

THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS
2000 Perimeter Park Drive, Suite 160
Morrisville, North Carolina 27560
919-678-8223

**APPLICATION FOR MODERATE PARENTERAL AND
ENTERAL CONSCIOUS SEDATION PERMIT**

1. _____
Full Name As It Appears On Your Dental License
2. _____
Address
3. NC Dental License Number: _____
4. Telephone Number: _____
5. Email: _____
6. List all offices where you intend to use sedation:

(Permits are location specific – you will need a permit for each location that you administer sedation. Please indicate beside the location address if there is a dentist currently at the location that holds a permit.)

7. Check all specialty degrees that you hold:
____ Oral Surgery ____ Periodontics ____ Endodontics
____ Pediatrics ____ Public Health ____ Orthodontics
____ Prosthodontics ____ Oral Pathology ____ None
Other _____
8. Dental School: _____
Dates Attended: (Mon/Yr) _____
Degree Received: _____
9. Specialty Education:
Dental School/Hospital: _____
Dates Attended: (Mon/Yr) _____
Degree Received: _____

10. I qualify for a moderate conscious sedation permit under one or more of the following: (Please attach certificate/degree of completion):

_____ Completion of 60 hours of Board approved didactic training in intravenous conscious sedation, and 30 hours of clinical training that shall include successful management of a minimum of 20 live patients, under supervision of the course instructor, using intravenous sedation. Training shall be provided by one or more individuals who meet the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists that is hereby incorporated by reference, including subsequent amendments and editions. The guidelines may be found at www.ada.org/coda.

_____ Completion of a pre-doctoral dental or postgraduate program that included intravenous conscious sedation training equivalent to that defined in Part (c)(1)(A) of this Rule.

11. Attach a resume of your moderate conscious sedation qualifications (other than those listed above), including training and experience, indicating the location of any program completed and dates of attendance.

12. Do you have current/unexpired ACLS? _____
(Please provide a copy of ACLS card)

13. List the names of auxiliary staff that will be assisting with sedation.

_____	_____
_____	_____
_____	_____

14. Do all staff listed above have current/unexpired BLS? _____
(Please provide a copy of BLS card)

15. Are you in good standing with the Board? _____

16. Have you had any instances of mortality/morbidity in connection with your use of sedation? _____
(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, 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.

Signature

Date

THIS APPLICATION MUST BE ACCOMPANIED BY A NON-REFUNDABLE FEE OF \$375 AND VERIFICATION OF YOUR TRAINING IN MODERATE CONSCIOUS SEDATION. 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."

After your application is approved, you will be notified of the evaluator that has been assigned, along with a checklist in preparation of the evaluation. You will be responsible for coordinating your evaluation.
