



North Dakota State Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507-7246 • Phone 701-258-8600

Web www.nddentalboard.org • Email info@nddentalboard.org

Application – Dental Anesthesia Assistant Class I Permit

Who May Apply

- Applicants must be one of the following in order to be granted a Dental Anesthesia Assistant Class I Permit:
 - Registered dental hygienist
 - Registered dental assistant
 - Qualified dental assistant
 - Qualified dental assistant-limited radiology registrant
 - Other individuals

Applicable Laws for Class I Anesthesia Permit

- N.D.A.C. 20-03-01-01.2(1) explains the criteria for those seeking a Dental Anesthesia Assistant Class I Permit and N.D.A.C. 20-03-01-01.1(2) explains the duties a permit holder may perform, and explains that all duties must be carried out under direct supervision.
- Applicants must thoroughly review N.D.A.C. [20-03-01.pdf](#), and be able to demonstrate an understanding of the laws cited above, including the requirement of obtaining patient informed consent before the permit holder may place restorations and the requirement that the final restorations shall be checked and documented by the supervising dentist.

Application

- Be sure to attach/download additional materials and documents as requested.
- If you have questions on the application and or materials, please email us at: info@nddentalboard.org
- When completing this application, you will be required to (a) identify the dentist who will supervise your work under this permit, and (b) provide proof of their anesthesia education. Approved courses are listed on the website. If you are unsure if your course has received Board-approval, contact the Board before applying.
- This permit must be renewed biennially.

Accepted Forms of Payment

- Check (personal/cashiers).
- Online payment through debit or credit card (once online payments are available on the Board's website).
- Unacceptable forms of payment include cash, money orders, and American Express cards.

Contact Information and Names

- Current and complete contact information is required for all applicants. Email addresses must be included on the application and will be used by the Board related to the processing of your application.
- Submit documentation of any legal name change.
- If your application is granted, you must always update the Board with any change of name, address, email address, phone, employers, and other contact information. Failure to do so can result in you not receiving critical information in a timely manner and may result in discipline.



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Non-refundable Fee: \$50.00

OFFICE USE ONLY - Postmarked: _____ Received: _____ Amount: _____ Payment Type: Check # _____ Online # _____

General Contact Information			
Legal First Name	Legal Middle Name	Legal Last Name	Today's Date (mm/dd/yyyy)
Other Legal Names Previously Used (include proof of legal name changes and indicate if exam scores use these names)			
Name as you wish it to appear on license (if not your current legal name, you must provide documentation of name change)			
Home Street Address		Apt. Number	Home City, State, Zip (4+ digits)
Phone Numbers (c) (h) (w)	Business/Employer Name, Address, Unit #		Employer/Business City, State, Zip (4+ digits)
Personal Email Address (required)		Business/Employment Email Address	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/> X <input type="checkbox"/>	Date of Birth (mm/dd/yyyy)	Social Security Number	
<p>Military Status: Are you a member of the armed forces of the United States or a reserve component of the armed forces of the United States stationed in this state in accordance with military orders or stationed in this state before a temporary assignment to duties outside of this state; or are you the spouse of such member? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Attach military orders, duty station assignment, base identification, etc. Depending on submissions, your application may be processed as a military application.</p>			

Cardiopulmonary Resuscitation or Basic Life Support (applicants must hold either current CPR or BLS certification)
Hold an active cardiopulmonary resuscitation (CPR) certification; course must include a hands-on component. Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration date: _____
Basic life support (BLS) certification. Yes <input type="checkbox"/> No <input type="checkbox"/> Expiration date: _____

Attach certificates.

Education

<p>Applicants must meet all of the following criteria and attach supporting documentation:</p> <p><input type="checkbox"/> Completed hands-on training in IV access or phlebotomy that includes live experience in starting and maintaining IV lines and infection control. The evidence may be either:</p> <ul style="list-style-type: none"> •A certificate of completion issued by a Board-approved dental anesthesia assistant education and training course, or •An attestation by a supervising dentist who provided the training. The dentist shall retain documentation of the training and provide it to the Board upon request; <p><input type="checkbox"/> Evidence of completing a Board-approved dental anesthesia assistant education and training course that includes vital sign monitoring, training on emergency oxygen administration, suction, use of advanced automated external defibrillators, and crash cart equipment.</p> <p><input type="checkbox"/> A copy of the dentist’s North Dakota general anesthesia, deep sedation, or moderate sedation permit under whom the individual will be performing anesthesia assistant services.</p>	<p>Name of IV Program: _____</p> <p>Location of IV Program: _____</p> <p>Date of Completion: _____</p> <p>Name of Anesthesia Program: _____</p> <p>Location of Anesthesia Program: _____</p> <p>Date of Completion: _____</p> <p>Name of Dentist: _____</p> <p>Dentist License Number: _____</p>
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Additional life support certifications beyond CPR or BLS is not required for this permit, but the Board seeks to maintain records of such advanced training related to this permit. Please indicate whether you currently maintain any of the following.

Advanced cardiovascular life support (ACLS) certification.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Expiration date: _____
Pediatric advanced life support (PALS) certification.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Expiration date: _____

Attestation of Applicant

I have reviewed North Dakota Century Code §§ 43-20-05 and 43-28-25, and understand that including false information or false documentation in this application may result in denial of my application and could result in a class A misdemeanor.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I certify that I am the person referred to in this application.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I certify that the entirety of this application and the attached materials are true and correct.	Yes <input type="checkbox"/> No <input type="checkbox"/>
I authorize all persons and organizations to release any requested information, files, or records in connection with this application to the North Dakota State Board of Dental Examiners.	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant’s Name (Printed)	Applicant’s Signature	Date (mm/dd/yyyy)