# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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

## ADVANCED ANESTHESIA APPLICATION FOR PERMIT
## CLASS II PROVIDER: MODERATE SEDATION

Reset

| Instructions: | Date of application (mm/dd/yyyy) |
|---|---|
| • This form must be typewritten.<br>• If more space is required, attach additional sheets<br>• This is an initial application and approval is contingent on successful completion of a provider evaluation | |

| *Identifying Information* | | | | |
|---|---|---|---|---|
| Last Name<br>asdf | First Name | Middle Name | | Birth Date (mm/dd/yy) |
| License Number | Specialty License Number | | D.E.A. Number | |
| 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* | | | |
|---|---|---|---|
| Pre-Dental | Name of Institution | Degree | Dates (mm/yy – mm/yy) |
| 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 | Name of Institution | Degree | Dates |

| *Categories of Training* | |
|---|---|
| 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 **dentist or dental specialist** who has successfully completed a CODA-accredited dental residency that includes comprehensive training in administering moderate sedation. | |
| ☐ A **dentist or dental specialist** who has successfully completed a board-approved course in the administration and management of moderate sedation. (as outlined in regulation 30) | |
| *Please describe your training and experience (drugs utilized and route of administration)* | |
| ACLS Certification (AHA or board approved) | Date Expired (mm/yyyy) |

| *Pediatric Endorsement* | |
|---|---|
| If you are applying for a pediatric endorsement you must attest to one of the following | |
| ☐ Have completed a CODA-accredited residency that has a standard for pediatric anesthesia training and is in compliance with such a standard. | |
| ☐ Completed requirements for a Class II permit AND a board approved level of training specific to sedation of pediatric patients. (as outlined in regulation 30) | |
| PALS Certification (AHA or board approved) | Date Expired (mm/yyyy) |

| *All Current and Past Hospital Affiliations* | | |
|---|---|---|
| Name and Location of Hospital | Status | Appointment Dates (mm/yyyy) |
| 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(mm/yyyy) |
| State | License Number | Date of Issue |
| State | License Number | Date of Issue |

| *Practice History* | |
|---|---|
| List in chronological order ending with most current. Including military. | |
| Name and address of facility | Dates (mm/yyyy) |
| Name and address of facility | Dates |
| Name and address of facility | Dates |
| Name and address of facility | Dates |
| Name and address of facility | Dates |
| Name and address of facility | Dates |

| *Professional Liability Information (Please attach document)* | | |
|---|---|---|
| Current Insurance Carrier | Policy Number | Expiration Date (mm/yyyy) |
| Agent name and Full address | | Amount of Coverage |
| Prior Carriers (last ten years) | | |
| | | |
| | | |

| YES | NO | Please provide full explanation to any “Yes” answers on separate sheet |
|---|---|---|
| ☐ | ☐ | During the past 10 years, have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice? |
| ☐ | ☐ | Have you ever been denied Professional Liability Insurance or has your policy ever been cancelled? |

| *Questionnaire* | | |
|---|---|---|
| YES | NO | |
| ☐ | ☐ | Have you ever been suspended from staff membership or denied staff privileges by a hospital? |
| ☐ | ☐ | Have your hospital privileges ever been curtailed or revoked or has your application for any hospital privileges been denied? |
| ☐ | ☐ | Have you ever been denied membership or a renewal thereof or been subjected to disciplinary proceedings in any dental organization or jurisdiction? |
| ☐ | ☐ | Have you ever been subject to a National Practitioner data Bank adverse action report? |
| ☐ | ☐ | Have you ever been convicted of a felony? |
| ☐ | ☐ | Have you ever been or are you now being investigated for Medicare/Medicaid or insurance Fraud and abuse? |
| YES | NO | Have any of the following been voluntarily or involuntarily relinquished or currently are in the process of being DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, or SURRENDERED? |
| ☐ | ☐ | Employment, dental staff appointment, including avoiding disciplinary action? |
| ☐ | ☐ | License to practice in any jurisdiction? |
| ☒ | ☐ | Federal (DEA) or State Narcotics Registration Certificate? |
| ☐ | ☐ | Other Professional Registrations/Licenses? |
| ☐ | ☐ | Participation in any Federal or State Health Insurance Program? |
| ☐ | ☐ | Clinical Privileges? |
| ☐ | ☐ | Academic Appointment? |
| ☐ | ☐ | Other Institutional Affiliations? |
| ☐ | ☐ | Professional Society Membership? |
| ☐ | ☐ | Specialty Board Certification? |
| ☐ | ☐ | Professional Office or other Professional Sanction? |
| ☐ | ☐ | Other Health care Organizations (PPO, HMO, MCO, Surgical center, MSO, etc)? |

*If the answer to any of the following question is "YES", please give full details*

List all instances of mortality or morbidity in connection with your care, including a detail explanation of any such occurrence. Use a separate sheet if necessary

| *Additional space (if needed)* |
| --- |
| Please provide any additional information in the space below |
| |

# *Signature Page*

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.

Applicant Anesthesia Provider recognizes that healthcare providers may suffer from potentially impairing health conditions, just like their patients, including psychiatric illness, physical illness which may impact cognition, and substance use disorders. All healthcare providers are expected to properly address their healthcare concerns, in order to ensure patient safety. This includes seeking appropriate medical care and limitations on healthcare practice, when appropriate. Failure of a healthcare practitioner to adequately address any health condition which may impair their ability to practice medicine with reasonable skill and safety to patients will likely result in loss of collaboration with other healthcare providers and possibly loss of license. By submitting this application, I acknowledge I have read and understood this statement

| Date (mm/dd/yyyy) | 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 (PALS if applying for pediatric endorsement)
3. Documents and/or credentials substantiating educational requirements must be sent directly to the Board Office from the institution or organization
4. Copy of DEA certificate

# *Release of Information*

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 (mm/dd/yyyy) | Signature of Applicant |
|---|---|
| | |

| *Submit options* | | | |
|---|---|---|---|
| **Submit** | Email<br>danielle@dentalboard.ms.gov | Fax<br>(601) 944-9624 | Mail<br>Attn: Dental Licensing<br>Mississippi State Board of Dental Examiners<br>Suite 100, 600 East Amite St. |