

# South Dakota: Dental Hygienist Collaborative Supervision Reporting Form

Dental Hygienist Name: \_\_\_\_\_

Supervising Dentist Name: \_\_\_\_\_

Beginning Service Date: \_\_\_\_\_ Ending Service Date: \_\_\_\_\_

Public Health Setting: (Check one)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> School                            | <input type="checkbox"/> Head Start Program               | <input type="checkbox"/> Dept. of Corrections Program    |
| <input type="checkbox"/> Mobile Dental Unit                | <input type="checkbox"/> Dept. of Social Services Program | <input type="checkbox"/> Dept. of Human Services Program |
| <input type="checkbox"/> Federally Qualified Health Center | <input type="checkbox"/> Dept. of Health Program          | <input type="checkbox"/> Nursing Home                    |

Clinic/Location Name or Service Site: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Service Provided	Total Number Provided	Total Number Clients Served Ages 0-18	Total Number Clients Served Ages 19-64	Total Number Clients Served Ages 65+	Total Hygienist Hours
Sealant					
Prophylaxis					
Fluoride varnish application					
Other (please specify)					

Referral to Dentist(s)	Clients Age 0-18		Clients Age 19-64		Clients Age 65+	
	Regular Care	Urgent Care	Regular Care	Urgent Care	Regular Care	Urgent Care

Each dental hygienist who has rendered services under collaborative supervision must complete this summary report and submit this information to the board at the completion of a program or, in the case of an ongoing program, at least annually. Please enter this information by logging into your account at [www.sdboardofdentistry.com](http://www.sdboardofdentistry.com).