North Dakota Board of Dental Examiners

PO Box 7246, Bismarck, ND 58507 • Phone 701-258-8600 • Fax 701-224-9824
Web www.nddentalboard.org • Email info@nddentalboard.org

Initial Application for Permit to Administer General Anesthesia, Deep Sedation or Moderate Sedation

OFFICE USE ONLY	Postmark Date	Date Received	Permit Fee $200	Check #

CRITERIA AND APPLICATION INSTRUCTIONS

1. You must obtain written notification of approval to administer general anesthesia, deep sedation or moderate sedation. A dentist licensed under North Dakota Century Code chapter 43-28 and practicing in North Dakota may not use general anesthesia, deep sedation or moderate sedation on any patient unless such dentist meets the requirements of the anesthesia permit application, the site evaluation and pays the fee for the anesthesia permit. The permit issued by the Board is renewable at the same time the dental license is renewed. Site evaluations must be renewed prior to the third anniversary of the last site evaluation.
2. Submit application, all documentation including evidence of completion of an advanced dental education program, accredited by the Commission on Dental Accreditation (CODA) in accord with the Accreditation Standards for advanced dental education programs, and application fee of $200. Incomplete applications will be returned to the applicant. **Prior to the final granting of approval to administer general anesthesia or moderate sedation, however, office inspection and evaluation must be completed for each location where anesthesia/sedation will be administered.**
3. The Anesthesia Committee evaluates the application and identifies any additional information required. The site evaluation must be completed within 60 days of the approval of the initial anesthesia permit application. It is the OMFS's responsibility to schedule an OMFS or Anesthesiologist to provide the office evaluations**.** *It is the Anesthesia Committee's prerogative to suspend privileges if the permit holder's site evaluation is overdue.* For practitioners requesting authorization for moderate sedation, it is the dentist's responsibility to schedule the Board appointed CRNA to provide the office evaluation. Office inspections conducted as part of the AAOMS certification process may be considered in lieu of the office evaluation required by the Board.
4. Upon final approval of the application and the site evaluation the Anesthesia Committee will recommend a final action to the Board. If an application is denied for failure to meet the requirements of the NDBDE, the applicant may re-apply when the requirements are met. The site evaluation fee is $550 plus mileage rate of $0.62/mile paid directly to the site evaluator on the day of the evaluation.
5. Pediatric Advanced Life Support (PALS) is required for administration of general anesthesia and moderate sedation on
   patients AGE 10 and under.
6. Both the permit and the site evaluation are subject to expiration and renewal. Pursuant to N.D.A.C. § 20-02-01-05, the permit holder must have the credentials, facilities, satellite facility, equipment, personnel, and procedures re-evaluated within 3 years of the anniversary of the initial site evaluation. Six hours of CE related to anesthesia/sedation are required for renewal of the anesthesia/sedation permit and two hours of closed claim anesthesia continuing education courses [Effective Jan 1/2026 and every five years thereafter, successful completion of a board-approved anesthesia simulation course and the completion of anesthesia simulation training shall be required].
7. Return application and permit application fee of $200.00 with supporting documentation to: **ATTN: Anesthesia Committee North Dakota Board of Dental Examiners, PO Box 7246, Bismarck, ND 58507-7246.** Documentation includes copies of ACLS/PALS/BLS of auxiliary and a photocopy of the credentials of auxiliary that have direct patient contact during or after surgical procedures.

TYPE OR PRINT LEGIBLY

Full Name (First, Middle, Last)			
DEA Number	Date of Birth	Email	
Office Address		Office Phone	Fax Number
City	State		Zip Code + 4
Home Address			Home Phone
City	State		Zip Code + 4

Specialty	ND Dental License Number
Name of Conscious Sedation Course	Date of Completion
Accredited Program	Date of Completion

NOTE: For each "yes" response to question 1, 2, or 3 include for each decided or pending case: a personally written explanation; a copy of the formal complaint/pleadings; the answer to the complaint for malpractice issues; a copy of the final outcome(s) and/or a report of status if judgment is pending; proof of compliance if under criminal probation;
and
For each "yes" response to question 4, 5, 6, 7, 8 or 9 include a personally written explanation. For question 5 or 6 provide dates of onset, description of treatment; name and address of treating physician; and your description of the current status of your condition. The Board will require evidence that any recommendations from counselors or physicians have been met.

1. Have you ever had **any** criminal conviction, deferred judgment or plea of nolo contendere issued against you or is there any criminal charge now pending against including any judgments, charges related to sales, distribution, possession, manufacture, or dispensation of any controlled substance.	**YES**	**NO**
2. Have you ever had **any** malpractice judgment, malpractice settlement, or governmental/private agency disciplinary order issued against you or is there any complaint, malpractice claim, or disciplinary action now pending against you?	**YES**	**NO**
3. Do you have any criminal charges pending against you?	**YES**	**NO**
4. Has your license to practice dentistry ever been suspended, revoked or otherwise disciplined in any state or territory of the United States, or in any foreign country, related to an anesthesia/analgesia incident?	**YES**	**NO**
5. Are you presently engaged in or have you in the last four years been engaged in the excessive use, abuse, addiction to or dependency upon any controlled substance, habit-forming substance or alcohol?	**YES**	**NO**
6. Do you now have, or in the past four (4) years have you had a physical or mental condition, which might affect your ability to practice dentistry?	**YES**	**NO**
7. Has any action ever been taken against hospital or clinical privileges such as a suspension, revocation or any other action?	**YES**	**NO**
8. Are there any other facts concerning your background history, experience, or activities which may have a bearing on your fitness to practice dentistry? If YES provide written explanation.	**YES**	**NO**
9. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of your use of antianxiety premedication, nitrous oxide inhalation analgesia, minimal, moderate sedation, deep sedation, or general anesthesia? If YES provide written explanation and supporting documents.	**YES**	**NO**
10. Do you utilize anesthesia /sedation on children ages **10** and under?	**YES**	**NO**

11. Is your practice limited to an ADA recognized specialty? Specialty:	**YES**	**NO**
12. Do you have a number from the Drug Enforcement Agency? DEA Number:	**YES**	**NO**
13. Has your DEA number ever been revoked or suspended? If YES provide written explanation.	**YES**	**NO**

SUBMIT DOCUMENTATION FOR THE FOLLOWING EDUCATIONAL REQUIREMENTS:

GENERAL ANESTHESIA & DEEP SEDATION

- ❑ Successful completion of a post-doctoral training program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage general anesthesia and deep sedation commensurate with the American Dental Association's most recent **GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS.**

AND

- ❑ A current certification in BLS for Healthcare Providers and ACLS

MODERATE SEDATION

- ❑ Successfully completed a comprehensive sixty-hour predoctoral dental school, post graduate education or continuing education in moderate sedation with a participant-faculty ratio of not more than four-to-one. The course must include courses in enteral and parenteral moderate sedation plus individual management of twenty live patient clinical case experiences by the intravenous route and provide certification of competence in rescuing patients from a deeper level of sedation than intended, including managing the airway, intravascular or intraosseous access, and reversal medications. The formal training program must be sponsored by or affiliated with a university, teaching hospital, or tother facility approve by the board or provided by a curriculum of an accredited dental school and have a provision by course director or faculty of additional clinical experience if participant competency has not been achieved in allotted time. The course must be directed by a dentist or physician qualified by experience and training with a minimum of three years of experience, including formal postdoctoral training in anxiety and pain control. The course director must possess a current permit or license to administer moderate or deep sedation and general anesthesia in at least one state.

OR

- ❑ Successful completion of the ND requirements for administration of General Anesthesia/Deep Sedation

AND

- ❑ A current certification in BLS for Healthcare Providers and ACLS or if treating pediatric patients PALS
  Attach documentation of course work and live clinical case experiences; attach patient medical history to each live case documentation.

A dentist administering or supervising general anesthesia or deep sedation, or moderate sedation shall at all times be certified in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Cardiac Life Support (PALS). It **is the dentist's responsibility to maintain current ACLS and/or PALS certification if treating patients 10 years of age or less.**

List below and submit evidence of current Basic Life Support (BLS) certification, and Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) certification as appropriate. **It is the dentist's responsibility to maintain current CPR or BLS and ACLS or PALS certification at all times.** Include photo copy of:

CPR or BLS certification issue date: _____ Expiration date: _____

AND;

ACLS certification issue date: _____ Expiration date: _____

OR

PALS certification issue date: _____ Expiration date: _____

LIST auxiliary staff and credentials (RN, RDA or CRNA). Submit copy of credentials for staff that have direct patient care responsibilities during and after surgical procedures. Submit copy of auxiliary BLS, ACLS, or PALS, DAANCE certification. Submit copies of dental assistant's current NDBDE registration. Use additional pages if necessary.

Name: _____ Credential _____ Life Support date of expiration _____

Name: _____ Credential _____ Life Support date of expiration _____

Name: _____ Credential _____ Life Support date of expiration _____

Name: _____ Credential _____ Life Support date of expiration _____

Name: _____ Credential _____ Life Support date of expiration _____

Name: _____ Credential _____ Life Support date of expiration _____

ATTESTATION: I hereby certify that I have met ALL the requirements for administration of anesthesia and/or conscious sedation in the State of North Dakota and under the requirements of the North Dakota State Board of Dental Examiners for (check one):

____ **General Anesthesia & Deep Sedation**
____ **Moderate Sedation**

The documentation I have provided verifies I have met the requirements as claimed. The information contained in this application is true and correct to the best of my knowledge. I understand that under the North Dakota Century Code 43-28-18 providing false information is grounds for denial, suspension, or revocation of a license. I further attest that I am in full compliance with all the requirements of North Dakota Administrative Code 20-02-01-05 and understand the scope of practice for the auxiliary utilized in the direct patient care of sedation patients. Furthermore, I attest that I shall remain in compliance with the NDBDE requirements including CE requirements during all periods of time that anesthesia is administered, whether in my office or in another dentist's office.

Signature of Licensee _____ **Date** _____

Rev 7/09/2022