Parenteral Sedation Permit

APPLICATION

Parenteral Sedation
Initial Application

$1,350.00

AL Dental License #: D._____

AL CS#:_____

DEA #:_____

Application Instructions

- Complete the application and attach required documents.
- Attach a copy of the DEA Registration assigned to this location.
  - The below clinic address is where you will provide anesthesia services with this permit.
- If you need additional space, use additional pages (date and initial additional pages)
- All payments will be made through the payment portal at **https://bdeal.igovsolution.net/Feefine/pay/**
  NOTE: You must have a separate DEA registration for **each** clinic in which you will provide PS. There is a 30-day turnaround time for scheduling and completing a Facility Inspection. Please do not apply until you are ready to be inspected.

PERSONAL INFORMATION

Name:_____ Date:_____

Clinic Address:_____
Street City County State Zip

Clinic Phone:_____ Email:_____

Home Address:_____
Street City County State Zip

Home Phone:_____ Cell Phone:_____

GENERAL INFORMATION

Type of Practice: ☐ GENERAL ☐ SPECIALTY (List)_____

Will you provide PS services at more than 1 clinic? ☐ **Y** ☐ **N**

*If yes, you must complete a separate application for each clinic.

☐ **CPR** ☐ **ACLS** ☐ **PALS** ☐ **ATLS**

(Mark all that apply)

REQUIRED TRAINING/EDUCATION

(Mark all that apply and provide documentation)

- ☐ Fellow of American Dental Society of Anesthesiology
- ☐ Diplomate of American Board of Oral and Maxillofacial Surgery
- ☐ Eligible for examination by the American Board of Oral and Maxillofacial Surgery (Include expected exam dates or dates of any previous exams)
- ☐ Member of American Association of Oral and Maxillofacial Surgeons
- ☐ Completed minimum of one (1) year of advanced training in anesthesiology and related academic subjects (or equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the American Dental Association's guidelines for teaching pain control and sedation. (Attach full details, to include courses taken, school name, dates attended, etc.)
- ☐ Qualification by experience in accordance with the requirements set forth by the Alabama Dental Practice Act and associated Alabama Administrative Code.
  - Have you used/employed General Anesthesia prior to 06/01/1985? ☐ **Y** ☐ **N**
    - If yes, provide number of times used, types of procedures:_____

_____

_____

_____

EDUCATION/TRAINING

UNDERGRADUATE

Name of College/University:_____

Degree:_____ Dates attended:_____

DENTAL SCHOOL

Name of College/University:_____

Degree:_____ Dates attended:_____

OTHER PROFESSIONAL EDUCATION

Name of College/University:_____

Degree:_____ Dates attended:_____

Name of College/University:_____

Degree:_____ Dates attended:_____

POSTDOCTORAL EDUCATION

Name of College/University:_____

Degree:_____ Dates attended:_____

RESUMÉ OF ANESTHESIA QUALIFICATIONS

List all training, experience, use prior to 06/01/1985, etc.:

_____

_____

_____

_____

_____

HOSPITAL PRIVILEGES

List all hospitals in which you have privileges and types of appointment:

_____

_____

_____

_____

DOCUMENTATION OF ADVERSE OCCURRENCE

Have you experienced an Adverse Occurrence as defined in Code of Alabama (1975), §34-9-65 or Alabama Administrative Code r. 270-X-2- .20? ☐ **Y** ☐ **N** *If yes, attach documentation to this application.

AUXILIARY PERSONNEL

(Applicant must include copies of Auxiliary Personnel Training)

Name:_____ License #:_____

Date of CPR course:_____

List Additional certification(s):_____ (include all documentation)

Name:_____ License #:_____

Date of CPR course:_____

List Additional certification(s):_____ (include all documentation)

Name:_____ License #:_____

Date of CPR course:_____

List Additional certification(s):_____ (include all documentation)

Name:_____ License #:_____

Date of CPR course:_____

List Additional certification(s):_____ (include all documentation)

Name:_____ License #:_____

Date of CPR course:_____

List Additional certification(s):_____ (include all documentation

ATTESTATION OF UNDERSTANDING

I hereby attest that I have reviewed and fully completed this application, to include attachments of any required documentation and fees. I attest that I am currently licensed to practice dentistry in the State of Alabama. I attest that all the information provided in this application is true and correct and I further acknowledge and understand that the Board is relying upon the truthfulness of this information in the issuance of this permit.

I hereby attest that I have personally reviewed all applicable provisions of the Alabama Dental Practice Act and Alabama Administrative Code (Board Rules) pertaining to this permit.

I hereby attest that I am required to successfully pass both a Facility Inspection and an Anesthesia Evaluation to obtain a permit for Parenteral Sedation. I attest that submission of this application indicates that my clinic and personnel are prepared to have a Facility Inspection as quickly as it can be scheduled by the Board.

I attest that any falsifications, omissions, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient grounds to bar me from this or any future application requests to the Board of Dental Examiners of Alabama. I attest that any falsifications, omissions, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient grounds for disciplinary action up to and to include revocation of my Alabama Dental License if it is not discovered until after issuance.

By typing my signature below and submitting this application, I affirm that I have personally reviewed all the information contained within this application, as well as any/all documents uploaded for this application, and affirm it to be true and factual. I also acknowledge that any/all fees submitted with this application are non-refundable and non-transferable.

_____ _____

Signature Date

Checklist for Completion

- ☐ **Complete application and required documents.**
- ☐ **Copy of payment receipt from online payment portal**
- ☐ **Copy of DEA registration for the clinic address where you are providing anesthesia services.**
- ☐ **Copy of training/education documentation**
- ☐ **Copy of documentation of adverse occurrence (if applicable)**
- ☐ **Copy of training for ALL Auxiliary Personnel.**