Mobile Dental Facility or Portable Dental Unit Permit Application

West Virginia Board of Dentistry
1319 Robert C. Byrd Drive
PO Box 1447
Crab Orchard, WV 25827
Phone: (304)252-8266
Fax: (304)253-9454
Email: wvbde@suddenlinkmail.com
Website: www.wvdentalboard.org

Instructions:
Please attach all required documents and the appropriate fee to this application.
Make checks payable to the West Virginia Board of Dentistry.

Applicant: (check one)	**Fee**
_____ Is a Non-Profit entity applying for Mobile Dental Facility Permit.	$250.00
_____ Is a Licensed West Virginia Dentist applying for Mobile Dental Facility Permit.	$1,500.00
_____ Is a Non-Profit entity applying for a Portable Dental Unit Permit.	$50.00
_____ Is a Licensed West Virginia Dentist applying for a Portable Dental Unit Permit.	$500.00

ORGANIZATION INFORMATION

Organization Name:____

Contact Name & Email Address:

First Name	Middle Name	Maiden Name (if applicable)	Last Name

Address:

E-Mail Address

Street (No P.O. Box #s)	City	State	Zip Code

Mailing Address	City	State	Zip Code

APPLICANT INFORMATION

Applicant Name:

First Name	Middle Name	Maiden Name (if applicable)	Last Name

Permanent Address:

E-Mail Address

Street (No P.O. Box #s)	City	State	Zip Code

Business Address:

Street (No P.O. Box #s)	City	State	Zip Code

License Number: ______________________

Twenty-Four hour accessible phone number __________________________

If a Mobile Dental Facility: (circle one)

Is this mobile facility a vehicle?	Yes	No
Is this mobile facility a facility that is towed?	Yes	No

Are you a Medicaid provider: (circle one) Yes No

Medicaid Number_____________________

National Provider Identifier (NPI):_____________________________________

List the name(s) of any/all driver(s) of the mobile dental facility:

First Name	Middle Name	Last Name	WV Drivers License Number
First Name	Middle Name	Last Name	WV Drivers License Number
First Name	Middle Name	Last Name	WV Drivers License Number

APPLICATION ATTACHMENTS

_____ NAME and ADDRESS, and when applicable, the license number of each dentist, dental hygienist, and dental assistant associated with the facility or unit for which a permit is sought; (see form for this listing attached to this application).

_____ NAME and ADDRESS of the owners of the facility or unit for which permit is sought; (see form for this listing attached to this application).

_____ NAME and ADDRESS of the members of the Board of Directors; (see form for this listing attached to this application).

_____ A copy of a written agreement for the emergency follow-up care for patients treated in the mobile dental facility or portable dental unit and such agreement must include identification of and arrangements for treatment in a dental office which is permanently established within a reasonable geographic area.

_____ A statement that the mobile dental facility or portable dental unit has access to communication facilities which will enable dental personnel to contact assistance as needed in the event of an emergency.

_____ A statement that all applicable federal, state, local laws, regulations and ordinances dealing with radiographic equipment, storage and use of flammable materials, acceptable sanitation and zoning standards along with the facility construction standards, including required or suitable access for disabled individuals have been complied with.

_____ A statement that the applicant possesses all applicable county and city licenses or permits to operate the mobile dental facility or portable dental unit.

_____ A copy of a written policy concerning infection control procedures and how instruments are to be sterilized and transported, which must comply with the Centers for Disease Control's recommendations for infection control practices for dentistry.

_____ A copy of the informed consent form and post treatment care forms to be used by the mobile dental facility or portable dental unit.

_____ Proof of insurance from a licensed insurance carrier that the operator has in force at least one million dollars/three million dollars of general liability insurance, malpractice insurance or bond or the Federal/State non-profit equivalency. Coverage must be maintained at all times.

_____ A list of locations where dental services will be provided. (see form for this listing attached to this application)

_____ A copy of the vehicle registration form when applicable for a mobile dental facility.

_____ An inventory listing including all serial numbers of each component of the portable unit for which permit is sought. All portable units must be a whole unit, component parts may not be transferred from one unit to another.

CERTIFICATIONS & NOTARIZATION

I certify the mobile dental facility or portable dental unit referred to in this application satisfies all the equipment required and meets all the operational requirements set forth in 5CSR14, Legislative rule for Mobile Dental Facilities & Portable Dental Units.

____ _______________________
Signature Date

I hereby certify and acknowledge that I have completed and reviewed this application. I certify and acknowledge that I am currently licensed to practice dentistry in the State of West Virginia. I certify and acknowledge that all the information provided in this application is true and correct and I further acknowledge and understand the Board is relying upon the truthfulness of this information in the issuance of a permit. I acknowledge that the furnishing of any false information in this application constitutes cause for disciplinary action or the possible loss of permit.

I have carefully read the rules applicable to the operation of mobile dental facilities and portable dental units and the West Virginia Dental Practice Act. I hereby agree to abide by and remain current with all applicable laws and rules.

____ _______________________
Signature Date

STATE OF ______________________
COUNTY OF____________________

Sworn to and subscribed before me this _____________ Day of ______________________, 20_______.

____
NOTARY PUBLIC

____
My commission expires

Listing for Dentists, Dental Hygienists & Dental Assistants Providing Services

DENTISTS

First Name	Middle Name	Last Name	License #	DEA #	NPI

HYGIENISTS

First Name	Middle Name	Last Name	License #

ASSISTANTS

First Name	Middle Name	Last Name

You may make additional copies of this form if necessary.

List of owners of the facility of portable unit for which permit is sought.

First Name	Middle Name	Last Name	License #

List of Board of Directors.

☐ **No Board of Directors**

First Name	Middle Name	Last Name	License #

You may make additional copies of this form if necessary.

Listing of locations where dental services will be provided.

Location: ____

Physical Address:

______________________	____________	____________	____________
Street (No P.O. Box #s)	City	State	Zip Code

Contact for this location:

______________________	____________
Name	Phone Number

Location: ____

Physical Address:

______________________	____________	____________	____________
Street (No P.O. Box #s)	City	State	Zip Code

Contact for this location:

______________________	____________
Name	Phone Number

Location: ____

Physical Address:

______________________	____________	____________	____________
Street (No P.O. Box #s)	City	State	Zip Code

Contact for this location:

______________________	____________
Name	Phone Number

You may make additional copies of this form if necessary.