**NOTIFICATION OF NON-DENTIST ANESTHESIA PROVIDER**

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| --- | --- | --- | --- | --- | --- | --- |
| *Mississippi Dentist and Facility Information* | | | | | | |
|  | | | | | | |
| Last Name | First Name | Middle Name | | | Birth Date | |
| License # | Specialty License # | | Anesthesia Permit # | | | |
| Facility/Clinic 1 Name | Address | | City | State | | Zip |
| Facility/Clinic 2 Name | Address | | City | State | | Zip |

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| Non-Permitted Anesthesia Provider (NPAP) Information | | | | | | | | | |
| Last Name | | | | First Name | | Middle Name | | | DEA# (physicians only) |
| Address | | | | City | | State | | Zip | Telephone |
| License # | | | | Mississippi Licensing Board | | | | | |
| Is there any other name under which you have been known? | | | | | | | | | |
|  | No |  | Yes (AKA, Maiden name, etc.) | | Name(s) | |  | | |

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| Name of Issuing Board | Certification # | Dates (mm/yy – mm/yy) | |
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| Name of Issuing Board | Certification # | Dates (mm/yy – mm/yy) | |
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| Name of Issuing Board | Certification # | Dates (mm/yy – mm/yy) | |
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| NPAP’s Professional Liability Information (Please attach document) | | |
| Current Insurance Carrier | Policy # | Expiration Date |
| Agent name and Full address | | Amount of Coverage |

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| *Signature Page* | |
| All information submitted by me in this application is true to my best knowledge and belief. | |
| Date | Signature of Applicant |

|  |  |
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| ***MSBDE Office use only:*** | |
| License verification: | By person(s) |