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 (ie. 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 (ie. 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.

Date: __________________________________________________________
Signature: ______________________________________________________
Printed Name of Supervising Dentist: ______________________________
Address: _______________________________________________________
Phone: _________________________________________________________

Date: __________________________________________________________
Signature: ______________________________________________________
Printed Name of Supervising Dentist: ______________________________
Address: _______________________________________________________
Phone: _________________________________________________________

Revised 11/17/11