

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 AN UNRESTRICTED PERMIT ADMINISTRATION OF GENERAL ANESTHESIA/DEEP SEDATION

REQUIREMENTS ARE AS FOLLOWS:

- 1) 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.
- 2) Please submit the application fee of \$100.00 by check or money order payable to the "Commonwealth of PA". Fees are non-refundable. Note: A \$20.00 processing fee will be charged for any check or money order returned by the bank, regardless of the reason for non-payment.
- 3) Forward pages 1-2-3 along with the \$100.00 application fee to the Board office at the address listed above.
- 4) Education (Page 4) - Choose one of the following:

- _____ 1) Complete Section 1 and forward to the educational facility/hospital for completion of Section 2. The program director must complete Section 2 certifying that you have completed at least two years in a post-graduate program for advanced training in anesthesiology and related academic subjects that conforms to Part II of the American Dental Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. **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.

OR

- 2) The official original certificate or an original letter relating to your status must be signed, sealed and sent directly to the Board office in an official envelope from one of the following:
- _____ A) Current certification as a Diplomate of the American Board of Oral and Maxillofacial Surgeons; OR
- _____ B) Current certification as a Fellow of the American Association of Oral and Maxillofacial Surgeons; OR
- _____ C) Current certification as a Fellow from the American Society of Dental Anesthesiology; OR
- _____ D) An original letter from the American Board of Oral and Maxillofacial Surgeons verifying that you are candidate for the examination.

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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APPLICATION FOR AN UNRESTRICTED PERMIT ADMINISTRATION OF GENERAL ANESTHESIA/DEEP SEDATION

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: _____

PLEASE READ THE FOLLOWING INFORMATION:

- 1) The Board's Regulations relating to the Administration of General Anesthesia, Deep Sedation, Conscious Sedation and Nitrous Oxide/Oxygen Analgesia are available on the Board's website at www.dos.pa.gov/dent.
- 2) Upon receipt and processing of your application, fee and supporting documentation, you will be sent notification from the Board office advising that you are eligible to have the required clinical evaluation and office inspection through PSOMS. Upon receipt of the notification from the Board office, you will be required to contact PSOMS, Dr. Robert Lindner at (412) 422-4353 to schedule the clinical evaluation/office inspection.
- 3) Once the inspection date has been scheduled with PSOMS, you will need to submit the Request for Provisional Approval form to the Board office. (This form will be sent to you upon completion of your application.) You may **NOT** administer general anesthesia, deep sedation, conscious sedation and/or nitrous oxide/oxygen analgesia in the Commonwealth of Pennsylvania until the Board has issued you an Anesthesia Unrestricted Permit except for the purpose of the clinical evaluation/office inspection only. Once the full permit has been issued, verification that a permit has been issued is available through our website at www.mylicense.state.pa.us.
- 4) All permits, regardless of the issuance date, will expire March 31st of the odd-numbered years and are subject to renewal.

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 TRAINING

SECTION 1 – Complete section 1 and forward to the post-graduate program.

Applicant’s Name: _____
Last First Middle

Applicant’s Address: _____
Street

City State Zip Code

SECTION 2 – To be completed by the Program Director. Form must be submitted directly to the State Board office from the educational facility/hospital in an official sealed envelope.

I CERTIFY THAT _____ HAS SUCCESSFULLY COMPLETED A COURSE FOR
Name of Applicant

ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS THAT CONFORMS TO PART II OF THE AMERICAN DENTAL ASSOCIATION’S GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY IN _____ PROGRAM.
Name of Post-graduate program

NAME OF TRAINING FACILITY: _____

ADDRESS OF FACILITY: _____
Street

City State Zip Code

Date Training Began

Date Training Ended

Signature of Program Director

Title

Date

HOSPITAL/FACILITY

SEAL