VIRGINIA BOARD OF DENTISTRY

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Tel: (804) 367-4538 Fax: (804) 527-4428

APPLICATION FOR A PERMIT TO ADMINISTER CONSCIOUS/MODERATE SEDATION

First Name in Full:	Middle/Maiden:	Last Name in Full:
*Address of record for Board business:	City:	State / Zip Code:
*Address for public information:	City:	State / Zip Code:
*Telephone Number:	*Email address:	Virginia Dental License Number:
*If any of the information starred (*) above is different than the information on file for your dental license, initial here to request that your dental license information be updated: _____		
Provide addresses for additional offices where you intend to administer conscious/moderate sedation below or attach another sheet:		
Address:	City:	State / Zip Code:
Address:	City:	State / Zip Code:

Check if you have an advanced/ specialty degree or certificate in: ____ General Dentistry ____Periodontics ____Endodontics
____Public Health ____Pediatrics ___Orthodontics ____Prosthodontics ____Oral and Maxillofacial Pathology
____Oral and Maxillofacial Radiology ____Oral and Maxillofacial Surgery ____Other Specify _____
Are you currently Board certified? ____ Yes ___ No
Enter the name of the school or hospital where advanced/specialty education was completed: _____
Location: _____ Dates of attendance (i.e. Sept 1990 – Sept 1994): _____

INSTRUCTIONS

1. Please read these instructions and the application carefully. Information in bold print which is underlined identifies the documentation you must provide with your application. If you have any questions regarding this application please call the Board at (804) 367-4538.

2. You should know and understand the law in Virginia regarding sedation and anesthesia before completing the application. The Emergency Regulations for Sedation and Anesthesia Permits, 18VAC60-20-10 et seq., are on the Board's website at http://www.dhp.virginia.gov/dentistry/dentistry_laws_regs.htm. Please be aware that sedation and anesthesia laws change with time. You are responsible for knowing the current law.

3. Failure to comply with legal requirements, failure to properly complete the application or failure to provide required documentation will result in the delay or denial of your application. Please check carefully to assure that all required information is provided with your application. Please print and write legibly.

4. Return the completed application, all required documentation, and **a check or money order made payable to the "Treasurer of Virginia" for the amount of $100,** to the Virginia Board of Dentistry at the above address. Fees are non-refundable pursuant to 18VAC60-20-40.

5. It is your responsibility to maintain a copy of this application and all documents submitted to the Board or received from the Board for your future reference.

6. Permits issued between September 17, 2012 and March 31, 2013 will expire on March 31, 2014, except temporary conscious/moderate sedation permits as addressed in A(1) below. Thereafter, all permits, regardless of the issuance date, will expire **March 31** each year and are subject to annual renewal. A renewal notice will be sent in conjunction with your dental license renewal notice.

Applicant: _____

A. TYPE OF PERMIT AND QUALIFICATIONS

(1) ____I am applying for a temporary conscious/moderate sedation permit. Prior to January 1989, I certified to the Board that I was qualified to administer anesthesia and conscious sedation and **I am attaching the letter I received from the Board acknowledging my self-certification**. I understand that a temporary permit issued after September 17, 2012 will permanently expire on September 14, 2014. Further, I understand in order to administer conscious/moderate sedation after September 14, 2014, I must qualify for and obtain a permit to administer by any method of administration or by enteral administration only.

or

I qualify and am applying for a permit to administer conscious/moderate sedation by:

(2) ____any method of administration and **I am attaching the transcript, certification and/or documentation of training content which confirms that I meet the education requirement checked below:**

_____ Completion of training for administering conscious/moderate sedation according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred, while enrolled in a CODA accredited doctoral dental program or a post-doctoral university or teaching hospital program.

_____Completion of a continuing education course offered by a provider approved in 18VAC60-20-50(C) of the **Regulations Governing Dental Practice** consisting of 60 hours of didactic instruction plus the management of at least 20 patients per participant, demonstrating competency and clinical experience in parenteral conscious sedation and management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

or

(3) ____ an enteral method of administration only and **I am attaching the transcript or the certification and documentation of training content which confirms that I completed** a continuing education course offered by a provider approved in 18VAC60-20-50(C) of the **Regulations Governing Dental Practice** of not less than 18 hours of didactic instruction plus 20 clinically-oriented experiences in enteral and/or combination inhalation-enteral conscious sedation techniques. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

B. I hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, including basic electrocardiographic interpretation such as Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals and current Drug Enforcement Administration registration. **I am attaching a photocopy of my certification card and my DEA registration**.

C. By signing below, I certify that all licensed and auxiliary personnel who assist in the administration of controlled substances and who monitor patients during administration hold current certification in basic resuscitation techniques with hands-on airway training for health care providers. I further certify that such personnel are required to maintain current certification.

Applicant: _____

D. By signing below, I certify that I maintain a properly equipped facility for the administration of conscious/moderate sedation, which is staffed with auxiliary personnel who shall be capable of reasonably handling procedures, problems and emergencies incident thereto as required by the Emergency Regulations for Sedation and Anesthesia Permits.

E. Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia? ____Yes ____No

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

_____ _____

Applicant Signature Date

LIST OF SUPPORTING ATTACHMENTS REFERENCED IN THE APPLICATION:

1. A check or money order for $100 made payable to the "Treasurer of Virginia" – see instruction #4 .
2. a. The letter from the Board acknowledging self-certification prior to January 1989 for a temporary permit – see section A(1).

   or

   b. A transcript, certification and/or documentation of training content for a permit for administration by any method – see section A(2).

   or

   c. A transcript or the certification and documentation of training content for a permit for administration by an enteral method only – see section A(3).
3. A photocopy of my certification card for advanced resuscitation techniques– see section B.
4. A photocopy of the DEA registration – see section B

Revised July 29, 2014

Virginia Board of Dentistry
(804) 367-4538 FAX (804) 527-4428 denbd @dhp.virginia.gov

PRE-INSPECTION SURVEY FORM

Each dentist applying to hold a permit to administer conscious/moderate sedation or deep sedation and general anesthesia (hereinafter referred to as a Permit Holder) is required to provide the following information. This completed form must be returned with your application.

Permit Holder's full name is: _____

Permit Holder practices: ___ **general dentistry**
___ **the specialty of** _____

Permit Holder practices at the following location(s):

- **Full name of the practice:** _____
  Full address of the practice: _____
  _____
  Full name of the primary contact person: _____
  Telephone number of the primary contact person: _____
  E-mail address of the primary contact person: _____
  The number of other permit holders at this location: _____

- **Full name of the practice:** _____
  Full address of the practice: _____
  _____
  Full name of the primary contact person: _____
  Telephone number of the primary contact person: _____
  E-mail address of the primary contact person: _____
  The number of other permit holders at this location: _____

- **Full name of the practice:** _____
  Full address of the practice: _____
  _____
  Full name of the primary contact person: _____
  Telephone number of the primary contact person: _____
  E-mail address of the primary contact person: _____
  The number of other permit holders at this location: _____

Use a separate piece of paper to provide information on all additional locations.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR BOARD USE ONLY

Permit number _____ **was issued on** _____