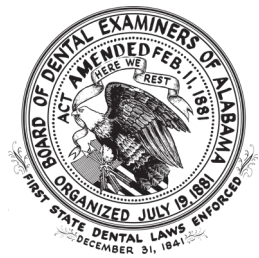


Date Received	Date Processed	Date Inspected	Pass (Circle One)	Fail
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Oral Conscious Sedation Permit APPLICATION



***Effective January 1, 2023, a Facility Inspection will be required to obtain an OCS Permit.**

Initial Application
\$200.00

AL Dental License #: D.
DEA #: _____

Application Instructions

- Mark appropriate request above, complete form and attach required documents
- Attach a copy of the DEA Registration assigned to this location
- Attach fee (check/money order)-All fees non-refundable
 - Mail completed application/fee to: **BDEAL, 2229 Rocky Ridge Road, Birmingham, AL 35216**
- **NOTE:** You must have an OCS permit and separate DEA registration for each clinic in which you will provide OCS.

PERSONAL INFORMATION

Name: _____ Date: _____

Office Address: _____
Street City County State Zip

Office Phone: _____ Email: _____

Home Address: _____
Street City County State Zip

Home Phone: _____ Cell Phone: _____

GENERAL INFORMATION

Type of Practice: GENERAL SPECIALTY (List) _____

AL Dental License #: _____ DEA Registration #: _____

CPR ACLS PALS ATLS

(Mark all that apply and include documentation for each)

Will you provide Oral Conscious Sedation in more than 1 clinic? **Y** **N**

*If yes, you must complete a separate application for each clinic.

REQUIRED TRAINING/EDUCATION

Applicant must have completed at least 1 of the following. Complete all that apply. Documentation must accompany application.

- **ADA-accredited postgraduate General Dentistry or Specialty Residency Program that included specific training in Oral Conscious Sedation**

School/College/University: _____

Program: _____

Degree: _____ Date Graduated: _____

- **Completion of sixteen (16) minimum hours of training in a Board-approved Oral Conscious Sedation Course.**

Course Title: _____

Course Sponsor: _____

Presenter: _____ Date(s) Attended: _____

- **Oral Conscious Sedation Certification by Board-approved entity or organization**

Entity/Organization Name: _____

Presenter: _____ Date(s) Attended: _____

DOCUMENTATION OF ADVERSE OCCURRENCE

Have you experienced an Adverse Occurrence as defined in Code of Alabama (1975), §34-9-65 or Alabama Administrative Code r. 270-X-2-.20? **Y** **N**

*If yes, attach documentation to this application.

ALLIED PERSONNEL

(Applicant must include copies of Allied Personnel CPR Training)

Name: _____

License #: _____

Date of CPR course: _____

Name: _____

License #: _____

Date of CPR course: _____

Name: _____

License #: _____

Date of CPR course: _____

ATTESTATION OF UNDERSTANDING

I hereby attest that I have reviewed and fully completed this application, to include attachments of any required documentation and fees. I attest that I am a currently licensed to practice dentistry in the State of Alabama. I attest 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 this permit. I understand that a Facility Inspection must be completed by the Board, and successfully passed, prior to this permit being issued by the Board.

I hereby attest that I have personally reviewed all applicable provisions of the Alabama Dental Practice Act and Alabama Administrative Code (Board Rules) pertaining to this permit.

I attest that any falsifications, omissions, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient grounds to bar me from this or any future application requests to the Board of Dental Examiners of Alabama. I attest that any falsifications, omissions, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient grounds for disciplinary action up to and to include revocation of my Alabama Dental License if it is not discovered until after issuance.

Signature

Date

STATE OF _____)

COUNTY OF _____)

Sworn to and subscribed before me this _____ day of _____, 20_____

<SEAL>

Notary Signature

My commission expires: _____