NEVADA STATE BOARD OF DENTAL EXAMINERS
2651 N Green Valley Parkway, Suite 104,
Henderson, Nevada 89014
nsbde@dental.nv.gov
Phone(702) 486-7044 | (800) DDS-EXAM | Fax (702)486-7046

OFFICE STAMP ONLY

INFECTION CONTROL INSPECTION APPLICATION

A. INSPECTION TYPE

Select one (1) of the options below:

☐ Initial Inspection $250.00

Pursuant to NAC 631.1785, you are required to, no later than thirty (30) days after a licensed dentist becomes the owner of an office or facility in this State where dental treatments are to be performed, request in writing that the Board conduct an initial inspection of the office or facility and submit the applicable fee to ensure compliance with CDC guidelines adopted by reference pursuant to NAC 631.178

☐ Reinspection $150.00

B. SITE TYPE

Select one (1) of the options below:

New or Pre-existing:	☐ New Dental Clinic *(select this option if the building is being renovated)* Opening Date:	☐ Pre-existing Dental Clinic *(select this option if the building was a dental office when purchased)* Purchase Date:
Brick and Mortar Dental Clinic: ☐	☐ Mobile Bus/Van Dental Clinic ☐ On-site sterilization ☐ Off-site sterilization	☐ Off-Site/Temporary Location ☐ On-site sterilization ☐ Off-site sterilization
If off-site, provide address:		
Sterilization N/A/ Disposable items only: ☐		

C. BUSINESS ENTITY INFORMATION

Owner's First Name:	Owner's Middle Name:	Owner's Last Name:	License Number:
Name/Practice Name/DBA:		Office Address:	
City:	State:	Zip Code:	
Office Phone:	Office Fax:	Owner's Personal Phone:	
Email:		Website Address:	

☐ **By selecting this box,** I, the owner of the above practice/facility, hereby affirm and attest that I request an infection control site inspection be conducted at the location listed above in accordance with NAC 631.1785.

D. SUPERVISING LICENSEE-OF-PRACTICE INFORMATION

First Name:	Middle Name:	Last Name:
License Type:		License Number:
Email:	Personal Phone:	

E. PRACTICE/FACILITY HOURS OF OPERATION

Choose the Section that applies to your Site Type and complete the section accordingly

If Site Type is Brick and Mortar, complete Section E.1
If Site Type is Mobile or Off-Site, complete Section E.2

E.1 If Site Type is Brick and Mortar complete the below:

MONDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
TUESDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
WEDNESDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
THURSDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
FRIDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
SATURDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED
SUNDAY	From:	☐ AM	☐ PM	To:	☐ AM	☐ PM	☐ CLOSED

E.2 If Site Type is Mobile or Off-Site, attach a list of dates, hours of operations, and locations for which services/products will be provided to the Nevada State Board of Dental Examiners no fewer than thirty (30) days from the earliest service date requested. To ensure regulatory compliance, an infection control inspection resulting in a "PASS" must be completed no less than one (1) business day prior to the commencement of operations at any Mobile or Off-Site facility, regardless of the duration of its operation.

☐ **By selecting this box,** I hereby affirm and attest that I have attached a list of dates, hours of operations, and locations for which services/products will be provided to the Nevada State Board of Dental Examiners no fewer than thirty (30) days from the earliest service date requested.

F. NEVADA BUSINESS LICENSE INFORMATION

☐ I have a Nevada business license number assigned by the Nevada Secretary of State upon compliance with the provisions of NRS Chapter 76.

Nevada Business ID:	
Nevada Business Name:	
Nevada Business License Exp Date:	Nevada Business License Filing Date:

G. PRACTICE/FACILITY MANAGER(S)

List all employees that are managers or in supervisory roles that work at the practice/facility

1)	First Name:	Middle Name:	Last Name:
	License Type:	License Number (if applicable):	Title:
	Email:		Personal Phone:
2)	First Name:	Middle Name:	Last Name:
	License Type:	License Number (if applicable):	Title:
	Email:		Personal Phone:
3)	First Name:	Middle Name:	Last Name:
	License Type:	License Number (if applicable):	Title:
	Email:		Personal Phone:
4)	First Name:	Middle Name:	Last Name:
	License Type:	License Number (if applicable):	Title:
	Email:		Personal Phone:
5)	First Name:	Middle Name:	Last Name:
	License Type:	License Number (if applicable):	Title:
	Email:		Personal Phone:

If there are more managers or persons' in supervisory roles than spaces provided above, please list them on a separate sheet of paper and attach them to the end of this application.

H. DENTAL PROCEDURES DELIVERED

List all goods and services provided in the space below or attach a list to the back of this application.

☐ Preventive Services	☐ Prosthodontic Services
☐ Diagnostic	☐ Oral Surgery
☐ Restorative Services	☐ Orthodontic Services
☐ Endodontic Services	☐ Pediatric Dentistry
☐ Periodontal	☐ Cosmetic Dentistry

I. OTHER SERVICES	
☐ Injectables (i.e. Botox)	
☐ Laser	
☐ Moderate Sedation/General Anesthesia (Current)	
☐ Moderate Sedation/General Anesthesia (Future)	
IF YES:	☐ I have submitted proper documentation to the Board. (e.g., Laser/Injectables Certificate).

J. PAYMENT			
Inspection Type			
☐ Initial Inspection **$250.00**		☐ Reinspection **$150.00**	
PAYMENT METHOD			
Payment Method: ☐ Check/Money Order (attach with application)		☐ Credit/Debit Card	**Total Amount Authorized**
Name on Card:	Card Number - - -		
Card Billing Street Address:	Exp Date:	CVV:	
City:	State:	Zip:	$

By signing below, I hereby affirm and attest, that if I ever decide to open, operate, or work at a pop-up, portable, or mobile dental clinic/facility or practice in the State of Nevada while licensed by the Nevada State Board of Dental Examiners, I acknowledge that infection control measures apply to those types of practices and facilities in the same manner as they apply to traditional/stationary dental practices and facilities. Thus, I agree to self-report any proposed pop-up, portable, or mobile dental clinic or practice at least ten (10) days in advance of my intent to open, operate, or work at same, so that the Board can determine if, when, and how to inspect the operation for infection control purposes prior to the commencement of patient treatment. I acknowledge that failure to self-report and allow the Board to conduct an infection control inspection of said operation, if they deem it appropriate, could result in disciplinary action and/or a loss of a compliant infection control status.

By signing below, I hereby affirm and attest, that I have answered the above questions truthfully, accurately, and by myself, the licensee, so named on this form as Owner and so stating, under penalties of perjury, that all answers provided herein are provided willfully. I further state that I authorize and empower the Nevada State Board of Dental Examiners or its agents, staff, or appointed authority to contact any person, firm, service, agency, entity, or the like to obtain information deemed necessary or desirable by the Board to verify any information contained in my infection control inspection application.

Licensee Signature: Date:

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