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 #)

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
_____	_____	_____/_____/____	_____/_____/_____
_____	_____	_____/_____/____	_____/_____/_____
_____	_____	_____/_____/____	_____/_____/_____
_____	_____	_____/_____/____	_____/_____/_____
_____	_____	_____/_____/____	_____/_____/_____

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

_____/_____/____ _____/_____/_____
Course Date Expiration Date

CPR Certification Level: _____

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

_____

School, College or University Date Graduated

_____

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.

_____

Course Sponsor and Title* Date(s) Attended

_____

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.

_____

Training Entity* Date(s) Attended

_____

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.

I hereby certify and acknowledge that I have completed and reviewed this application. I certify and acknowledge that I am currently licensed to practice dentistry in the State of Alabama. I certify and acknowledge that all the information provided in this application is true and correct and I further acknowledge and understand that the Board is relying upon the truthfulness of this information in the issuance of the permit. I certify and acknowledge that I am familiar with and will abide by the provisions of the Alabama Dental Practice Act and any applicable Board rule in connection with the administration of oral conscious sedation.

_____

Signature of Applicant LNO

STATE OF ALABAMA

COUNTY OF _____

Sworn to and subscribed before me this _____day of _____, 200_____.

_____

Notary Public

Seal

_____

My commission expires