

PENNSYLVANIA STATE BOARD OF DENTISTRY

Mailing Address:

STATE BOARD OF DENTISTRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649

Tel: 717-783-7162 Fax: 717-787-7769

E-Mail: st-dentistry@pa.gov
Website: www.dos.pa.gov/dent

Courier Delivery Address:

STATE BOARD OF DENTISTRY
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR RESTRICTED PERMIT II ADMINISTRATION OF NITROUS OXIDE/OXYGEN ANALGESIA

REQUIREMENTS ARE AS FOLLOWS:

- 1) Attach a **\$15.00** check or money order made payable to the “**Commonwealth of PA**”. **DO NOT SEND CASH.** Fee is non-refundable. Note: A \$20.00 processing fee will be assessed for any payment returned by your bank, regardless of the reason for non-payment.
- 2) Please read and complete pages 1-2-3 of the application in their entirety. Incomplete applications will cause delay in the issuance of your permit. Please allow at least 2-4 weeks for processing of your application. Forward pages 2-3 along with the required application fee to the address above.
- 3) Education (Page 4) – Complete Section 1 and forward to the educational facility/hospital for completion of Section 2. The course instructor or other authorized person must complete Section 2 certifying that you have completed a 14-hour course in nitrous oxide/oxygen analgesia on page 4 of the application. The completed form must be mailed directly to the Board office from the educational facility/hospital in an official sealed envelope. **NOTE:** If the educational facility/hospital does not have an official seal, the proper official must make a notarized statement to that effect on page 4 of the application.

PLEASE READ THE FOLLOWING INFORMATION:

- 1) You may **NOT** administer nitrous oxide/oxygen analgesia in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Dentistry has issued a permit. You may verify a permit has been issued through our website at www.mylicense.state.pa.us.
- 2) All permits, regardless of the issuance date, will expire March 31st of the odd-numbered years and are subject to renewal.

Note: Should the application not be completed within six months, updated documentation may be required. Additionally, if the application process has not been completed within one year from the date it was received, applicants will be required to submit an updated application-processing fee.

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APPLICANT INFORMATION:

Name of Applicant: _____
Last First Middle

Address: _____
Street

City State Zip Code

****If the address you provide on this application is different than the address the Board has on file for your Dental license, then your change of address will be reflected on your Dental license record, as well as, with this application.****

Pennsylvania Dental License Number: _____

Telephone Number: _____ Email Address: _____

OFFICE / EQUIPMENT CERTIFICATION

1) Provide the make, model and serial number of any nitrous equipment utilized below:

- a) Make: _____
- b) Model: _____
- c) Serial Number: _____

*If there is additional equipment, please provide additional information on a separate 8 1/2 x 11 sheet of paper.

***NOTE: This page may be duplicated. A completed "Office/Equipment Certification" page must be submitted for each unit you will utilize under this permit.

2) Is the equipment in proper working order?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3) Is the equipment properly calibrated?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4) Does the equipment contain a fail-safe system?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5) Do you have written office procedures for administering nitrous oxide/oxygen analgesia and handling emergencies related to the administration of nitrous oxide/oxygen analgesia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PERSONAL HISTORY INFORMATION:

Please check Yes or No to each of the following questions:

Yes No

- 1) Have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline? ___ ___
- 2) Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction? ___ ___
- 3) Have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction? ___ ___
- 4) Have you been convicted (found guilty or pleaded guilty or entered a plea of nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by the court.) ___ ___
- 5) Do you currently have any criminal charges pending and unresolved in any state or jurisdiction? ___ ___
- 6) Have you had your DEA registration denied, revoked, suspended or restricted or have you had your provider privileges terminated by any medical assistance agency for cause? ___ ___
- 7) Have you ever had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority? ___ ___
- 8) Have you ever had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility? ___ ___
- 9) Have you ever been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct? ___ ___
- 10) Do you currently engage in, or have you ever engaged in, the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination? ___ ___

VERIFICATION STATEMENT

By signing below, I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S.§4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S.§4904 relating to unsworn falsification to authorities and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Applicant: _____ Date: _____

CERTIFICATION OF EDUCATION

SECTION 1 – Complete section 1 and forward to the educational institution.

Applicant's Name: _____
Last First Middle

Applicant's Address: _____
Street

City State Zip Code

SECTION 2 – To be completed by the Course Instructor or other authorized person. Form must be submitted directly to the State Board office from the educational facility/hospital in an official sealed envelope.

I CERTIFY THAT _____ SUCCESSFULLY COMPLETED A COURSE IN
Name of Applicant

CHECK ONE OF THE FOLLOWING:

_____ **NITROUS OXIDE/OXYGEN ANALGESIA** COMPRISING OF AT LEAST 14 HOURS OF **UNDER-GRADUATE** DIDACTIC INSTRUCTION AND CLINICAL EXPERIENCE THAT CONFORMS TO PART I (FOR AN UNDER-GRADUATE PROGRAM) OF THE AMERICAN DENTAL ASSOCIATION'S "GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY".

_____ **NITROUS OXIDE/OXYGEN ANALGESIA** COMPRISING OF AT LEAST 14 HOURS OF **POST-GRADUATE** DIDACTIC INSTRUCTION AND CLINICAL EXPERIENCE THAT CONFORMS TO PART III (FOR A POST-GRADUATE PROGRAM) OF THE AMERICAN DENTAL ASSOCIATION'S "GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY".

Name of training facility: _____

Address of facility: _____
Street

City State Zip Code

Date Course Began

Date Course Ended

Signature

Title

Date

HOSPITAL/FACILITY

SEAL