Virginia Department of Health Professions
Board of Dentistry

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4538 (Tel)
(804) 698-4266 (eFax)
denbd@dhp.virginia.gov
www.dhp.virginia.gov/dentistry

INSTRUCTIONS FOR A PERMIT TO MODERATE SEDATION

1. Please read Guidance Document 60-27, these instructions and the application carefully. Information in bold print which is underlined identifies the documentation you must provide with your application. If you have any questions regarding this application please call the Board at (804) 367-4538.

2. You are required to know and understand the laws and regulations in Virginia which govern the administration of sedation and anesthesia before completing the application. Particular attention should be given to the definitions in **18VAC60-21-10.D** and the provisions for administration in **18VAC60-21-260** through **18VAC60-21-301** of the Regulations Governing the Practice of Dentistry. Please be aware that sedation and anesthesia laws change over time. You are responsible for knowing the current legal requirements.

3. Failure to comply with legal requirements, failure to properly complete the application or failure to provide required documentation will result in the delay or denial of your application. Please check carefully to assure that all required information is provided with your application. Please print and write legibly.

4. Return the completed application, all required documentation, and a check or money order made payable to the "Treasurer of Virginia" for the amount of **$100** to the Virginia Board of Dentistry at the above address. Fees are non-refundable pursuant to **18VAC60-21-40(G)**.

5. It is your responsibility to maintain a copy of this application and all documents submitted to the Board or received from the Board for your future reference,

6. Once the application is deem complete, an employee of the Department of Health Professions (inspector) will conduct an announced inspection(s) at all applicable locations.

   Pre-permit Inspection

   - An employee of the Department of Health Professions (inspector) will conduct an announced inspection, at all applicable locations, to review compliance with required sedation equipment 18VAC60-21-291 (B) and 18VAC60-21-301 (C); appropriate training of staff 18VAC60-21-260.H (2), 18VAC60-21-260 (I), 18VAC60-21-260 (J), 18VAC60-21-290 (D) (E), 18VAC60-25-100, and 18VAC60-21-300 (C); physical plant requirements 18VAC60-21-60.A (1); and Drug Control Act requirements **§** 54.1-3404.

   - If an applicant is compliant with all applicable regulations, the applicant will receive a permit. However, if the applicant is found to be in non-compliance with applicable regulations, the applicant will receive a report listing the non-compliance. Depending upon the non-compliance, the applicant will be required to submit evidence of the correction or another announced inspection will be scheduled. When the applicant is in compliance, the applicant will receive a permit.

7. All permits are subject to annual renewal. A renewal notice will be sent in conjunction with your dental license renewal notice.

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APPLICATION FOR A PERMIT TO ADMINISTER MODERATE SEDATION Page 1

GENERAL INFORMATION: COMPLETE ALL SECTIONS (PRINT OR TYPE)				
Name: Full Last**	Full First	Full Middle/Maiden		Suffix
Address of record (Mailing Address)*	City	State	Zip Code	Telephone Number*
Publically Disclosable Address*	City	State	Zip Code	Telephone Number*
Email Address*	Virginia Dental License #			Fax #*
Date of Birth* _____/_____/_____ Month Day Year	**Social Security Number or Virginia DMV control Number***** ___ ___ ___---___ ___--___ ___ ___ ___			

*If any of the information starred (*) above is different than the information on file for your dental license, initial here to request that your dental license information be update:_____

Provide the addresses for additional offices where you will administer sedation (use separate page if necessary)**:**

Address:	City	State	Zip Code
Address:	City	State	Zip Code

Check if you have an advanced/specialty degree or certificate in: ____ General Dentistry ____ Periodontics ____ Endodontics

____ Public Health ____ Pediatrics ____ Orthodontics ____Prosthodontics ____ Oral & Maxillofacial Pathology

____ Oral & Maxillofacial Radiology ____ Oral & Maxillofacial Surgery ____Other; Specify _____

Are you currently Board Certified? ____ Yes ____ No

Enter the name of the school or hospital where the advanced/specialty education was completed: _____

Location: _____ Dates of Attendance (i.e. Sept 1990 – Sept 1994): _____

****Name change: Documentation must be provided to show name change(s) if name has ever been changed from the time you attended school or while you were licensed in other jurisdictions.**

*****In accordance with § 54.1-116 of the *Code of Virginia*, you are required to submit your Social Security Number or your control number issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other agencies for child support enforcement activities.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY			
Fee:	**Applicant #:**	**Date Issued:**	**Permit #:**

A. I am applying for a permit to administer moderate sedation and **I am attaching the official transcript, certification and documentation of training content which confirms that I meet the education requirement checked below**:

_____ Completion of training for administering moderate sedation according to guidelines published by the American Dental Association (Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students) in effect at the time the training occurred, while enrolled in a CODA accredited doctoral or post-doctoral dental education program at a university or teaching hospital.

_____ Completion of a continuing education course for administering moderate sedation offered by a provider approved in 18VAC60-21-250 of the Regulations Governing the Practice of Dentistry consisting of (i) 60 hours of didactic instruction plus the management of at least 20 patients per participant, (ii) demonstration of competency and clinical experience in moderate sedation, and (iii) management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students) in effect at the time the training occurred.

B. I hold **current** certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, such as Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals. **I am attaching a photocopy of my certification card.**

C. I hold a **current** Drug Enforcement Administration (DEA) registration which contains my **Virginia** place of business/practice address as required pursuant to **§21-1301.12 of the Code of Federal Regulations** in accordance with **21 U.S.C §822(e)** of the **U.S. Code. I am attaching a photocopy of my DEA registration card.**

D. I have completed the **PRE-INSPECTION SURVEY FORM** and **I am submitting it with my application**.

E. By signing below, I certify that all licensed and ancillary personnel who assist in the administration of controlled substances and who monitor patients during administration hold current certification in basic resuscitation techniques with hands-on airway training for health care providers and are trained in implementing my written emergency procedures. I further certify that such personnel are required to maintain current certification.

F. By signing below, I certify that I maintain a properly equipped facility for the administration of moderate sedation as required by the Regulations Governing the Practice of Dentistry.

G. Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) on federal active duty orders, or 2) a veteran who has left active duty service within one year of submission of this application?
_____Yes _____No **If "YES", include a copy of the official military orders with the application.**

H. Are you active-duty military? _____Yes _____No **If "YES", include a copy of your official military orders with the application.**

I hereby certify that I am the person referred to in the forgoing application and the attached supporting documents and that the information on this application and in the attachments is true, complete, and correct to the best of my knowledge.

_____ _____
Applicant Signature Date

LIST OF SUPPORTING ATTACHMENTS REFERENCED IN THE APPLICATION:

1. A check or money order for $100 made payable to the "Treasurer of Virginia" -see instruction #4.
2. The transcript, certification and documentation of training content for a permit to administer deep sedation/general anesthesia- see section A.
3. A photocopy of my certification card for advanced resuscitation techniques- see section B.
4. A photocopy of my current DEA registration (**must contain your Virginia place of business/practice address**) -see section C.
5. All supporting attachments and pages of this application including the pre-inspection survey form must be submitted to the Board.

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PRE-INSPECTION SURVEY FORM

Each dentist applying to hold a permit to administer moderate sedation or deep sedation and general anesthesia (hereinafter referred to as a Permit Holder) is required to provide the following information. This completed form must be returned with your application.

Permit Holder's full name is: _____

Permit Holder practices: __ **general dentistry**
__ **in the specialty of** _____

Permit Holder practices at the following location(s):

Full name of the practice: _____

Full address of the practice: _____

_____

Full name of the primary contact person: _____

Telephone number of the primary contact person: _____

E-mail address of the primary contact person: _____

The number of other permit holders at this location: _____

Is this location a licensed hospital as defined in §32.1-123 of the Code of Virginia? **YES** **NO**

Is this location a state-operated hospital? **YES** **NO**

Is this location a facility directly maintained or operated by the federal government? **YES** **NO**

And

Full name of the practice: _____

Full address of the practice: _____

_____

Full name of the primary contact person: _____

Telephone number of the primary contact person: _____

E-mail address of the primary contact person: _____

The number of other permit holders at this location: _____

Is this location a licensed hospital as defined in §32.1-123 of the Code of Virginia? **YES** **NO**

Is this location a state-operated hospital? **YES** **NO**

Is this location a facility directly maintained or operated by the federal government? **YES** **NO**

Use a separate piece of paper to provide information on all additional locations.

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Permit number _____ **was issued on** _____