

# MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

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

## DENTIST UTILIZING NON-PERMITTED ANESTHESIA PROVIDER FORM

<b>Instructions:</b> <ul style="list-style-type: none"> <li>This form must be typewritten</li> <li>If more space is required, attach additional sheets</li> <li>Dentist must provide this form for each non-permitted anesthesia provider.</li> </ul>	<b>For <u>MSBDE</u> Only:</b>  Date of Receipt:
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<i>Dentist Identifying Information</i>			
Last Name	First Name	Middle Name	Birth Date (mm/dd/yy)
License Number	Specialty License Number	Anesthesia Permit Number	

<i>NPAP Identifying Information</i>				
<i>non-permitted anesthesia provider (NPAP)</i>				
Last Name	First Name	Middle Name	Birth Date (mm/dd/yy)	
License #	D.E.A. # (physicians only)			
Home Address	City	State	Zip	Telephone
Is there any other name under which you have been known?				
<input type="checkbox"/> No	<input type="checkbox"/> Yes (AKA, Maiden name, etc.)	Name(s)		

<i>Education (use additional sheets if needed)</i>				
Undergraduate	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Degrees	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Other Degrees	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Internship	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Residency	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)

Fellowship	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Teaching Appointments	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Certification	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Preceptorship	Name of Institution	Degree	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)

<i>Board Certification</i>			
Name of Issuing Board	Certification #	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Name of Issuing Board	Certification #	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Name of Issuing Board	Certification #	Completed <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates (mm/yy – mm/yy)
Have you ever taken and failed a certification exam?			
<input type="checkbox"/> No	<input type="checkbox"/> Yes	If Yes, specify	
If not certified, are you actively involved in the certification process?			
<input type="checkbox"/> No	<input type="checkbox"/> Yes		

<i>Professional Society Memberships (list all current and pending, include offices held)</i>	
Organization	Office Held
Organization	Office Held
Organization	Office Held

<i>Military Service</i>			
Branch of Military	Type of Affiliation	Location	Dates (mm/yy – mm/yy)
Branch of Military	Type of Affiliation	Location	Dates (mm/yy – mm/yy)

<i>Licenses Held From Other States</i>				
State	License #	Medicaid / Medicare Provider #	Date of Issue	Exp. Date (mm/yy)
State	License #	Medicaid / Medicare Provider #	Date of Issue	Exp. Date (mm/yy)
State	License #	Medicaid / Medicare Provider #	Date of Issue	Exp. Date (mm/yy)
<p>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</p> <hr/>				

<i>Peer Reference</i>				
#1 Last Name	First Name		Title	Email
Address	City	State	Zip	Telephone
#2 Last Name	First Name		Title	Email
Address	City	State	Zip	Telephone
#3 Last Name	First Name		Title	Email
Address	City	State	Zip	Telephone

<i>Practice History</i>	
List in chronological order ending with most current. Including military.	
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
Name and address of facility	Dates
Levels of anesthesia provided in Current Practice (Check all that apply):	
<input type="checkbox"/> General Anesthesia <input type="checkbox"/> Deep Sedation <input type="checkbox"/> Moderate Sedation	
Number of patients treated in the past year with indicated level of anesthesia above	
<input type="checkbox"/> 0 - 10 <input type="checkbox"/> 11 - 20 <input type="checkbox"/> > 20	
Number of patients <u>7 years old and younger</u> treated in the past year with indicated level of anesthesia above	
<input type="checkbox"/> 0 - 10 <input type="checkbox"/> 11 - 20 <input type="checkbox"/> > 20	

<i>Current and Past Hospital Affiliations</i>		
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

**Professional Liability Information (Please attach document)**

Current Insurance Carrier		Policy #	Expiration Date
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	
<input type="checkbox"/>	<input type="checkbox"/>	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?	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been denied Professional Liability Insurance or has your policy ever been cancelled?	

**Questionnaire**

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been suspended from staff membership or denied staff privileges by a hospital?
<input type="checkbox"/>	<input type="checkbox"/>	Have your hospital privileges ever been curtailed or revoked or has your application for any hospital privileges been denied?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been denied membership or a renewal thereof or been subjected to disciplinary proceedings in any dental organization or jurisdiction?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been subject to a National Practitioner data Bank adverse action report?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been convicted of a felony?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been or are you now being investigated for Medicare/Medicaid or insurance Fraud and abuse?
<b>YES</b>	<b>NO</b>	<b>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?</b>
<input type="checkbox"/>	<input type="checkbox"/>	Employment, dental staff appointment, including avoiding disciplinary action?
<input type="checkbox"/>	<input type="checkbox"/>	License to practice in any jurisdiction?
<input type="checkbox"/>	<input type="checkbox"/>	Federal (DEA) or State Narcotics Registration Certificate?
<input type="checkbox"/>	<input type="checkbox"/>	Other Professional Registrations/Licenses?
<input type="checkbox"/>	<input type="checkbox"/>	Participation in any Federal or State Health Insurance Program?
<input type="checkbox"/>	<input type="checkbox"/>	Clinical Privileges?
<input type="checkbox"/>	<input type="checkbox"/>	Academic Appointment?
<input type="checkbox"/>	<input type="checkbox"/>	Other Institutional Affiliations?
<input type="checkbox"/>	<input type="checkbox"/>	Professional Society Membership?
<input type="checkbox"/>	<input type="checkbox"/>	Specialty Board Certification?
<input type="checkbox"/>	<input type="checkbox"/>	Professional Office or other Professional Sanction?
<input type="checkbox"/>	<input type="checkbox"/>	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 Documents*

All copies must be included with this initial registration form

Copy of ACLS/BLS/PALS certification

Copy of DEA certificate (if applicable)

Copy of MS State Medical license OR MS State Nursing license

## *Dentist 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	Signature of Dentist Utilizing a Non-Permitted Anesthesia Provider

## *NPAP 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.

By submitting this application and agreement, I authorize the Dentist identified above to contact any and all healthcare facilities, hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications.

Date	Signature of Non-Permitted Anesthesia Provider

### ***MSBDE Office use only:***

License verification:	Staff Member:
National practitioner database inquiry date:	Staff Member: