



APPLICATION FOR
PARENTERAL MODERATE SEDATION PERMIT
 LOUISIANA STATE BOARD OF DENTISTRY
 365 CANAL STREET, SUITE 2680 ~ NEW ORLEANS, LOUISIANA 70130
 TELEPHONE (504) 568-8574 FAX (504) 568-8598

ENCLOSE APPROPRIATE FEES AND DOCUMENTATION—INCLUDING COPY OF CURRENT ACLS OR PALS CARD—WITH YOUR COMPLETED APPLICATION

All information **must** be completed (**including** DEA and Louisiana controlled substance license numbers).

NEW LICENSEES: You may NOT apply for any anesthesia permit unless and until you have been granted a Louisiana dental license number, a DEA number, and a Louisiana controlled substance license number.

INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.

ARE YOU APPLYING FOR A PERSONAL PERMIT OR AN OFFICE PERMIT OR BOTH?

- PERSONAL PERMIT (\$400.00 fee) OFFICE PERMIT (\$400.00 fee **per office**)

DO YOU INTEND TO ADMINISTER PARENTERAL MODERATE SEDATION ON ADULT OR PEDIATRIC PATIENTS?

- ADULTS ONLY (attach copy of current ACLS certification)
 ADULTS AND/OR PEDIATRIC PATIENTS (attach copy of current PALS certification)

Last name _____ First name _____ Middle initial _____

LA Dental License # _____ DEA License # _____ LA Controlled Substance License # _____

 Mailing address _____ City _____ State _____ Zip _____ Telephone _____

Indicate below ALL office addresses where you intend to administer anesthesia. **If you are applying for an office permit, check the box below the address for which you are applying.** Please list any additional offices on a separate sheet and attach it to this application.

*NOTE: There **must** be an office permit in every office where you intend to administer anesthesia. If our records indicate you are practicing in an office location without an office permit, you must either apply for an office permit at that location **or** send us written notification that you will not be administering the applicable level of anesthesia in said location.*

 Office address _____ City _____ State _____ Zip _____ Telephone _____

- I am applying for an office permit for this location.

 Office address _____ City _____ State _____ Zip _____ Telephone _____

- I am applying for an office permit for this location.

 Office address _____ City _____ State _____ Zip _____ Telephone _____

- I am applying for an office permit for this location.

QUALIFICATIONS

Enclose a copy of documentation of completion of the formal post-doctoral training which qualifies you for a parenteral moderate sedation permit with your application. If your program was taken outside Louisiana, you must also enclose a **complete** outline of the course. Brochures are not sufficient.

RECORDS

1. Adequate medical history and physical evaluation update prior to each administration.
 - a. Name, age, sex, and weight;
 - b. ASA Risk Assignment (American Society of Anesthesiologists Classification);
 - c. Rationale for the sedation/anesthesia of the patient;
 - d. Written informed consent of patient or guardian.
2. Parenteral moderate sedation records will include the following:
 - a. Baseline vital signs. If obtaining vital signs is prevented by the patient’s physical resistance or emotional condition, the reason or reasons must be documented;
 - b. Intermittent quantitative monitoring of oxygen saturation, partial pressure of carbon dioxide, heart and respiratory rate, blood pressure and ECG as appropriate for specific techniques;
 - c. IV site, drug amounts and time or times administered, including local and inhalation anesthetics;
 - d. Proper maintenance of drug log;
 - e. Length of procedure;
 - f. Any complications;
 - g. Statement of patient’s condition at time of discharge.

*PER R.S. 37:792 E (1) ALL ANESTHESIA INCIDENTS RESULTING IN MORTALITY, OR TEMPORARY OR PERMANENT PHYSICAL OR MENTAL INJURY TO A PATIENT REQUIRING HOSPITALIZATION OF THE PATIENT DURING OR AS A RESULT OF ANY TYPE OF ANESTHESIA MUST BE REPORTED TO THE BOARD WITHIN TEN DAYS.

FACILITIES, PERSONNEL, AND EQUIPMENT

By your signature and completion of this application you are certifying that any location where you administer parenteral moderate sedation meets the board’s requirements set forth in regulations.

INFORMATION AUTHORIZATION

I hereby authorize release of any information requested by the Louisiana State Board of Dentistry.

DATE _____ LICENSEE SIGNATURE _____

ACKNOWLEDGMENT

BEFORE ME _____, **Notary Public**, duly commissioned and qualified within and for the state of Louisiana, Parish of _____.

PERSONALLY CAME AND APPEARED, _____(applicant/affiant), who declared and acknowledged to me, Notary, under oath, after being by me duly sworn, that affiant swears that all information provided in this application is correct and true, and in the case of affiant’s application for an office permit that affiant has or will have the equipment required for the administration of anesthesia/analgesia pertaining to the requested permit(s) on location wherein said permit is requested.

AFFIANT/APPLICANT’S SIGNATURE

SWORN TO AND SUBSCRIBED BEFORE ME, this _____ day of _____, 20 _____

NOTARY PUBLIC