



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

Facility Permit Application Form

TYPE OF SEDATION ADMINISTERED

- Oral Moderate Sedation
Parenteral Conscious Sedation (Intravenous) – 1 Sedative Agent only
Parenteral Conscious Sedation (Intravenous) – 2 Sedative Agents'
Deep Sedation
General Anaesthesia

FACILITY ADDRESS

STREET: SUITE:
CITY: PROVINCE: POSTAL CODE:
TEL: FAX: E-MAIL (OPTIONAL):

FACILITY OWNER/PRINCIPAL DENTIST

If there is more than one owner/principal dentist, please designate one dentist as the Facility Permit Holder.

Table with 2 columns: Name, Facility Permit Holder. Contains 3 rows for listing dentists.

NAMES OF DENTISTS WHO WILL PROVIDE TREATMENT AT THIS FACILITY USING SEDATION AND/OR GENERAL ANAESTHESIA

LIST all principal, associate or employee dentists who will provide treatment at this facility using sedation and/or general anaesthesia, EITHER by administering it themselves OR by using the services of another dentist/physician qualified to administer sedation and/or general anaesthesia.

Table with 1 column: Name. Contains 3 rows for listing dentists.

FACILITY CONTACT PERSON

NAME:
TEL:

*Permitted for oral and maxillofacial surgeons, dental anaesthesiologists, dentists with formal training in dental anaesthesia, or dentists who have received written approval from the College prior to December 31, 2004.

NAMES OF DENTISTS/PHYSICIANS WHO WILL ADMINISTER SEDATION AND/OR GENERAL ANAESTHESIA AT THIS FACILITY

LIST all dentists and/or physicians who will administer sedation and/or general anaesthesia at this facility. If the facility will not provide the required sedation/anaesthetic equipment and emergency drugs, please indicate who will bring these items to your facility.

Name	Who will provide the sedation/anaesthetic equipment and emergency drugs?	
	Visiting Dentist/Physician	Facility
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

ATTESTATION (Must be the designated Permit Holder)

1. I understand that parenteral conscious sedation, deep sedation and/or general anaesthesia 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.
2. I understand that a 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 Guidelines on the Use of Sedation and General Anaesthesia in Dental Practice (the Guidelines).
3. I understand that a Facility Permit is NOT transferable to another facility. I further understand that if I open or move to a new facility and wish to offer sedation and/or anaesthesia services at my new facility, I must first apply for and be issued a new Facility Permit.
4. I shall notify the College of any change to the list of dentists and/or physicians who administer sedation and/or general anaesthesia at this facility. Further, I shall ensure that each dentist and/or physician who administers sedation and/or general anaesthesia 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 Guidelines. 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 Facility Permit and any renewal thereof upon notice to me if the College is not satisfied that I am in full compliance with the Guidelines.

Name of Facility Permit Holder (please print)

Witness Name (please print)

Signature

Signature

Date



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**Facility Permit
Application Fee - \$150
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