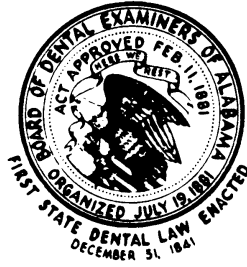


**Cost of Initial OCS  
permit - \$100**



Administrative Use

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

Approved: \_\_\_\_\_

Denied: \_\_\_\_\_

Returned incomplete: \_\_\_\_\_

**BOARD OF DENTAL EXAMINERS OF ALABAMA**

**2229 Rocky Ridge Road**

**Birmingham, AL 35216**

**Phone: (205) 985-7267 Fax: (205) 985-0674**

**Email: bdeal@dentalboard.org**

**Website: www.dentalboard.org**

**INITIAL APPLICATION FOR ORAL CONSCIOUS SEDATION PERMIT**

**Renewal is DUE by October 1st for each succeeding year**

**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 the space for any answer is insufficient, the applicant must complete the answer on a separate page, signed by him/her, specifying the question, which it relates to, and enclose with this application. DO NOT STAPLE ENCLOSURES TO THIS APPLICATION FORM.

I hereby make application for an Oral Conscious Sedation Permit in accordance with and subject to the provisions of the Alabama Dental Practice Act and the rules of the Board of Dental Examiners of Alabama as found in Code of Alabama, (1975) §34-9-80 et.seq.

\_\_\_\_\_  
(First Name)

\_\_\_\_\_  
(Middle Name)

\_\_\_\_\_  
(Last Name)

\_\_\_\_\_  
(Social Security #)

a)

\_\_\_\_\_  
Primary Office Address

\_\_\_\_\_  
(Street, City, State & Zip Code)

\_\_\_\_\_  
(Area Code & Phone #)

b)

\_\_\_\_\_  
Satellite Address

\_\_\_\_\_  
(Street, City, State & Zip Code)

\_\_\_\_\_  
(Area Code & Phone #)

c)

\_\_\_\_\_  
Satellite Address

\_\_\_\_\_  
(Street, City, State & Zip Code)

\_\_\_\_\_  
(Area Code & Phone #)

ORAL CONSCIOUS SEDATION PERMIT APPLICATION

Type of practice: General Dentistry \_\_\_\_ or Specialty \_\_\_\_\_  
Name

Alabama License Number \_\_\_\_\_ Expiration \_\_\_\_\_

DEA Registration Number \_\_\_\_\_ Expiration \_\_\_\_\_

Any dentist utilizing oral conscious sedation must have a properly equipped facility staffed with a supervised team of allied dental personnel who are appropriately trained and capable of reasonably assisting the dentist with procedures, problems and emergencies incident thereto. Allied dental personnel who assist a dentist during oral conscious sedation must be currently certified in cardiopulmonary resuscitation. During a procedure utilizing oral conscious sedation, at least one allied dental personnel shall be present in addition to the dentist.

List the name(s), provide license number if applicable, of any allied dental personnel who will be assisting the permit holder with any procedures utilizing oral conscious sedation. A copy of the cardiopulmonary resuscitation certification for each allied dental personnel who will assist is required to be submitted with this application.

\_\_\_\_\_  
Name LNO if applicable \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

\_\_\_\_\_  
Name LNO if applicable \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

\_\_\_\_\_  
Name LNO if applicable \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

\_\_\_\_\_  
Name LNO if applicable \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

\_\_\_\_\_  
Name LNO if applicable \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

A copy of the applicant's cardiopulmonary resuscitation certification is required to be submitted with this application.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Course Date \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expiration Date

CPR Certification Level: \_\_\_\_\_

ORAL CONSCIOUS SEDATION PERMIT APPLICATION

The dentist applying for the oral conscious sedation permit must show evidence of the completion of one of the following:

1. Completion of an American Dental Association accredited postgraduate general dentistry or specialty residency program which included specific training in oral conscious sedation training

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School, College or University Date Graduated

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Program Degree Designation

2. Completion of a minimum of sixteen (16) hours training in an oral conscious sedation course approved by the Board. To determine course approval refer to rule 270-X-2.21.

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Course Sponsor and Title\* Date(s) Attended

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Presenter

\*You must submit evidence of completion of the course with this application.

3. Certification of training in oral conscious sedation by any entity or organization approved by the Board. To determine course approval refer to rule 270-X-2.21.

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Training Entity\* Date(s) Attended

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Presenter

\*You must submit evidence of completion of the course with this application.

Has any mortality or any other incident occurred as defined in Code of Alabama, (1975) § 34-9-65 either at your primary facility or any other practice facility in the State of Alabama?    Yes    No

**Any adverse consequence shall be reported to the Board pursuant to and in the manner set forth in rule 270-X-2.20.**

