CHECKLIST AND INFORMATION SHEET FOR DENTAL CT MEMBER AUTHORIZATION

AUTHORIZATION TYPES

A Dental CT Member Authorization issued by the College authorizes a qualified member to prescribe, order, take, interpret and report on dental CT scans in a dental facility.

There are two types of dental CT member authorizations based on the maximum size of the image or "field of view" generated:

- DV-SCANNER (DV) – dentoalveolar CT scanner with a field of view of 8 centimetres or less.
- CF-SCANNER (CF) – craniofacial CT scanner with a field of view greater than 8 centimetres.

CURRENT TRAINING OR EXPERIENCE

The training requirements for dentoalveolar CT Member Authorization and craniofacial CT Member Authorization are set out in the *Standard of Practice for Dental CT Scanners*.

Dentists must apply for CT Member Authorization within one (1) year of completing their education or training in dental CT scans or they must be able to demonstrate they have current experience prescribing, ordering, taking, interpreting and reporting on dental CT scans in practice. Current experience is defined as prescribing, ordering, taking, interpreting and reporting on a minimum 5 dental CT scans, in a consecutive 12 month period, in the preceding three (3) years. Experience obtained during an educational program or training course does not satisfy this requirement.

EXPIRY OF AUTHORIZATIONS

Provisional Authorizations expire six months after the date of issuance. All Annual Authorizations expire annually on October 31st of each year regardless of the initial date of issuance.

CHECKLIST OF APPLICATION REQUIREMENTS

- ☐ Completed application package
- ☐ Documentation of formal training and continuing education
- ☐ Payment **(non-refundable)**

Submit your completed application form to ctscanners@rcdso.org

DENTAL CT MEMBER AUTHORIZATION APPLICATION

TYPE OF AUTHORIZATION BEING SOUGHT (SELECT ONE)

☐ **Dentoalveolar** – I will prescribe, order, take, interpret and report on CT scans of a Small Field of View (8cm or less).

☐ **Craniofacial** – I will prescribe, order take, interpret and report on CT scans of both Small and Large Field of View (greater than 8cm).

APPLICANT INFORMATION (please print)

FULL NAME: RCDSO Registration #:

PRIMARY DENTAL FACILITY WHERE YOU INTEND TO PRESCRIBE, ORDER, TAKE, INTERPRET AND REPORT ON DENTAL CT SCANS

FACILITY:

STREET: SUITE:

CITY: PROVINCE: POSTAL CODE:

TEL: FAX: EMAIL:

DETAILS OF FORMAL TRAINING PROGRAM IN DENTOALVEOLAR CT SCANS

☐ Not Applicable for Members applying for Craniofacial CT Authorization

COURSE NAME:

COURSE DATES: COURSE LOCATION:

AFFILIATED UNIVERSITY:

NAME OF COURSE DIRECTOR:

Please attach a certificate or other evidence of satisfactory completion of the course, as well as a description of the program, signed by the course director.

DETAILS OF FORMAL TRAINING PROGRAM IN CRANIOFACIAL CT SCANS

☐ Not Applicable for Members applying for Dentoalveolar CT Authorization

☐ Post-Graduate Program in Oral and Maxillofacial Surgery **AND** Mentoring Program

☐ Post-Graduate Program in Oral and Maxillofacial Radiology

If you are not registered with the College as a specialist in Oral and Maxillofacial Surgery, please attach a copy of your diploma/degree.

NAME OF MENTOR:

MENTOR QUALIFICATIONS:

DATE MENTORING STARTED: DATE MENTORING COMPLETED:

Please attach a letter or other evidence of satisfactory completion of the mentoring program, as well as a description of the mentoring program, signed by the mentor.

AGREEMENT TO CEASE

1. I agree to immediately cease prescribing, ordering or taking dental CT scans upon notice from the Registrar in the event that the Registrar notifies me that the Registrar has determined, as a result of an inspection or by any other means, that there is a risk of harm to the public should I continue to prescribe, order or take dental CT scans.

2. This agreement is pursuant to College By-Law 20.2.5.

Name (please print)	Witness Name (please print)
Signature	Signature
Date	

ATTESTATION

1. I acknowledge that I have read and fully understand the College's *Standard of Practice for Dental CT Scanners* ("*Standard of Practice*") and the College's By-Laws governing Dental CT Scanners (effective as of October 31, 2020) which form part of the *Standard of Practice*.

2. I confirm I have met the training requirements for the dental CT scanner field of view(s) corresponding to the authorization for which I am applying, dentoalveolar or craniofacial, as outlined in the *Standard of Practice*.

3. I confirm I have completed a training program that was:

    a. A CT certification course, affiliated with an accredited university*, that was at least two days in duration with an examination, and organized and taught by dentists certified in oral and maxillofacial radiology; or

    b. A formal post-graduate program,
    - in oral and maxillofacial radiology, suitable for certification in the province of Ontario**; or
    - in oral and maxillofacial surgery, suitable for certification in the province of Ontario**, and a mentoring program with a certified oral and maxillofacial radiologist or certified medical radiologist, involving the interpreting and reporting of at least 50 craniofacial CT scans.

    * Accredited university means a university accredited by the Commission on Dental Accreditation of Canada (CDAC) or Commission on Dental Accreditation (CODA).

    ** The post-graduate program must have been accredited by Commission on Dental Accreditation of Canada (CDAC) or Commission on Dental Accreditation (CODA) at the time of attendance.

4. I confirm the training program curriculum included theoretical and practical components, addressing radiation physics and protection, indications and contraindications for dental CT scans, patient positioning, selection of parameters, development and implementation of protocols, and processing, interpreting and reporting of images.

5. I confirm my competence was evaluated during the training program and the program instructor(s) has/have attested my competence.

6. I understand that I may only prescribe, order, take, interpret and report the type of dental CT scans for which I have been authorized by the Registrar (College).

7. I confirm that I will include courses and/or other educational programs related to the prescribing, ordering, taking, interpreting and reporting of dental CT scans in my continuing dental education planning as set out by the *Standard of Practice*.

8. I understand that it is my responsibility to ensure that any dental CT scanner I operate is in compliance with the *Standard of Practice* and the facility where the dental CT scanner is located has a valid CT Facility Permit issued by the College.

9. I understand I am only permitted to take scans for the field of view for which I have been authorized by the College. I further understand that any deficiency observed in the course of any inspection will be posted on the Public Register.

10. I understand that, unless extended, my Provisional Authorization expires either six months from the date of its issuance or upon the issuance of an Annual Authorization whichever first occurs.

11. I understand and agree that the Registrar may rescind my authorization where the Registrar is satisfied that the issuance of the authorization was based upon information or representations that were inaccurate, false or misleading or where I no longer meet the requirements of the Authorization issued to me.

12. **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 of Practice*.**

Name (please print)	Witness Name (please print)
Signature	Signature
Date	

DENTAL CT MEMBER AUTHORIZATION APPLICATION FEE - $150

PAYABLE TO RCDSO

Application Fee is NON-REFUNDABLE

NAME OF CARD HOLDER (please print)

FULL NAME:

STREET: SUITE:

CITY: PROVINCE: POSTAL CODE:

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