Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

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Facility Permit Application Form
Dental CT Scanner

TYPE OF DENTAL CT SCANNER TO BE INSTALLED AND OPERATED

☐ Dentoalveolar CT Scanner (*Field of view 8cm or less*)

☐ Craniofacial CT Scanner (*Field of view greater than 8cm*)

MANUFACTURER AND MODEL OF DENTAL CT SCANNER

MANUFACTURER: ______________________________

MODEL: ______________________________

FACILITY ADDRESS

STREET: ______________________________ SUITE: ______________

CITY: ______________ PROVINCE: ______________ POSTAL CODE: ______________

TEL: ______________ FAX: ______________ E-MAIL (optional) ______________

FACILITY OWNER(S) / PRINCIPAL DENTIST(S)

If there is more than one owner / principal dentist, please list them.

NAME	REGISTRATION NUMBER

FACILITY PERMIT HOLDER / PRESCRIBING DENTIST

Please designate one dentist as the Facility Permit Holder, who MUST be registered with the College as a prescribing dentist for the type of dental CT scanner to be installed and operated.

NAME	REGISTRATION NUMBER

ADDITIONAL PRESCRIBING DENTIST(S)

Please list any additional prescribing dentist(s) at this facility.

NAME	REGISTRATION NUMBER

ATTESTATION (Must be signed by the designated Facility Permit Holder)

1. I understand that as the Facility Permit Holder, I must serve as the Radiation Protection Officer (as defined under the Healing Arts Radiation Protection Act) for the dental CT scanner to be installed and operated in the above-noted facility. I further understand and accept the responsibility for:

   - developing and maintaining a procedure to ensure that only dental CT scans that are indicated and appropriate are provided;
   - developing, implementing and reviewing all dental CT imaging protocols for both adult and pediatric patients, including acquisition parameters, scanning region, patient positioning and use of protective shielding;
   - ensuring that a qualified prescribing dentist is present in the facility whenever the dental CT scanner is being operated;
   - reviewing the qualifications, on-site training and continuing education of all prescribing dentists ordering and taking dental CT scans;
   - developing and maintaining a quality assurance program to ensure the accuracy and reliability of the facility's equipment.

2. I understand that unless extended, a Provisional Facility Permit expires in six months from the date of its issuance or upon the issuance of an Annual Facility Permit. I further understand and acknowledge that an Annual Facility Permit will not be issued unless and until an inspection has been completed, an inspection report has been received by the College, and College staff have confirmed that my facility is in full compliance with all aspects of the College's Standard of Practice for Dental CT Scanners (the Standard of Practice).

3. I understand that in order to change the practice location referred to in an existing Annual Facility Permit, I must first apply for and be issued a revised Annual Facility Permit.

4. I shall notify the College of any change to the list of prescribing dentists at this facility. Further, I shall ensure that each dentist who orders and takes dental CT scans at this facility is registered with the College as being qualified to do so.

5. I understand that I have a professional responsibility to ensure that the information contained on this form is accurate and complete and to ensure that I comply fully with the Standard of Practice. I further understand and acknowledge that the College has the right, independent of its right to commence proceedings in relation to any misconduct on my part, to cancel the Annual Facility Permit and any renewal thereof upon notice to me if the College is not satisfied that I am in full compliance with the Standard of Practice.

Please sign below and return to the College. Our fax number is 416-922-1507.

Name of Facility Permit Holder (please print) ______________________

Name of Witness (please print) ______________________

Signature ______________________

Signature ______________________

Date ______________________

Dental CT Scanner Facility Permit Application Fee - $850
Payable to RCDSO

PLEASE PRINT

NAME

SURNAME: ______________________ GIVEN NAMES: ______________________

ADDRESS

STREET: ______________________ CITY/TOWN: ______________________

POSTAL CODE: ______________________ TEL: ______________________

PLEASE COMPLETE THIS SECTION FOR METHOD OF PAYMENT

You may elect to pay your fees by any one of the following methods:

A) CERTIFIED Cheque or Money Order.
B) Credit Card. If you pay by credit card, the form below must be completed. While we are pleased that we are able to accept payment by credit card, we are unable to do so by telephone.

☐ CERTIFIED CHEQUE ☐ MONEY ORDER ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

CREDIT CARD #: ______________________ EXPIRY DATE: ______________________

SIGNATURE: ______________________

FOR OFFICE USE ONLY - AUTHORIZATION APPROVED - COMMENTS

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