Received: _____

Applying for: GA_____
PA_____

BOARD OF DENTAL EXAMINERS OF ALABAMA
5346 Stadium Trace Parkway
Ste – 112
Hoover, AL 35244
Phone: (205) 985-7267 Fax: (205) 985-0674
Email: bdeaal@bellsouth.net
Website: www.dentalboard.org

INITIAL APPLICATION FOR PERMIT OF AUTHORIZATION TO USE GENERAL ANESTHESIA AND PARENTERAL SEDATION ON AN OUTPATIENT BASIS

INCOMPLETE FORMS WILL BE RETURNED

Fee: $900.00

TYPE OR PRINT LEGIBLY USING BLACK INK. Read carefully before answering. Each question must be answered completely, truthfully and accurately. All supporting data requested must accompany this application. If space for any answer is insufficient, the applicant must complete the answer on a separate page, singed by him/her; specifying the questions, which it relates to, and enclose with this application. DO NOT STAPLE ENCLOSURES TO THIS APPLICATION FORM.

_____ (____)_____
FIRST NAME MIDDLE LAST NAME Phone number

_____ _____ _____
AL DENTAL LICENSE NUMBER AL CONTROLLED SUBSTANCES PERMIT NUMBER EXPIRATION DATE

_____ _____ _____
Federal Drug Enforcement Registration number Expiration Date Social Security Number

Mailing address: _____

_____ (____)_____
CITY STATE ZIP PHONE

Office or Facility address for this permit:_____

_____ ( ) _____

CITY STATE ZIP PHONE

Type of Practice: General Specialty:_____

Check categories of Training and Education Criteria qualifying applicant for permit (Credentials and/or substantiating documents must be enclosed)

_____ **A. Fellow of American Dental Society of Anesthesiology**

_____ **B. Diplomate of American Board of Oral and Maxillofacial Surgery.**

_____ **C. Eligible for examination by the American Board of Oral and Maxillofacial Surgery. (Include dates of any expected examination to be taken and date of any previous examination(s) taken.**

_____ **D. Member of American Association of Oral and Maxillofacial Surgeons.**

_____ **E. Completed minimum of one year of advanced training in anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in part II of the guidelines for teaching the comprehensive control of pain and anxiety in dentistry. (Please include a detailed explanation, i.e. courses taken, name of school, dates, etc.)**

_____

_____

_____ **F. Employment or work in conjunction with a qualified medical doctor who is a member of the anesthesiology staff in an accredited hospital, provided that such anesthesiologist must remain on the premises of the dental office or facility until any patient given a general anesthetic regains consciousness and is discharged.**

_____ **G. Qualification by experience in accordance with the requirements set forth by law. (Refer to law for requirements.) If this category is checked, please state whether you have used or employed general anesthesia in your practice prior to June 1, 1985, including details of such i.e. number of times used, type of procedures or treatment, etc.**

_____

_____

EDUCATION AND TRAINING:

1. **Pre-Professional Education:**

_____

School, College or University Degree Dates

2. **Dental Education:**

_____

School, College or University Degree Dates

3. **Other Professional Education:**

School, College or University	Degree	Dates
School, College or University	Degree	Dates

4. **Post – Doctoral Education**

School, College or University	Degree	Dates

List hospital, with type of appointment, of which applicant is a member or staff:

Give resume of your general anesthesia qualifications, including training and experience. (Include whether you used general anesthesia prior to June 1, 1985).

Are you currently certified in CPR? Yes No
If yes, state where and when you received this certification: _____

Are your auxiliary personnel currently certified in CPR? Yes No
If yes, state their names and when and where they received this certification.

NOTE: Any dentist using general anesthesia and his auxiliary personnel shall be currently certified in cardiopulmonary resuscitation.

List all instance of the following in connection with your use of general anesthesia and/or parenteral sedation, including a detailed explanation of any such occurrence.

_____ **Mortality**

_____ **Morbidity**

Issuance of a permit for general anesthesia shall include the privileges of administering parenteral sedation in accordance with the requirements of law.

Prior to the issuance of this permit, the Board, at its discretion, may require an on-site inspection of your office(s) or facility(ies), equipment and personnel to determine if the requirements of law have been met.

AFFIDAVIT OF APPLICANT

I hereby certify that I am the person who executed this application for a permit to employ or use general anesthesia in the practice of dentistry in the State of Alabama. All statements herein contained are true in every respect.

_____

Signature of applicant

STATE OF ALABAMA

COUNTY OF _____

Sworn to and subscribed before me this _____ **day of** _____**,** _____

_____

Notary Public

_____

My commission expires: _____