

2010 Oral Health Risk Assessment Preceptorship Program Application

Name: _____

Title: _____

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

E-mail: _____

Please answer the following questions (Note-you need not limit your answers, this form allows space for as extensive an answer as is needed):

- 1. Describe your site/practice (eg patient population, case mix, referral pattern, teaching facility, practice organization [eg solo, single specialty, multi-specialty], staff complement, [eg, MD, PNP, RN, clerical, etc.]).**

- 2. Check the demographics that apply to your site and the surrounding community (check all that apply) –**
 - Urban
 - Rural
 - Suburban
 - Agricultural
 - Industrial

- 3. Describe further details about your site/community that will help us to understand your need for oral health education/risk assessment training (eg population of low socio-economic status, high rate of uninsured, high rate of children ages 0 – 3 at risk for caries, site diversity with multiple cultures and languages spoken, lack of pediatric dental providers, etc).**

- 4. If you are currently providing some oral health care in your office, please describe what is done and your coordination of care with dental health providers.**

- 5. If there are pediatric dentists or general dentists who see children in your community, please indicate approximately how many are available and describe your interactions with them (ie are they willing to see patients 0 – 3, can you easily refer to them, can your patients get to their office, do they provide care for Medicaid children, do they communicate back to you about your patients, etc).**

If none, please indicate below and describe the barriers to having pediatric dental care in your community.

6. Describe the oral health risk assessment that you are providing to your pediatric population currently. *If you are using a formal risk assessment, please attach to this application.* If none, please describe the barriers that prevent you from performing these assessments.

7. Does your site/practice provide services such as fluoride varnish application, use of and information about fluoridation? If yes, please explain.

8. Please provide any final details not covered in the questions above to describe how your practice/site would benefit from the training program.

9. Indicate your familiarity with the AAP's Bright Futures Guidelines for Health Supervision?

Very Familiar

Somewhat Familiar

Not at all Familiar

10. Have you had an opportunity to implement Bright Futures Guidelines/AAP Pediatric Preventive Care Recommendations (periodicity schedule) in your practice?

Yes

No

If yes, what aspects:

11. If awarded this opportunity, please indicate how you would disseminate the information learned to others within your practice/community (ie provide in-service to office staff, present at local association meetings, partner with your AAP Chapter to share acquired oral health training).

12. If awarded, are there barriers within your communities or health systems that make it difficult to implement Bright Futures in your practice setting?

13. Please indicate here if you have a preference for a specific preceptor to come to your site. If so, please provide the preceptor's name and email below. *Note – this is not required nor is it guaranteed that the requested preceptor will visit your site if the grant is awarded. Past preceptors can be found on the Oral Health Initiatives Web site <http://www.aap.org/oralhealth/preceptorship-all.cfm>.*

Preceptor Name

Preceptor Email

DEADLINE: Completed application should be sent ELECTRONICALLY to oralhealth@aap.org by April 19, 2010.