ARKANSAS STATE BOARD OF DENTAL EXAMINERS
101 EAST CAPITOL AVENUE, SUITE 111
LITTLE ROCK, AR 72201
PHONE: 501-682-2085 FAX: 501-682-3543

FOR BOARD USE ONLY
MOD Permit # _____
Facility Permit #_____
Date Issued _____
- ❑ Fee
- ❑ ACLS/PALS
- ❑ Training

Application for Sedation and Facility Permit for

MODERATE SEDATION

(formerly known as "Level 3 Conscious Sedation")

With this application, enclose the following:

- **Documentation of the required training**
- **Current ACLS or PALS certification (if another dental emergency management course was taken, list the name of the course and provide a syllabus to the Board office)**
- **Application fees of $150.00 (check or money order) for Moderate Sedation Permit and $50.00 for Facility Permit (you may write one check in the amount of $200.00).**

Name (DDS/Owner or DDS who is the primary care provider in the facility):	**DDS License #:**
Office Address (if practicing in multiple locations, a separate facility permit is required for each location):	
City, State, Zip:	
Office Telephone:	
I have training to the level of competency in Moderate Sedation to the level of competency consistent with that prescribed in Article XIII of the *Rules and Regulations* from this source: **School or other course:**_____ **Date of successful completion:** _____	

I confirm that all staff members monitoring patients undergoing sedation have met the following requirements:

- ☐ Hold a current permit from the board to monitor nitrous oxide
- ☐ Trained in emergency procedures with at least annual updates
- ☐ Hold current certification in health-care provider level of basic life support
- ☐ Monitor patients who are sedated only under my personal or direct supervision

List of all licensed dentists who provide patient treatment in the facility (use back if more room needed):

NAME	DDS LICENSE #	SEDATION PERMIT # (or NA)

I confirm that each patient who is sedated has the following information recorded in their treatment record:

- ☐ Informed consent
- ☐ Health history
- ☐ Blood pressure, heart rate, respiration rate and oxygen saturation levels (as necessary)
- ☐ Names of all drugs administered including dosages and the weight of patients under the age of 12
- ☐ Local anesthetic record
- ☐ Record of all procedures
- ☐ Post operative instructions
- ☐ Level of consciousness at discharge
- ☐ Time-oriented anesthetic record

I confirm that the following functional equipment and drugs are available in my office:

- ☐ Fail safe nitrous oxide equipment
- ☐ Scavenging system for nitrous oxide
- ☐ Pulse oximeter
- ☐ Blood pressure cuff and stethoscope
- ☐ Oral airway
- ☐ Emergency drugs
- ☐ Automated external defibrillators
- ☐ Positive pressure oxygen delivery system, appropriately sized masks and connectors
- ☐ Operating theater large enough for patient and three other individuals
- ☐ Operating table or chair which adjusts quickly to provide platform for CPR
- ☐ Lighting system
- ☐ Battery powered back-up lighting system
- ☐ Suction equipment with tonsilar suction tip and pharyngeal suction tip
- ☐ Backup suction device
- ☐ Backup oxygen system
- ☐ Recovery area (can be same as operating theater)
- ☐ All controlled drugs are stored in accordance with federal and state guidelines
- ☐ No medications or drugs are expired

If equipment listed above is not available, please explain:

Have you ever received an Order or been charged with any violation of any Rules and Regulations or Dental Practice Act from this or any other dental licensing board? ☐ Yes ☐ No
If yes, please explain fully on separate paper.

By my signature, I affirm that I am familiar with Article XIII of the Rules of the Board and the standard of care expected in the administration of Moderate Sedation. I am familiar with the required level of training for qualified staff and assure the Board that applicable permits or documentation have been attained by qualified staff members. I have all the required equipment and emergency drugs available in my dental treatment facility. Only dentists with current, valid Moderate Sedation permits from the board, or contracted sedation providers as defined in Article XIII, D., 6. are allowed to administer sedation to patients in this facility. I further understand that this facility permit is valid ONLY for the address indicated above. I am aware that the Board investigators may inspect this facility at any time with 30 days written notice. I fully understand that I will be considered in violation of the Arkansas Dental Practice Act and Rules and Regulations of the Board if any of the information provided on this application is untrue.

_____ _____

Signature Date

Printed name