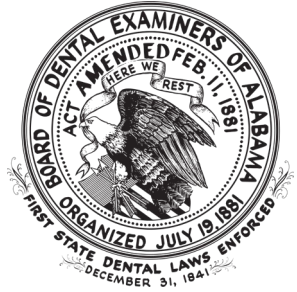


| | | | | |
|---------------|----------------|----------------|----------------------|------|
| Date Received | Date Processed | Date Inspected | Pass (Circle One) | Fail |
|---------------|----------------|----------------|----------------------|------|

Parenteral Sedation/ General Anesthesia Permit



APPLICATION

(Mark Appropriate Box)

| | |
|---|--|
| <p>Parenteral (IV) Sedation Initial Application</p> <p style="font-size: 1.2em;">\$1,350.00</p> | <p>General Anesthesia or GA-MD Initial Application</p> <p style="font-size: 1.2em;">\$1,350.00</p> |
|---|--|

| |
|--|
| <p>AL Dental License #: <u>D. _____</u></p> <p>AL CS#: _____</p> <p>DEA #: _____</p> |
|--|

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: _____

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: _____

Checklist for Completion

- Complete application and required documents.
- Payment included.
- Copy of DEA registration for the clinic address where you are providing anesthesia services.
- Copy of training/education documentation for that section on page 2.
- Copy of documentation of adverse occurrence (if applicable)
- Copy of training for **ALL** Auxiliary Personnel.
- Copy of Anesthesiologist's resume or CV (if applicable)