



# North Dakota State Board of Dental Examiners

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## Anesthesia-Adverse Incident Report

### Applicable Laws

- N.D.A.C. 20-02-01-05(14)(d) explains that all licensed dentists shall submit a report to the Board, within a period of seven (7) days, any mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, minimal sedation, nitrous oxide inhalation analgesia, moderate sedation, deep sedation, or general anesthesia.
- Attach additional pages or supporting documentation if and as needed.

**OFFICE USE ONLY - Postmarked: \_\_\_\_\_ Received: \_\_\_\_\_**

Dentist			
First Name	Middle Name	Last Name	Today's Date (mm/dd/yyyy)
Home Street Address		Apt. Number	Home City, State, Zip (4+ digits)
Office Name and Street Address		Unit Number	Office City, State, Zip (4+ digits)
Phone Numbers (c) (h) (w)	Personal Email Address		Business Email Address

Adverse Incident Facility (leave blank if the incident occurred at the office address listed above)	
Facility Name	Phone
Street Address and Unit Number	City, State, Zip (4+ digits)

**Adverse Incident Report**

1. Date of the dental procedure.

2. Description of the dental procedure.

3. Description of the preoperative physical condition of the patient

4. List of drugs and dosage administered.

5. Description, in detail, of techniques utilized in administering the drugs utilized.

6. Description, in detail, of symptoms of any complications, to include onset and type of symptoms in patient.

7. Treatment instituted on the patient.
8. Response of the patient to the treatment.
9. Description of the patient's condition on termination of any procedures undertaken.
10. The unique reporting identification issued by the dental anesthesia incident reporting system, indicating a report has been submitted to the national database.

<b>Attestation of Dentist</b>		
I have reviewed North Dakota Century Code § 43-28-18.1(1)(c), and North Dakota Administrative Code 20-02-01-05, including 20-02-01-05(14)(d), and understand my obligations under those laws.		Yes <input type="checkbox"/> No <input type="checkbox"/>
I certify that I am the dentist completing and submitting this report.		Yes <input type="checkbox"/> No <input type="checkbox"/>
I certify that the entirety of this report and any attached materials are true and correct.		Yes <input type="checkbox"/> No <input type="checkbox"/>
Name (Printed)	Signature	Date (mm/dd/yyyy)