



**ARKANSAS STATE BOARD  
OF DENTAL EXAMINERS**

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FOR BOARD USE ONLY  
Permit # \_\_\_\_\_

Date Issued \_\_\_\_\_

- Fee
- ACLS/PALS
- Training

Application for Sedation  
**GENERAL/DEEP SEDATION**

With this application, enclose the following:

- Documentation of the required training
- Current ACLS certification (if another dental emergency management course was taken, list the name of the course and provide a syllabus to the Board office)
- Application fee of \$25.00

Name:	DDS License #:	
Address:		
City:	State:	Zip:
Office Telephone:		
I have training to the level of competency in General/Deep Sedation to the level of competency consistent with that prescribed in Article XIII of the <i>Rules and Regulations</i> from this source:		
School or other course: _____		
Date of successful completion: _____		

I confirm that all staff members monitoring patients undergoing sedation have met the following requirements:

- Hold a current permit from the board to monitor nitrous oxide
- Trained in emergency procedures with at least annual updates
- Hold current certification in health-care provider level of basic life support
- Monitor patients who are sedated only under my personal or direct supervision
- Hold a Sedation Monitoring Permit if monitoring patients under general/deep sedation

List of staff members who are allowed to monitor sedated patients (use back if more room needed):

NAME	NITROUS OXIDE PERMIT #	CPR EXPIRATION DATE	SEDATION MONITORING PERMIT #

List of all licensed dentists who provide patient treatment in the facility (use back if more room needed):

NAME	DDS LICENSE #	SEDATION PERMIT # (OR N/A)

I confirm that each patient who is sedated has the following information recorded in their treatment record:

- Informed consent
- Health history
- Blood pressure, heart rate, respiration rate and oxygen saturation levels (as necessary)
- Names of all drugs administered including dosages and the weight of patients under the age of 12
- Local anesthetic record
- Record of all procedures
- Post operative instructions
- Level of consciousness at discharge
- Time-oriented anesthetic record

I confirm that the following functional equipment and drugs are available in my office:

- Fail safe nitrous oxide equipment
- Scavenging system for nitrous oxide
- Pulse oximeter
- Blood pressure cuff and stethoscope
- Oral airway
- Emergency drugs
- Automated external defibrillators
- Positive pressure oxygen delivery system, appropriately sized masks and connectors
- Operating theater large enough for patient and three other individuals
- Operating table or chair which adjusts quickly to provide platform for CPR

- Lighting system
- Battery powered back-up lighting system
- Suction equipment with tonsillar suction tip and pharyngeal suction tip
- Backup suction device
- Backup oxygen system
- Recovery area (can be same as operating theater)
- All controlled drugs are stored in accordance with federal and state guidelines
- No medications or drugs are expired

I further confirm that the following functional equipment and drugs are available in my office where deep sedation or general anesthesia will be administered: (Do not complete this section if applying for Moderate Sedation permit.)

- Electrocardioscope
- Laryngeal mask airway
- Laryngoscope complete with adequate selection of blades, batteries and bulb
- Endotracheal tubes and appropriate connectors
- Adequate equipment for the establishment of an intravenous infusion
- Automated blood pressure monitoring device
- McGill forceps
- Appropriate drugs for ACLS
- Thermometer
- Records and storage security are maintained for all drugs
- Drugs for the treatment of malignant hyperthermia are maintained and immediately available if the office administers agents known to trigger this condition

If equipment listed above is not available, please explain:

Have you ever received an Order or been charged with any violation of any Rules and Regulations or Dental Practice Act from this or any other dental licensing board?  Yes  No

If yes, please explain fully on separate paper.

*By my signature, I affirm that I am familiar with Article XIII of the Rules of the Board and the standard of care expected in the administration of General/Deep Sedation. I am familiar with the required level of training for qualified staff and assure the Board that applicable permits or documentation have been attained by qualified staff members. I have all the required equipment and emergency drugs available in my dental treatment facility. I fully understand that I will be considered in violation of the Arkansas Dental Practice Act and Rules and Regulations of the Board if any of the information provided on this application is untrue.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date