

BOARD OFFICE USE ONLY

FEE \_\_\_\_\_

PERMIT # \_\_\_\_\_

EVALUATION DATE \_\_\_\_\_

APPLICATION FOR  
**CLASS 3B DENTAL ANESTHESIA PERMIT**  
WEST VIRGINIA BOARD OF DENTAL EXAMINERS  
1319 Robert C. Byrd Drive  
PO Box 1447  
Crab Orchard, WV 25827

I hereby make application for a permit to employ or use parenteral sedation, enteral conscious sedation, and anxiolysis in the practice of dentistry in the State of West Virginia and submit the following information. (IN THE EVENT THERE IS NOT SUFFICIENT SPACE TO REPLY, SHOW ANSWER ATTACHED AND ON ATTACHMENT SHEET, PLACE QUESTION NUMBER BEFORE ANSWER.) **(PLEASE TYPE OR PRINT LEGIBLY.)**

1. Name in Full \_\_\_\_\_  
LAST FIRST MIDDLE DEGREE

2. Office Address \_\_\_\_\_  
NUMBER AND STREET SUITE NUMBER

\_\_\_\_\_  
CITY STATE ZIP CODE

Telephone # \_\_\_\_\_

Secondary Office(s), Address(es) & Phone Numbers

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. West Virginia Dental License # \_\_\_\_\_ Issued \_\_\_\_\_

West Virginia Specialty License # \_\_\_\_\_ Issued \_\_\_\_\_

Specialty Type \_\_\_\_\_

4. Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**QUALIFICATIONS**

5. I hereby qualify for a class 3b parenteral conscious sedation, enteral conscious sedation, and anxiolysis permit under one of the following:

**(VERIFICATION SHALL BE SENT TO THE WEST VIRGINIA BOARD OF DENTAL EXAMINERS AT THE ADDRESS AT THE TOP OF THIS APPLICATION BY THE ENTITY VERIFYING THE INFORMATION BEARING THE SIGNATURE OF A PROGRAM OFFICIAL.)**

- \_\_\_\_\_ (a) Certificate of completion of a comprehensive training program in conscious sedation that satisfies the requirements described in Part III of the ADA *Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry* at the time training was commenced.
  
- \_\_\_\_\_ (b) Certificate of completion of an ADA accredited postdoctoral training program which affords comprehensive and appropriate training necessary to administer and manage conscious sedation, commensurate with these guidelines.
  
- \_\_\_\_\_ (c) In lieu of these requirements, the Board may accept documented evidence of equivalent training or experience in conscious sedation anesthesia:

\*\*Comprehensive (Parenteral) Permit (3(b)) must have a Board approved course of at least sixty hours didactic and twenty mentored clinical cases.

6. UNDERGRADUATE EDUCATION

College \_\_\_\_\_ Location \_\_\_\_\_  
Dates Attended \_\_\_\_\_ to \_\_\_\_\_ Degree Earned \_\_\_\_\_

7. DENTAL EDUCATION

University \_\_\_\_\_ Location \_\_\_\_\_  
Dates Attended \_\_\_\_\_ to \_\_\_\_\_ Degree Earned \_\_\_\_\_

8. SPECIALTY EDUCATION

Hospital or University \_\_\_\_\_  
Location \_\_\_\_\_  
Dates Attended \_\_\_\_\_ to \_\_\_\_\_  
Degree or Certificate earned \_\_\_\_\_

Hospital or University \_\_\_\_\_  
Location \_\_\_\_\_  
Dates Attended \_\_\_\_\_ to \_\_\_\_\_  
Degree or Certificate earned \_\_\_\_\_

9. Are you currently certified in Advanced Cardiac Life Support?  
\_\_\_\_\_ yes \_\_\_\_\_ no (If yes, attach copy of certificate.)

10. Are your auxiliary personnel certified in Basic Life Support/CPR?  
\_\_\_\_\_ yes \_\_\_\_\_ no (If yes, attach copy of certificate.)

11. Are your auxiliary personnel qualified as a monitor to monitor and record the condition of patients? \_\_\_\_\_ yes \_\_\_\_\_ no

The Board's completed qualified monitor checklist is attached.  
\_\_\_\_\_ yes \_\_\_\_\_ no

12. I further certify that I have a properly equipped facility for the administration of parenteral sedation and it is staffed with a supervised team of auxiliary personnel.  
\_\_\_\_\_ yes \_\_\_\_\_ no

The Board's completed facility checklist is attached. \_\_\_\_\_ yes \_\_\_\_\_ no

13. List all instances of the following in connection with your use of parenteral conscious sedation, including a detailed explanation of any such occurrence.

(a) Mortality

(b) Morbidity

I hereby certify that I am the person who executed this application for a permit to employ or use parenteral conscious sedation, enteral conscious sedation and anxiolysis in the practice of Dentistry in the State of West Virginia in conformance with Chapter 30, Article 4A of the West Virginia Code and the information supplied on this application is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public

My Commission expires \_\_\_\_\_

SEAL

Please make check or money order payable to the West Virginia Board of Dental Examiners in the amount of \$600.00 for the application fee, no part of which is refundable, and mail to the West Virginia Board of Dental Examiners, PO Box 1447, Crab Orchard, WV 25827.

## FACILITY CHECK LIST

A dentist who induces conscious sedation shall have the following facilities, properly maintained age appropriate equipment and age appropriate medications available during the procedures and during recovery:

- \_\_\_\_\_ An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two individuals to freely move about the patient;
- \_\_\_\_\_ An operating table or chair which permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;
- \_\_\_\_\_ A lighting system which permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure;
- \_\_\_\_\_ Suction equipment which permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;
- \_\_\_\_\_ An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;
- \_\_\_\_\_ A nitrous oxide delivery system with a fail-safe mechanism that will insure appropriate continuous oxygen delivery and a scavenger system;
- \_\_\_\_\_ A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room;
- \_\_\_\_\_ Sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, intravenous fluid administration equipment;
- \_\_\_\_\_ Emergency drugs including, but not limited to: pharmacologic antagonists appropriate to the drugs used, vasopressors, corticosteroids, bronchodilators, antihistamines, antihypertensives and anticonvulsants; and
- \_\_\_\_\_ A defibrillator device.

\_\_\_\_\_  
Signature of Applicant

## QUALIFIED MONITOR CHECKLIST

The dentist shall monitor and record the patient's condition or shall use an assistant qualified as a monitor to monitor and record the patient's condition. A qualified monitor shall be present to monitor the patient at all times.

\_\_\_\_\_ The trained personnel must have a certificate showing successful completion in the last two years of BLS/CPR training and the American Association of Oral and Maxillofacial Surgeons Office Anesthesia Assistant certification or an equivalent. (Attach a copy for our records)

\_\_\_\_\_ Trained personnel must be able to monitor the patient's blood pressure, heart rate, respirations and oxygen saturation.

\_\_\_\_\_ Trained personnel must be able to properly document the patient's vital signs.

\_\_\_\_\_  
Signature of Applicant