NOTE: In order for your application to be considered complete, all applicants MUST also submit a copy of the following documents:

1. ☐ Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation);
2. ☐ Citizenship, lawful permanent residence, and/or immigration status Information: You must submit a **copy** of at least one of the following documents:
   (1) A U.S. Passport (unexpired or expired);
   (2) A birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal;
   (3) An American Indian Card (I-872);
   (4) A Certificate of Naturalization (N-550 or N-570);
   (5) A Certificate of Citizenship (N-560 or N-561);
   (6) Certification of Report of Birth (DS-1350);
   (7) A Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240);
   (8) Certification of Birth Abroad (FS-545 or DS-1350);
   (9) A United States Citizen Identification Card (I-197 or I-179);
   (10) A Northern Mariana Card (I-873);
   (11) An Alien Registration Receipt Card (Form I-551, otherwise known as a "Green Card");
   (12) An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
   (13) A document showing an Alien Registration Number ("A#") with Visa Status; or
   (14) A Form I-94 (Arrival-Departure Record) with Visa Status;
3. ☐ Education: You must submit an official school/college/university two day training certificate;
4. ☐ Conviction Information: If you have been convicted of a felony or misdemeanor, you must submit:
   (1) A copy of the court record, which includes charges and disposition;
   (2) Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
   (3) All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
   (4) A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation;
5. ☐ Disciplinary Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition; and
6. ☐ Fee: The required fee.

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

This form may be completed online and mailed to the address listed below.

DHHS
NEBRASKA

APPLICATION FOR A PERMIT TO ADMINISTER INHALATION ANALGESIA
(Please print or type application)

_____

Date: _____

DHHS - Licensure Unit
P.O. Box 94986
Lincoln NE 68509-4986
Telephone #: 402-471-2118

Fee $200.00

SECTION A – PERSONAL INFORMATION (All applicants must complete this section) **This section is public information and will be displayed on the INTERNET** http://www.nebraska.gov/LISSearch/search.cgi ***Items 1-2 are displayed on the Internet.***

NOTE: To expedite notification of any pending requirements, the notification will sent to the e-mail address or mailing address you provide. If you change your address, you must advise this office.

1	Legal Name	First:	Middle/MI:	Last:	
	Maiden Name	Name:	Other Names you are known as (AKA):		
2	Mailing Address	Street/PO/Route:			
		City:	State or Country:	Zip:	
3	Date of Birth:	Month/Day/Year:	Place of Birth:	City/State or Country:	
4	Check the Appropriate Box(s):	☐ Social Security Number (SSN); ☐ Alien Registration Number ("A#"); or ☐ Form I-94 (Arrival-Departure Record) number: ***If you have both a SSN and an A# or I-94 number, you must report both.***	SSN#: A#: I-94 #:		
	Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.				
5	Phone #:		Fax #: (optional)		
6	E-Mail Address:				
7	Nebraska Dental License Number:				

SECTION B – Office Address Where Inhalation Analgesia will be Administered (All applicants must complete this section) Applicants will need separate permits for each location where administration will take place.

Office Address:	Street/PO/Route:		
	City:	State:	Zip:

SECTION C –LICENSURE INFORMATION (All applicants must complete this section) Direct source verification/certification of any dental license that you hold or have held is required. You will need to request that each state or jurisdiction sends a verification/certification of your license directly to our office.

License Number	State	Issue Date	Expiration Date

SECTION E – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

- If you have any criminal charges or license disciplinary actions pending that results in conviction or license discipline, you are required to report such actions to the Investigative Unit within 30 days http://www.dhhs.ne.gov/reg/investi.htm or by telephone at 402-471-0175.

Answer each of the following questions by placing a (✓) in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation and you may attach a separate page if needed.

The following questions relate to any credential that you hold or have held in health services, health-related services or environmental services in another jurisdiction.			
1	Have you ever had any disciplinary or adverse action imposed against a professional license or permit in any state or jurisdiction?	YES	NO
2	Have you ever voluntarily surrendered or voluntarily limited in any way a license or permit issued to you by a licensing or disciplinary authority?	YES	NO
3	Have you ever been requested to appear before any licensing agency?	YES	NO
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	YES	NO
5	Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your license or permit in any jurisdiction?	YES	NO
6	Have you ever been asked to and/or permitted to withdraw an application for licensure or permit with any Board or jurisdiction?	YES	NO

7	Has any state or jurisdiction refused to issue, refused to renew or denied you a license or permit to practice?	YES	NO
8	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	YES	NO
9	Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	YES	NO
10	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	YES	NO
11	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	YES	NO
12	Have you ever been restricted, suspended, terminated, requested to voluntarily resign, place on probation, counseled, received a warning or been subject to any remedial or disciplinary action during dental school or postgraduate training?	YES	NO
13	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	YES	NO
14	Have you ever been requested to voluntarily resign or suspend hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other dental related employment?	YES	NO
15	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	YES	NO
16	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	YES	NO
17	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	YES	NO
18	Have you ever been convicted of a felony? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES	NO
19	Have you ever been convicted of a misdemeanor? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES	NO
20	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	YES	NO
21	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	YES	NO
22	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	YES	NO
23	Have you ever surrendered your state or federal controlled substances registration?	YES	NO
24	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	YES	NO
25	Have you ever been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	YES	NO
26	Are you aware of any professional liability claims currently pending against you?	YES	NO

PLEASE NOTE: There is a separate application for anesthesia permits are available on our website at the following address:

Separate anesthesia permits are required at each location you will be administering anesthesia.

SECTION D – EDUCATIONAL OR EXPERIMENTAL QUALIFICATIONS TO ADMINISTER INHALATION ANALGESIA - To be filled out by applicants that wish to administer inhalation analgesia.

- ☐ I completed an approved two-day training course or equivalent training in administration of inhalation analgesia which was acquired while studying at an accredited school/college of dentistry.
  - ☐ I have submitted the required affidavit completed by the school/college which sponsored the two-day training course. (Attachment A)
- ☐ I am a licensed Nebraska dentist who administered inhalation analgesia in a competent and efficient manner for 12 months preceding October 1, 1988.
  - ☐ I have submitted the required letter of verification by a dentist with personal knowledge that you had been administering inhalation analgesia for 12 months immediately preceding October 1, 1988. (Attachment B)
  - ☐ I have submitted an affidavit which states that no incident occurred within the three years immediately preceding October 1, 1988 (Attachment C); or
  - ☐ I have submitted an affidavit for each incident of death, physical, or mental injury requiring hospitalization of a patient that occurred within the three years immediately preceding October 1, 1988 (Attachment D).

AND

- ☐ I have submitted a copy of a current certification in basic life support from the American Red Cross or the American Heart Association or the equivalent. **(REQUIRED)**

SECTION F – QUESTIONS ABOUT THE OFFICE WHERE INHALATION ANALGESIA WILL BE ADMINISTERED. – Individuals wishing to administer inhalation analgesia must answer the following questions. Please explain any NO answers.

Operating Room	**Yes**	**No**
1. Is operating room large enough to adequately accommodate the patient on a table or in an operating chair?	☐	☐
2. Does the operating room permit an operating team of at least two individuals to freely move about the patient?	☐	☐
Suction Equipment	**Yes**	**No**
1. Does suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
Oxygen Delivery System	**Yes**	**No**
1. Does oxygen delivery system have full-face masks and connectors?	☐	☐
2. Is it capable of delivering 100% oxygen to the patient under positive pressure?	☐	☐
3. Is there a backup oxygen delivery system available?	☐	☐

Nitrous Oxide Delivery System	Yes	No
1. Does the nitrous oxide delivery system have connectors?	☐	☐
2. Is it capable of delivering nitrous oxide with oxygen to a patient within 0% to 80% output range?	☐	☐
Recovery Area (Recovery area can be the operating room)	**Yes**	**No**
1. Does recovery area have oxygen available	☐	☐
2. Does recovery area have suction available?	☐	☐
3. Does recovery area have lighting?	☐	☐
4. Does recovery area have available electrical outlets?	☐	☐
5. Can the patient be observed by a member of the staff at all times during the recovery period?	☐	☐
Ancillary Equipment	**Yes**	**No**
1. Are there oral pharyngeal airway(s)?	☐	☐
2. Is there a sphygmomanometer?	☐	☐
3. Is there a stethoscope?	☐	☐
RECORDS – ARE THE FOLLOWING RECORDS MAINTAINED?	**Yes**	**No**
1. A medical history of the patient prior to the administration of inhalation analgesia and physical evaluation records?	☐	☐
2. Inhalation analgesia records listing any complications of inhalation analgesia?	☐	☐
3. Inhalation analgesia records listing the name(s) of those assisting the dentist?	☐	☐
4. Inhalation analgesia records verifying that the dentist and any person who assists the dentist in the administration of inhalation analgesia has a current certification in basic life support?	☐	☐
DRUGS WITH CURRENT DATES AVAILABLE FOR TREATMENT OF MEDICAL EMERGENCIES	**Yes**	**No**
1. Do you have drugs available for the treatment of medical emergencies?	☐	☐

SECTION G – PRACTICE PRIOR TO CREDENTIAL

An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have administered inhalation analgesia in Nebraska prior to being issued a permit?	YES	NO
2	If yes, what are the actual number of days you administered inhalation analgesia in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____	
		Name of Business:	
		City:	
		Telephone #:	

SECTION H - ATTESTATION

Lawful Presence in the United States Attestation:

For the purpose of complying with Neb. Rev. Stat. §38-129, I attest as follows:

Please check the appropriate box below:

- ☐ I am a citizen of the United States.
- ☐ I am an alien lawfully admitted into the United States who is eligible for a credential under the Uniform Credentialing Act.
- ☐ I am a non immigrant whose visa for entry, or application for visa for entry, is related to such employment in the United States.

If you are not a citizen of the United States, complete the following:

For the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, I attest as follows:

- ☐ I am a qualified alien under the Federal Immigration and Nationality Act. My immigration and alien number are as follows: _____ and I agree to provide a copy of my USCIS.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete;
3. I am of good character; and
4. I have not committed any act that would be grounds for denial under Neb. Rev. Stat. §§38-178 and/or 38-179. If you have committed an act(s), you must provide an explanation of all such act(s).

Print Name: _____

Signature: _____ Date: _____

AFFIDAVIT FOR CERTIFICATION OF A TWO-DAY TRAINING COURSE ON THE ADMINISTRATION OF INHALATION ANALGESIA
Attachment A

All applications must complete #1

1. I, _____, being first duly sworn say that I
(Print Name)

am the person referred to in this affidavit and that I have completed a two-day training course or its equivalent on the administration of inhalation analgesia.

_____
(Legal Signature of Applicant)

_____
(Month-Day-Year)

****

This section must be completed by instructional facility where you received your education.

2. This is to certify that _____ has completed a two-day
(Name of Applicant)

training course or its equivalent on the administration of inhalation analgesia at

_____ from_____
(Name of Facility) (Month-Day-Year)

to _____.
(Month-Day-Year)

_____
(Date signed, Month-Day-Year)

_____
(Signature of Dean/Authorized person) (No stamp)

NAME AND ADDRESS OF INSTITUTIONAL FACILITY

_____
(Type or printed name and title)

_____
(Address)

(SCHOOL SEAL)

_____
(City) (State) (Zip)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986

LETTER OF VERIFICATION
ANALGESIA ADMINISTRATION
PRIOR TO OCTOBER 1, 1988
Attachment B

All applicants must complete #1

1. I, _____, being first duly sworn say that I am the
(Print Name)
person referred to in the affidavit and that I administered inhalation analgesia in a competent and efficient manner for 12 months immediately preceding October 1, 1988.

_____
(Legal Signature of Applicant)

_____
(Month-Day-Year)

****

This section must be completed by a dentist with personal knowledge of the applicant's practice activities during the 12 months immediately preceding October 1, 1988.

2. This is to certify that I have personal knowledge of the practice activities of

_____ during the 12 months immediately preceding
(Named of Applicant)
October 1, 1988 and I certify that s/he administered inhalation analgesia in a competent and efficient manner for 12 months immediately preceding October 1, 1988.

_____ _____
(Print Name of Certifying Dentist) (Certifying Dentist license Number)

_____ _____
(Legal Signature of Certifying Dentist) (Month-Day-Year)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986

AFFIDAVIT OF NO INCIDENT
Attachment C

I, _____, certify that in the three years immediately
(Name of Applicant)

preceding October 1, 1988 during my administration of inhalation analgesia at an outpatient dental facility, I have not had an incident which resulted in the death or physical or mental injury requiring hospitalization of a patient.

_____
(Legal Signature of Applicant)

_____
(Month-Day-Year)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986

INCIDENT REPORT
Attachment D

Name of Dentist _____ License No. _____

Address _____
Street City State Zip

Name of Patient _____

Address _____
Street City State Zip

Description of dental procedure _____

_____

Description of preoperative physical condition of the patient _____

_____

	Name	Dosage
Drugs	_____	_____
	_____	_____
	_____	_____

Techniques used in administering drugs (please explain) _____

_____

Description of incident (be sure to include symptoms of any complications, the symptoms at onset and

Type of symptoms in the patient) _____

_____

Description of the treatment instituted _____

_____

Description of patients response to the treatment _____

_____

Description of the patient's condition on termination of any procedures undertaken _____

_____

PLEASE ATTACH A COPY OF THE PATIENT'S HEALTH AND DENTAL HISTORY.

OVER

I, _____, depose and say that I am the person named
(Name of Applicant)

submitting this report of an incident which resulted in death or physical or mental injury requiring hospitalization of a patient during administration of _____

that occurred within the last three years that I have completed the above incident report; and that the information I provided is true and correct to the best of my knowledge and belief.

_____
(Legal Signature of Applicant)

_____
(Type or print name of applicant)

_____
(Date Signed, Month-Day-Year)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986