



National Institute for Health Specialties

Dental Internship Accreditation Information Form

1. GENERAL INFORMATION	
1 Application Information	
Date:	
Application Type:	<input type="checkbox"/> New (Initial Accreditation Application) <input type="checkbox"/> Renewal (Continued Accreditation Application)
2 Institution Information	
Name of Sponsoring Institution:	
Address:	
PO Box:	
Governmental institution:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sponsoring Institution's Governing Body:	
Accreditation Status:	
Is the sponsoring institution accredited by NIHS:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Commission International Approved:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If above is (No), Is it recognized by Equivalent Entity:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does sponsor have an affiliation with a dental school (could be the sponsoring institution):	<input type="checkbox"/> Yes <input type="checkbox"/> No
If (Yes), The name of the dental school:	
Total Number of Interns per year:	
Total Number of Interns last year:	

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3 Program Leadership			
<i>Program Director</i>			
Name:			
Address:			
Telephone:			
Email:			
<i>Associate Program Director (if applicable in compliance with NIHS program size requirements)</i>			
Name:			
Address:			
Telephone:			
Email:			
<i>Program Coordinator:</i>			
Name:			
Address:			
Telephone:			
Email:			
4 Vision and Mission			
Educational Vision and Mission statement:			
Rationale statement for seeking NIHS accreditation:			
2. PARTICIPATING SITES			
1 Provide the following information for each participating site.			
Speciality (Rotation)	Institution	Name of Site Director	Email
2 Does at least one participating site provide Fundamental Clinical Skills (FCS) rotations? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", which rotation(s)? Click or tap here to enter text.			
3 Is there a Program Letter of Agreement (PLAs) with participating sites in compliance with the NIHS requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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If the answer is No, explain: [Click or tap here to enter text.](#)

3. PERSONNEL AND RESOURCES

A. Program Director (PD)

1. Does the program director?

a) Have at least three years of documented educational and/or administrative experience?

Yes

No

b) Hold license as consultant/specialist and have at least three years post residency documented experience?

Yes

No

c) Actively participate in program administration and educational activities?

Yes

No

2. What is the PD Qualification(s)?

3. Select the FTE of non-clinical time provided to Program Director to the administration of the program based on program size according to the NIHS requirements as follows:

Number of Approved Interns Positions	Minimum FTE	Check
1-11	0.25	<input type="checkbox"/>
12-1	0.3	<input type="checkbox"/>
20 or more	0.4	<input type="checkbox"/>

B. Associate Program Director (APD) (if applicable in compliance with NIHS program size requirements)

a) Has the program appointed (an) associate program director(s)?

Yes

No

b) Does the associate program director actively participate in program administration and educational activities?

Yes

No

c) Does the sponsoring institution provide the associate program director with adequate protected time for program administration (0.2 Full-Time Equivalent)?

Yes

No

C. Resources: Describe how the program will ensure that interns have access to adequate resources. (Limit response to 400 words)

[Click or tap here to enter text.](#)

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4. FACULTY INFORMATION

Faculty information

A. Complete the following table: (for your convenience, you may submit it as separate attachment)

Name of faculty as written in passport	Faculty Type: (faculty, core faculty, PD, APD)	Gender	Nationality	Emirates ID	Date of Birth	Email	Mobile No.	Date first appointed in the current position

B. Number of hours per week faculty member devotes to this program's activities in the following:

Name of faculty as written in passport:	Clinical Supervision of Interns	Administration of the program	Research	Didactics/Teaching with residents	Total hours devoted to this program	Case Log Attendings (Active) Yes\No

C. Specialty Certifications:

Name of faculty as written in passport	Specialty	Certification Board or Equivalent	Certification Date	Formal Trainer: Yes\No	If yes, Training: Institution\University	Postgraduate Training: (Residency\ fellowship\ others, please specify)	First attended	Last attended

D. Licensing:

Name of faculty as written in passport	License Number	Licensing Authority	Licensed As: (Consultant, specialist, GP)	Specialty as written in medical license	Expiration Date	Health Facility Name

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E. Professional Experience							
Name of faculty as written in passport	Academic Position (DIO, PD, APD, Faculty, Others, please Specify)	Start Date	End Date	Organization	Summary of duties and responsibilities		
	Current						
F. Teaching Program Details							
Name of faculty as written in passport	Specialty Name	Year	Institution	Role	FTE	Faculty Evaluation	
						Attachment	
G. Awards and Honors							
Name of faculty as written in passport	Type	Awards and Honors Title	Awarded By	Country	Date Awarded		
H. Scholarly Activities							
Name of faculty as written in passport	PMID (Not Mandatory)	Publication Title	Publication Date	Publisher\Journal	Role (First Author, Corresponding, Co Author)	Type of Publication (Journal Articles, Case report, letter, Clinical Trial, Conference Abstract, Book and Documents, Editorial, Review)	Research Interest

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I. Core Faculty to Interns Ratio:	Click or tap here to enter text.
J. Faculty to Interns Ratio:	Click or tap here to enter text.
K. Describe the process to maintain faculty development and enhance their teaching interest. Click or tap here to enter text.	
L. With regards to Faculty Development, in which areas have program faculty participated in faculty development over the past year?	<input type="checkbox"/> as educators <input type="checkbox"/> in quality improvement and patient safety <input type="checkbox"/> in fostering their own and their interns' well-being <input type="checkbox"/> in patient care based on their practice-based learning and improvement efforts <input type="checkbox"/> None of the above
M. Do you have a performance assurance and reward system for the faculty? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below: Click or tap here to enter text.	
N. Describe Faculty involvement in the program planning and ongoing program review and evaluation. Click or tap here to enter text.	

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5. INTERNS INFORMATION

Intern information

A. Complete the below table about the actively enrolled interns in the program (add rows as required)

Name as written in passport	Gender	Nationality	Emirates ID	Date of Birth	Email	Mobile	Intern current status (active, completed training, inactive)	Internship Start Date	Expected Completion Date	Did this intern have prior training in another accredited/approved program? Yes/No

B. Academic Qualifications

Name as written in passport	Institution/University	Degree level (Bachelor's Degree BDS/ DDS/ DMD)	Degree Title	First Attended	Last Attended	Graduation Date

C. Internship training license

Name as written in passport	Internship Training license No.	Licensing authority	Date of issue	Date of expiry

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6. EDUCATIONAL PROGRAM

Professionalism

1. Indicate the settings and activities in which interns will demonstrate competence in each of the following areas of Professionalism. Also indicate the method(s) used to assess competences

Competency Area	Setting/Activities	Assessment Method(s)
Compassion, integrity, and respect for others		
Responsiveness to patient needs that supersedes self-interest		
Respect for patient privacy and autonomy		
Accountability to patients, society, and the profession		
Respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation.		
Ability to recognize and develop a plan for one's own professional well-being.		
Recognize professional scopes and limitations of practice and importance of referral to professional colleagues when indicated.		
Maintain effective relationships with peers and respect professional boundaries.		
Appropriately disclosing and addressing conflict or duality of interest.		

Patient Care and Procedural Skills

1. Indicate the settings and activities in which interns will demonstrate competence in each of the following areas of patient care. Also indicate the method(s) used to assess competences:

Competency Area	Setting/Activities	Assessment Method(s)
Obtaining a comprehensive medical history		
Performing a comprehensive extra-oral and intra-oral examination.		
Assessing patient's problems and/or chief complaint.		

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Appropriately using diagnostic methods and tests and interpret findings.		
Integrating information to develop a differential diagnosis.		
Developing and implementing a treatment plan.		
Identifying patient's anxiety and pain related to the oral cavity and associated structures.		
Evaluating the periodontium and managing with non-surgical periodontal therapy.		
Performing non-surgical endodontic treatment of the pulp and periapical conditions.		
Performing uncomplicated tooth extractions and minor oral surgeries.		
Administering/prescribing pharmacological agents relevant to routine dental treatments.		
Preventing, recognizing, and managing medical emergencies in the dental office.		
Restoring appearance, function and stabilize occlusion with fixed and/or removable prostheses.		
Applying universal infection control standards in clinical procedures.		
Performing preventive and restorative procedures that preserve, restore, or replace tooth structure, and maintain soft and hard tissue health using direct or indirect restorative procedures.		
Recognizing and managing acute mucosal and dento-alveolar infections.		
Managing patients from different age groups, medically compromised patients, and people of determination according to their needs.		
Undertaking orthodontic assessment, including an indication of treatment need and interceptive orthodontics treatment.		

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Medical Knowledge		
<p>1. Describe how the program encourages interns to take EDREE/MFD/MFDS/National Boards or relevant exams to further their knowledge prior to the completion of the internship year program. (Limit response to 400 words)</p> <p>Click or tap here to enter text.</p>		
Practice-based Learning and Improvement		
<p>1. Briefly describe one planned learning activity in which interns demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. (Limit response to 400 words)</p> <p>Click or tap here to enter text.</p>		
<p>2. Indicate the settings and activities in which interns will demonstrate competence in each of the following Practice-based Learning and Improvement. Also indicate in method(s) used to assess competences.</p>		
Competency Area	Setting/Activities	Assessment Method(s)
Identifying strengths, deficiencies, and limits in one's knowledge and expertise.		
Setting learning and improvement goals.		
Identifying and performing appropriate learning activities.		
Systematically analysing practice using quality improvement methods and implementing changes with the goal of practice improvement.		
Incorporating feedback and formative evaluation into daily practice.		
Locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems.		
Using information technology to optimize learning.		
Interpersonal and Communication Skills		
<p>1. Briefly describe one learning activity in which interns develop competence in communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. (Limit response to 400 words).</p> <p>Click or tap here to enter text.</p>		
<p>2. Indicate the settings and activities in which interns will demonstrate competence in each of the following Interpersonal and Communication Skills. Also indicate the method(s) used to assess competences.</p>		

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Competency Area	Setting/Activities	Assessment Method(s)
Communicating effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.		
Communicating effectively with fellow dentists and auxiliary staff, other health professionals and health-related agencies.		
Working effectively as a member of a health care team or other professional group.		
Educating patients, families, students, and other health professionals.		
Maintaining comprehensive, timely, and legible medical records, if applicable.		

Systems-based Practice

1. Briefly describe the learning activity(ies) through which interns demonstrate an awareness of and responsiveness to the larger context and system of health care, including to social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Limit response to 400 words).
[Click or tap here to enter text.](#)

2. Indicate the settings and activities in which interns will demonstrate competence in each of the following Systems-based Practice. Also indicate in method(s) used to assess competences.

Competency Area	Setting/Activities	Assessment Method(s)
Working effectively in various health care delivery settings and systems relevant to their clinical training.		
Coordinating patient care within the health care system as relevant to their role.		
Advocating for quality patient care and optimal patient care systems.		
Working in interprofessional teams to enhance patient safety and improve patient care quality.		
Participating in identifying system errors and implementing potential systems solutions.		
Incorporating considerations of cost awareness and risk benefit analysis in patient and/or population-based care as appropriate.		

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7. CURRICULUM ORGANIZATION AND INTERN EXPERIENCES

1. Fundamental Clinical Skills

1. Briefly describe how the program ensures that intern's clinical and educational responsibilities qualify him/her to be an independent general dental practitioner (Limit response to 400 words).

Click or tap here to enter text.

2. For fundamental clinical skills rotations, are interns given responsibility for decision making and direct patient care in all settings, subject to review and approval by attending supervisor.

Yes

No

3. does this responsibility include:

- a. Planning of care.

Yes

No

- b. Writing orders.

Yes

No

- c. Writing of progress notes.

Yes

No

2. Emergency/Hospital Dentistry

1. This pertains to rotation in the Oral and Maxillofacial surgery department including attending on-call duties, performing/observing /attending procedures under GA, trauma cases, and admission and discharge protocols.

(Limit response to 400 words).

2. Does each intern have:

- a. The opportunity to participate in the evaluation and management of the care of all types and acuity levels of patients who present to a site's Emergency Department?

Yes

No

- b. First-contact assessment for these patients?

Yes

No

3. Ambulatory Care

1. Briefly identify and/or describe:

- a. Site(s) of ambulatory experience

Click or tap here to enter text.

- b. Supervision of the intern

Click or tap here to enter text.

- c. Average number of patients seen by the intern per half-day session

Click or tap here to enter text.

- d. Role of the intern in patient care

Click or tap here to enter text.

4. Elective Rotations

1. Does the program provide elective rotations? Yes No

If yes, please specify these rotations. Click or tap here to enter text.

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5. Non-clinical patient Care Experience				
1. If applicable, describe the non-clinical patient care experience (e.g, research, administration, clinical informatics) in which the interns may participate. (Limit response to 400 words).				
Click or tap here to enter text.				
2. Does the program director ensure that rotations taken away from the sponsoring institution and its participating site(s) have educational or training justification?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
a. If so, are these rotations: Limited to no longer than a total of eight weeks?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Briefly describe how the program counsels and assists interns seeking admission into residency programs or defining a career path (Limit response to 400 words).				
Click or tap here to enter text.				
8. DIDACTIC SESSIONS				
1. Does the interns' educational experiences include:				
a. Multidisciplinary conference?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b. Journal or evidence-based reviews?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
c. Case-based planned didactic experiences?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
d. Seminars and workshops to meet specific competencies?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
e. Computer-aided instruction?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
f. Grand rounds?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
g. Quality improvement and safety?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
h. One-on-one instruction?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. List all required conferences for all (FCS) rotations. Provide the name of conference, (FCS) specialty, frequency per month, whether attendance is monitored, and if protected time to attend will be available. Add rows as necessary:				
Name of conference	FCS Specialty	Frequency per week/month	Attendance monitored (Y/N)	Protected time to attend (Y/N)
Example: Interdisciplinary case management	Multi-specialty	1/mo.	Y	Y
(Have documentation of attendance available for review by the site visitor)				

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3. Describe how conference attendance is monitored and documented.
Click or tap here to enter text.

9. EVALUATION

1. Is there written documentation of performance evaluations for each intern at least twice a year?

Yes No

(Interns files containing these records must be available for site visitor review)

10. APPENDIX

Attach the following documents in the Appendix:

1. Institution License Certificate – including License No., Date of Issue, Date of Expiry, and Authority Licensing body.
2. Current Institution Accreditation/Recognition certifications – e.g. JCI, ACGME-I (letter without citations), ISO etc.
3. Organizational Chart of the Sponsoring Institution.
4. If applicable, attach as an appendix affiliation agreement with a Medical/Dental School.
5. The job description and current curriculum vitae of the Program Director (or equivalent designate).
6. Internship Policy & Procedures Manual (including strategy, funding, information system).
7. Institutional commitment statement for sponsoring internship programs signed by Board or senior management (at minimum the Chief Executive Officer, Chief Medical Officer, Chief Finance Officer, the Designated Institutional Official and Chief/Director of Human Resource).
8. A letter of commitment from each participating site in place that specifies responsibilities and arrangements.
9. Program Letter of Agreement (PLAs) with participating sites in compliance with the NIHS requirements.
10. Interns Agreement or Contract.
11. Faculty and interns Emirates ID Copy.
12. Faculty License.
13. Interns Internship training License.
14. Graduation letter template.
15. Faculty Information Form.
16. Intern Information Form.

11. DECLARATION BY PROGRAM DIRECTOR

The Program Director applying for Dental Program Internship Accreditation must complete this declaration.

I hereby declare that the information I have provided in this application form and attached as supporting evidence are valid. I understand that should this application for Accreditation be successful, the program must be able to demonstrate compliance on the *National Institute for Health Specialties Accreditation Requirements and Bylaws* for continued accreditation.

I understand that this application may be rejected or cancelled if the program does not provide the necessary evidence or fails to provide valid information.

Program Director

Name

Click or tap here to enter text.

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Signature	Click or tap here to enter text.
Date	Click or tap here to enter text.
<i>DIO or Hospital Medical Director</i>	
Name	Click or tap here to enter text.
Signature	Click or tap here to enter text.
Date	Click or tap here to enter text.

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