



**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](mailto:wvbde@suddenlinkmail.com)  
Website: [www.wvdentalboard.org](http://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.

<b>Applicant:</b>	(check one)	<b>Fee</b>
_____	Is a Non-Profit entity applying for Mobile Dental Facility Permit.	\$225.00
_____	Is a Licensed West Virginia Dentist applying for Mobile Dental Facility Permit.	\$1,350.00
_____	Is a Non-Profit entity applying for a Portable Dental Unit Permit.	\$45.00
_____	Is a Licensed West Virginia Dentist applying for a Portable Dental Unit Permit.	\$450.00

**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

## Listing for Dentists, Dental Hygienists & Dental Assistants Providing Services

### DENTISTS

_____ First Name	_____ Middle Name	_____ Last Name	_____ License #	_____ DEA #	_____ NPI
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #	_____ DEA #	_____ NPI
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #	_____ DEA #	_____ NPI
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #	_____ DEA #	_____ NPI

### HYGIENISTS

_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #

### ASSISTANTS

_____ First Name	_____ Middle Name	_____ Last Name
_____ First Name	_____ Middle Name	_____ Last Name
_____ First Name	_____ Middle Name	_____ Last Name
_____ 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 #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #

**List of Board of Directors.**

**No Board of Directors**

_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ First Name	_____ Middle Name	_____ Last Name	_____ License #
_____ 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.