New York State Department of Health School-Based Health Center Dental Program Reopening Addendum

Sponsor Name: _____

Name of Person Completing Form: _____

Title of Person Completing Form: _____

Name of Primary Contact (if different): _____

Title of Primary Contact (if different): _____

Email Address of Primary Contact: _____

Number of Sites Applying for Reopening Approval Total: _____

Number of Sites Applying for Reopening Approval by Facility Type:

Fixed Sites: _____ Mobile Sites: _____ Portable Sites: _____

The signature affixed to this form attests and affirms all the following criteria have been met:

- All School-Based Health Center Dental clinics identified in the attached list meet all requirements as outlined in *Interim Guidance for School-Based Health Centers Regarding COVID-19*, including references to additional guidance referenced therein.
- Collaboration has occurred with the school administration for each of the sites listed herein to ensure all requirements have been met.
- Any changes impacting the ability of any clinic to safely and effectively provide dental health services will be immediately (i.e., within no more than 24 hours) communicated to the New York State Department of Health.
- I have the authority to attest to the foregoing and sign this certification on behalf of the above-identified School-Based Health Center Dental Program.

Signature: _____

Date: _____

Site Name:	

DUPLICATE AS NEEDED

Justification for N/A Response to *Best Practices for Infection Control In Dental Clinics During the COVID-19 Pandemic* Checklist Item(s):

DUPLICATE AS NEEDED