

APPLICATION FOR A PERMIT TO ADMINISTER
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 the addresses for additional offices where you will administer sedation (use separate page if necessary):		
Address:	City:	State /Zip Code:
Address:	City:	State /Zip Code:
Address:	City:	State /Zip Code:

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 are required to know and understand the laws and regulations in Virginia which govern the administration of sedation and anesthesia before completing the application. Particular attention should be given to the definitions in **18VAC60-21-10.D** and the provisions for administration in **Part VI, 18VAC60-21-260** through **18VAC60-21-301** of the Regulations Governing the Practice of Dentistry. Please be aware that sedation and anesthesia laws change over time. You are responsible for knowing the current legal requirements.
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 **18VAC60-21-40.G**.
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. 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.

- A. I am applying for a permit to administer moderate sedation and **am attaching the transcript, certification and documentation of training content**, which confirms that I meet the education requirement checked below:

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

_____ Completion of a continuing education course for administering moderate sedation offered by a provider approved in 18VAC60-21-250 of the Regulations Governing the Practice of Dentistry consisting of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in moderate sedation, and (iii) management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students) 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, such as Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals. **I am attaching a photocopy of my certification card.**
- C. I hold a **current** Drug Enforcement Administration (DEA) registration which contains my **Virginia** place of business/practice address as required pursuant to **§21-1301.12 of the Code of Federal Regulations** in accordance with **21 U.S.C §822(e)** of the U.S. Code. **I am attaching a photocopy of my DEA registration card.**
- D. I have completed the **PRE-INSPECTION SURVEY FORM** and **I am submitting it with my application.**
- E. By signing below, I certify that all licensed and ancillary 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 and are trained in implementing my written emergency procedures. I further certify that such personnel are required to maintain current certification.
- F. By signing below, I certify that I maintain a properly equipped facility for the administration of moderate sedation as required by the Regulations Governing the Practice of Dentistry.

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 AND INSTRUCTIONS:

1. A check or money order for \$100 made payable to the "Treasurer of Virginia" - see instruction #4.
2. A transcript, certification and documentation of training content for a permit for administration of moderate sedation - see section A.
3. A photocopy of my certification card for advanced resuscitation techniques - see section B.
4. A photocopy of my current DEA registration with the Virginia place of business/practice address - see section C.
5. A completed PRE-INSPECTION SURVEY FORM – see section D.

Virginia Board of Dentistry

(804) 367-4538

eFAX (804) 698-4266

denbd@dhp.virginia.gov

PRE-INSPECTION SURVEY FORM

Each dentist applying to hold a permit to administer 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
 in 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: _____
 Is this location a licensed hospital as defined in §32.1-123 of the Code of Virginia? YES NO
 Is this location a state-operated hospital? YES NO
 Is this location a facility directly maintained or operated by the federal government? YES NO
- 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: _____
 Is this location a licensed hospital as defined in §32.1-123 of the Code of Virginia? YES NO
 Is this location a state-operated hospital? YES NO
 Is this location a facility directly maintained or operated by the federal government? YES NO

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 _____