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## NOTICE TO ALL APPLICANTS FOR PEDIATRIC CONSCIOUS SEDATION, CONSCIOUS SEDATION AND GENERAL ANESTHESIA PERMITS

### IMPORTANT RULE CHANGES

#### Amendment to Rule 64B5-14.004

Effective June 23, 2004, each anesthesia permit holder must complete at least four (4) hours of continuing education relating to anesthesia each biennium the permit is held. Two (2) of these hours must be dealing with the management of medical emergencies. These hours would be included in the 30 hours of continuing education required by Section 466.0135(1), Florida Statutes.

#### PLEASE NOTE:

Upon receipt of a completed application, the Board staff will submit the application to designated committee members for review. You will be notified in writing when a decision has been made, however, an inspection of the facility and an evaluation of the applicant administering anesthesia will be conducted **PRIOR** to the permit being issued.

If you have any questions concerning the information listed above or the application process itself, please contact our office at (850) 245-4444, Extension 3491.

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Board of Dentistry  
4052 Bald Cypress Way, #C08  
Tallahassee, FL 32399-3258  
(850) 245-4474  
[www.doh.state.fl.us/mqa/dentistry](http://www.doh.state.fl.us/mqa/dentistry)





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**FACILITY**

1) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Email \_\_\_\_\_

**List of Associates:**

Name	License Number	Type of Permit

Has this facility been inspected by DOH/AHCA? Yes\_\_\_ No\_\_\_

If yes, when and for whom? \_\_\_\_\_

Was the section of the physical plant you will utilize included in the inspection?  
Yes\_\_\_ No\_\_\_

Were the assistants to be used as part of the anesthesia team included in the inspection?  
Yes\_\_\_ No\_\_\_

For any additional facilities, please provide information as requested for Facility #1.  
Use separate pages and attach to application.

Are you licensed in any state(s) that require(s) an anesthesia permit, license, and/or  
certificate? Yes\_\_\_ No\_\_\_ If yes, please list \_\_\_\_\_



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**Has any action been initiated against your license concerning the use of anesthesia in any state(s)?** Yes\_\_\_ No\_\_\_ If yes, please submit a full detailed report, including all board and/or civil documentation. Your application will not be considered for approval until complete documentation is received.

**Are you licensed in another state(s)?** Yes\_\_\_No\_\_\_ **Have there been any disciplinary actions initiated against your license in any state (including Florida)?**  
Yes\_\_\_No\_\_\_

**Are there current disciplinary or litigation proceedings being conducted?**  
Yes\_\_\_No\_\_\_ If yes, please submit full detailed report on separate pages.

**Rule 64B5-14.003(1) provides for several methods of obtaining a general anesthesia permit. Check appropriate blanks and provide any additional information requested. Please answer each question. Please indicate "N/A" if not applicable.**

*64B5-14.003(1)(a1) requires that an applicant "has completed a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program as described in Part II of the "Guidelines for Teaching the Comprehensive Control in Pain and Anxiety in Dentistry" as published by American Dental Association."*

*A. I have completed advanced anesthesiology training beyond the undergraduate dental school level as described in "Guidelines for Teaching Comprehensive Control in Pain and Anxiety in Dentistry" as published by the American Dental Association.*

Yes\_\_\_ No\_\_\_ If yes, provide the following information:

1. Training dates from\_\_\_\_\_ to\_\_\_\_\_
2. Name of training program or institution\_\_\_\_\_
3. Attach copy of certificate of completion to application



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**B. I am a diplomat of the American Board of Oral and Maxillofacial Surgeons.**

Yes\_\_\_ No\_\_\_ If yes, please submit documentation

**C. I am eligible for examination by the American Board of Oral and Maxillofacial Surgeons. Yes\_\_\_ No\_\_\_ If yes, please submit documentation**

**D. I am a member/fellow of the American Association of Oral and Maxillofacial Surgeons. Yes\_\_\_ No\_\_\_ If yes, please submit documentation**

**E. I am a Fellow of the American Dental Society of Anesthesiology.**

Yes\_\_\_ No\_\_\_ If yes, please submit documentation

**F. Approximate number of administrations given during the preceding year \_\_\_\_\_  
Where administered \_\_\_\_\_**

**G. Have you experienced any mortality or other incident resulting in the temporary, permanent physical or mental injury requiring hospitalization of the patient as a result of the use of general anesthesia, parenteral anesthesia, or pediatric conscious sedation? Yes\_\_\_ No\_\_\_ If yes, describe each occurrence in full detail on a separate page, including the following details, and attach to this application:**

- 1. Description of dental procedure(s)**
- 2. Description of preoperative physical condition of patient(s)**
- 3. List of drugs and dosage administered**
- 4. Detailed description of techniques utilized during drug administration**
- 5. Description of adverse occurrence(s)**
- 6. Treatment instituted on patient(s)**
- 7. Response of patient(s) to treatment**
- 8. Describe patient's condition on termination of procedure undertaken**

**H. I have properly equipped facility/facilities for administering general anesthesia Staffed by supervised dental assistants/hygienists/personnel capable of reasonably handling procedures, problems, and emergencies. Yes\_\_\_ No\_\_\_**



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I have oxygen equipment capable of delivering positive pressure oxygen ventilation.

Yes \_\_\_ No \_\_\_

*I have an appropriate defibrillator for my patient population.* Yes \_\_\_ No \_\_\_

H. 64B5-14.003(1)(c) states that “a dentist employing or using general anesthesia or deep sedation and all assistant/dental hygienist personnel shall be certified in an American Heart Association or American Red Cross or equivalent agency sponsored cardiopulmonary resuscitation course at the basic life support level to include one person CPR, two person CPR, infant resuscitation, and obstructed airway with a periodic update not to exceed two years. In addition to CPR certification, a dentist utilizing general anesthesia or deep sedation must be currently trained in ACLS (Advanced Cardiac Life Support) or ATLS (Advanced Trauma Life Support).”

*Note that the “Heartsaver” course is NOT acceptable.*

- Attach copies of current ACLS and BLS cards for applicant and copies of current BLS card for each support staff listed below in order for application to be deemed complete.

\* List support staff available when general anesthesia, conscious sedation or pediatric conscious sedation is being administered.

\_\_\_\_\_

\_\_\_\_\_

**I have read all questions in the foregoing application and have answered them fully, without reservation of any kind. I declare under penalty of perjury that all my answers and statements are true and correct. Should I furnish false information in this application, I hereby agree that such an act shall constitute cause for suspension, revocation or denial of any license to practice in the State of Florida for the profession for which I am applying.**

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

Print name of applicant \_\_\_\_\_