



# OHIO STATE DENTAL BOARD

77 South High Street, 18th Floor • Columbus, Ohio 43266-0306  
614/466-2580 • 614/752-8995

## APPLICATION FOR APPROVAL AS A TREATMENT PROVIDER FOR IMPAIRED DENTISTS AND DENTAL HYGIENISTS

### GENERAL INFORMATION AND INSTRUCTIONS

This application must be completed by any provider of chemical dependency treatment services who wishes to obtain approval from the *Ohio State Dental Board* to treat impaired practitioners in accordance with Section 4715.301 Ohio Revised Code. Thoroughly read these instructions and the enclosed statutes and rules, Chapter 4715.301, Ohio Revised Code, and Chapter 4715-21-01, Ohio Administrative Code, before completing the application. After the *Ohio State Dental Board* has received and reviewed the properly completed application, it may schedule and conduct an on-site inspection and any further investigation deemed necessary to assure compliance with the applicable laws before notifying the applicant of its decision.

- 1) Please complete the entire application and attach all required documentation. An application submitted with questions left blank or with documentation missing will be considered an incomplete application and will not be processed by the *Ohio State Dental Board*.
- 2) If additional space is required to answer any question(s), please attach an additional sheet(s) designating the question(s) referred to.
- 3) The applicant's chief executive officer and medical director must properly execute the Affidavit and Release of Applicant. The signatures **must** be notarized.
- 4) Please return the completed application to:

**OHIO STATE DENTAL BOARD**  
**77 South High Street, 18th Floor**  
**Columbus, Ohio 43266-0306**

- 5) Should you desire notification of receipt of your application, an acknowledgment card is enclosed for that purpose. You must enter your mailing address on the card and affix appropriate postage or it **will not** be returned to you.

1) Treatment Provider (applicant) Name: \_\_\_\_\_

2) Mailing Address (**NOTE:** Do not use a Post Office Box Number):

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip Code

3) Telephone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

4) Name and address of Treatment Provider Owner. If a sole proprietor, give full name:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street (**Note:** Do not use a Post Office Box Number.)

\_\_\_\_\_  
City State Zip Code

Telephone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_

5) Legal Structure of Treatment Provider Owner:

\_\_\_\_ Sole Proprietor

\_\_\_\_ Partnership

\_\_\_\_ Corporation for Profit Chartered in the State of \_\_\_\_\_

\_\_\_\_ Corporation Not for Profit Chartered in the State of \_\_\_\_\_

\_\_\_\_ Professional Association

\_\_\_\_ Other (Please Describe): \_\_\_\_\_

6) Type of Governing Body (e.g. Board of Trustee; Board of Directors):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) Describe composition and method of appointment of members of Governing Body:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach a table of organization that reflects lines of authority and relationship with the Governing Body.)

- 8) Provide the following information for each Program Site operated by the applicant. If the applicant operated more than one Program Site, photocopy this page and complete and attach for each Program Site.

<b>PROGRAM SITE</b> (where treatment services are delivered)	
Name: _____	
Street Address: _____	
City: _____	
State: _____ Zip Code: _____	
County: _____	
Telephone Number: (     ) _____ Fax Number: (     ) _____	
Hours of operation for services at this site:	
Monday through Friday: _____	
Saturday: _____	
Sunday: _____	
Holidays: _____	
Indicate treatment services provided at this site. Place a check mark in the box of each service listed below that is available at this program site.	
<input type="checkbox"/> Intensive inpatient	<input type="checkbox"/> Medical / somatic
<input type="checkbox"/> Intensive outpatient (day/night treatment)	<input type="checkbox"/> Hospital detoxification
<input type="checkbox"/> Extended residential care	<input type="checkbox"/> Freestanding residential detoxification
<input type="checkbox"/> Assessment	<input type="checkbox"/> Ambulatory medical detoxification
<input type="checkbox"/> Individual and group counseling	<input type="checkbox"/> Ambulatory social detoxification
<input type="checkbox"/> Case management	<input type="checkbox"/> Aftercare
<input type="checkbox"/> Crisis intervention	<input type="checkbox"/> Toxicology screening
<input type="checkbox"/> Referral and information	<input type="checkbox"/> Methadone administration
Please list other services provided at this program site.	

9) Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulations?  YES  NO

10) Is the applicant accredited by JCAHO to provide substance abuse treatment?  
 YES  NO

If not, has it applied for such accreditation?  YES  NO

(Attach a copy of JCAHO accreditation certificate and JCAHO reports reflecting the most recent review or inspection.)

11) Are costs of the applicant's treatment program covered by most insurance policies that provide coverage for alcohol/substance abuse treatment?  YES  NO

12) List any insurance companies or other third party payers that have given pre-approval to cover treatment.

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13) Describe the applicant's procedures to arrange payment plans for treatment costs not covered by insurance.

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14) Does the applicant offer advocacy services at a cost to the patient?  YES  NO

15) Describe in detail the medical and nursing services the applicant provides for patients in each state of treatment, including detoxification treatment.

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16) List the names, position titles and specialties of all licensed physicians on staff, indicating which, if any, are certified by the American Society of Addiction Medicine.

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(Attach copies of ASAM Certificates.)

17) List treatment plan options which the applicant provides (e.g. inpatient, outpatient, extended residential care, aftercare), indicating number of days, weeks, or months in each stage of treatment. \_\_\_\_\_

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18) List all agencies and professionals to which the applicant refers patients and significant others to meet needs which exceed the applicant's expertise or available facilities. \_\_\_\_\_

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19) Describe in detail the applicant's facilities and procedures for conducting toxicology screens, including measures taken to prevent tampering with specimens, to assure proper chain of evidence, and to verify positive screens. Attach copy of submission/chain of evidence form (custody and control form) and any associated instruction. (See below if testing is done by an independent facility.)

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20) If toxicology testing is done by contract with an independent facility or facilities, attach copy of contract(s). If no written contract exists, describe in detail the agreement between the applicant and the testing facility, and explain the mechanics of testing. \_\_\_\_\_

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21) Describe in detail the evaluation process and procedures used to identify patterns, progressions, and stages of recovery during treatment.

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# AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by BOTH the chief executive officer and the medical director of the applicant treatment provider. The form MUST be notarized. Failure to submit the completed and notarized affidavit and release with the application will result in the application being considered incomplete.

STATE OF \_\_\_\_\_  
ss. COUNTY OF \_\_\_\_\_

On behalf of \_\_\_\_\_, an applicant for approval as an Ohio State Dental Board recognized treatment provider for impaired dentists and dental hygienists, the undersigned hereby certify under oath that we are the duly appointed chief executive officer and medical director, respectively, of the applicant; that we submit this application under the authority of the governing body of the applicant; that all statements we have or shall make with respect to the application are true; and that all documents, forms or copies thereof furnished or to be furnished with respect to this application are strictly true in every aspect.

We acknowledge that we have read the general information and instructions and that we have answered all questions in compliance with those instructions.

We further state that by filing this application for approval as an Ohio State Dental Board recognized treatment provider for impaired dentists and dental hygienists, we hereby authorize and consent to have an investigation made as to the applicant's qualifications to provide such treatment. We agree to give any further information which may be required in reference to the applicant's qualifications or eligibility for approval.

We further understand that this application for approval as an Ohio State Dental Board recognized treatment provider for impaired dentists and dental hygienists is an ongoing process. We will immediately notify the Ohio State Dental Board in writing of any changes to the answers of any questions contained in the application if such changes occur at any time prior to approval by the Ohio State Dental Board.

On behalf of the applicant, we authorize every person, hospital, clinic, governmental agency (local, state, or federal), court, association, institution, or law enforcement agency having control of any documents, records, and other information pertaining to the application to furnish to the Ohio State Dental Board any such information, documents, or records, including records regarding charges or complaints filed against the applicant, formal or informal, pending or closed, and we authorize the Ohio State Dental Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent to approval as a recognized treatment provider.

On behalf of the applicant and acting under the authority of its governing body, we hereby release, discharge, and exonerate the Ohio State Dental Board, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of the investigation made by the Ohio State Dental Board. We authorize the Ohio State Dental Board to release information, material, documents, orders or the like relating to the applicant or to this application to any governmental agency (local, state, or federal); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

We further understand that issuance of a provisional certificate of good standing will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject the applicant to denial of said certificate.

\_\_\_\_\_  
Signature of Chief Executive Officer Title

\_\_\_\_\_  
Signature of Medical Director Title

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

**(NOTARY SEAL)**

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Date Commission Expires

## **AGREEMENT OF APPLICANT**

By execution of the Affidavit and Release of Applicant, the applicant agrees that upon the issuance of approval as a treatment provider;

- 1) It shall be bound by and comply with the requirements contained in Chapter 4715., Ohio Revised Code, and Chapter 4715-21-01, Ohio Administrative Code; and
- 2) It shall provide appropriate training to its staff to assure compliance; and
- 3) It shall provide to each patient and referral source who is under the jurisdiction of the Ohio State Dental Board (Board) the written statements and notices required by the Board; and
- 4) It shall immediately notify the Ohio State Dental Board if changes occur which could affect its eligibility for approved status under Section 4715.301, Ohio Revised Code, or Chapter 4715-21-01, Ohio Administrative Code; and
- 5) It shall notify the Ohio State Dental Board of any transfer of ownership of the program or change in location or locations of the program prior to such transfer or change becoming effective.