Virginia Department of Health Professions
Board of Dentistry

**9960 Mayland Drive, Suite 300**
**Henrico, Virginia 23233**
**(804) 367-4538 (Tel)**
**(804) 698-4266 (eFax)**
**denbd@dhp.virginia.gov**
**www.dhp.virginia.gov/dentistry**

# APPLICATION FOR REINSTATEMENT OF A PERMIT TO ADMINISTER MODERATE SEDATION or DEEP SEDATION/GENERAL ANESTHESIA

| 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: | |
| Virginia Dental License Number: | Sedation Permit Number: | *Telephone Number: | *Email Address: |

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: |

**Reinstatement is sought for:**

___ MODERATE SEDATION PERMIT

___ DEEP SEDATION/GENERAL ANESTHESIA PERMIT

**Please check below:**

___ 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. For a Deep Sedation/General Anesthesia Permit, I verify that the training included basic electrocardiographic interpretation. **I am attaching a photocopy of my certification card.**

___ 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.**

___ I am attaching documentation to demonstrate that I am currently competent to practice the applicable level of sedation.

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 the required certification.

By signing below, I certify that I maintain a properly equipped facility for the administration of either moderate sedation or deep sedation/general anesthesia as appropriate to my practice as required in 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 _____

## INSTRUCTIONS

1. Please read these instructions and the application carefully and ensure that all required information is provided and that all required documentation is included. An incomplete application will delay the processing of your application. Incomplete applications are kept for one year, then destroyed.

2. Return the completed application and all required documentation, to the Virginia Board of Dentistry at the above address.

3. 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,

4. 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 **Part VI, 18VAC60-21-260** through **18VAC60-21-301** in the Regulations Governing the Practice of Dentistry. Please be aware that sedation and anesthesia laws and regulations change over time. You are responsible for knowing the current legal requirements.

5. To qualify for reinstatement of a sedation permit, the applicant must include documentation in the application sufficient to **demonstrate continuing competence**. To evaluate continuing competence, the Board shall consider hours of continuing education that meet the requirements of section 18VAC60-21-250.G; evidence of active practice in another state or in federal service or a refresher or training course on the administration of the specified permit type which meets the education requirements of sections 18VAC6021-290 and 18VAC60-21-300. Completion of only home study, journal or internet courses is generally not sufficient to demonstrate continuing competence.

6. **NOTICE:** The Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students adopted by the American Dental Association in October 2016 detail the current education standards for a moderate sedation course. In keeping with these Guidelines and the Regulations Governing the Practice of Dentistry, the Board no longer issues permits for enteral administration of moderate sedation and such permits cannot be reinstated.

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# 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 _____**