Oral Conscious Sedation Permit

APPLICATION

Initial Application	**AL Dental License #:** D._____
$200.00	**DEA #:**_____

Application Instructions

- Complete application and attach required documents.
- Attach a copy of the DEA Registration assigned to this location.
  - The clinic address below is where you will provide anesthesia services with this permit
- Check or money order
- **NOTE**: You must have an OCS permit and separate DEA registration for each clinic in which you will provide OCS. 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:_____

Office Address:_____
Street City County State Zip

Office Phone:_____ Email:_____

Home Address:_____
Street City County State Zip

Home Phone:_____ Cell Phone:_____

GENERAL INFORMATION

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

AL Dental License #:_____ DEA Registration #:_____

Required	Required	Optional	Optional
☐ **CPR**	☐ **ACLS**	☐ **PALS**	☐ **ATLS**

(Mark all that apply)

Will you provide Oral Conscious Sedation in more than 1 clinic? ☐ **Y** ☐ **N**

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

REQUIRED TRAINING/EDUCATION

Applicant must have completed at least 1 of the following. Complete all that apply. Documentation must accompany application.

- **ADA-accredited postgraduate General Dentistry or Specialty Residency Program that included specific training in Oral Conscious Sedation**

School/College/University:_____

Program:_____

Degree:_____ Date Graduated:_____

- **Completion of sixteen (16) minimum hours of training in a Board-approved Oral Conscious Sedation Course.**

Course Title:_____

Course Sponsor:_____

Presenter:_____ Date(s) Attended:_____

- **Oral Conscious Sedation Certification by Board-approved entity or organization**

Entity/Organization Name:_____

Presenter:_____ Date(s) Attended:_____

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 Allied Personnel CPR Training)

Name:_____ License #:_____

Date of CPR course:_____

Name:_____ License #:_____

Date of CPR course:_____

Name:_____ License #:_____

Date of CPR course:_____

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 a 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 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.

I have reviewed all applicable Board Rules and attest I have all emergency equipment and medications.

By typing my signature below and submitting this application, I affirm that I have personally reviewed all of 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.
- ☐ Check or money order
- ☐ Copy of DEA registration for the clinic address where you are providing anesthesia services.
- ☐ Copy of training/education documentation for the section on page 2
- ☐ Copy of documentation of adverse occurrence (if applicable)
- ☐ Copy of training for ALL Auxiliary Personnel.