Application for Registration of Portable Dental Operation

Board of Dental Examiners of Alabama
2229 Rocky Ridge Road
Birmingham, AL 35216
Ph: 205-985-7267  Fax 205-823-9006
email: sonya@dentalboard.org

TYPE OR PRINT LEGIBLY USING BLUE OR BLACK INK. Read carefully before answering. Each question must be answered completely, truthfully and accurately. All supporting data requested must accompany this application. If the space for any answer is insufficient, the applicant must complete the answer on a separate page, signed by him/her, specifying the question which it relates to, and enclose with this application.

DO NOT STAPLE ENCLOSURES TO THIS APPLICATION FORM.
(Incomplete application will be returned without processing.)

NOTICE: THIS APPLICATION WILL NOT BE CONSIDERED UNLESS FILLED OUT COMPLETELY WITH ALL REQUIRED DOCUMENTS AND INITIAL APPLICATION FEE $750.00 ENCLOSED

1. Name of Operator(s):

A. ____________________________________________________________
   (First Name)       (Middle Name)       (Last Name)

B. ____________________________________________________________
   (First Name)       (Middle Name)       (Last Name)

C. ____________________________________________________________
   (First Name)       (Middle Name)       (Last Name)
2. Official Business Title/Name for Certificate: ________________________________________________________________

CIRCLE ONE:  
1. Licensed to practice dentistry in the State of Alabama  
2. Tax exempt status 501 C (3) of the Internal Revenue Service Code  
   (Documentation evidencing approval of this status must be attached)

3. Address(es):

   A. Official Business Address ____________________________________________________________ 
      (Street, City, State & Zip Code) (Area Code & Phone #)

   B. Address(es) of associated established dental facility/facilities:

      1) ____________________________________________________________  
         (Street, City, State & Zip Code) (Area Code & Phone #)

      2) ____________________________________________________________  
         (Street, City, State & Zip Code) (Area Code & Phone #)

4. Twenty-Four (24) hour accessible phone number ________________.
   (Include documentation of 911 capability)

5. Names of dentist(s) providing dental service:

   1. ____________________________________________________________  
      (First Name) (Middle Name) (Last Name)  
      Alabama License Number ________________
      Controlled Substance permit YES or NO Expires __________
      If YES; Drug Enforcement Agency Number __________ Expires________
      Other permits issued by the Board of Dental Examiners of Alabama ____________________________

   2. ____________________________________________________________  
      (First Name) (Middle Name) (Last Name)  
      Alabama License Number ________________
      Controlled Substance permit YES or NO Expires __________
      If YES; Drug Enforcement Agency Number __________ Expires________
      Other permits issued by the Board of Dental Examiners of Alabama ____________________________

   3. ____________________________________________________________  
      (First Name) (Middle Name) (Last Name)  
      Alabama License Number ________________
      Controlled Substance permit YES or NO Expires __________
      If YES; Drug Enforcement Agency Number __________ Expires________
      Other permits issued by the Board of Dental Examiners of Alabama ____________________________

6. Names of dental hygienist(s) providing a dental service:

   1. ____________________________________________________________  
      (First Name) (Middle Name) (Last Name)  
      Alabama License Number ________________  Expires: ________________
2. 
(First Name)  (Middle Name)  (Last Name)  
Alabama License Number _____________ Expires: ________________________

3. 
(First Name)  (Middle Name)  (Last Name)  
Alabama License Number _____________ Expires: ________________________

7. Names of non-licensed personnel:

1. 
(First Name)  (Middle Name)  (Last Name)  

2. 
(First Name)  (Middle Name)  (Last Name)  

3. 
(First Name)  (Middle Name)  (Last Name)  

8. Include with application a copy of the following forms to be utilized:
   a. Copy of written procedure for emergency follow up care.
   b. Consent form, approved by the Board, for allowing treatment of a minor.

9. Please provide copy of any applicable registration.

10. Are you a Medicaid provider? Yes/No  
    IF Yes, Medicaid Number ____________ 
    Please provide proof of your mobile facility’s approved Medicaid status

11. Name of liability carrier: ________________________________  
    (Please attach proof of $1,000,000.00 general liability insurance coverage.)
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 Alabama. I certify and acknowledge that all the information provided in this application is true and correct and I further acknowledge and understand that the Board is relying upon the truthfulness of this information in the issuance of the permit. I certify and acknowledge that I am familiar with and will abide by the provisions of the Alabama Dental Practice Act and any applicable Board rule in connection with the operation of a portable dental operation.

____________________________________________
Signature of Applicant   LNO

STATE OF ALABAMA
COUNTY OF ________________

Sworn to and subscribed before me this _____day of ________________, 20_____.

____________________________________
Notary Public

My commission expires