

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 RESTRICTED PERMIT II ADMINISTRATION OF NITROUS OXIDE/OXYGEN ANALGESIA

REQUIREMENTS ARE AS FOLLOWS:

- 1) Attach a **\$15.00** check or money order made payable to the **“Commonwealth of PA”**. **DO NOT SEND CASH**. Fee is non-refundable. Note: A \$20.00 processing fee will be assessed for any payment returned by your bank, regardless of the reason for non-payment.
- 2) 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. Forward pages 1-2 along with the required application fee to the address above.
- 3) 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 certifying that you have completed a 14-hour course in nitrous oxide/oxygen analgesia 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.

PLEASE READ THE FOLLOWING INFORMATION:

- 1) You may **NOT** administer nitrous oxide/oxygen analgesia in the Commonwealth of Pennsylvania until the Pennsylvania State Board of Dentistry has issued a permit. You may verify a permit has been issued through our website at www.mylicense.state.pa.us.
- 2) 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. 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.

APPLICANT INFORMATION:

Name of Applicant: _____
Last First Middle

Address: _____
Street

City State Zip Code

Pennsylvania Dental License Number: _____

Telephone Number: _____ Email Address: _____

OFFICE / EQUIPMENT CERTIFICATION

1) Provide the make, model and serial number of any nitrous equipment utilized below:

a) Make: _____

b) Model: _____

c) Serial Number: _____

***If there is additional equipment, please provide additional information on a separate 8 1/2 x 11 sheet of paper.**

2) Is the equipment in proper working order?

YES NO

3) Is the equipment properly calibrated?

YES NO

4) Does the equipment contain a fail-safe system?

YES NO

5) Do you have written office procedures for administering nitrous oxide/oxygen analgesia and handling emergencies related to the administration of nitrous oxide/oxygen analgesia?

YES NO

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: _____

VERIFICATION 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:

_____ **NITROUS OXIDE/OXYGEN ANALGESIA** COMPRISING OF AT LEAST 14 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".

_____ **NITROUS OXIDE/OXYGEN ANALGESIA** COMPRISING OF AT LEAST 14 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

Title

Date

HOSPITAL/FACILITY

SEAL