



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

IMPORTANT RULE CHANGES

Amendment to Rule 64B5-14.005

Effective June 23, 2004, an applicant for any type of anesthesia permit must demonstrate training and administration of the particular type of anesthesia within the two (2) years prior to application. **NOTE:** DOCUMENTATION OF ACTUAL CLINICAL ADMINISTRATION OF ANESTHETICS TO 20 PATIENTS WITHIN 2 YEARS OF APPLICATION MUST BE ATTACHED TO THIS APPLICATION. THE BOARD OF DENTISTRY WILL ACCEPT PATIENT LOGS OR CHARTS, AS LONG AS THEY INCLUDE DATES, MEDICATIONS ADMINISTERED, AND NAME OF DENTIST ADMINISTERING ANESTHESIA.

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.

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



APPLICATION FOR PERMIT

PEDIATRIC CONSCIOUS SEDATION PERMIT

**PLEASE SUBMIT A \$300 APPLICATION & PERMITTING FEE
(PLEASE PRINT OR TYPE ALL INFORMATION)**

Name _____

Home Address _____
Street Apt# City State Zip

Home Telephone Number (____) _____

Florida Dental License # _____

Date of Birth _____

Dental School Attended & Year of Graduation _____

Post Graduate Residency Training from _____ to _____

Institution _____ Specialty _____

List each facility at which you plan to administer sedation. For each facility, please include the address, telephone number, and indicate all permitted associates at each facility with his/her type permit and license number.

Please note that the address(es) you provide is(are) the address(es) we shall approve or deny for certification as a properly equipped facility. All facilities at which you administer sedation **must be listed!** Official written notification must be provided to the Board Office of any additions or deletions. These addresses are only for the purpose of anesthesia permitting; address changes to your basic license must be in writing and sent to the board separately from this information. Attach additional sheet/s if necessary.



FACILITY 1 _____

Office Telephone (____) _____

Office Fax (____) _____ Email _____

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 you will use as part of the anesthesia team included in the inspection?

Yes___ No___

FACILITY 2 (PROVIDE INFORMATION REQUESTED IN FACILITY 1 ON SEPARATE SHEET. REPEAT FOR EACH ADDITIONAL FACILITY. USE SEPARATE PAGES AND ATTACH TO THIS APPLICATION)

Are you licensed in any state(s) which requires an anesthesia permit, certificate, and/or license? Yes___ No___ If yes, has any action been initiated against your license concerning the use of anesthesia in any of these states(s)? Yes___ No___ If yes, submit a full separate detailed report including all board and/or civil documentation. (Applications will not be presented 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 you answer yes to any question, submit a full separate detailed report, including all board and/or civil documentation.

Rule 64B5-14.003(3) states that an applicant must have received formal training in the use of Pediatric Conscious Sedation. The formal training must be sponsored by or affiliated with a University, Teaching Hospital, or other facility approved by the Board, or may be part of the undergraduate curriculum of an accredited Dental School and must contain, at a minimum, sixty (60) hours of didactic training and the supervised personal administration of sedation to at least twenty (20) patients including supervised training, clinical experience and demonstrated competence in management of the compromised airway.

A. IDENTIFY TRAINING PROGRAM IN PEDIATRIC CONSCIOUS SEDATION

1. Sponsoring Institution _____
2. Program Chairperson _____
3. Date of Certification _____
4. Number of patients to whom sedation was administered _____

Submit a copy of certification or letter from the dean of the dental school or head of the teaching hospital attesting to and describing your formal training. **APPROVAL WILL NOT BE GIVEN WITHOUT THE ABOVE INFORMATION AND AFFIRMATION OF PERSONAL ADMINISTRATION OF SEDATION. (SEE ENCLOSED FORM)**

**B. APPROXIMATE NUMBER OF ADMINISTRATIONS GIVEN WITHIN LAST (12 MONTHS) _____
WHERE ADMINISTERED? _____**



C. HAVE YOU EXPERIENCED ANY MORTALITY OR OTHER INCIDENT RESULTING IN THE TEMPORARY OR PERMANENT PHYSICAL OR MENTAL INJURY OF THE PATIENT REQUIRING HOSPITALIZATION AS A RESULT OF THE USE OF PEDIATRIC SEDATION? YES ___ NO ___ If yes, give full descriptions on a separate page, including the following details:

1. Description of dental procedures(s)
2. Description of preoperative physical condition of patient(s)
3. List of drugs and dosage administered
4. 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. Description of patient's condition on termination of each procedure

D. I HAVE A PROPERLY EQUIPPED FACILITY/FACILITIES FOR THE ADMINISTRATION OF PEDIATRIC CONSCIOUS SEDATION STAFFED WITH SUPERVISED ASSISTANTS AND/OR DENTAL HYGIENE PERSONNEL TRAINED IN BASIC CARDIAC LIFE SUPPORT AND CAPABLE OF REASONABLY HANDLING PROCEDURES, PROBLEMS, AND EMERGENCIES. YES ___ NO ___

I HAVE EQUIPMENT CAPABLE OF DELIVERING POSITIVE PRESSURE OXYGEN VENTILATION. YES ___ NO ___

E. *64B5-14.003(3)(b)* states that a DENTIST UTILIZING PEDIATRIC CONSCIOUS SEDATION AND HIS 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 MAN CPR, TWO MAN CPR, INFANT RESUSCITATION, AND OBSTRUCTED AIRWAY WITH A PERIODIC UPDATE NOT TO EXCEED TWO YEARS. STARTING WITH THE LICENSURE BIENNIUM COMMENCING ON MARCH OF 2000, A DENTIST AND ALL ASSISTANT/DENTAL HYGIENIST PERSONNEL SHALL ALSO BE TRAINED IN THE USE OF EITHER AN AUTOMATED EXTERNAL DEFIBRILLATOR OR A DEFIBRILLATOR AND ELECTROCARDIOGRAPH AS PART OF THEIR CARDIOPULMONARY RESUSCITATION COURSE AT THE BASIC LIFE SUPPORT LEVEL. IN ADDITION TO CPR CERTIFICATION, A DENTIST UTILIZING PEDIATRIC



CONSCIOUS SEDATION MUST BE CURRENTLY TRAINED IN ACLS (ADVANCED CARDIAC LIFE SUPPORT), ATLS (ADVANCED TRAUMA LIFE SUPPORT, OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS), or AN EQUIVALENT COURSE APPROVED BY THE BOARD OF DENTISTRY.”

- **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 pediatric sedation is being administered. Please note that the “Heartsaver” course is NOT acceptable for these purposes.

_____	_____
_____	_____
_____	_____

NOTE: ATTACH DOCUMENTATION OF ACTUAL CLINICAL ADMINISTRATION OF ANESTHETICS TO 20 PATIENTS WITHIN 2 YEARS OF APPLICATION.

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

Signature of Applicant

Date



**ANESTHESIA CREDENTIALING SUPPLEMENT
RULE 64B5-14.003(2)(3), FLORIDA ADMINISTRATIVE CODE**

This form is to be completed and signed by the program director or instructor, and the school or hospital seal embossed on this certification. Failure to comply may delay approval of your conscious sedation or pediatric conscious sedation application. This portion of the rule specifically requires certification that the dentist is competent in the administration of conscious sedation or pediatric conscious sedation and that the dentist completed at least sixty didactic hours and personally administered this anesthesia to at least 20 patients in a competent manner.

CERTIFICATION

I _____, HEREBY CERTIFY THAT
(name and title of director or instructor)

_____, COMPLETED AT LEAST SIXTY
(name of applicant)

DIDACTIC HOURS AS DESCRIBED IN ABOVE RULE, AND PERSONALLY ADMINISTERED CONSCIOUS SEDATION OR PEDIATRIC CONSCIOUS SEDATION TO AT LEAST 20 PATIENTS WHILE COMPLETING THIS PROGRAM, AND HAS BEEN TRAINED TO COMPETENCY. THE TRAINING WAS COMPLETED _____.

(LIST DATES OF TRAINING)

Signature – Instructor/Director

Date of Signature

Print Name of Director/Instructor

Name of School

Address of School

School/Hospital Seal

Board of Dentistry
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