Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

6 Crescent Road, Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814 Toll Free: 1.800.565.4591 www.rcdso.org

Type B Facility Permit Information Sheet

A Type B Facility Permit is one which requires the dental facility to use a Visiting Member or a Visiting Physician to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia at the facility. The visiting member or visiting physician must provide all the sedation and/or general anesthetic equipment and emergency drugs needed to meet the requirements of the Standard of Practice for the Use of Sedation and General Anesthesia in Dental Practice.

Facility permits are non-transferable. If the ownership of the practice changes, or the practice moves, the Facility Permit Holder must notify the College. The Facility Permit will consequently be cancelled, and the new owner will be responsible for applying for a new Facility Permit.

Please note that all Facility Permits expire March 31st of each year regardless of the initial date of issuance.

03/17_4500

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Application Form for Type B Facility Permit

Please submit your completed application form duly signed, witnessed and dated to **sedation@rcdso.org**

1. FACILITY ADDRESS

STREET: SUITE:

CITY: PROVINCE: POSTAL CODE:

TEL:

2. FACILITY OWNER/PRINCIPAL DENTIST

List all owners of the practice (must be a dentist and member of the College).
If there is more than one owner/principal dentist, please designate one dentist as the Facility Permit Holder.

Full Name (Please include first and last name)	Facility Permit Holder
	☐
	☐
	☐

3. FACILITY CONTACT PERSON

NAME:

TEL: E-MAIL:

4. NAMES OF DENTISTS/PHYSICIANS WHO WILL ADMINISTER SEDATION AND/OR GENERAL ANESTHESIA AT THIS FACILITY

LIST all dentists and/or physicians (including yourself, if applicable) who will administer sedation and/or general anesthesia at this facility.
Using the check boxes on the right, check the appropriate column beside each name, and (if a dentist) include RCDSO Registration number.

Full Name (Please include first and last name)	Dentist	RCDSO Registration #	Physician
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐

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ATTESTATION (Must be the designated Facility Permit Holder)

1. I acknowledge that I have read and fully understand the College's Standard of Practice for the use of Sedation and General Anesthesia in Dental Practice ("Standard") and the College's By-Laws governing Sedation and General Anesthesia, which form part of the Standard.

2. I understand that oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia services must not be administered at my facility by me or any other individual unless and until a Facility Permit has been issued by the College.

3. I understand that a Facility Permit will not be issued unless and until the facility has undergone an inspection and I satisfy the Registrar, or failing the Registrar, the Sedation and General Anesthesia Committee that the facility is in compliance with the Standard.

4. I understand that it is my responsibility to ensure that the sedation and/or general anesthetic equipment and emergency drugs required for the administration of oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia are present at all times and in compliance with the Standard. I further understand that any deficiency observed in the course of any inspection will be posted on the Public Register.

5. I shall ensure that any member (dentist) who administers oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia in my dental facility holds a visiting member's authorization permitting them to do so.

6. I shall ensure that any physician who administers oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia in my dental facility has notified the Out-of-Hospital Premises Inspection Program of the College of Physicians and Surgeons of Ontario that s/he will be providing sedation and/or general anesthesia services at my facility, and further assure that s/he has maintained the life support certification required by that College.

7. I understand that a Facility Permit is **NOT** transferable to another owner or facility. I further understand that if I sell my practice, I must notify the College and cease to use oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia services at this location. I also understand that if I open or move to a new facility and wish to use oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia services at my new facility, I must first (apply for and) be issued a new Facility Permit.

8. I agree to immediately cease to use oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia at my facility in the event the Registrar notifies me that the Registrar has determined, either as a result of an inspection or by any other means, that I am in breach of this agrement or there is a risk of harm to the public should the facility continue to do so.

9. I agree to immediately cease to use a physician to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia at the facility in the event the Registrar notifies me that the Registrar has reasonable and probable grounds to believe that the physician is not in compliance with the Standard or that there is a risk of harm to the public should the facility continue to use that physician.

10. **I understand that by signing this attestation I am declaring that the information contained on this form is accurate and complete and that I am agreeing that I will comply fully with the Standard.**

Name of Facility Permit Holder (please print)

Witness Name (please print)

Signature

Signature

Date

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Sedation and/or General Anesthesia Facility Permit Application Fee - $750 Payable to RCDSO

APPLICATION FEE IS NON-REFUNDABLE

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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