ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 East Capitol Avenue, Suite 111
Little Rock, AR 72201
Ph: 501-682-2085
Web: healthy.arkansas.gov Email: asbde@arkansas.gov

APPLICATION FOR A MOBILE DENTAL FACILITY PERMIT

Please type. Handwritten applications will not be accepted.

Please submit a check/money order in the amount of $250 (made payable to "ASBDE") along with this application and supporting information as required.

The address and official telephone number of record of the Dentist who will receive the mobile dental facility permit:

Name	Address	Official telephone number (Note: Telephone number must be accessible 24 hrs per day and have 911 capability.)

Proof that the Operator (Dentist) is licensed to practice dentistry in the State of Arkansas:

Arkansas Dental License Number	Date issued	License Expiration date

Full name, address and telephone number of each dentist and dental hygienist who will work in the Mobile Dental Facility:

Dentist or Hygienist (Check one)	Name	Address	Telephone Number
☐ Dentist ☐ Hygienist			
☐ Dentist ☐ Hygienist			
☐ Dentist ☐ Hygienist			
☐ Dentist ☐ Hygienist			
☐ Dentist ☐ Hygienist			
☐ Dentist ☐ Hygienist			

The Driver of the Mobile Dental Facility must provide the following to the Arkansas State Board of Dental Examiners:

Name	Address	Telephone Number	Driver's License Number

The name of the licensed dentist located within a 50 mile radius of the location where the services are to be provided by the Mobile Dental Facility, who will provide follow-up or emergency care:
Name:

Please attach the following supporting documentation to this application:

- A copy of the Driver's License of the driver.
- A copy of the Motor Vehicle Registration of the Vehicle.
- Proof of insurance from a licensed insurance carrier that the Operator (dentist) has in force at least $1,000,000 of general liability insurance.
- Copies of all written printed documents utilized by the Mobile Dental Facility which shall contain the official business address and telephone number of record for the Mobile Dental Facility.
- Proof of X-ray/Radiation Producing Equipment Permit.
- Autoclave spore test results.
- If a qualified dentist is located in the area and the licensed dentist has agreed to provide the follow-up care, a statement should be provided from the dentist showing he agrees to provide the same **-OR-** provide an affirmative statement of the Operator, that if there is not a qualified dentist in the area who has agreed to provide follow-up care, stating the procedure set forth and distributed by the Mobile Dental Facility to the patients on where to go to the "Established Dental Practice" of the Operator or any other facility that has agreed to provide the follow up care.
- A copy of the document given to the patient so that the patient or parent or guardian of the patient, treated in the Mobile Dental Facility, will know who to contact for emergency care, or follow up care, or for information about treatment received.
- A copy of the information given to any provider, who renders follow up care, so that the follow up provider may contact the Operator, and receive treatment information, including without limitation, radiographs.

- A copy of all informed consent forms (i.,e. informed consent of a minor by a parent or guardian, informed consent for adults, informed consent for an incapacitated person).

- A copy of information that must be given to the patient at the conclusion of the treatment.

- A copy of the log or record reflecting the location(s) of treatment.

In addition to the foregoing:

1. I hereby give my permission for the Arkansas State Board of Dental Examiners to secure information concerning me or any of the statements in this application from any person or any source the Board may desire.

2. I further agree to submit to questions concerning my qualifications as an applicant by the Board or any member thereof, and to substantiate my statements if desired by the Board.

3. I have attached a check or money order in the amount of **$250.00** to cover the non-refundable application fee.

4. I agree to read the Dental Practice Act of Arkansas and the Rules & Regulations of the Board pertaining to Dentistry and Dental Hygiene. I also agree to abide by the Rules as set forth in Act 414 ("*an act to allow the operation of mobile dental facilities under the authority of the Arkansas State Board of Dental Examiners*").

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Signature of Applicant/Operator