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STATE OF DELAWARE

BOARD OF DENTISTRY AND DENTAL HYGIENE

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APPLICATION FOR UNRESTRICTED PERMIT
General Anesthesia, Deep Sedation, and Conscious Sedation
INSTRUCTION SHEET

What Does an *Unrestricted Permit* Allow?

An Unrestricted Permit applies only to one office location where anesthesia is administered. The two types of Unrestricted Permits are *Individual* and *Facility*. **The type of permit selected determines who is allowed to administer anesthesia at that location, as follows:**

- An *Unrestricted Permit - Individual* allows the **dentist** to administer conscious sedation, general anesthesia and deep sedation, as defined by the Board's Rules and Regulations governing anesthesia, at the location. If you wish to employ a certified registered nurse anesthetist (CRNA) for deep sedation or general anesthesia at an office location, *you must also hold an Unrestricted Permit – Individual*.
- An *Unrestricted Permit-Facility* allows a **board-certified anesthesiologist**, who is employed by or working in conjunction with the dentist, to administer general anesthesia, deep sedation, and conscious sedation at the location. The board-certified anesthesiologist must have an active Delaware license, and must remain on the premises of the dental facility until any patient given a general anesthetic or deep sedation regains consciousness.

Important Information about Anesthesia

Before applying for a permit for sedation or anesthesia, it is imperative for you to thoroughly review Section 7.0 of the [Rules and Regulations](#) of the Delaware Board of Dentistry and Dental Hygiene. The Board's rules define conscious sedation (both via nitrous oxide inhalation and by the parenteral route), deep intravenous sedation and general anesthesia using definitions adapted from the American Dental Association (ADA). The educational requirements for deep sedation and general anesthesia are much more stringent than for conscious sedation. This distinction is important both from the standpoint of this permit application and from the standpoint of clinical practice.

- **Conscious Sedation:** a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command and that is produced by a pharmacologic or non-pharmacologic method or a combination thereof
- **General Anesthesia:** a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, and is produced by a pharmacologic or non-pharmacologic method or a combination thereof
- **Deep Sedation:** a controlled state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to verbal command, and is produced by a pharmacologic or non-pharmacologic method or combination thereof

Inspection Requirement

The Anesthesia Advisory Committee (AAC) must complete a satisfactory inspection of your office before a permit is issued. The AAC reviews applications and performs inspections under the Board's direction.

- Submit a separate application for **each location** where you will administer sedation or anesthesia.
- Submit your application for a permit only when the location is **ready** for AAC inspection.

Requirements for All Unrestricted Permit Applications

It is your responsibility to arrange for the Board office to receive all documents listed below. If clarification is needed, the Board may request more information or documents.

- Submit completed, signed and notarized [Application for Unrestricted Permit](#).
- Enclose the non-refundable [processing fee](#) by check or money order made payable to the "State of Delaware."
- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
 - The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

The additional documentation you must submit depends on whether you are applying for an Individual or Facility type.

Additional Requirements for Unrestricted Permit-Individual

If you are applying to administer the anesthesia yourself or wish to employ a CRNA to administer the anesthesia, the following additional requirements apply.

- Enclose a copy of your current Advanced Cardiac Life Support (ACLS) certification card.
- Submit documentation that you meet at least **one** of the following qualifications:
 - You have two years of advanced training in Anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry.
 - You are certified as a diplomat of the American Board of Oral and Maxillofacial Surgeons.
 - You have satisfactorily completed a residency in Oral and Maxillofacial Surgery at an institution approved by the ADA Council of Dental Education.
 - You are a fellow of the American Dental Society of Anesthesiology.

Additional Requirement for Unrestricted Permit-Facility

If you employ or work in conjunction with a board-certified, Delaware-licensed anesthesiologist to administer the anesthesia at the office location, the following additional requirement applies.

- Arrange for the Board to receive a letter *directly* from the individual anesthesiologist or anesthesiology practice stating that you are employing their services *and* attesting that they will remain on the premises of the dental facility until any patient given a general anesthetic or deep sedation regains consciousness.



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APPLICATION FOR UNRESTRICTED PERMIT
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TYPE OF PERMIT

1. Check the type of Unrestricted Permit you are applying for:

- Unrestricted Permit - Individual* – I will personally administer conscious sedation, general anesthesia and deep sedation. (Check this type if you will employ a certified registered nurse anesthetist (CRNA) to administer the anesthesia.)
- Unrestricted Permit-Facility* – I will employ or work in conjunction with a Delaware-licensed, board-certified anesthesiologist who will administer general anesthesia, deep sedation, and conscious sedation and who will remain on premises until any patient given a general anesthetic or deep sedation regains consciousness.

2. Enter your Delaware Dental License Number: **G1** - _____

An active Delaware Dentist license is required. If approved, your *Unrestricted Permit* will be mailed to the address on your Dentist license. You may change the *mailing* address for your Dentist license and permit(s) online at [Update Contact Information](#).

IDENTIFYING AND CONTACT INFORMATION

3. Dentist Name: _____
Last/Family Name First Middle Maiden

4. Other Name(s) Used: _____

5. Date of Birth (month/day/year): _____ Gender: Male Female

6. Have you been issued a U.S. Social Security Number? Yes No If yes, enter your SSN: _____
If no, you must file a [Request for Exemption from Social Security Number Requirement](#).

7. Phone: _____ Email: _____
Daytime Home

INFORMATION ABOUT LOCATION WHERE SEDATION/ANESTHESIA ADMINISTERED

8. Enter the following information about the **physical location** of the office where sedation/anesthesia will be administered:

Office Address: _____

City State Zip

An *Unrestricted Permit* is limited to one office location. If you will administer deep sedation or anesthesia at more than one office, submit a separate application for each location.

9. Answer each item to indicate whether the office has each of the following:

Operating theater large enough to adequately accommodate the patient on a table or in an operating chair and to permit an operating team of at least three persons to move freely about the patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Operating table or chair that allows the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, and provide a firm platform for management of cardiopulmonary resuscitation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery-powered and of sufficient intensity to safely conclude any procedure underway at the time of general power failure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Suction equipment that permits aspiration of the oral and pharyngeal cavities and a non-electric backup suction device?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recovery area (can be the operating theater) that has available oxygen, adequate lighting, suction and electrical outlets where a staff member can observe the patient throughout the recovery period?	Yes <input type="checkbox"/> No <input type="checkbox"/>

10. Answer each item to indicate whether the office has the following ancillary equipment:

Laryngoscope complete with adequate selection of blades and bulb?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Endotracheal tubes and appropriate connectors?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Oral and nasopharyngeal airways?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tonsillar or pharyngeal-type suction tip adaptable to all office outlets?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Endotracheal tube forcep?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sphygmomanometer and stethoscope?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Adequate equipment for establishment of an intravenous line?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Precordial stethoscope?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Electrocardioscope and pulse oximetry? Note: This is desirable but not always necessary.	Yes <input type="checkbox"/> No <input type="checkbox"/>

11. Answer each item to indicate whether you know how to treat the following emergencies and whether you have the armamentarium and appropriate drugs to manage these emergencies at this location:

Laryngospasm?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hypertension?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Syncope?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cardiac arrest?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bronchospasm?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergic reaction?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Angina pectoris?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Convulsions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Myocardial infarction?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emesis and aspiration of foreign materials under anesthesia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hypotension?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

12. Answer each item to indicate whether you maintain records in the following manner at this location:

Adequate medical history and physical evaluation records?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Adequate informed consent for surgery and anesthesia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Adequate anesthesia records which must include <i>all</i> of the following: <ul style="list-style-type: none"> • cardiovascular status (blood pressure and pulse) • respiratory status (respiratory rate or oxygen saturation status) • amount and routes of administered drugs • length of the procedure • any complications of anesthesia? 	Yes <input type="checkbox"/> No <input type="checkbox"/>

13. Is the office properly equipped to administer deep sedation, conscious sedation and general anesthesia? Yes No
14. Is the office properly staffed with a supervised team of auxiliary personnel capable of reasonably handling procedures, problems and emergencies related to deep sedation, conscious sedation and general anesthesia? Yes No
15. Is the office ready for inspection by the Anesthesia Advisory Committee? Yes No **If no, do NOT submit this application until your office is ready for inspection.**

QUALIFICATIONS – Complete this section only if you are applying for an *Unrestricted Permit – Individual*

16. Select the qualification on which you are basing this permit application.
- I have two years advanced training in Anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Part II of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. **Submit proof of training.**
 - I am certified as a diplomat of the American Board of Oral and Maxillofacial Surgeons. **Submit proof of your certification.**
 - I have satisfactorily completed a residency in Oral and Maxillofacial Surgery at an institution approved by the ADA Council of Dental Education. **Submit proof of completing your residency.**
 - I am a fellow of the American Dental Society of Anesthesiology. **Submit proof of fellowship.**
17. Are you currently certified in Advanced Cardiac Life Support (ACLS) as documented by the American Heart Association? Yes No

Enclose a copy of your current Advanced Cardiac Life Support (ACLS) certification card with this application.

ANESTHESIOLOGIST– Complete this section only if you are applying for an *Unrestricted Permit – Facility*

18. Enter the following information about the Board-certified anesthesiologist or anesthesiology practice whom you employ or with whom you will work in conjunction.

Full Name of Anesthesiologist: _____

Delaware License Number: C ____ - _____

Name of Anesthesiology Practice: _____

Arrange for the Board to receive a letter *directly* from the individual anesthesiologist or anesthesiology practice stating that you are employing their services and attesting that they will remain on the premises of the dental facility until any patient given a general anesthetic or deep sedation regains consciousness.

DISCLOSURES AND DUTY TO REPORT

19. Have you engaged in the illegal use of controlled dangerous substances within the past two years? Yes No If yes, continue to Question 20. If no, skip to Question 21.
20. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes No **If yes, explain fully:** _____
21. Have you ever been denied a DEA (Narcotic) registration number? Yes No Current DEA # _____ **If yes, submit a letter explaining fully.**
22. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes No **If yes, submit a complete explanation and a certified copy of your criminal history record from any jurisdiction in which you have been convicted or pardoned. For information on obtaining a Delaware criminal history record, see [State Bureau of Identification](#).**

23. Are any criminal charges pending against you? Yes No **If yes, enclose a complete explanation and any documentation related to the charges.**
24. Have you ever had your professional license subject to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes No **If yes, submit an official Board order or other documents describing the disciplinary action.**
25. Has any jurisdiction rejected your application or revoked your professional license? Yes No **If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.**
26. Have you had any malpractice actions brought against you in the past five years? Yes No **If yes, submit a list of all such actions. Include dates, disposition and amount of awards or settlements, if any.**
27. Are any complaints currently pending against you? Yes No **If yes, submit a letter explaining fully. Include copies of all official documents or Board orders.**
28. To obtain a permit in Delaware, you must certify that you understand that you have a **mandatory** obligation to report to the Board within 30 days any mortality or other incident occurring in your dental facility that results in temporary or permanent physical or mental injury requiring hospitalization of a patient during, or as a direct result of, conscious sedation, deep sedation or general anesthesia.

I certify that I have read and understand Section 7.5 of the [Rules and Regulations](#) listed above, and that I understand my *duty to report* adverse occurrences. Yes No

To assure consideration of your permit application, the Board office must receive all of these items:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six months of filing may be considered abandoned and discarded. When your application is complete, please allow 4-6 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for an *Unrestricted Permit* by the Board of Dentistry and Dental Hygiene under the standards, qualifications and procedures established under Title 24, Chapter 11, of the *Delaware Code*. I have read the State statute governing the practice of dentistry and dental hygiene in Delaware. I have also received and read the Board's Rules and Regulations regarding anesthesia in Delaware. I understand that the Board may require evidence additional to the material herein.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the office of the Attorney General.

APPLICANT SIGNATURE: _____ Date: _____

County of _____ State of _____

Sworn or affirmed before me a Notary Public this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.