

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

**NOTICE TO ALL APPLICANTS FOR PEDIATRIC CONSCIOUS SEDATION,
CONSCIOUS SEDATION AND GENERAL ANESTHESIA PERMITS**

Please review rule chapter 64B5-14, Anesthesia, Florida Administrative Code, prior to completing the application. You may access the rule chapter at www.flrules.org.

Upon receipt of a completed application, the Board staff will submit the application to designated committee member for review. You will be notified in writing when a decision has been made, however, an inspection of the facility and an evaluation of the applicant administering anesthesia will be conducted **PRIOR** to the permit being issued.

If you have any questions concerning the information listed above or the application process, please contact our office at (850) 245-4444, Extension 3491.

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

FACILITY 1:

Office Telephone (____)_____

Office Fax (____)_____ Email_____

Associates:

Name	License Number	Type of Permit
------	----------------	----------------

Name	License Number	Type of Permit
------	----------------	----------------

Has this facility been inspected by DOH/AHCA? Yes___ No___

If yes, **when**, and **for whom**_____

Was the section of the physical plant you will utilize included in the inspection?
Yes___ No___

Were the assistants you will use as part of the anesthesia team included in the inspection?
Yes___ No___

**For any additional facilities, please provide information as requested for Facility #1.
Use separate pages and attach to application.**

Are you licensed in any state(s) that require(s) an anesthesia permit, license, and/or certificate?
Yes _____ No _____

If yes, please list_____

Has any action been initiated against your license concerning the use of anesthesia in any state(s)? Yes___ No___

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

- If yes, please submit a full detailed report, including all board and/or civil documentation. Your application will not be considered for approval until complete documentation is received.

Are you licensed in another state(s)? Yes___No___

Have there been any disciplinary actions initiated against your license in any state (including Florida)? Yes___No___

Are there current disciplinary or litigation proceedings being conducted? Yes___No___

- If you answer yes to any question, submit a full separate detailed report, including all board and/or civil documentation.

Rule 64B5-14.003(3) states that an applicant must have received formal training in the use of Pediatric Conscious Sedation. The formal training must be sponsored by or affiliated with a University, Teaching Hospital, or other facility approved by the Board, or may be part of the undergraduate curriculum of an accredited Dental School and must contain, at a minimum, sixty (60) hours of didactic training and the supervised personal administration of sedation to at least twenty (20) patients including supervised training, clinical experience and demonstrated competence in management of the compromised airway.

A. IDENTIFY TRAINING PROGRAM IN PEDIATRIC CONSCIOUS SEDATION

1. Sponsoring Institution _____
2. Program Chairperson _____
3. Date of Certification _____
4. Number of patients to whom sedation was administered _____

Submit a copy of certification or letter from the dean of the dental school or head of the teaching hospital attesting to and describing your formal training. APPROVAL WILL NOT BE GIVEN WITHOUT THE ABOVE INFORMATION AND AFFIRMATION OF PERSONAL ADMINISTRATION OF SEDATION. (SEE ENCLOSED FORM)

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

B. APPROXIMATE NUMBER OF ADMINISTRATIONS GIVEN WITHIN LAST (12 MONTHS) _____
WHERE ADMINISTERED? _____

C. HAVE YOU EXPERIENCED ANY MORTALITY OR OTHER INCIDENT RESULTING IN THE TEMPORARY OR PERMANENT PHYSICAL OR MENTAL INJURY OF THE PATIENT REQUIRING HOSPITALIZATION AS A RESULT OF THE USE OF PEDIATRIC SEDATION? YES___ NO___

If yes, give full descriptions on a separate page, including the following details:

1. Description of dental procedures(s)
2. Description of preoperative physical condition of patient(s)
3. List of drugs and dosage administered
4. Description of techniques utilized during drug administration
5. Description of adverse occurrence(s)
6. Treatment instituted on patient(s)
7. Response of patient(s) to treatment
8. Description of patient's condition on termination of each procedure

D. I HAVE PROPERLY EQUIPPED FACILITY/FACILITIES AS OUTLINED IN CHAPTER 64B5-14.010, F.A.C., STAFFED WITH SUPERVISED ASSISTANT AND/OR DENTAL HYGIENIST PERSONNEL WHICH ARE TRAINED IN BASIC CARDIAC LIFE SUPPORT AND CAPABLE OF REASONABLE HANDLING EMERGENCIES: YES___ NO___

I HAVE EQUIPMENT CAPABLE OF DELIVERING POSITIVE PRESSURE OXYGEN VENTILATION: YES___ NO___

E. *64B5-14.003(3)(b) states that a DENTIST UTILIZING PEDIATRIC CONSCIOUS SEDATION AND HIS ASSISTANT/DENTAL HYGIENIST PERSONNEL SHALL BE CERTIFIED IN AN AMERICAN HEART ASSOCIATION OR AMERICAN RED CROSS OR EQUIVALENT AGENCY SPONSORED CARDIOPULMONARY RESUSCITATION COURSE AT THE BASIC LIFE SUPPORT LEVEL TO INCLUDE ONE MAN CPR, TWO MAN CPR, INFANT RESUSCITATION, AND OBSTRUCTED AIRWAY WITH A PERIODIC UPDATE NOT TO EXCEED TWO YEARS. STARTING WITH THE LICENSURE BIENNIUM COMMENCING ON MARCH OF 2000, A DENTIST AND ALL ASSISTANT/DENTAL HYGIENIST PERSONNEL SHALL ALSO BE TRAINED IN THE USE OF EITHER AN AUTOMATED EXTERNAL DEFIBRILLATOR OR A DEFIBRILLATOR AND ELECTROCARDIOGRAPH AS PART OF THEIR CARDIOPULMONARY RESUSCITATION COURSE AT THE BASIC LIFE SUPPORT*

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

LEVEL. IN ADDITION TO CPR CERTIFICATION, A DENTIST UTILIZING PEDIATRIC CONSCIOUS SEDATION MUST BE CURRENTLY TRAINED IN ACLS (ADVANCED CARDIAC LIFE SUPPORT), ATLS (ADVANCED TRAUMA LIFE SUPPORT, OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS), or AN EQUIVALENT COURSE APPROVED BY THE BOARD OF DENTISTRY.”

- **ATTACH COPIES OF CURRENT ACLS AND BLS CARDS FOR APPLICANT AND COPIES OF CURRENT BLS CARD FOR EACH SUPPORT STAFF LISTED BELOW IN ORDER FOR APPLICATION TO BE DEEMED COMPLETE.**

List support staff available when pediatric sedation is being administered. Please note that the “Heartsaver” course is NOT acceptable for these purposes.

NOTE: ATTACH DOCUMENTATION OF ACTUAL CLINICAL ADMINISTRATION OF ANESTHETICS TO 20 PATIENTS WITHIN 2 YEARS OF APPLICATION.

I have read the questions in the foregoing pages of this pediatric conscious sedation application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of any license to practice in the State of Florida, for the profession for which I am applying.

Signature of Applicant

Date

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov

**FLORIDA DEPARTMENT OF HEALTH
BOARD OF DENTISTRY**

**ANESTHESIA CREDENTIALING SUPPLEMENT
RULE 64B5-14.003(2)(3), FLORIDA ADMINISTRATIVE CODE**

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 conscious sedation or pediatric conscious sedation application. This portion of the rule specifically requires certification that the dentist is competent in the administration of conscious sedation or pediatric conscious sedation and that the dentist completed at least sixty didactic hours and personally administered this anesthesia to at least 20 patients in a competent manner.

CERTIFICATION

I _____, HEREBY CERTIFY
(name and title of director or instructor)

THAT _____, COMPLETED AT LEAST SIXTY
(name of applicant)

DIDACTIC HOURS AS DESCRIBED IN ABOVE RULE, AND PERSONALLY ADMINISTERED CONSCIOUS SEDATION OR PEDIATRIC CONSCIOUS SEDATION TO AT LEAST 20 PATIENTS WHILE COMPLETING THIS PROGRAM, AND HAS BEEN TRAINED TO COMPETENCY.

Signature – Instructor/Director

Date of Signature

Print Name of Director/Instructor

School/Hospital Seal

Name/Address of School

Dates of Training

Board of Dentistry • 4052 Bald Cypress Way, Bin #C-08
Tallahassee, FL 32399-3258 • (850) 245-4474
www.floridasdentistry.gov
info@floridasdentistry.gov