

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@state.pa.us
Website: www.dos.state.pa.us/dent

Courier Delivery Address:

STATE BOARD OF DENTISTRY
2601 NORTH THIRD STREET
HARRISBURG, PA 17110

APPLICATION FOR A RESTRICTED PERMIT I ADMINISTRATION OF CONSCIOUS SEDATION

REQUIREMENTS ARE AS FOLLOWS:

- 1) Please read and complete pages 1-2 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) Forward pages 1-2 to the Board office at the address listed above.
- 3) Please submit the application fee of \$100.00 by check or money order payable to the "Commonwealth of PA". Fees are non-refundable. A \$20.00 processing fee will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.
- 4) Education (Page 3) – Complete Section 1 and forward to the educational facility/hospital for completion of Section 2. The course instructor or other authorized person must complete Section 2, on page 3 of the application, certifying that you have completed an 60-hour course in conscious sedation on page 3 of the application. 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 3 of the application.

APPLICANT INFORMATION:

Name of Applicant: _____
Last First Middle

**Address: _____
Street

City State Zip Code

****Address must be the same as the address reflected on your dental license -
Otherwise a change of address form must also be submitted.**

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.state.pa.us/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 conscious sedation and/or nitrous oxide/oxygen analgesia in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Dentistry has issued you an Anesthesia Restricted Permit I 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) It is your responsibility to maintain a copy of this application and all documents submitted to the Board or received from the Board for your future reference.
- 5) All permits, regardless of the issuance date, will expire March 31st of the odd-numbered years and are subject to renewal. A renewal application will be sent in conjunction with your dental license renewal application.

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.

CERTIFICATION 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.

Additionally, I certify that the statements in this application are true and correct to the best of my knowledge, information and belief, and that I am of good moral character. 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 or revocation of my license, permit or certificate.

Signature of Applicant: _____ Date: _____

CERTIFICATION OF EDUCATION

SECTION 1 – Complete section 1 and forward to the educational institution.

Applicant's Name: _____
Last First Middle

Applicant's Address: _____
Street

City State Zip Code

SECTION 2 – To be completed by the Course Instructor or other authorized person. Form must be submitted directly to the State Board office from the educational facility/hospital in an official sealed envelope.

I CERTIFY THAT _____ SUCCESSFULLY COMPLETED A COURSE IN
Name of Applicant

CHECK ONE OF THE FOLLOWING:

_____ **CONSCIOUS SEDATION** COMPRISING OF AT LEAST 60 HOURS OF **UNDER-GRADUATE** DIDACTIC INSTRUCTION AND CLINICAL EXPERIENCE THAT CONFORMS TO PART I (FOR AN UNDER-GRADUATE PROGRAM) OF THE AMERICAN DENTAL ASSOCIATION'S "GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY".

_____ **CONSCIOUS SEDATION** COMPRISING OF AT LEAST 60 HOURS OF **POST-GRADUATE** DIDACTIC INSTRUCTION AND CLINICAL EXPERIENCE THAT CONFORMS TO PART III (FOR A POST-GRADUATE PROGRAM) OF THE AMERICAN DENTAL ASSOCIATION'S "GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF PAIN AND ANXIETY IN DENTISTRY".

Name of training facility: _____

Address of facility: _____
Street

City State Zip Code

Date Course Began

Date Course Ended

Signature

HOSPITAL/FACILITY

Title

SEAL

Date