Facility changes form for moderate sedation, deep sedation & general anesthesia facilities

Thank you for informing the British Columbia College of Oral Health Professionals (BCCOHP) that there have been changes to your moderate sedation, deep sedation and/or general anesthesia (GA) facility.

Please complete this form and return it to accreditation@oralhealthbc.ca.

If the facility is withdrawing from moderate sedation, deep sedation and/or GA services, please complete and submit the **BCCOHP Withdrawal form for moderate sedation, deep sedation & general anesthesia facilities.**

Facility information

Name of facility (as it appears on signage): ____

Name of the facility director: ____

As per the BCCOHP HPOA Bylaws section 14.01 a "facility director" means a licensee who the registrar approves as the facility director for an accredited facility.

Changes to the facility

Please check all applicable changes:

- ☐ Facility name
- ☐ Facility director
- ☐ Facility ownership
- ☐ Facility address
- ☐ Contact information
- ☐ Sedation or GA level
- ☐ Sedation and/or GA providers & mobile anesthesia providers

Other: ____

Facility name

New facility name (as it appears on signage): ______________________________

Date of the change (m/d/y): ______________________

Facility director

As per the BCCOHP HPOA Bylaws section 14.07(5)(a), a "facility director" means a licensee who the registrar approves as the facility director for an accredited facility).

New facility director (full legal name): ______________________________

Facility director's email address: ______________________________

Facility director's phone number: ______________________________

Date of the change (m/d/y): ______________________

Facility ownership

As per the BCCOHP HPOA Bylaws, section 14 Accreditation, an "owner" means a licensee or health profession corporation that:

- owns a facility, or
- is an occupant having control of the premises where a facility is located.

Name(s) of the **new** facility owner(s): ______________________________

Date of the change (m/d/y): ______________________

Name(s) of **all** the facility owners (enter below):

Full legal name or health profession corporation	Licence number (only applicable for licensees)

Name(s) of any additional owners: ____

Facility address

New facility address: ____

Date of the change (m/d/y): __________________________

Contact information

Facility's primary email address: ____

Facility's secondary email address: ____

Facility's phone number: ____

Date of the change (m/d/y): __________________________

Sedation or GA level

Check off all the **former** sedation and/or GA services provided at the facility:

- ☐ No sedation
- ☐ Minimal sedation
- ☐ Moderate sedation
- ☐ Deep sedation
- ☐ General anesthesia

Check off all the **new** sedation and/or GA services provided at the facility:

☐ No sedation
☐ Minimal sedation
☐ Moderate sedation
☐ Deep sedation
☐ General anesthesia

Date of the change (m/d/y): ______________________________

Sedation and/or GA providers & mobile anesthesia providers

Sedation and/or GA providers

Name(s) of the **new** sedation and/or GA provider(s): ___________________________________

Date of the change (m/d/y): ______________________________

Name(s) of **all** the sedation and/or GA providers (enter below):

Full legal name	Licence number

Name(s) of any additional provider(s): ____

Mobile anesthesia providers (applicable to moderate sedation facilities only)

Does a mobile anesthesia provider(s) administer moderate sedation for this facility?

☐ Yes
☐ No (If no, you are not required to complete the mobile anesthesia provider information below.)

Name(s) of the **new** mobile anesthesia provider(s): ___________________________________

Date of the change (m/d/y): _____________________________

Name(s) of **all** mobile anesthesia providers (enter below):

Full legal name	Licence number

Name(s) of any additional mobile anesthesia provider(s): _____________________________

The mobile anesthesia provider(s):

☐ Do(es) not bring any moderate sedation emergency equipment, emergency drugs or airway management supplies to the facility. The facility is self-sufficient.

☐ Provide(s) **all** emergency equipment, **all** emergency drugs **and** airway management supplies to the facility.

Note: *The shared provision of emergency equipment and drugs is prohibited.*

Declaration

I ____ (name of the facility director) confirm and certify that all information provided for the BCCOHP facility changes form to be accurate, true, and up to date.

Printed name: _____________________________ Signature: _________________________

Date (m/d/y): _____________________________