Royal College of
Dental Surgeons of Ontario

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

INFORMATION SHEET FOR DENTAL CT SCANNER FACILITY PERMIT APPLICATION

Dental CT Facility Permits consist of two permit types.

- Dentoalveolar facility permit: enables members authorized by the College to prescribe, order, take, interpret and report on dental CT scans with a field of view of 8 centimetres or less.

- Craniofacial facility permit: enables members authorized by the College to prescribe, order, take, interpret and report on dental CT scans with a field of view that is greater than 8 centimetres.

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

Application fees are non-refundable.

Checklist of requirements

- ☐ Completed application form
- ☐ Payment
- ☐ Checklist for Facility Inspection

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FACILITY PERMIT APPLICATION FORM
DENTAL CT SCANNER

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

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: _____

Facility owner(s) / principal dentist(s)

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

NAME	REGISTRATION NUMBER

Facility permit holder

Please designate one dentist as the Facility Permit Holder, who MUST practice at the dental facility and hold the appropriate Member's Authorization for the type of dental CT scanner to be installed and operated.

NAME	REGISTRATION NUMBER

Names of all CT authorized members at this facility

LIST all dentists who will prescribe, order, take, interpret and report on CT scans at this facility, and include their RCDSO Registration number.

NAME	REGISTRATION NUMBER

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

1. I hold the appropriate member authorization for the type of dental CT scanner and I practice at the dental facility for which the permit is issued.

2. 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:

a. developing and maintaining a procedure to ensure that only dental CT scans that are indicated and appropriate are provided;

b. 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;

c. ensuring that an authorized prescribing dentist is present in the facility whenever the dental CT scanner is being operated;

d. reviewing the qualifications, on-site training and continuing education of all authorized members ordering and taking dental CT scans;

e. developing and maintaining a quality assurance program to ensure the accuracy and reliability of the facility's equipment.

3. As a Facility Permit holder, I shall submit a written agreement to comply with the Standard of Practice, and the by-law, including the duties of facility permit holders (s.20.8.1) and the duty to provide information (s.20.8.2).

4. I understand that my Annual Facility permit is granted by the Registrar once satisfied on the basis of an inspection that the dental facility is in compliance with the Standard of Practice and current by-law provisions.

5. I understand that I am to cease the operation of a dental CT scanner at the dental facility in the event that the Registrar has determined as a result of an inspection or by any other means that there is risk of harm to the public should the dental facility continue the operation of the dental CT scanner or that I am in breach of the written agreement required in s.20.6.6 of the by-law.

6. I understand that I must submit an application for a new facility permit if there is a change in the installed location of the dental CT scanner in the current dental practice or if the dental practice location referred to in the existing Facility Permit changes.

7. I further understand and acknowledge that the Registrar may immediately cancel the Annual Facility Permit where the Registrar has determined that I, as the permit holder, am not in compliance with the written agreement required by s.20.6.6.

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 (please print)

Witness Name (please print)

Signature

Signature

Date

DENTAL CT SCANNER FACILITY PERMIT APPLICATION FEE - $850 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

CHECKLIST FOR FACILITY INSPECTION

To obtain an annual facility permit you must have your facility inspected. Prior to scheduling an inspection, you are required to obtain the following documentation as indicated in the checklist and once all items have been received you must formally submit a written request to the College to have your facility inspected.

Checklist of requirements

- ☐ Letter of approval from the Director of X-Ray Safety
- ☐ Approved schematic floor plan from the Director of X-Ray Safety
- ☐ Letter of designation from the Ministry of Health and Long-Term Care
- ☐ Signed letter from the CBCT supplier/manufacturer that lists the date of installation; that the dental CT scanner was new when installed in the facility and that it was manufactured within twelve months of installation
- ☐ Copy of reports for the acceptance tests conducted at the time of installation
- ☐ Training documentation/certificates in the safe operation of the equipment installed in your facility issued by the on-site trainer for the authorized dentists that prescribe, order, take, interpret and report on CT scans in the dental facility
- ☐ A quality assurance program that complies with the College's Standard of Practice for Dental CT Scanners

Please note, it is your responsibility to have all the above-mentioned documentation available for our inspector to review at the time of the facility inspection.

Please submit all documentation to ctscanners@rcdso.org