

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.

APPLICATION FOR PERMIT

CONSCIOUS SEDATION

***PLEASE SUBMIT A \$300 APPLICATION AND PERMITTING FEE
(PLEASE PRINT OR TYPE ALL INFORMATION)***

Name: _____

Home Address: _____
Street Apt# City State Zip

Home Telephone Number: _____

Date of Birth: _____ Florida Dental License # _____

Email Address: _____

Dental School Attended & Year of Graduation: _____

Post Graduate Residency Training: _____

From: _____ To: _____

Institution: _____

Specialty: _____

List each facility at which you plan to administer sedation. For each facility, please include the address, telephone number, and indicate all permitted associates at each facility with his/her type permit and license number.

Please note that the address(es) you provide is(are) the address(es) we shall approve or deny for certification as a properly equipped facility. All facilities at which you administer sedation must be listed! Official written notification must be provided to the Board Office of any additions or deletions. These addresses are only for the purpose of anesthesia permitting; address changes to your basic license must be in writing, separate from this information. Attach separate sheet(s) if necessary.

FACILITY 1:

Office Telephone Number () _____

Office Fax Number () _____

Email Address:

Associates (list all sedation permit holders):

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

Has this facility been inspected by Board of Dentistry Consultant? Yes___ No___

If yes, when?_____ 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___

- 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___.

Currently, are there any disciplinary or litigation proceedings being conducted? Yes___ No___ . If yes to any question, please submit written detailed report.

Rule 64B5-14.003(2) states “that an applicant must have received formal training in the use of 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 at least twenty (20) patients including supervised training, clinical experience and demonstrated competence in management of the compromised airway.”

A. IDENTIFY TRAINING PROGRAM IN CONSCIOUS SEDATION:

1. Name of Sponsoring Institution:_____
2. Date of Certification:_____
3. Number of patients personally administered for sedation:_____

Submit a copy of certification or a letter from the dean of the dental school or head of the teaching hospital attesting to and describing the formal training, along with patient chart or log containing type(s) and concentration of medication used for sedation. (APPROVAL WILL NOT BE GIVEN WITHOUT THIS INFORMATION AND AFFIRMATION OF PERSONAL ADMINISTRATION OF SEDATION).

B. APPROXIMATE NUMBER OF ADMINISTRATIONS GIVEN WITHIN THE LAST YEAR:_____

Where administered?_____.

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

Yes___ No___; if yes, describe for each occurrence, in complete detail, the following on a separate sheet:

1. Description of dental procedure(s).
2. Description of preoperative physical condition of patient(s).

3. List of drugs and dosage administered.
4. A detailed description of techniques utilized in administering the drugs.
5. A description of adverse occurrence(s).
6. Treatment instituted on patient(s).
7. Response of patient(s) to treatment.
8. Describe patient's condition on termination of any procedure undertaken.

D. I HAVE PROPERLY EQUIPPED FACILITY/FACILITIES AS OUTLINED IN CHAPTER 64B5-14.009, 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___.

I HAVE A DEFIBRILLATOR APPROPRIATE FOR MY PATIENT POPULATION: Yes___ No___.

E. 64B5-14.003(2)(E) STATES: *“A dentist utilizing 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 March/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 level. In addition to CPR certification, a dentist utilizing conscious sedation must be currently trained in ACLS (Advanced Cardiac Life Support) or ATLS (Advanced Trauma Life Support).”*

- Attach proof of BLS and ACLS OR ATLS for dentist and attach proof of BLS for each support staff utilized when conscious sedation is being administered.

Please note that the “Heartsaver” course is not acceptable for these purposes.

* List support staff available when conscious sedation is being administered.

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 application and have answered them completely, without reservations of any kind, and I declare under the 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 licensed to practice in the State of Florida, for the profession for which I am applying.

Signature of applicant

Date

**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