BOARD OFFICE USE ONLY
FEE_____
PERMIT # _____
EVALUATION DATE_____

APPLICATION FOR
CLASS 3A DENTAL ANESTHESIA PERMIT
WEST VIRGINIA BOARD OF DENTAL EXAMINERS
1319 Robert C. Byrd Drive
PO Box 1447
Crab Orchard, WV 25827

I hereby make application for a permit to employ or use enteral conscious sedation/moderate sedation and anxiolysis/minimal sedation in the practice of dentistry in the State of West Virginia and submit the following information. (IN THE EVENT THERE IS NOT SUFFICIENT SPACE TO REPLY, SHOW ANSWER ATTACHED AND ON ATTACHMENT SHEET, PLACE QUESTION NUMBER BEFORE ANSWER.) ***(PLEASE TYPE OR PRINT LEGIBLY.)***

1. Name in Full_____
LAST FIRST MIDDLE DEGREE

2. Office Address_____
NUMBER AND STREET SUITE NUMBER

_____
CITY STATE ZIP CODE

Telephone # _____

Secondary Office(s), Address(es) & Phone Numbers

_____

_____

_____

3. West Virginia Dental License # _____ Issued _____

West Virginia Specialty License # _____ Issued _____

Specialty Type _____

4. *Social Security Number _____
Date of Birth_____

*The Social Security Number is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state dental boards to report to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.

QUALIFICATIONS

5. I hereby qualify for a class 3a enteral conscious sedation/moderate sedation, and anxiolysis/minimal sedation permit under one of the following:

(VERIFICATION SHALL BE SENT TO THE WEST VIRGINIA BOARD OF DENTAL EXAMINERS AT THE ADDRESS AT THE TOP OF THIS APPLICATION BY THE ENTITY VERIFYING THE INFORMATION BEARING THE SIGNATURE OF A PROGRAM OFFICIAL.)

_____ (a) Certificate of completion of a comprehensive training program in conscious sedation that satisfies the requirements described in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* and the ADA *Guidelines for the Use of Sedation and General Anesthesia by Dentists* at the time training was commenced.

___ (b) Certificate of completion of an ADA accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage conscious sedation, commensurate with the guidelines in paragraph 5(a).

_____ (c) In lieu of these requirements, the Board may accept documented evidence of equivalent training or experience in conscious sedation anesthesia.

** enteral conscious sedation permit 3(a) must have a Board approved course of at least eighteen hours didactic and twenty mentored clinical cases

6. UNDERGRADUATE EDUCATION

College _____ Location_____
Dates Attended _____ to _____ Degree Earned_____

7. DENTAL EDUCATION

University_____ Location_____
Dates Attended _____ to _____ Degree Earned_____

8. SPECIALTY EDUCATION

Hospital or University_____
Location_____
Dates Attended _____ to _____
Degree or Certificate earned_____

Hospital or University_____
Location_____
Dates Attended _____ to _____
Degree or Certificate earned_____

9. Are you currently certified in Advanced Cardiac Life Support or Pediatric Advanced Life Support?
_____ yes _____ no (If yes, attach copy of certificate.)

_____ ACLS

_____ PALS

10. Are your auxiliary personnel certified in Basic Life Support/CPR?
_____ yes _____ no (If yes, attach copy of certificate.)

11. Does your auxiliary personnel possess a qualified monitor certificate issued by the Board to monitor and record the condition of patients undergoing anesthesia services? _____ yes _____ no

The Board's completed qualified monitor checklist is attached.
_____ yes _____ no

12. I further certify that I have a properly equipped facility for the administration of enteral conscious sedation/moderate sedation and it is staffed with a supervised team of auxiliary personnel and qualified monitors. _____ yes _____ no

The Board's completed facility checklist is attached. _____ yes _____ no

13. List all instances of the following in connection with your use of enteral conscious sedation/moderate sedation, including a detailed explanation of any such occurrence.

(a) Mortality (b) Morbidity

I hereby certify that I am the person who executed this application for a permit to employ or use enteral conscious sedation/moderate sedation and anxiolysis/minimal sedation in the practice of Dentistry in the State of West Virginia in conformance with Chapter 30, Article 4A of the West Virginia Code and the information supplied on this application is true and correct to the best of my knowledge.

_____
Signature of Applicant

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____, 20__.

_____
Notary Public

My Commission expires _____ SEAL

Please make check or money order payable to the West Virginia Board of Dentistry in the amount of $900.00 for the application fee, no part of which is refundable, and mail to the West Virginia Board of Dentistry, PO Box 1447, Crab Orchard, WV 25827.

FACILITY CHECK LIST

A dentist who induces conscious sedation/moderation sedation shall have the following facilities, properly maintained age appropriate equipment and age appropriate medications available during the procedures and during recovery as recommended by the Board in its Anesthesia Emergency Drug & Equipment Requirements (list attached to this application) and those listed as follows:

_____ An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;

_____ An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;

_____ A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;

_____ Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;

_____ An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;

_____ A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;

_____ A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;

_____ Sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, intravenous fluid administration equipment;

_____ Precordial Stethoscope;

_____ Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants; and

_____ A defibrillator device.

_____
Signature of Applicant

QUALIFIED MONITOR CHECKLIST

The dentist shall monitor and record the patient's condition or shall use an assistant qualified as a monitor to monitor and record the patient's condition. A qualified monitor shall be present to monitor the patient at all times.

_____ The trained personnel must have a certificate showing successful completion in the last two years of BLS/CPR training and the American Association of Oral and Maxillofacial Surgeons Office Anesthesia Assistant certification or an equivalent. (Attach a copy for our records)

_____ Trained personnel must be able to monitor the patient's blood pressure, heart rate, respirations and oxygen saturation.

_____ Trained personnel must be able to properly document the patient's vital signs.

_____
Signature of Applicant

QUALIFIED MONITOR (QM) REPORTING FORM

Please list the name of each qualified monitor and list their qualifications in the spaces provided. Examples are provided at the bottom of the sheet.

QM Name	Qualified Monitor # Issued by the Board	AAOMS Certification	AAOMS Equivalent	Nitrous Monitoring Cert.	Healthcare Provider CPR

DOCUMENTATION IS NOT NECESSARY WITH THIS FORM

Example

QM Name	Qualified Monitor # Issued by the Board	AAOMS Certification	AAOMS Equivalent	Nitrous Monitoring Cert.	Healthcare Provider CPR
Rita Smith	QM0010		LPN	Yes	Yes
Donna Jones	QM0101	Yes		Yes	Yes
Susie Williams	QM0200		ACLS	Yes	Yes

Anesthesia Emergency Drug & Equipment Requirements

Class 3A and B and Class 4

Oxygen portable
Aspirin 325mg chewable
Diphehydramine 50mgs/ml vial
Albuterol Inhaler
Ammonia Capsule
Epi-pen auto injector (adult and child)
Morphine
Nitroglycerine tablets or spray
Insta-glucose
Flumazenil
Naloxone
Epi ampoules 1:10,000 and 1:1,000
Atropine
D50
Midazolam
Diazepam
Adenosine
Amiodarone
Succinylcholine
Ephedrine
Labatelol
Solu-cortef
Odensatron(Zofran)

Class 3A and B and Class 4

AED
Blood Pressure Monitor
Pulse Oximeter
EKG Monitor
Pre-Cordial Stethoscope
CO2 Monitor **(Class 3B & 4 only)**
Thermometer
Glucometer