

Registration cycle /

Any PEI dental facility employing qualified dentists who operate a dental CT scanner must have a valid Dental CT Scanner Facility Permit issued by PEIDC.

A dentist registered with PEIDC may request a Dental CT Scanner Facility Permit as the principal applicant by:

1. Submitting this completed form;
2. Submitting proof of completed training for each dentist who will prescribe, order, take, interpret and report on dental CT scans using the facility's CT scanner (when included in the application for the first time); and
3. Paying the applicable fee.

Once the permit is granted, the principal applicant will be considered the Dental CT Scanner Facility Permit Holder.

The registrar may rescind a facility authorization where it is determined that the permit was issued on the basis of information or representations that were inaccurate, false, or misleading.

Permit Type

- Dentoalveolar CT Facility Permit - CT scans with a field of view of 8 centimetres or less (\$250)
- Craniofacial CT Facility Permit - CT scans with a field of view greater than 8 centimetres (\$250)

A facility may apply for one or both permit types. The applicable fee is payable by e-transfer to PEIDC (payment@peidc.ca). After the payment is received, a receipt will be issued within the principle applicant's HMS profile, under Payment History.

Facility Information

FACILITY/CLINIC				
Name <input style="width: 90%;" type="text"/>				
FACILITY/CLINIC NAME				
Address <input style="width: 90%;" type="text"/>				
STREET NUMBER - STREET NAME - UNIT/SUITE NUMBER		CITY / COMMUNITY	PROVINCE	POSTAL CODE
Phone <input style="width: 80%;" type="text"/>			Email <input style="width: 80%;" type="text"/>	
Owner(s) <input style="width: 90%;" type="text"/>				
FACILITY OWNER(S) NAME(S)				
Scanner(s) <input style="width: 90%;" type="text"/>				
DENTAL CT SCANNER(S) MANUFACTURER AND MODEL				

*List all dentists who will prescribe, order, take, interpret and report on CT scans at this facility, specify the CT scanner type for each dentist, and **indicate the principal applicant** below. **The principal applicant is considered the permit holder.***

DENTISTS OPERATING THE CT SCANNER				
DENTIST'S NAME	DENTIST'S REGISTRATION #	DENTOALVEOLAR CT	CRANIOFACIAL CT	PRINCIPAL APPLICANT?

V20260615

Principal Applicant's Attestations

- I practise at the facility indicated in this application.
- I have completed the appropriate training for the type of dental CT scanner that is subject to this application.
(Please submit verification of the training program along with this completed form when applying for the first time)
- I have read and understand the College's Practice Standard: Use of Cone Beam Computed Tomography (CBCT) in Dental Practice.**
- I will ensure that any dentist who prescribes, orders, takes, interprets and reports on dental CT scans in the dental facility indicated on this application has completed the appropriate training and is authorized to do so.
- I understand that:**
 - The annual Dental CT Scanner Facility Permit will be granted only if the registrar is satisfied that the dental facility is in compliance with the Standard of Practice.
 - I must apply for a new Dental CT Scanner Facility Permit if the dental CT scanner installed at the facility or the location of the dental practice indicated in this application change.
 - **As the Dental CT Scanner 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 installed and operated in the facility indicated in this application.
- I further understand and accept the responsibility for:**
 - a. Maintaining a procedure to ensure that only dental CT scans that are indicated and appropriate are provided;
 - b. 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. Maintaining a quality assurance program to ensure the accuracy and reliability of the facility's equipment
- I understand that by signing this form I am declaring that the information contained in it is accurate and complete, and that I am agreeing that I will comply fully with the Practice Standard.**

Applicant's Signature: _____

Date:

FOR OFFICE USE ONLY

Payment Received:

- \$250
- \$500

Date Application Received:

Date Permit Granted:

Permit Number: _____