Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

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Registration Form
Prescribing Dentist

All dentists who wish to prescribe dental CT scans **MUST** register with the Royal College of Dental Surgeons of Ontario **AND** have successfully completed a theoretical and practical training program designed to produce competency in the ordering, taking, interpreting and reporting of dental CT scans with respect to the field of view generated.

TYPE OF DENTAL CT SCANS TO BE PRESCRIBED

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

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

NAME AND DENTAL FACILITY ADDRESS

NAME: ____________________ REGISTRATION NUMBER: ____________________

STREET: ____________________ SUITE: ____________________

CITY: ____________________ PROVINCE: ____________________ POSTAL CODE: ____________________

TEL: ____________________ FAX: ____________________ E-MAIL (OPTIONAL) ____________________

PREFERRED CONTACT INFORMATION (IF DIFFERENT FROM ABOVE): ____________________

DETAILS OF FORMAL TRAINING PROGRAM IN DENTOALVEOLAR CT SCANS

COURSE NAME: ____________________

COURSE DATES: ____________________

COURSE LOCATION / AFFILIATED UNIVERSITY: ____________________

NAME OF COURSE DIRECTOR: ____________________

Please attach a certificate or other evidence of satisfactory completion of the course, as well as a description of the program, signed by the course director.

DETAILS OF FORMAL TRAINING PROGRAM IN CRANIOFACIAL CT SCANS

☐ Post-Graduate Program in Oral and Maxillofacial Surgery **AND** Mentoring Program

☐ Post-Graduate Program in Oral and Maxillofacial Radiology

If you are not registered with the College as a specialist in Oral and Maxillofacial Surgery, please attach a copy of your diploma/degree.

NAME OF MENTOR: ____________________ MENTOR QUALIFICATIONS: ____________________

DATE MENTORING STARTED: ____________________ DATE MENTORING COMPLETED: ____________________

Please attach a letter or other evidence of satisfactory completion of the mentoring program, as well as a description of the mentoring program, signed by the mentor.

PLEASE SIGN BELOW AND RETURN TO THE COLLEGE.

Our fax number is 416-922-1507.

____________________ ____________________ ____________________

Name Signature Date

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