State of New Hampshire
OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
DIVISION OF LICENSING AND BOARD ADMINISTRATION
Board of Dental Examiners
7 Eagle Square, Concord, NH 03301-4980
Phone: 603-271-2152

Public Health Supervision Program
Summary Report Form

I. Program Information and Demographics

A. Dates covered by this report: _____

B. General information

1. Program Name: _____
   Address: _____
   Phone: _____

2. Program services provided (check all that apply):

___ Oral screenings	___ Referrals
___ Prophylaxis	___Radiography
___ Fluoride treatments	___Operative
___ Individual oral hygiene education	___Endodontics
___ Group dental health education	___Surgery
___ Sealants applied by program staff	___Other: _____
___ Fluoride rinse programs	

3. Towns or counties served: _____
   _____
   _____

4. Population served (i.e. school children, underserved adults, etc.): _____
   _____
   _____

II. Program Services Provided

A. Total number of clients screened: _____

B. Number of clients receiving referral to a dentist: _____

Number of referrals to dentist for evaluation of caries_____
Divided by the
Number of clients screened_____ = Percent referred to dentist _____%

% Last year_____ % Previous year_____

C. Number of clients receiving preventive care (prophylaxis, OHI, fluoride treatments and/or sealants): _____

D. Number of clients participating in a fluoride rinse program: _____

E. Number of group (i.e. classroom) dental health presentations: _____

III. Licensed Professional Staff and Support

A. Registered Dental Hygienists

1. Number of dental hygienists employed by this program: _____

2. Number of dental hygienists that volunteer with this program: _____

3. Please list names of dental hygienists associated with this program as employees or volunteers: (attach additional sheet if necessary)

_____

_____

_____

B. Dentists

1. Number of Supervising Dentists for this program: _____

2. Number of dentists that volunteer with this program:

_____

3. Please list names of dentists associated with this program as volunteers: (attach additional sheet if necessary)

_____

_____

_____

Report Submitted by:_____ Date:_____

For Supervising Dentist(s):

I authorize the procedures carried out by the dental hygienists associated with this program and review the dental records of clients served by this public health dental program once in a twelve-month period.

Signature:_____ Date:_____

Printed Name of
Supervising Dentist:_____ Phone #:_____

Address:_____

Signature:_____ Date:_____

Printed Name of
Supervising Dentist:_____ Phone #:_____

Address:_____