MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 100, 600 East Amite Street ● Jackson, Mississippi 39201-2801 ● (601) 944-9622 ● www.msbde.state.ms.us

M E M O R A N D U M

TO: **APPLICANTS FOR A PARENTERAL CONSCIOUS SEDATION PERMIT**

FROM: **CHRIS L. HUTCHINSON, EXECUTIVE DIRECTOR**

SUBJECT: **INSTRUCTIONS**

IMPORTANT INFORMATION
PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION FORM

Enclosed is an application for a permit to administer Parenteral Conscious Sedation (includes Enteral Conscious Sedation) on an outpatient basis. Please complete the items that apply to you. If an item is not applicable to you, please type "N/A" in the blank. **ALL QUESTIONS MUST BE ANSWERED.**

The completed application should be returned by certified mail, return receipt requested to:

Mississippi State Board of Dental Examiners
Suite 100, 600 East Amite Street
Jackson, MS 39201-2801

Application fee in the amount of $300.00 and photocopies of current ACLS certification for you and CPR certification for your auxiliaries should accompany the application.

Certification from the program in which you received your post-graduate training in the administration of Parenteral Conscious Sedation must be sent from the institution directly to the Board office. Certification should specify the type, the number of hours and the length of training; and the number of didactic hours and the number of patient contact hours.

Upon receipt of your application, the Board office will contact you to schedule an on-site visit.

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APPLICATION FOR PERMIT TO ADMINISTER PARENTERAL CONSCIOUS SEDATION ON AN OUTPATIENT BASIS

DATE _____

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

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Birth Date
License No.	Specialty License No.	D.E.A. No.	

Primary Office Street Address	City	State	Zip	Telephone
Second Office Street Address	City	State	Zip	Telephone
Home Street Address	City	State	Zip	Telephone

Type of Practice

Practicing with Whom and Nature of Affiliation

EDUCATION

	Name of Institution	Degree	Dates
Pre-Dental			
Dental School			
Other Degrees:			

	Name of Institution	Type	Dates
Internship:			

	Name of Institution	Dates
Residency:		

	Specialty Board	Dates
Certification:		

GIVE FULL DETAILS OF ALL POST-GRADUATE TRAINING

Dates of Attendance of Post-Graduate_____ or Graduate_____ Training. Total months_____

Name of Director or Program_____

Name and Address of School, Sponsoring Agency, or Group:

_____

_____

Was a Degree or Certificate Awarded?_____ Date Awarded _____

Number of Hours in Program Specifically Devoted to: Didactic_____ Patient Contact _____

Was Outpatient Parenteral Conscious Sedation Specifically Emphasized in Your Training?_____

Name and Address of Director or Chairman of Department of Anesthesiology Where Training Was Taken:

_____

_____

LICENSES HELD FROM OTHER STATES

State	License No.	Date of Issue
State	License No.	Date of Issue
State	License No.	Date of Issue

LIST FELLOWSHIP OR MEMBERSHIP IN SPECIALTY COLLEGE OR ACADEMY

_____

_____

INFORMATION ABOUT YOUR OUTPATIENT FACILITY

What Anesthetic Techniques Do You Employ? (I.V., N2 O, Inhalation, Etc.) Give details.

_____

_____

_____

_____

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 Separate Sheet if Necessary):

Your ACLS Certification _____
Name of Course Date

ATTACH A SEPARATE SHEET LISTING NAMES OF AUXILIARIES AND DATES OF THEIR CPR CERTIFICATION.

PRACTICE HISTORY

List in Chronological Order Ending with Most Current (Include Military):

Address Date

Address Date

Address Date

Address Date

LIST 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
Name and Location of Hospital	Status	Appointment Dates

CONTINUING DENTAL EDUCATION

List on a Separate Sheet All Professional Meetings, Seminars, Etc. Attended in the Past Two (2) Years.

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 _____

List All Instances of Mortality or Morbidity in Connection with Your Use of Parenteral Conscious Sedation or Enteral Conscious Sedation, Including a Detailed Explanation of Any Such Occurrence. Use a Separate Sheet if Necessary.

_____

_____

_____

_____

_____

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 further understand that the Board will post on its Internet web site all information it deems necessary to enable the public to verify my licensure status.

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

_____ _____

Date Signature of Applicant

To Whom It May Concern:

This is authorization for release of any information requested by the Mississippi 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

NOTE: Enclose the Following with Application Form:

1. **Application Fee in the Amount of $300.00.**
2. **Photocopies of Current ACLS Certification for You and Current CPR Certifications for Your Auxiliaries.**

Certification of Your Post-Graduate Training in Parenteral Conscious Sedation Must Be Sent Directly to the Board Office from the Institution.

Print Form