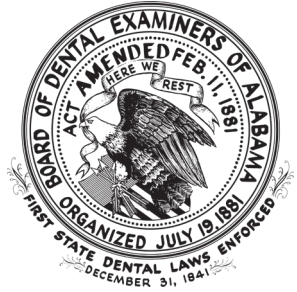


Date Received	Date Processed	Date Inspected	Pass (Circle One)	Fail
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# Parenteral Sedation/ General Anesthesia Permit



## APPLICATION

(Mark Appropriate Box)

<p><b>Parenteral Sedation Initial Application</b></p> <p><b>\$1,350.00</b></p>	<p><b>General Anesthesia Initial Application</b></p> <p><b>\$1,350.00</b></p>
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<p>AL Dental License #: <u>D.</u></p> <p>AL CS#: _____</p> <p>DEA #: _____</p>
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### Application Instructions

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

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Address: \_\_\_\_\_  
Street City County State Zip

Clinic Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City County State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**GENERAL INFORMATION**

Type of Practice:          GENERAL          SPECIALTY (List) \_\_\_\_\_

Will you provide PA/GA services at more than 1 clinic?                                  Y                                  N

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

**CPR****ACLS****PALS****ATLS**

(Mark all that apply)

**REQUIRED TRAINING/EDUCATION**

(Mark all that apply)

- Fellow of American Dental Society of Anesthesiology
- Diplomate of American Board of Oral and Maxillofacial Surgery
- Eligible for examination by the American Board of Oral and Maxillofacial Surgery (Include expected exam dates or dates of any previous exams)
- Member of American Association of Oral and Maxillofacial Surgeons
- Completed minimum of one (1) year of advanced training in anesthesiology and related academic subjects (or equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the American Dental Association's guidelines for teaching pain control and sedation. (Attach full details, to include courses taken, school name, dates attended, etc.)
- Qualification by experience in accordance with the requirements set forth by the Alabama Dental Practice Act and associated Alabama Administrative Code.
  - Have you used/employed General Anesthesia prior to 06/01/1985?                                  Y                                  N
    - If yes, provide number of times used, types of procedures: \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
    - \_\_\_\_\_
- Employment or work in conjunction with a qualified medical doctor who is a member of the anesthesiology staff of 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. (Attach Physician Anesthesiologist's CV)

## EDUCATION/TRAINING

### UNDERGRADUATE

Name of College/University: \_\_\_\_\_

Degree: \_\_\_\_\_ Dates attended: \_\_\_\_\_

### DENTAL SCHOOL

Name of College/University: \_\_\_\_\_

Degree: \_\_\_\_\_ Dates attended: \_\_\_\_\_

### OTHER PROFESSIONAL EDUCATION

Name of College/University: \_\_\_\_\_

Degree: \_\_\_\_\_ Dates attended: \_\_\_\_\_

Name of College/University: \_\_\_\_\_

Degree: \_\_\_\_\_ Dates attended: \_\_\_\_\_

### POSTDOCTORAL EDUCATION

Name of College/University: \_\_\_\_\_

Degree: \_\_\_\_\_ Dates attended: \_\_\_\_\_

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## RESUMÉ OF ANESTHESIA QUALIFICATIONS

List all training, experience, use prior to 06/01/1985, etc.:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### HOSPITAL PRIVELAGES

List all hospitals in which you have privileges and types of appointment:

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### 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.

### AUXILIARY PERSONNEL

(Applicant must include copies of Auxiliary Personnel Training)

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date of CPR course: \_\_\_\_\_

List Additional certification(s): \_\_\_\_\_

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date of CPR course: \_\_\_\_\_

List Additional certification(s): \_\_\_\_\_

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date of CPR course: \_\_\_\_\_

List Additional certification(s): \_\_\_\_\_

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date of CPR course: \_\_\_\_\_

List Additional certification(s): \_\_\_\_\_

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Date of CPR course: \_\_\_\_\_

List Additional certification(s): \_\_\_\_\_

### 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 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 hereby attest that I am required to successfully pass both a Facility Inspection and an Anesthesia Evaluation in order to obtain a permit for Parenteral Sedation or General Anesthesia. I attest that submission of this application indicates that my clinic and personnel are prepared to have a Facility Inspection as quickly as it can be scheduled by the Board.

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: \_\_\_\_\_