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

APPLICATION FOR MODERATE PEDIATRIC 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 pediatric sedation permit under one or more of the following: (Please attach certificate/degree of completion within the last two years or show evidence of moderate pediatric conscious sedation practice within the last two years in another state or U.S. Territory.):

_____ completion of a postgraduate program that included pediatric intravenous conscious sedation training

_____ completion of a Commission On Dental Accreditation (CODA) approved pediatric residency that included intravenous conscious sedation training

_____ completion of a pediatric degree or pediatric residency at a CODA approved institution that includes training in the use and placement of IVs or intraosseous vascular. A list of CODA approved institutions that is hereby incorporated by reference, including subsequent amendments and editions, appears at www.ada.org/coda and is available at no cost.

11. Attach a resume of your pediatric 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 PALS? _____
(Please provide a copy of PALS 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 use of anesthesia/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 pediatric 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 PEDIATRIC 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.

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