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

Instructions:	For MSBDE Only:
• This form must be typewritten • If more space is required, attach additional sheets • Dentist must provide this form for each non-permitted anesthesia provider.	Date of Receipt:

Dentist Identifying Information			
Last Name	First Name	Middle Name	Birth Date (mm/dd/yy)
License Number	Specialty License Number	Anesthesia Permit Number	

NPAP Identifying Information				
non-permitted anesthesia provider (NPAP)				
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?				
☐ No ☐ Yes (AKA, Maiden name, etc.) Name(s)				

Education (use additional sheets if needed)			
Undergraduate	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Degrees	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Other Degrees	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Internship	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Residency	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)

Fellowship	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Teaching Appointments	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Certification	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)
Preceptorship	Name of Institution	Degree Completed ☐ Yes ☐ No	Dates (mm/yy – mm/yy)

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

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

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

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

Peer Reference				
#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

Practice History	
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): ☐ General Anesthesia ☐ Deep Sedation ☐ Moderate Sedation	
Number of patients treated in the past year with indicated level of anesthesia above ☐ 0 - 10 ☐ 11 - 20 ☐ > 20	
Number of patients 7 years old and younger treated in the past year with indicated level of anesthesia above ☐ 0 - 10 ☐ 11 - 20 ☐ > 20	

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

Professional Liability Information (Please attach document)			
Current Insurance Carrier		Policy #	Expiration Date
Agent name and Full address			Amount of Coverage
Prior Carries (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 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 Applicant

MSBDE Office use only:	
License verification:	Staff Member:
National practitioner database inquiry date:	Staff Member: