**Wyoming State Board of Dental Examiners**
**1800 Carey Avenue 4th Floor**
**Cheyenne WY 82002**

# APPLICATION FOR PERMIT TO ADMINISTER LEVEL 3 PARENTERAL CONSCIOUS SEDATION, LEVEL 4 DEEP SEDATION, AND LEVEL 5 GENERAL ANESTHESIA

INSTRUCTIONS: This form must be **TYPED OR PRINTED**. If more space is required, attach additional sheets.

## IDENTIFYING INFORMATION

______________________________________________________________
Last Name First Name M.I. Birth Date

______________________________________________________________
License Number DEA Number

______________________________________________________________
Primary Office Address City State Zip Telephone

______________________________________________________________
Second Office Address City State Zip Telephone

______________________________________________________________
Home Address City State Zip Telephone

______________________________________________________________
Type of Practice

______________________________________________________________
Practicing with whom and nature of affiliation

## EDUCATION

Pre-Dental: ______________________________________________
Name of Institution Degree Dates

Dental School: ______________________________________________
Name of Institution Degree Dates

Other Degrees: ______________________________________________
Name of Institution Degree Dates

Internship: ______________________________________________
Name of Institution Degree Dates

Residency: ______________________________________________
Name of Institution Degree Dates

Certification: ______________________________________________
Specialty Board Dates

CHECK CATEGORIES OF TRAINING AND EDUCATION CRITERIA QUALIFYING YOU FOR PERMIT. (CREDENTIALS AND/OR SUBSTANTIATING DOCUMENTS MUST BE SENT DIRECTLY TO THE BOARD OFFICE FROM THE INSTITUTION OR ORGANIZATION.)

__________ (A) Proof that he is a licensed dentist who has documented experience at the graduate level, acceptable to the Board, specifying the type, the number of hours, the length of training and the number of patient contact hours, including documentation of the number of supervised enteral conscious sedation (Level 3) cases; or

__________ (B) Proof that he is a licensed dentist who has successfully completed a formal training program approved by the Board which includes a minimum of sixty hours of didactic instruction and ten cases of clinical experience involved with enteral conscious sedation (Level 3). The training program must include physical evaluation, enteral conscious sedation (Level 3), airway management monitoring, advanced cardiac life support and emergency management: or

__________ (C) Those licensed dentists who hold permits for parenteral conscious sedation, deep sedation, or general anesthesia may administer enteral conscious sedation (Level 3).

GIVE A RESUME OF YOUR LEVEL 3 PARENTERAL CONSCIOUS SEDATION, LEVEL 4 DEEP SEDATION AND LEVEL 5 GENERAL ANESTHESIA QUALIFICATIONS INCLUDING TRAINING AND EXPERIENCE.

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**ALL CURRENT AND PAST HOSPITAL AFFILIATIONS**

______________________________________________________________
Name and Location of Hospital Status Appointment Dates

______________________________________________________________
Name and Location of Hospital Status Appointment Dates

______________________________________________________________
Name and Location of Hospital Status Appointment Dates

**LICENSES HELD FROM OTHER STATES**

______________________________________________________________________
State License Number Date of Issue

______________________________________________________________________
State License Number Date of Issue

______________________________________________________________________
State License Number Date of Issue

List all instances of mortality or morbidity in connection with your use of Level 3 Parenteral Conscious Sedation, Level 4 Deep Sedation and Level 5 General Anesthesia including a detailed explanation of any such occurrence. Use a separate sheet if necessary.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**INFORMATION ABOUT YOUR OUTPATIENT FACILITY**

What anesthesia techniques do you employ? (Enteral Sedation, IV, N2 O, inhalation, etc.)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What major drugs do you employ relating to sedation:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

List drugs and equipment on hand in your office available for resuscitation of a patient: (Use a separate sheet if necessary).

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Your ACLS Certification: ________________________________________
Name of Course Date

ATTACH A SEPARATE SHEET LISTING NAMES OF AUXILIARIES AND DATES OF THEIR C.P.R. CERTIFICATION.

**PRACTICE HISTORY**

List in chronological order ending with most current. Include military.

_________________________________________________________________
Address Date

_________________________________________________________________
Address Date

_________________________________________________________________
Address Date

_________________________________________________________________
Address Date

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET.

Have you ever been suspended from staff membership or denied staff privileges by a hospital?

No______ Yes______

Have your hospital privileges ever been curtailed or revoked or has your application for any hospital privileges been denied?

No______ Yes______

Have you ever been denied membership or a renewal thereof or been subject to disciplinary proceedings in any dental organization or jurisdiction?

No______ Yes______

**CONTINUING DENTAL EDUCATION**

LIST ALL PROFESSIONAL MEETINGS, SEMINARS, ETC. ATTENDED IN THE PAST TWO YEARS.

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of approval. All information submitted by me in this application is true to my best knowledge and belief.

I have read the Wyoming State Dental Practice and promise to conduct myself in an ethical manner at all times. I further promise to abide by future policies that may be established by the Wyoming Board of Dental Examiners.

______________________ ______________________________

Date Signature of Applicant

**NOTE:** Enclose the following with application form:

1. Application fee in the amount of $500.00 in the form of a cashier's check or money order.
2. Photocopies of current ACLS certification for you and current C.P.R. certifications for your auxiliaries.

Documents and/or credentials substantiating items on Page 2 must be sent directly to the Board office from the institution or organization.

TO WHOM IT MAY CONCERN:

This is authorization for release of any information requested by the Wyoming State Board of Dental Examiners.

This information is to be held in strict confidence and is to be used only in the evaluation of the application and credentials for privileges requested herein.

______________________ ______________________________

Date Signature of Applicant