1. Purpose
1.1. This Standard defines the requirements that must be satisfied by dentists wishing to practise implant dentistry and defines the categories of dentists licensed by HAAD eligible for attaining privileges to practise implant dentistry.

1.2. It aims to ensure that only appropriately qualified, trained and skilled dentists practise implant dentistry, and that patients receiving dental implant therapy and treatment are assured of quality and safe Implantology services.

2. Scope
2.1. The requirements of this Standard apply to the following HAAD licensed categories of dental practitioners:
   2.1.1. GP Dentist
   2.1.2. Consultant / Specialist Oral & Maxillofacial Surgery
   2.1.3. Consultant / Specialist Orthodontics
   2.1.4. Consultant / Specialist Prosthodontics
   2.1.5. Consultant / Specialist Endodontics
   2.1.6. Consultant / Specialist Pedodontics
   2.1.7. Consultant / Specialist Periodontics
   2.1.8. Consultant / Specialist Oral Medicine/Oral Pathology

2.2. This Standard also applies to all HAAD licensed healthcare facilities providing dental services and wishing to offer dental Implantology services to patients.

3. Duties
3.1. All HAAD licensed healthcare providers employing dentists to provide implant dentistry services must:
3.1.1 Comply with the requirements of this Standard and ensure that dentists employed at their facilities are familiar with the requirements of this Standard and that they comply with its provisions. It is the responsibility of the employing healthcare facility management to monitor and assure compliance of dentists employed at their facilities with this Standard’s requirements;

3.1.2 Have policies and procedures and relevant resources to provide quality and safe implant dentistry treatment, management and care for patients in accordance with internationally recognised evidence-based best practice;

3.1.3 Comply with the requirements of the HAAD Standard for Clinical Privileging Framework;

3.1.4 Comply with the health insurance pre-authorization requirements, where appropriate for payment for Implantology services as per the patient’s health insurance product;

3.1.5 Submit data to HAAD via e-claims and in accordance with the with the Data Management Policy, Chapter VI, Healthcare Regulator Policy Manual Version 1.0 and as set out in the HAAD Data Standards and Procedures (found online at www.haad.ae/datadictionary);

3.1.6 Comply and cooperate with HAAD authorised auditors, as and when requested for inspections and audits by HAAD;

3.1.7 Comply with HAAD policies and standards on managing patient medical records, including developing effective recording systems, maintaining patient records, maintaining confidentiality, privacy and security of patient information and educating patients and fulfilling the requirements of patient consent and patients’ rights and responsibilities charter and the HAAD Policy on Cultural Sensitivity and Awareness in Healthcare Facilities;

3.1.8 HAAD licensed dentists responsible for managing patients must also ensure that:

3.1.8.1 Patients’ assessment, review, treatment and management is documented in a patient tailored care plan that is subject to follow up and regular evaluation, as required; and

3.1.8.2 they comply with HAAD requirements for patient informed consent, protecting patient confidentiality, respecting cultural diversity, managing patient records and data in accordance with HAAD Policies and Standards.

4. **Enforcement and Sanctions**

4.1 Healthcare providers must comply with the requirements of this Standard, the HAAD Standard Provider Contract and the HAAD Data Standards and Procedures. HAAD may impose sanctions in relation to any breach of requirements under this standard in accordance with Chapter IX, HAAD Policy on Complaints, Investigations, Regulatory Action, and Sanctions, The Healthcare Regulator Policy Manual Version 1.0.

5. **Implant Dentistry Privileging Requirements**

5.1 Eligibility for Implantology privileges. The dentist obtains the privilege of practicing implant dentistry after fulfilling **EITHER ONE** of the following three requirements:

5.1.1 If the candidate has undergone training in implant dentistry as a part of the postgraduate specialty program. Submission of syllabus and credit hours that he/she has completed from an internationally recognized dental school. Upon review and acceptance of the program details by HAAD, the candidate will then be eligible to a privileged HAAD licensure in the practice of implant dentistry; *e.g.* - *Periodontics Or Oral Surgery post graduate programs that are coupled with implant dentistry.*
5.1.2. Proof of successful completion of Residency program in implant dentistry (minimum ONE year of full-time study both clinical and theoretical components) from an internationally recognized dental school.

5.1.3. The combination of BOTH of the following requirements:
   5.1.3.1. Proof of successfully completed series of multiple accredited courses in implant dentistry with an accumulated total of 120 CME hours (Category I) over a period of TWO YEARS; and
   5.1.3.2. Submission of 20 Self Treated Cases with Dental Implants under Supervision of a HAAD Licensed Dental Implantologist.

5.1.4. Applicants, who are eligible according to the requirements at sub-paragraph 5.1.3, will be required to attend an assessment for the evaluation of his/her proficiency with a HAAD appointed panel. Award of privileges for the practice of implant dentistry will be granted by HAAD upon their passing of this assessment.

5.2. Applying for Implant Dentistry Privileges

5.2.1. Applicants wishing to obtain implant dentistry privileges must apply to HAAD by completing and submitting to HAAD the form provided at Appendix 1 to this Standard.

5.2.2. Where an applicant chooses to apply for implant dentistry privileges under requirement 5.1.3, the applicant is required to provide the following information for the Case Reports:
   5.2.2.1. Only list fifteen of the Implantology cases at Section 6 of Appendix 1. Case Reports for the fifteen cases are not required;
   5.2.2.2. Select 5 cases of the total minimum of 20 cases for 5 different patients to present in-depth discussion with the HAAD appointed panel;
   5.2.2.3. The applicant must have provided both the surgical and prosthetic treatment for these 5 cases. These 5 cases must include the following:
      5.2.2.3.1. Implants fully restored with a final prosthesis;
      5.2.2.3.2. Of the 5 cases only 2 should be single implant cases and the remaining 3 cases of the candidate’s choice should be multiple implants;
      5.2.2.3.3. Cases in which implants of less than 3mm in diameter are used as definitive therapy should not be submitted;
      5.2.2.3.4. All cases presented for examination must have been performed on patients such that an implant is functioning for a minimum of 3months by the examination date;
      5.2.2.3.5. Consent to release information from patients for whom the case report is being submitted as a part of the evaluation (Appendix 2);
      5.2.2.3.6. Duplicates of the pre-operative, inter-operative and post-operative radiographs and photographs taken within one year of the examination date are required. For cases that have been in function for more than two years, duplicates of the recall radiographs are also required.

6. Application Checklist

6.1. Completed application form (Appendix 1) with completed declaration by the Licensed Health Care Facility including their official stamp and the applicant’s;
6.2. Professional qualifications / Training / Residency / Courses (As mentioned in the requirements under Section 5 above);
6.3. Transcript of Program of Study – include theory and clinical hours, if applicable.
6.4. HAAD Practising Professional Licence (Must be Valid not Expired);
6.5. Dental Implant cases as per HAAD format (Appendix 2), if applicable; and
6.6. Consent section (Appendix 2) for release of information from each dental implant case.
IMPLATOLOGY APPLICATION FORM

Name: ____________________________________________

First                         Middle                      Last

Date of Birth:    /   /   /   Nationality: __________________________

Telephone No: __________________ Mobile No: __________________

Fax No: ______________ Email Address: __________________________

Have you taken the Examination before?  Yes ☐ No ☐

If yes, date of exam:    /   /   .

1. Dental Education / Residency

<table>
<thead>
<tr>
<th>Title</th>
<th>Institute / University</th>
<th>Country</th>
<th>Date obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Document at least 120 hours of continuing education in dental Implantology and related subjects beyond that required for Licensure Privilege. **Proof of attendance must be submitted.**

<table>
<thead>
<tr>
<th><strong>Title of Course</strong></th>
<th><strong>Institute</strong></th>
<th><strong>Instructor</strong></th>
<th><strong>Subject Matter Code</strong>*</th>
<th><strong>Total Hrs.</strong></th>
<th><strong>Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Subject Matter Code*

- **BS** – Basic Science
- **ML** – Medical/Legal
- **O** – Occlusion
- **P** – Prosthetics
- **S** – Surgery

3. Licenses

<table>
<thead>
<tr>
<th><strong>License No</strong></th>
<th><strong>Licensing Authority</strong></th>
<th><strong>Country</strong></th>
<th><strong>Status</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has Disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in any country?   Yes ☒  No ☐

Have you ever been denied a license, certificate, registration or permit to practice in your professional capacity or any regulated health occupation in any country? Yes ☒ No ☐

Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice in your professional capacity or as another health care professional? Yes ☒ No ☐
4. Experience

<table>
<thead>
<tr>
<th>Position</th>
<th>Facility Name</th>
<th>Country</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which phase(s) of implant dentistry do you perform?  Surgical ☐ Restorative ☐

5. Dental Implant Cases

For each case, place an “x” in each column that applies. Note: These cases must meet the requirements described in the Requirements for the Licensure Privilege Examination and be ones for which you provided both the surgical and prosthetic phases of treatment.

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Implant location / numbers</th>
<th>Type of Prosthesis</th>
<th>Bone Deficiency</th>
<th>In Function 3-6 Months or More</th>
<th>Written Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. List fifteen (15) additional implant cases that you have completed.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Release form</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACCEPTANCE OF CONDITIONS FOR APPLICATION

Knowledge of Requirements and Accuracy of Information

I certify that I have read the Requirements for the Dental Implantology Licensure Privilege Examination and that the information in this application is true and correct in all material respects.

I acknowledge and understand that if any of the foregoing information is found to be false or misleading in any respect, the Health Authority – Abu Dhabi in its sole discretion may revoke my license.

I also understand that my case reports will become the property of the Health Authority – Abu Dhabi.

Authorization and Release

I hereby grant the Admissions and Credentials Board of HAAD and/or its authorized representative’s permission to make general inquiries and to obtain information from any source, including my patients, whose cases are used in the examination process, concerning my professional standing, reputation, skill, character and fitness as it deems appropriate.

I release and hold harmless the HAAD and its authorized representatives from any and all liability relating to any such good faith inquiry made pursuant to my application for Dental Implantology Licensure Privilege.

Applicant Name: ____________________________

Applicants Signature: __________________________

Date: / / 
Appendix 2

Case Report Format

Case No: ____
Attending Professional: Dr.__________________
Patient Name: _____________________________
Mobile No: ________________________________

<table>
<thead>
<tr>
<th>Patient Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
</tr>
<tr>
<td>History</td>
</tr>
<tr>
<td>Clinical Examination</td>
</tr>
<tr>
<td>Development of Treatment plan</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Treatment Goals</td>
</tr>
</tbody>
</table>

Evaluation of existing natural dentition
<table>
<thead>
<tr>
<th><strong>Interarch relationships</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Evaluation of edentulous ridge</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prosthetic restoration selection</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hard and soft tissue modifications</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Prosthetic procedures</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Clinical Resume</td>
</tr>
<tr>
<td>Comparison of preoperative and post-operative diagnoses</td>
</tr>
<tr>
<td>Type of patients instructions</td>
</tr>
</tbody>
</table>
Complications

Patient acceptance and prognosis

Release of Information

I__________________ accept and acknowledge that the information regarding my treatment with Dental Implant Restoration by Dr. __________________have been released with my full approval. I also accept being contacted by the Health Authority – Abu Dhabi with regards to my implant case for the purpose of examination of the professional.

Name: ______________________

Signature: ___________________

Date:        /         /

Photographs and Radiographs

Submit Pre-operative and Post-operative photographs and radiographs. Please note that all Photographs and Radiographs must be clear and of good quality.