**APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT**

# GEORGIA BOARD OF DENTISTRY

**2 Peachtree Street, N.W.**
**6th Floor**
**Atlanta, Georgia 30303**
**www.gbd.georgia.gov**

Please read the instructions carefully and be familiar with the **laws and rules** governing the practice of dentistry in the State of Georgia. Visit the following web site for information: **www.gbd.georgia.gov**

****Important****

**The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board.**

**Please review this application before you submit it to ensure that all information and documentation is complete and correct.**

**Incomplete applications are maintained in the Board office for a period of one (1) year. After such time the application is rendered void and the applicant must re-apply and pay all required fees.**

## Application Checklist

**The following checklist is an important part of your application. Please use this checklist to ensure that you submit a COMPLETE application.**

**The $300 non-refundable application fee payable by check or money order to the Georgia Board of Dentistry must be included with your application.**
**Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. § 16-9-20.**

1. **GENERAL INFORMATION: Permits are not transferable between offices.** You MUST have a permit for each office in which you will be administering Deep Sedation/General Anesthesia.

2. **COMPLETED APPLICATION**: The completed application form must be accompanied by a **non-refundable application** fee. **NOTE: The application fee includes one site evaluation.** If you list more than one facility on your application or if you request the inspection of an additional facility at a later date, you will be required to pay an additional non-refundable $300.00 site evaluation fee.

3. **ACLS/BCLS REQUIREMENT:** Deep sedation/general anesthesia permits require current certification in both BLS and ACLS or an appropriate equivalent emergency management course approved by the Board.

4. **NATIONAL PRACTITIONER DATA BANK:** Please obtain an updated self-query from the NPDB-HIPDB by visiting www.npdb.hrsa.gov or call the Customer Service Center at 1-800-767-6732.

5. **MALPRACTICE QUESTIONNAIRE:** Complete one for each suit and attach the necessary documentation. (If not applicable, write N/A on the form sign, date, and return with application).

6. **DEEP SEDATION/GENERAL ANESTHESIA PERMITS:** Applicants for deep sedation/general anesthesia must meet all the requirements of O.C.G.A. § 43-11-21.1 and Board Rule 150-13-.02.

7. **REQUIRED INSPECTION:** A board designated examiner will contact the applicant in order to schedule a facility examination and demonstration by the applicant of proficiency in administering deep sedation/general anesthesia in accordance with O.C.G.A. 43-11-21(b) and 43-11-21.1(b) respectively.

8. **RENEWAL & PROVISIONAL PERMITS:** If a permit is granted, the permit will be required to be renewed by the last day of December in ODD numbered years, regardless of when you were issued the permit. Provisional permits are valid for six (6) months and **MAY** be renewed once upon your request and at the discretion of the board prior to the expiration date.

**Applications cannot be processed until all requirements set forth in the Laws and Rules governing Deep Sedation/General Anesthesia have been met.**

## CHECK LIST FOR ITEMS TO ACCOMPANY APPLICATION

Enclosed

_____ Copy of current ACLS and/or PALS card

_____ Copies of current Healthcare Provider CPR cards for dentist and all support personnel (minimum of two support personnel)

_____ Malpractice Questionnaire

_____ National Practitioner Data Bank Query

_____ Application fee

For new applications

_____ Certificates of completion of advanced training, Board certificates, and/or letter of certification from program director or course director as outlined in the application under the headings for each permit type

If your training was over two years ago: (_____ Check here if not applicable)

_____ Submit evidence of current competency, i.e., a current permit from another agency, or a letter certifying current competency from an institution or supervising individual

_____ Submit copies of all sedation CE taken in the last six years or since completion training

**Please carefully read the requirements contained in the application. All pages of the application must be filled out and returned with the above items for the application to be considered complete. Please complete and return this check list indicating all necessary documents are attached.**

_____ _____

**Applicant Signature** **Date**

# Georgia Board of Dentistry

2 Peachtree Street, N.W., 6th Floor
Atlanta, GA 30303

(404) 651-8000 www.gbd.georgia.gov

**Do Not Write in this Section:**
**Receipt#:** _____
**Amount:** _____
**Applicant#:** _____
**Initials/Date:** _____

## APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA

**Application Fee $300. (non-refundable)**

**Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A. § 16-9-20.**

**License Type:** Deep Sedation/General Anesthesia

**Name** as desired on Permit _____
First Middle Last

_____D.M.D. _____D.D.S

Name as shown on exam records or transcripts
(if different) _____
First Middle Last

_____ _____
**Social Security Number** **Date of Birth**

**Physical Address** _____
Number and Street Apt. No City/State Zip
***P.O. Box not acceptable***

**Mailing Address** _____
(if different) Number and Street Apt. No City/State Zip

_____ _____ _____
Telephone Number Day Telephone Number Evening **FAX** Number

Georgia License No: _____

**E-Mail Address** (required) _____
Your e-mail is not public information and will not be shared with third parties.

**Affiliation:**
Name of Practice

_____

**Physical Address**_____
Number and Street Apt No City/State Zip
*P.O. Box not acceptable*

**Mailing Address** _____
(If different) Number and Street Apt No City/State Zip

Office Address of Facility applying for evaluation:
(If different from mailing address)

_____

_____

SECONDARY OFFICE(S) ADDRESS(S): (Must Be Evaluated/add'l $300.00 fee per site) / PHONE #

(1) _____ / _____

(2) _____ / _____

(3) _____ / _____

(4) _____ / _____

***If you are applying for more than one location, please include a written statement addressing how you will handle post operative issues/complications, including how patients will be able to contact you about post operative issues/complications, your anticipated response time to those patients, and the physical location(s) where you would anticipate seeing those patients, if necessary. Please also address how patients will be notified of how post operative issues/complications will be handled.**

I hereby certify that I have a properly equipped facility for the administration deep sedation/general anesthesia and it is staffed with a supervised team of certified auxiliary personnel. (In accordance with the Laws and Rules of the State of Georgia with respect to the practice of dentistry.) :

**( ) YES ( ) NO**

**I certify that all of the following equipment and supplies are present at each facility for which I am applying:**

( ) equipment capable of delivering positive pressure oxygen ventilation including ancillary airway devices
( ) pulse oximeter
( ) suction equipment
( ) operating table or chair that allows for patient positioning to maintain airway
( ) firm platform for CPR
( ) fail-safe nitrous oxide/oxygen inhalation system, **if used**
( ) equipment necessary to establish intravascular access
( ) equipment to continuously monitor blood pressure and heart rate
( ) defibrillator (AED or manual)
( ) emergency drugs per ACLS or PALS protocol
( ) **if a separate recovery area,** oxygen and suction are available
( ) support personnel have current certification in BLS. **Submit copies of cards.**

**If you answer yes to any of the following questions, attach a full written explanation pertaining to each positive response.**

Have you ever been arrested, convicted, sentenced, pled guilty or given first offender status for any felony, misdemeanor or any offense other than a minor traffic violation? DWI or DUI are not minor traffic violations? **( ) YES ( ) NO**

Have you undergone treatment for drug or alcohol use? **( ) YES ( ) NO**

Has any disciplinary action been taken against you by any state board, or any regulatory board? **( ) YES ( ) NO**

Have you had any patient require hospitalization or medical attention, or have you had any patient deaths in the office? **( ) YES ( ) NO**

Have you ever had any malpractice suits filed against you? **( ) YES ( ) NO**

Are there any other facts not disclosed by your answers which may have a bearing on your fitness or eligibility to practice dentistry in Georgia and which should be placed at the disposal or brought to the attention of the State Board of Dentistry? **( ) YES ( ) NO**

**ANESTHESIA MONITOR ATTESTATION FORM**

( ) I understand that all monitoring equipment is site specific and may not be transported between locations.

Anesthesia monitor(s) for this location *(you may make additional copies as necessary)*:

Manufacturer_____

Serial Number_____

Model Number_____

Functions performed (circle)

a. Pulse oximetry
b. Blood pressure
c. ECG
d. Capnography

_____
Number and Street

_____
City/State Zip

Telephone: ( )_____ Fax: ( )_____

Anesthesia monitor(s) for this location *(you may make additional copies as necessary)*:

Manufacturer_____

Serial Number_____

Model Number_____

Functions performed (circle)

a. Pulse oximetry
b. Blood pressure
c. ECG
d. Capnography

_____
Number and Street

_____
City/State Zip

Telephone: ( )_____ Fax: ( )_____

I hereby certify that each piece of anesthesia monitoring equipment is dedicated to one site and the above serial numbers, model numbers and dates of inspection are accurate to the best of my records. This equipment is evaluated on a scheduled basis and has been calibrated for the safe administration of general anesthesia/deep sedation and/or conscious sedation. (This is in accordance with the Laws and Rules of the State of Georgia with respect to the practice of dentistry).

_____ _____
Print Name / Date Signature

## PLEASE READ CAREFULLY.

ALL APPLICANTS MUST SUBMIT WITH THIS APPLICATION PROOF OF SUCCESSFUL COMPLETION OF THE EDUCATIONAL REQUIREMENTS AND DOCUMENTATION OF ALL APPLICABLE REQUIREMENTS AS SPECIFIED.

DEEP SEDATION/GENERAL ANESTHESIA: I hereby qualify under one of the following:

**(Check all that apply and submit appropriate certificates. If your certificates of training were issued over two years ago, you must submit evidence of current competency, i.e., a current general anesthesia permit issued by another agency, or a letter certifying current competency from an institution or supervising individual; and submit all anesthesia CE taken in the last six years or since completion of training.)**

( ) I have completed a minimum of one year of advanced training, in Anesthesiology and related academic subjects beyond the undergraduate dental school level at an institution accredited by the American Dental Association, the Joint Commission on Accreditation of Hospitals, or their respective successor agencies.

( ) I am a Diplomate of The American Board of Oral and Maxillofacial Surgery.

( ) I am a member of The American Association of Oral and Maxillofacial Surgery.

( ) I have successfully completed an accredited OMS residency.

( ) I am a Fellow of The American Dental Society of Anesthesiology.

( ) I am a Diplomate of The National Dental Board of Anesthesiology.

Dental school attended _____

Year of graduation _____

POSTDOCTORAL PROGRAMS:

Name of accredited institution: _____

Type of program: _____

Program Director: _____

Dates of training: _____

CONTINUING EDUCATION COURSES:

Name of course and sponsoring organization: _____

_____

Course Director: _____

Dates attended: _____

Type of agents used and route of administration:

| | Type of Agents Used | Route of Administration |
|---|---|---|
| (a) Children | | |
| | | |
| | | |
| (b) Adults | | |
| | | |
| | | |

# GEORGIA BOARD OF DENTISTRY

**2 Peachtree Street, N.W.**
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**Atlanta, Georgia 30303**

## CONSENT FORM

I hereby authorize the Georgia Board of Dentistry ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____
Full Name (Print)

_____
Physical Address (P.O. Boxes NOT Accepted)

_____
City, State, Zip

_____ _____ _____ _____
Sex Race Date of Birth Social Security Number

**One of the following must be checked:**

- ☐ This authorization is valid for 90/180/___ (circle one) days from date of signature.
- ☐ I, _____ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

_____ _____
Signature of Applicant Date

**AFFIDAVIT OF APPLICANT:**

I hereby certify that I am the person who executed this application for a permit to employ or use deep sedation/general anesthesia in the practice of dentistry in the State of Georgia. All statements herein contained are true in every respect, and I hereby swear, if I am granted a permit to employ or use deep sedation/general anesthesia in the practice of dentistry in the State of Georgia in compliance with all its dental laws, I will faithfully serve humanity and refrain from anything in any manner which does not conform to the statutes and regulations which govern the practice of dentistry in the State of Georgia.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____I am a United States citizen 18 years of age or older. **Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or other document as indicated on the last two pages of the application.**

**2**) _____I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. **Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.**

I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation of my employment record and other information that may be necessary to verify my qualifications to practice. I understand that any final disciplinary action that may ever be taken against my license, if it is granted, would be provided to a national disciplinary reporting system and that my Social Security number would be a part of that report.

I further hereby certify that in the event I am granted a deep sedation/general anesthesia permit by the Georgia Board of Dentistry (hereinafter referred to as the "Board"), I agree to provide a thirty (30)-day advance notice to the Board should either or both of the following conditions occur:

(1) I implement a significant change in technique or agents for administering deep sedation/general anesthesia.

(2) If I relocate or open an additional facility where I will administer deep sedation/general anesthesia, I understand that all such facilities must be appropriately equipped with its own suction, physiologic monitoring equipment, positive pressure oxygen, emergency drugs, and equipment of administration of deep sedation/general anesthesia. All of the aforementioned items must be stationary and not subject to transfer from one site to another.

**SIGNATURE FOR AFFIDAVIT OF APPLICANT:**

_____

Signature of Applicant

**ATTACH RECENT PHOTOGRAPH**

( Passport Photo Size)

Please use glue or tape

Sworn to and subscribed before me this

_____ day of _____, _____.

_____

NOTARY PUBLIC

My Commission Expires: _____

**APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION.**

_____

**Name**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR §274a.2]

_____A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR §274a.2]

_____A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

_____A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

# MALPRACTICE QUESTIONNAIRE

_____

Name of Dentist/Dental Hygienist Business Telephone

_____

Address City, State, Zip

**MALPRACTICE CHARGES/ALLEGATIONS:** Include name of patient, age, sex, date of occurrence and location (include address).

_____

_____

_____

_____

_____

_____

List names of other dental hygienists and/or physicians:

_____

_____

_____

DISPOSITION: ☐ Pending ☐ Settled If settled, provide the following information:

Settlement Date_____

Total Settlement Amount_____

Amount Attributable to you: _____ ☐ In Court ☐ Out of Court

The Board requires that you furnish documentation of the above information directly from the insurance company or attorney to the above address. Such documentation should include plaintiff's complaint, settlement agreement, and/or court order.

_____ _____

Signature Date

COMPLETE ONE QUESTIONNAIRE ON EACH MALPRACTICE SUIT
YOU MAY DUPLICATE THIS FORM.

If not, applicable, please write (N/A), sign and return with completed application.