BCDA™
The Voice of BC Dentists

CBCT New Shielding Design Request

*Application for Non-Members**

BCDA Members: Please call 604-736-7202 to request Member Application Form

Date of Request: _____

DENTIST INFORMATION

Dentist Name: _____

Telephone: _____ Email: _____

☐ General Practitioner ☐ Certified Specialist *(please indicated area of specialty below if applicable)*

☐ Orthodontics ☐ Pedodontics ☐ Periodontics ☐ Endodontics

☐ Prosthodontics ☐ Oral Surgeon ☐ Oral Medicine

PRACTICE INFORMATION

Practice Name: _____

Site Address: _____

_____

BUILDING INFORMATION

Main Contact Person for Questions

Name: _____

Telephone: _____ Email: _____

Contractor

Name: _____

Address: _____

_____

Telephone: _____ Email: _____

Project Manager

Name: _____

Telephone: _____ Email: _____

EQUIPMENT INFORMATION

Make: _____ Model: _____

☐ New ☐ Used *(provide copy of last inspection report with application)* ☐ Unknown

Please check all that apply:

☐ New Construction ☐ Renovation ☐ Replacing Unit (*please provide copy of previous shielding design*)

Expected Examinations:

The number of exams per week (averaged) relates to the amount and type of radiation shielding material required. In deciding on the eventual number of exams to take per week, consider that the machine will most likely be in operation for 15 years and the practice may be resold or expanded during this interval.

Estimated # of weekly exams (immediate): _____

Estimated # of weekly exams (future): _____

Days used per week:

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Supplier/Designer:

Name: _____

Address: _____

_____

Telephone: _____ Email: _____

Would you like a copy of the completed shielding plan to be forwarded to your supplier/designer?

☐ No ☐ Yes

Do you have any specific requests or ideas for your shielding design?

(i.e. glass, special mouldings, color, types of wood etc.)

☐ No ☐ Yes *(please specify below)*

DIMENSIONED DRAWING REQUIREMENTS

Engineering grade drawings of the proposed location/installation of the CBCT must be provided if available. Otherwise, please provide a clear drawing on graph paper, stating dimensions, site address and contact information of the person who designed the drawing.

Note: Rough drawings or digital photos are unacceptable.

The drawings must show the following: *(see attached example for details)*

- size of the room that will contain the CBCT
- the planned location of the CBCT x-ray machine in the room
- the nature of the activities that take place outside the room
- the nature of the activities that occur both above and below the room
- floor and ceiling materials
- distances to the ceiling above the room
- distance to the floor of the space below the room
- the desired location of the exposure control.

Existing room

- What type of materials form the doors, walls and windows that surround the inside of the room?

PAYMENT INFORMATION

CARD TYPE: ☐ Visa ☐ Mastercard ☐ Amex

NAME AS IT APPEARS ON CREDIT CARD	***CARD NUMBER***	***EXPIRY*** ***Month*** ***Year***

AUTHORIZATION

I authorize the BC Dental Association to charge $3,850 + GST to my credit card.

_____ _____

Signature of Cardholder ***Today's Date***

RECEIPT

Please send payment receipt/invoice to: _____

Email Address

CVV Compliance

The 3-digit CVV (card verification value) found on the back of all credit cards is required and will be requested separately by telephone, prior to processing payment.

Please provide your preferred telephone number: _____

Submission of documents

- Completed application and dimensioned drawings should be sent to: cbctshielding@bcdental.org
- Please call Member Support if you have any questions: 604-736-7202