

**THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS  
507 AIRPORT BOULEVARD, STE. 105  
MORRISVILLE, N.C. 27560  
919-678-8223**

**APPLICATION FOR MODERATE CONSCIOUS SEDATION PERMIT  
LIMITED TO ORAL AND NITROUS OXIDE INHALATION**

- 1) \_\_\_\_\_  
(Full First Name) (Middle/Maiden Name) (Full Last Name)
- 2) \_\_\_\_\_  
(Office Street Address) (City) (State) (Zip)
- 3) **Office Telephone Number:** ( ) \_\_\_\_\_
- 4) **Office e-mail:** \_\_\_\_\_
- 5) **N.C. Dental License Number:** \_\_\_\_\_
- 6) **Social Security Number:** \_\_\_\_\_
- 7) **Satellite offices where you intend to use moderate conscious sedation limited to oral and nitrous oxide inhalation:** (attach additional sheets if necessary)
- A) \_\_\_\_\_  
(Office Street Address) (City) (State) (Zip)
- B) \_\_\_\_\_  
(Office Street Address) (City) (State) (Zip)
- 8) **Check all specialty degrees you hold:**
- \_\_\_ Oral Surgery \_\_\_ Periodontics \_\_\_ Endodontics \_\_\_ Public Health
- \_\_\_ Pediatrics \_\_\_ Orthodontics \_\_\_ Prosthodontics \_\_\_ Oral Pathology
- \_\_\_ Other \_\_\_\_\_

9) **Dental Education:**

Dental School: \_\_\_\_\_

Dates: Attended: \_\_\_\_\_  
(Ex.: Sept. 2000 – Sept. 2004)

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

10) **Specialty Education:**

Dental School/Hospital: \_\_\_\_\_

Dates Attended: \_\_\_\_\_

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

11) I qualify for a moderate conscious sedation permit limited to oral and nitrous oxide inhalation based upon the following:

\_\_\_ Successful completion of a BLS course within 12 months before the date of this application; AND

\_\_\_ Successful completion of 24 hours of Board approved didactic training and management of 10 adult case experiences, including at least three live clinical dental experiences and at least one experience in returning/rescuing a patient from deep to moderate sedation. All cases were handled in a group with a faculty/participant ratio of no more than 1:5; OR

\_\_\_ Successful completion and documentation of at least 100 cases of oral moderate conscious sedation procedures performed within one year before [effective date of rules];

**AND ONE of the following:**

\_\_\_ Successful completion of training equivalent to that described in Part I or Part III of the ADA Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry and documentation of successful administration of minimal conscious sedation in at least five cases; OR

\_\_\_ Successful completion of a Board approved accredited post-doctoral training program which affords comprehensive training necessary to administer and manage minimal conscious sedation; OR

\_\_\_\_\_ Successful completion of an 18 hour minimal conscious sedation course approved by the Board which affords comprehensive training necessary to administer and manage minimal conscious sedation; OR

\_\_\_\_\_ Successful completion of a Board approved postgraduate program in pediatric dentistry; OR

\_\_\_\_\_ I am a licensed North Carolina dentist in good standing who has been using minimal conscious sedation competently for at least one year immediately preceding [date] as demonstrated by my presentation of proof of successful administration of minimal conscious sedation in at least five clinical cases AND my office facility has passed an on-site inspection by a Board evaluator.

12) **Attach a resume of your oral and nitrous oxide inhalation qualifications, including training and experience, indicating the location of any program completed and dates of attendance.**

13) **Do you have current**

(a) **BLS training:** \_\_\_\_\_ Yes \_\_\_\_\_ No

(b) **ACLS training:** \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, attach photocopy of current certification card(s).

14) **List all auxiliary personnel** (attach additional sheet(s) if necessary):

Name: \_\_\_\_\_ BLS certified: \_\_\_ Yes \_\_\_ No  
(If yes, attach photocopy of BLS certification card)

Name: \_\_\_\_\_ BLS certified: \_\_\_ Yes \_\_\_ No  
(If yes, attach photocopy of BLS certification card)

15) **Have you had any instances of mortality/morbidity in connection with your use of sedation?** \_\_\_\_\_ Yes \_\_\_\_\_ No

(If yes, attach sheet listing all instances of mortality/morbidity, including detailed information concerning patient's name, date of event and relevant circumstances)

**By signing this Application, I hereby certify that:**

I maintain a properly equipped facility for the administration of moderate conscious sedation limited to oral and nitrous oxide inhalation which is or shall be staffed with auxiliary personnel who are capable of reasonably handling procedures, problems and emergency incidents thereto.

I personally filled out and executed this application and all information on this application is true and correct to the best of my knowledge.

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(SIGNATURE)

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(DATE)

**THIS APPLICATION MUST BE ACCOMPANIED BY A NON-REFUNDABLE FEE OF \$100.00 AND VERIFICATION OF YOUR TRAINING IN MODERATE CONSCIOUS SEDATION LIMITED TO ORAL AND NITROUS OXIDE INHALATION. MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS. PERMITS MUST BE RENEWED ANNUALLY.**

*"If your check is not paid on presentment or is dishonored, you agree to pay the amount allowed by state law. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment."*