Practice under General Supervision by a Supervising Dentist requires the following:

1. The supervising dentist must submit a complete application to the Board with payment of a \$25.00 registration fee for each dental hygienist he or she authorizes to practice under general supervision.
2. The supervising dentist may only authorize dental hygienists that are registered with the Board to practice under general supervision.
3. A supervising dentist may authorize no more than three (3) dental hygienists under general supervision at any time.
4. Express authorization by the supervising dentist shall be conferred to the dental hygienist exclusively through the Board's online licensure system.

Practice Considerations:

The supervising dentist shall establish written emergency protocols for general supervision, and the dental hygienist shall adhere to such protocols.

- A. The emergency protocols shall be signed and dated by the supervising dentist and all dental hygienists practicing under his or her general supervision, indicating review of, the opportunity to ask questions, and agreement by all parties.
- B. A copy of the signed and dated emergency protocols shall be made available to Board representatives within twenty-four (24) hours of request by the Board.

The supervising dentist shall provide written treatment protocols for patients seen under general supervision, and the dental hygienist shall adhere to such protocols.

A dental hygienist may not administer nitrous oxide or local anesthesia under general supervision.

A dental hygienist may not treat a patient under general supervision:

- A. That has not been examined by the supervising dentist within the previous seven (7) months or does not have a patient record;
- B. Twice consecutively;
- C. That is under eighteen (18) years of age; or
- D. That has an American Society of Anesthesiologists (ASA) Physical Status Classification beyond ASA Class II.

Patients seen under general supervision must receive advance notification that the supervising dentist will not be present.

- A. Such notification must be documented in the patient's record.
- B. Advance notification cannot be same-day notification.

The practice of general supervision shall be restricted in the number of days practiced as follows:

The supervising dentist shall not:

- A. Permit the practice of dental hygiene under general supervision, unless and until the dental hygienist is registered with the Board to practice under general supervision and the supervising dentist authorizes the dental hygienist to practice under general supervision via the Board's online licensure system.

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- B. Supervise an individual dental hygienist under general supervision for more than twenty-four (24) total days per calendar year.
- C. Practice general supervision for more than ten (10) consecutive business days, regardless of which dental hygienist(s) the supervising dentist supervises

The dental hygienist shall not:

- A. Practice under general supervision for more than twenty-four (24) total days per calendar year, regardless of the specific supervising dentist.
- B. Practice under general supervision for more than ten (10) consecutive business days, regardless of the specific supervising dentist.

The practice of dental hygiene under general supervision for any period of time, no matter how brief, shall constitute one (1) full day of general supervision practice, as applied to both the supervising dentist and the dental hygienist.

The general supervision of up to three (3) dental hygienists by the same supervising dentist on the same day shall only constitute one (1) day of general supervision practice, as applied to both the supervising dentist and the dental hygienist(s).

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APPLICATION TO AUTHORIZE GENERAL SUPERVISION

<i>Mississippi Dentist and Facility Information</i>				
Last Name	First Name	Middle Name		
Dental License #				
Facility/Clinic 1 Name	Address	City	State	Zip
Facility/Clinic 2 Name	Address	City	State	Zip

<i>Dental Hygienist(s)</i>			
Last Name	First Name	Middle Name	Hygiene Lic. #
Last Name	First Name	Middle Name	Hygiene Lic. #
Last Name	First Name	Middle Name	Hygiene Lic. #

In addition to the foregoing, I add the following:

- (a) I understand that I am responsible to ensure that the above registered Dental Hygienists practice under my general supervision pursuant to Miss. Code Ann. § 73-9-5 and MSBDE Regulation 13.
- (b) I hereby grant permission to the Mississippi State Board of Dental Examiners to secure additional information concerning me or any statement in this Application from any person or any source the Board may desire. Additionally, I understand that the Board will post on its Internet web site all information it deems necessary to enable the public to verify my registration as the supervising dentist for the licensed dental hygienists listed. I further agree to submit to questioning by the Board or any member thereof, and to substantiate my statements if desired by the Board.
- (c) I, _____, the applicant herein, depose and say that all facts, statements, and answers contained in this Application are true and correct; I am not omitting any information which might be of value to this Board in determining my qualifications and character, whether it is called for or not; and I agree that any falsification, omission, or withholding of information or facts concerning my qualifications as an applicant shall be sufficient to bar me from registration in Mississippi, and such falsifications, omissions, or withholding shall serve as sufficient grounds for the suspension, cancellation, or revocation of my Mississippi Dental License even though it is not discovered until after issuance.

Applicant's Signature: _____

Date: _____

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Return the notarized application with a check or money order for the registration fee to:

MS State Board of Dental Examiners
715 S. Pear Orchard Road
Suite 200
Ridgeland, MS 39157

SWORN TO AND SUBSCRIBED BEFORE ME on this the

_____ day of _____, 20_____

Notary Public:_____

State:_____ County:_____

My Commission Expires:_____

MSBDE Office use only:	
Date Registration Approved:	By person(s)