Date Received	Date Processed	Date Inspected	Pass Fail (Circle One)

Parenteral Sedation/ General Anesthesia Permit

APPLICATION

(Mark Appropriate Box)

Parenteral (IV) Sedation Initial Application	**General Anesthesia or GA-MD Initial Application**
☐ **$1,350.00**	☐ **$1,350.00**

AL Dental License #: D._____

AL CS#:_____

DEA #:_____

Application Instructions

- Mark the appropriate permit above, complete form, 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
- Attach fee (check/money order)-All fees are non-refundable
  - Mail completed application/fee to: **BDEAL, 2229 Rocky Ridge Road, Birmingham, AL 35216**
- **NOTE**: You must have a separate DEA registration for each clinic in which you will provide PS/GA.

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/GA services at more than 1 clinic? ☐ **Y** ☐ **N**

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

☐ **CPR/BLS** ☐ **ACLS** ☐ **PALS** ☐ **ATLS**

(Mark all that apply)

REQUIRED TRAINING/EDUCATION

(Mark all that apply)

☐ • 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:_____

_____

_____

_____

***For a dentist who will employ a physician anesthesiologist to provide sedation/anesthesia services, please mark this box. This only applies to General Anesthesia permits (GA-MD permit):**

☐ • Employment or work in conjunction with a qualified medical doctor who is a member of the anesthesiology staff of an accredited hospital, provided that such anesthesiologist must remail on the premises of the dental office or facility until any patient given a general anesthetic regains consciousness and is discharged. (Attach Physician Anesthesiologist's CV)

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. If you are employing a physician anesthesiologist (GA-MD permit), please list their name and credentials:

_____

_____

_____

_____

_____

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/BLS course:_____

List Additional certification(s):_____

Name:_____ License #:_____

Date of CPR/BLS course:_____

List Additional certification(s):_____

Name:_____ License #:_____

Date of CPR/BLS course:_____

List Additional certification(s):_____

Name:_____ License #:_____

Date of CPR/BLS course:_____

List Additional certification(s):_____

Name:_____ License #:_____

Date of CPR/BLS course:_____

List Additional certification(s):_____

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 in order to obtain a permit for Parenteral Sedation or General Anesthesia. 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.

_____ _____

Signature Date

STATE OF_____)

COUNTY OF_____)

Sworn to and subscribed before me this_____day of _____, 20_____

<SEAL> _____

Notary Signature

My commission expires:_____