

# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 100, 600 East Amite Street • Jackson, Mississippi 39201-2801 • (601) 944-9622 • www.dentalboard.ms.gov

## APPLICATION TO REGISTER A MOBILE OR PORTABLE DENTAL OPERATION

DATE \_\_\_\_\_

INSTRUCTIONS: This form must be **TYPEWRITTEN**. If more space is required, attach additional sheets.

### GENERAL INFORMATION

\_\_\_\_\_  
Legal Name of Business

\_\_\_\_\_  
Official and Physical Office Address Where All Dental and Official Records Shall Be Maintained (**NOT** a P.O. Box)

\_\_\_\_\_  
Website Address

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
Telephone Number of Record

\_\_\_\_\_  
Name of Contact Person

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Address of Contact Person

\_\_\_\_\_  
Operator Responsible for Operation of Facility

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address of Operator Responsible for Operation of the Facility

\_\_\_\_\_  
List All Corporate, Trade, or Business Names Used by the Corporation or Licensee

***I do solemnly swear or affirm, under the penalties of perjury, that I am the person authorized to sign this application for registration and that the statements made are true and correct in all respects.***

\_\_\_\_\_  
Signature of Operator

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signed (month/date/year)

\_\_\_\_\_  
Signature of Owner or Corporate Officer

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signed (month/date/year)

\_\_\_\_\_  
Printed Name of Owner or Corporate Officer

\_\_\_\_\_  
Name of Person to Contact Regarding Questions Concerning Application

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address



**Names of dentists to whom the Operator of the mobile dental facility or portable dental operation will refer patients for follow-up care, subject to the patient's right to choose another dental provider. A dentist who agrees to provide follow-up care must be practicing and located in a land-based dental office which provides dental services either in the county wherein the mobile dental facility or portable dental operation provides services, or in an adjacent county to the location wherein such services are being provided.**

**Attached Statement from Dentist**

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
 Full Name Business Address Telephone Number

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
 Full Name Business Address Telephone Number

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 Full Name Business Address Telephone Number

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\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
 Full Name Business Address Telephone Number

**ADDITIONAL REQUIRED DOCUMENTATION AND APPLICATION FEE**

1. Proof from the Mississippi State Board of Health that licensee's radiographic equipment has been approved.
2. Copy of written procedure for emergency follow-up care for patients treated in the mobile dental facility or portable dental operation, and such procedure includes arrangements for treatment in a dental facility that is permanently established in the area where services were provided. *(Any change in written procedure must be submitted to the Board within thirty (30) days of change.)*
3. Letters of support indicating the aforementioned arrangements for emergency follow-up care in the areas where services are to be provided.
4. Copy of valid Mississippi driver's license appropriate for the operation of the mobile dental facility.
5. Copy of consent form.
6. Copy of patient information sheet.
7. Identification of location where mobile dental facility or portable dental operation is to be provided.
8. Certified check or money order in the amount of \$300.00 made payable to the Mississippi State Board of Dental Examiners.