

The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th Floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

Portable Dental Operation (PDO) – Permit M—Dentist (See 234 CMR 7.00 Effective February 20, 2011)

Application Information and Instructions

Definition: A PDO is any non-facility where dental equipment utilized in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location.

Exemptions: A qualified licensee may provide dental services through the use of dental instruments and materials taken out of a dental office without a PDO permit if:

- (a) The service is provided as emergency treatment;
- (b) A patient of record is homebound;
- (c) The services rendered are limited to dental screening only;
- (d) The services are provided:
 - (1) By a hospital or clinic licensed pursuant to M.G.L.c.111, §51-56;
 - (2) In a school setting approved by the Commission on Dental Accreditation of the American Dental Association; or
 - (3) By a local or state government agency pursuant to M.G.L.c.112, §51.

Application:

The Board may issue a Permit M for operation of a Portable Dental Operation (PDO) to a dentist licensed pursuant to M. G. L. c. 112, § 45 provided that the applicant has met all the requirements of 234 CMR 7.00.

A check or money order for \$180 payable to the Commonwealth of Massachusetts must accompany the application.

Anesthesia and Sedation: All requirements pertaining to the administration of anesthesia and sedation in 234 CMR 6.00 must be fulfilled and valid permits obtained from the Board as applicable.

On-Site Inspection: The Board may require inspection of the PDO prior to the issuance of a permit.

Emergency Drugs: Following is a list of emergency drugs that must be immediately available to the PDO. In Attachment 3, all applicants must provide a detailed statement explaining how each of these drugs will be available in each setting visited by the PDO. The PDO may choose to have its own emergency drug kit and/or use a kit already located in a setting being visited by the PDO. If the PDO has its own emergency drug kit, the name of each specific drug, the dosage, and expiration date must be included in the statement in Attachment 3.

REQUIRED EMERGENCY DRUGS AND DRUG CLASSIFICATIONS TO BE IMMEDIATELY AVAILABLE TO THE PDO:

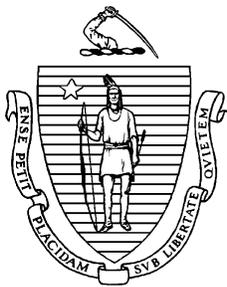
Acetylsalicylic acid (rapidly absorbable form)
Ammonia inhalants
Antihistamine
Antihypoglycemic agent
Bronchodilator
Epinephrine pre-loaded syringes (pediatric and adult)
Two epinephrine ampules
Oxygen
Vasodilator

Emergency Equipment if Local Anesthesia is to be Administered by a Dentist at the PDO: Following is a list of the minimum emergency equipment items that must be immediately available to any dentist administering local anesthesia in the PDO.

MINIMUM EMERGENCY EQUIPMENT REQUIRED TO BE IMMEDIATELY AVAILABLE IF LOCAL ANESTHESIA IS TO BE ADMINISTERED (BY A DENTIST ONLY) IN THIS PDO:

Alternative light source for use during power failure
Automated or manual external defibrillator including batteries and other components
Disposable CPR masks (pediatric and adult)
Disposable syringes (assorted sizes)
Oxygen (portable cylinder E tank) capable of giving positive pressure ventilation
(including bag-valve-mask system)
Sphygmomanometer and stethoscope (pediatric and adult)
Suction

In Attachment 3, all applicants for a PDO in which local anesthesia will be administered by a dentist must provide a detailed statement explaining how each of these items will be available in each setting in which a dentist from the PDO will be administering local anesthesia. The PDO may choose to have its own emergency equipment and/or use equipment already in a setting being visited by the PDO. If the PDO will provide its own emergency equipment, the date of last inspection of each piece of equipment must be provided in the detailed statement in Attachment 3.



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Application – Permit M- Portable Dental Operation—Dentist

1. APPLICANT NAME _____ MA Lic. # DN _____
Last First MI

2. RELATIONSHIP TO PRACTICE (i.e. owner, director, employee) _____

2. BUSINESS ADDRESS: _____
No. Street Unit #

City/Town State Zip Code

3. BUSINESS NAME/DOING BUSINESS AS: _____

4. TELEPHONE NUMBER-DAY: _____ CELL: _____ FAX: _____

5. EMAIL ADDRESS: _____

6. **OWNERSHIP** (if different from applicant)

Name: _____ MA DN/ DH Lic. # _____

Telephone: _____ Email: _____

Name: _____ MA DN/ DH Lic. # _____

Telephone: _____ Email: _____

Name: _____ MA DN/ DH Lic. # _____

Telephone: _____ Email: _____

7. **QUALIFIED PDO DIRECTOR** (pursuant to 234 CMR 2.03 if different from applicant)

Name: _____ MA Lic. #DN _____

Telephone: _____ Email: _____

FACILITY PERMIT M - DENTIST - PDO APPLICATION ATTACHMENTS

- **Attachment 1:** Personal or business check or money order made payable to THE COMMONWEALTH OF MASSACHUSETTS in the amount of \$180. **All fees are nonrefundable and nontransferable.**
- **Attachment 2:** Written statement of scope of services to be provided by PDO and CDT codes for services to be provided.
- **Attachment 3:** Statement regarding emergency drugs (and equipment, if applicable) to be immediately available to the PDO. (See Instructions, page 2.)
- **Attachment 4:** Photographs of all equipment, supplies, and instruments to be used in the PDO, including sterilizer.
- **Attachment 5:** Copy of a schedule and log demonstrating the regular inspection of all emergency drugs and equipment for administration of anesthesia, including the date(s) and name of person who last checked drugs and equipment and the results of the checks, including that of the condition of equipment according to manufacturers' specifications.
- **Attachment 6:** Copy of a written protocol for management of medical emergencies, including contact information for emergency care after business hours.
- **Attachment 7:** Copy of schedule and content of regular and routine emergency drills.
- **Attachment 8:** Request for on-site inspection by the Board.
- **Attachment 9:** Copy of the schedule, protocols, and procedures for and results of weekly spore testing.
- **Attachment 10:** Copy of DPH Radiation Control Program Certification for the PDO (M.G.L.c.111, §5N), if applicable. (Contact the Radiation Control Program for further details.)
- **Attachment 11:** Copy of ownership documents (corporation papers, DBA, partnership agreement, business certificate) for practice.
- **Attachment 12:** Copy of a logbook or protocol showing compliance with Federal, state, and local provisions for: handicap access; access to potable water; access to hand washing and toilet facilities; storage of local anesthesia and emergency drugs (if applicable); container for deposit of refuse and waste material as required by 310 CMR 73.00; personal protection equipment; patient protective eyewear; and protocol for maintenance of any other equipment necessary for services being provided.
- **Attachment 13:** Statement indicating location where dental records are maintained and protocol as to how a patient may obtain a copy of such records.
- **Attachment 14:** Copies of informed consent form and discharge/referral information sheet.

For the PDO that administers no anesthesia or local anesthesia only:

- **Attachment 15:** Copy of current BLS certificates for all individuals providing dental services, dental hygiene services, or assisting in the services being provided.

For the PDO that administers nitrous-oxide/oxygen, minimal sedation, moderate sedation, or general anesthesia:

- **Attachment 16:** Copy of current ACLS/PALS (if administering general anesthesia, moderate or minimal sedation) or BLS certificates for all individuals providing dental services, dental hygiene services, or assisting in the services being provided.
- **Attachment 17:** Copy of current Facility Permit D-P or other current anesthesia permits, as applicable.

APPLICANT ATTESTATION: I, _____ **HEREBY CERTIFY,**

Print Full Name of Applicant

UNDER THE PAINS AND PENALTIES OF PERJURY, THAT:

- **ALL INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE;**
- **I HAVE READ AND UNDERSTAND THE STANDARDS AND REQUIREMENTS FOR PERMIT AT 234.CMR 7.00, INCLUDING, BUT NOT LIMITED TO, THE REQUIREMENTS OF THIS PERMIT FOR:**
- **GENERAL REQUIREMENTS AT 7.04 INCLUDING BUT NOT LIMITED TO:**
 - OFFICIAL BUSINESS OR MAILING ADDRESS;
 - PROPER RECORDING OF PATIENT RECORDS;
 - INFORMED CONSENT;
 - DISCHARGE AND REFERRAL INFORMATION SHEET;
 - EMERGENCY OR OTHER FOLLOW-UP TREATMENT;
 - EMERGENCY PROTOCOL;
 - IDENTIFICATION OF PERSONNEL;
 - DISPLAY OF LICENSE(S);
 - BACKGROUND CHECKS FOR PERSONNEL.
- **PHYSICAL REQUIREMENTS FOR MOBILE DENTAL FACILITY AND PORTABLE DENTAL OPERATONS AT 7.05 INCLUDING BUT NOT LIMITED TO:**
 - COMPLIANCE WITH ALL APPLICABLE LOCAL, STATE, AND FEDERAL STATUTES, REGULATIONS, OR ORDINANCES CONCERNING RADIOGRAPHIC EQUIPMENT, FLAMMABILITY, VENTILATION, CONSTRUCTION, SANITATION, ZONING, INFECTIOUS WASTE MANAGEMENT, OSHA STANDARDS AT 29 CFR, *CDC GUIDELINES*, AND FOR THE REGISTRATION AND OPERATION OF A MOTOR VEHICLE BEING USED FOR THE PROVISION OF MOBILE OR PORTABLE DENTAL SERVICES.
 - HANDICAP ACCESS;
 - EQUIPMENT AND STERILIZATION SYSTEM WHICH IS NECESSARY TO COMPLY WITH *CDC GUIDELINES*;
 - READY ACCESS TO AN ADEQUATE SUPPLY OF POTABLE WATER;
 - READY ACCESS TO HAND-WASHING AND TOILET FACILITIES;
 - A COVERED GALVANIZED, STAINLESS STEEL, OR OTHER NON-CORROSIVE CONTAINER FOR DEPOSIT OF REFUSE AND WASTE MATERIAL AS REQUIRED BY 310 CMR 73.00, *AMALGAM, WASTEWATER AND RECYCLING REGULATIONS FOR DENTAL FACILITIES*; AND
 - EQUIPMENT NECESSARY FOR SERVICES BEING PROVIDED.
- **CESSATION OF OPERATION AND TRANSFER OF OWNERSHIP AT 7.06 INCLUDING BUT NOT LIMITED TO:**
 - WITHIN 30 CALENDAR DAYS NOTIFY THE BOARD IN WRITING OF THE LAST DAY OF OPERATIONS OF THE FINAL DATE OF SERVICE AND THE DISPOSITION OF PATIENT RECORDS;
 - PROPER NOTIFICATION PERMIT HOLDER'S PATIENTS;
 - WITHIN 30 CALENDAR DAYS MAKE ARRANGEMENTS WITH THE PATIENTS FOR THE TRANSFER OF THE PATIENTS' RECORDS.
- **I UNDERSTAND THAT THE TERMS OF THIS PERMIT ARE LIMITED SOLELY TO THE LICENSEE AND CANNOT BE TRANSFERRED TO ANOTHER PERSON OR ENTITY.**
- **I AM CURRENTLY, AND WILL CONTINUE TO BE, IN COMPLIANCE WITH ALL STATUTES, RULES, AND REGULATIONS PERTAINING TO THE PRACTICE OF DENTISTRY IN THE COMMONWEALTH OF MASSACHUSETTS AS REQUIRED BY LAW.**

SIGNATURE OF APPLICANT: _____ **DATE:** _____

SIGN AND SEND THIS APPLICATION AND ALL REQUIRED ATTACHMENTS TO:

**MASSACHUSETTS BOARD OF REGISTRATION IN DENTISTRY
239 CAUSEWAY STREET-SUITE 500, BOSTON, MA 02114**

KEEP A COPY OF THIS APPLICATION AND ALL ATTACHMENTS FOR YOUR RECORDS