ARKANSAS STATE BOARD OF DENTAL EXAMINERS
4815 W. Markham St., Slot 79
LITTLE ROCK, AR 72205
PHONE: 501-682-2085

FOR BOARD USE ONLY
Facility Permit #_____
Date Issued _____
- ❑ ACLS/PALS
- ❑ Training

Application for

FACILITY PERMIT FOR MODERATE SEDATION

Every dental office, clinic or facility where moderate sedation is to be administered to patients must have a moderate sedation facility permit issued by the Board. The dentist/owner of the practice or he dentist who is the primary provider of dental care in the office must complete a self-inspection facility permit application. Said application will be kept on file by the Board. The Board may, on a random basis, inspect any facility holding a moderate sedation facility permit. - Article XIII,E,3,a.

Name (DDS):	**DDS License #:**
Office Address (if practicing in multiple locations, a separate facility permit is required for each location):	
City, State, Zip:	
Office Telephone:	
Moderate Sedation Permit #:	

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

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

NAME	DDS LICENSE #	SEDATION PERMIT # (or NA)

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 tonsilar 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

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 Moderate 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. Only dentists with current, valid Moderate Sedation permits from the board, or contracted sedation providers as defined in Article XIII, D., 6. are allowed to administer sedation to patients in this facility. I further understand that this facility permit is valid ONLY for the address indicated above. I am aware that the Board investigators may inspect this facility at any time with 30 days written notice. 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

Printed name