

**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.

FACILITY 1:

Telephone () _____ Fax () _____ Email _____

LIST OF ASSOCIATES:

Name	License Number	Type of Permit
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Name	License Number	Type of Permit
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Name	License Number	Type of Permit
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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.

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

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 yes, please submit full detailed report on separate pages.

Rule 64B5-14.003(1) provides for several methods of obtaining a general anesthesia permit. Check appropriate blanks and provide any additional information requested. Please answer each question. Please indicate “N/A” if not applicable.

A. I have completed a minimum of one year residency program accredited by the Commission on Dental Accreditation in dental anesthesiology or I have completed an oral and maxillofacial surgery residency program accredited by the Commission on Dental Accreditation beyond the undergraduate dental school level.

Yes__ No__ If yes, provide the following information:

1. Training dates from: _____ to: _____

2. Name of training program or institution: _____

3. Attach copy of certificate of completion to application

B. I am a diplomate of the American Board of Oral and Maxillofacial Surgeons.

Yes___ No___ If yes, please submit documentation

C. I am eligible for examination by the American Board of Oral and Maxillofacial Surgeons

Yes___ No___ If yes, please submit documentation

D. I am a member of the American Association of Oral and Maxillofacial Surgeons.

Yes___ No___ If yes, please submit documentation

E. Approximate number of administrations given during the preceding year _____

Where administered _____

F. Have you experienced any mortality or other incident resulting in the temporary, permanent physical or mental injury requiring hospitalization of the patient as a result of the use of general anesthesia, parenteral anesthesia, or pediatric conscious sedation? Yes___ No___

If yes, describe each occurrence in full detail on a separate page, including the following details, and attach to this application:

1. Description of dental procedure(s)
2. Description of preoperative physical condition of patient(s)
3. List of drugs and dosage administered
4. Detailed 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. Describe patient's condition on termination of procedure undertaken

G. I have properly equipped facility/facilities as outlined in chapter 64B5-14.008, 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 oxygen equipment capable of delivering positive pressure oxygen ventilation.
Yes _____ No_____

I have an appropriate defibrillator for my patient population.
Yes _____ No_____

64B5-14.003(1)(c) states that “a dentist employing or using general anesthesia or deep sedation and all 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 person CPR, two person CPR, infant resuscitation, and obstructed airway with a periodic update not to exceed two years. In addition to CPR certification, a dentist utilizing general anesthesia or deep sedation must be currently trained in ACLS (Advanced Cardiac Life Support) or ATLS (Advanced Trauma Life Support).”

***Note that the “Heartsaver” course is NOT acceptable.**

- Attach copies of current ACLS and BLS cards for applicant and copies of current BLS card for each support staff (minimum of two) listed below in order for application to be deemed complete.

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* List support staff available when general anesthesia, conscious sedation or pediatric conscious sedation is being administered.

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

Signature of applicant _____ **Date** _____

Print name of applicant _____