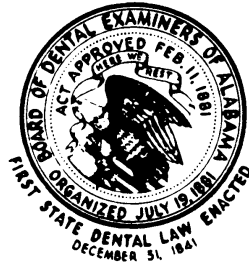


Fee: \$1,200.00



Received: \_\_\_\_\_

Applying for: CHECK ONE

GA \_\_\_\_\_ OR PA \_\_\_\_\_

**BOARD OF DENTAL EXAMINERS OF ALABAMA**  
2229 Rocky Ridge Rd  
Birmingham, AL 35216  
Ph: 205-985-7267 Fax: 205-985-0674  
Email: [bdeal@dentalboard.org](mailto:bdeal@dentalboard.org)  
Website: [www.dentalboard.org](http://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

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, signed by him/her; specifying the questions, which it relates to, and enclose with this application.

_____			( ) _____
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

Email:

\_\_\_\_\_

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:**

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School, College or University	Degree	Dates
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School, College or University	Degree	Dates
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**4. Post – Doctoral Education**

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School, College or University	Degree	Dates
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List hospital, with type of appointment, of which applicant is a member or staff:

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

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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.

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**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

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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.

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Signature of applicant

STATE OF ALABAMA

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

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Notary Public

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My commission expires: \_\_\_\_\_