# Application for Pediatric Moderate Sedation Permit



Board of Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasdentistry.gov
Email: info@floridasdentistry.gov

Phone: (850) 245-4474 FAX: (850) 921-5389





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Do Not Write in this Space For Revenue Receipting Only

Review chapter (ch.) 64B5-14, Florida Administrative Code (F.A.C.), prior to completing your application. https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B5-14

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Pediatric Moderate Sedation Permit \$300.00

Total fee includes the following:

Application Fee (non-refundable) \$100.00 Permit Fee \$200.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. The permit fee may be refunded if the application is denied without inspection of the applicant's facilities.

#### 1. PERSONAL INFORMATION

Name:					Date of Birth	:
Last/Surname		First		Middle		MM/DD/YYYY
Mailing Address: (The	address whe	re mail and your	license should be	e sent)		
Street/P.O. Box				Apt. No.	City	
State		ZIP	Country		Home/Cell Telephone (Inp	out without dashes)
Florida Dental License	Number: _					
EQUAL OPPORTUNIT	Y DATA:					
We are required to ask	that you furnise Selection Pi	rocedure (1978);	43 FR 38295 and	d 38296 (Au	luntary compliance with 41 CF gust 25, 1978). This information	
We are required to ask to Guidelines on Employee	that you furnise Selection Pi	rocedure (1978); ly and does not in Native Hawaiiar	43 FR 38295 and any way affect you or Pacific Island or Alaska Native	d 38296 (Au our candida er H	gust 25, 1978). This information	
We are required to ask to Guidelines on Employee statistical and reporting Gender: Male Female	that you furnise Selection Propurposes onlesses:  Race:	rocedure (1978); ly and does not in Native Hawaiiar American Indiar Two or More Ra	43 FR 38295 and any way affect you or Pacific Island or Alaska Native aces	d 38296 (Au our candida er He E	gust 25, 1978). This information for licensure.	White Asian ail address on the

Name:
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#### 2. APPLICANT BACKGROUND

A. Do you currently hold, or have ever held an anesthesia permit, license, and/or certificate? Yes No

If you responded "Yes," complete the following:

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

#### 3. TRAINING PROGRAM

Refer to Rules 64B5-14.0025 and 14.003(3)(a), F.A.C., which establish the criteria for issuance of a moderate sedation permit.

A. Have you completed a formal training course offered through a Commission on Dental Accreditation accredited dental school or program in the use of moderate sedation or through an accredited teaching hospital (Clinical training must take place at the accredited dental school or accredited teaching hospital)? Yes No

If you responded "Yes," complete the following:

Training Program or Institution	Date of Certification (MM/DD/YYYY)	Training Dates: From-To (MM/DD/YYYY)
		to
		to

#### Applicants must provide the following:

A copy of certification or letter from the dean of the dental school or head of the teaching hospital attesting to and describing the formal training.

A patient chart or log containing type(s) and concentration of medication used for sedation.

**Documentation of actual clinical administration** of anesthetics to 20 patients within two years of this application.

B. Have you completed clinical administration of anesthetics to 20 dental or oral and maxillofacial patients within two (2) years prior to application of the particular type of anesthetics for the permit applied for? Yes No

Practice Location (Where the administrations were provided)	# of Administrations Given

C.	Have you experienced any mortality or other incident resulting in temporary or permanent physical or mental
	injury requiring hospitalization or emergency room treatment of a dental patient that occurred during or as a
	direct result of the use of general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation,

Name:

minimal sedation, nitrous oxide, or local anesthesia? Yes No

If you responded "Yes" to C, you must provide the following:

A description of dental procedure(s)

A description of preoperative physical condition of patient(s)

A detailed list of the drugs administered and the dosage administered

A detailed description of the techniques utilized in administering the drugs

A detailed description of the **adverse occurrence**, to include 1) the onset and type of **complications** and the onset and type of **symptoms experienced** by the patient; 2) the onset and type of **treatment rendered** to the patient; 3) the onset and type of **response of the patient** to the treatment rendered; and 4) **final disposition** of the patient.

4. FACILITY INFORMATION (Attach additional pages for any additional facilities)

Facility Name:		
Facility Address:		
Street/P.O. Box		Suite No. City
State	ZIP	Country
Contact Information:		

#### 5. FACILITY OPERATIONS

- A. Is your anesthesia/sedation location(s) properly equipped as outlined in Rule 64B5-14.010, F.A.C.?

  Yes No
- B. At your anesthesia/sedation location(s), do you employ two or more qualified assistants/dental hygienists who, working under the direct supervision of the dentist, assist the dentist, and assist in emergency care of the patient as defined in Rule 64B5-14.001(9), F.A.C.? Yes No

All locations at which you administer sedation must be provided in writing to the board office. The holder of any general anesthesia, moderate sedation, or pediatric moderate sedation permit is authorized to practice pursuant to such permit only at the location or locations previously identified to the board office.

Official notification must be provided to the board office at <u>MQA.Dentistry@FLHealth.gov</u> for any additions, deletions, or changes of locations.

Name:	•	

#### 6. DISCIPLINE HISTORY

- A. Have there been any disciplinary actions initiated against your license in any state? Yes No
- B. Has any action been initiated against your license, permit, or certificate to administer anesthesia or sedation in any state? Yes No
- C. Is there any pending litigation or dental malpractice proceeding being conducted against your license, permit, or certification related to the practice of dentistry or the administration of anesthesia/sedation?
  Yes
  No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?	
				Υ	Ν
				Υ	Ν
				Υ	Ν

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Complaint** and **Final Order**.

#### 7. CARDIOPULMONARY RESUSCITATION

Review 64B5-14.003(3)(e) F.A.C. to view requirements for a dentist utilizing pediatric moderate sedation. https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B5-14.

List staff available when pediatric moderate sedation is being administered.

Name	Current Certif	ly CPR ied?
	Υ	N
	Υ	N
	Υ	N

Effective March 1, 2022, if treating a patient 7 years of age or under, a dentist utilizing any level of sedation must be currently trained in Pediatric Advanced Life Support (PALS).

Attach proof of your Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) certification, and after March 1, 2022, PALS certification, if required.

Attach proof of BLS certification for each support staff listed above.

CPR certification must be from the American Heart Association or American Red Cross or an equivalent agency sponsored CPR course at the basic life support level to include one person CPR, two person CPR, infant resuscitation, and obstructed airway. Note: The "**Heartsaver**" course **does not** meet this requirement.

8. APPLICANT RE	ELEASE		
I, the undersigned, s	state that I am the person referred to in this application for licensu	ure in the	state of Florida.
circumstances or co denial of the license	orida law requires me to immediately inform the board of any mandition stated in the application which takes place between the information on this application as needed including denial of licensure.	nitial filing	and the final granting or
Applicant Signature		_ Date _	
	You may print out this application and sign it or sign digitally.		MM/DD/YYYY

Name:

### Board *of* Dentistry Anesthesia Credentialing Supplement Rule 64B5-14.003(3)(2), F.A.C.



This form is to be completed and signed by the program director or instructor, and the school or hospital seal embossed on this certification. Failure to comply may delay approval of your moderate sedation or pediatric moderate sedation application. Rule 64B5-14.003(3)(2), F.A.C., specifically requires certification that the dentist is competent in the administration of moderate sedation or pediatric moderate sedation and that the dentist completed at least 60 didactic hours and personally administered this anesthesia to at least 20 patients in a competent manner.

I	, he	ereby certify th	nat	 of applicant)	
completed at least 60 c	didactic hours as de	scribed in abo	ve rule, including	4 hours in Airway ع ر	y
Management, and pers	sonally administered	d moderate se	dation or pediatri	c moderate sedati	ion to at
least 20 patients while	completing this prog	gram and has	been trained to o	competency.	
Print Name of Director/	/Instructor		MM/DD	/YYYY	
Signature – Instructor/I	Director				
School Name					
				<del></del>	
School Address					
Dates of Training:	Start·		End:		
Dates of Training.	Start:(MM/DE	D/YYYY)	End:(MM/DE	D/YYYY)	
(School/Hospital Seal)					