

Dental Anesthesia/Sedation Certification Form 1

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only

Application for Certification

Applicants Must Complete All Three Pages Of This Application ***In Ink***

1 Check what you are applying for (check only one):

<input type="checkbox"/> Dental General Anesthesia	82	\$100	ER
<input type="checkbox"/> Dental Parenteral Conscious Sedation 13 Years & Older	81	\$100	ER
<input type="checkbox"/> Dental Parenteral Conscious Sedation 12 Years & Younger*	81	\$100	ER
<input type="checkbox"/> Dental Enteral Conscious Sedation 13 Years & Older	83	\$100	ER
<input type="checkbox"/> Dental Enteral Conscious Sedation 12 Years & Younger*	83	\$100	ER

*A certificate in these categories also allows practice on patients 13 years and older and does not require application for a separate certificate.

2 Social Security Number

(Leave this blank if you do not have a U.S. Social Security Number)

3 Birth Date

Month Day Year

4 Print Name

Last

First

Middle

Licensee business address, phone and e mail address are public information. Failure to indicate business or home on this form for each item will deem it public information.

5 Mailing Address: Home or Business

(You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/Province

6 Telephone/E-Mail Address

Daytime Phone: Home or Business

Area Code Phone Number

E-Mail Address (Please print clearly):

Home or Business

7 New York State DMV ID Number

(Driver or Non-Driver ID)

(Leave this blank if you do not have a New York State DMV ID Number)

8 New York State dentistry license number: _____

Registration expiration date: _____ / _____ / _____

9 Do you now hold, or have you ever held, a license or certificate to practice any profession in any jurisdiction?

(If so, list below and attach other pages as needed.)

YES NO

_____ Profession	_____ License Number	_____ Jurisdiction
_____ Profession	_____ License Number	_____ Jurisdiction

10 Dental General Anesthesia, Parenteral Conscious Sedation and Dental Enteral Conscious Sedation Applicants

I am treating patients 12 years of age and younger and am attaching a copy of a valid course completion card in both Pediatric Advanced Life Support (PALS) and Advanced Cardiac Life Support (ACLS) or its equivalent. YES NO

I am treating patients 13 years of age and older and am attaching a copy of a valid course completion card in Advanced Cardiac Life Support (ACLS) or its equivalent. YES NO

I have met the professional study and/or other requirements that qualify me for certification as follows: (check one box)

Dental General Anesthesia certificate [authorizes a licensed dentist to employ general anesthesia, deep sedation, or conscious sedation (enteral or parenteral route with or without inhalation agents)]

Complete Form 2A

- a. Completion of two (2) years of post-doctoral education in anesthesia acceptable to the Department and accredited by an acceptable accrediting body.
- b. Completion of three (3) years of post-doctoral education in anesthesia acceptable to the Department and accredited by an acceptable accrediting body.
- c. Completion of a graduate level program in oral and maxillofacial surgery acceptable to the Department and accredited by an acceptable accrediting body.

Institution attended: _____

Location: _____ Attended _____ - _____
From To

Dental Parenteral Conscious Sedation 13 years old & older [authorizes a licensed dentist to employ conscious sedation (enteral or parenteral route with or without inhalation agents)]

Complete Form 2B

Completion of a post-doctoral education program acceptable to the Department and accredited by an acceptable accrediting body, which includes at least 60 clock hours of coursework and an additional clinical experience demonstrating the successful use of parenteral conscious sedation on no fewer than 20 live dental patients via the intravenous route who shall be 13 years old or older.

Institution attended: _____

Location: _____ Attended _____ - _____
From To

Type of residency program completed (if applicable): _____
(e.g. GPR, AEGD, OMS, etc.)

Dental Parenteral Conscious Sedation 12 years old or younger [authorizes a licensed dentist to employ conscious sedation (enteral or parenteral route with or without inhalation agents)]

Complete Form 2B

Completion of a post-doctoral education program acceptable to the Department and accredited by an acceptable accrediting body, which includes at least 60 clock hours of coursework and an additional clinical experience demonstrating the successful use of parenteral conscious sedation on no fewer than 15 live dental patients who shall be 12 years old or younger and **five (5) live dental patients who shall be 13 years old or older.**

Institution attended: _____

Location: _____ Attended _____ - _____
From To

Type of residency program completed (if applicable): _____
(e.g. GPR, AEGD, OMS, etc.)

Dental Enteral Conscious Sedation 13 years old & older [authorizes a licensed dentist to employ conscious sedation (enteral route only with or without inhalation agents)]

Complete Form 2C

- a. pre-doctoral education or post-doctoral education consisting of a specialty program or residency accredited by an acceptable accrediting body, and which shall include a formal course in Advance Cardiac Life Support and additional coursework consisting of at least 60 clock hours of coursework. In addition to the coursework, ten (10) clinically oriented experiences in the use of enteral conscious sedation techniques on dental patients who shall be 13 years of age or older.
- b. post-doctoral coursework approved by the Department which has equivalent rigor as coursework approved by an acceptable accrediting body which includes coursework in Advance Cardiac Life Support and additional coursework consisting of at least 60 clock hours of coursework. In addition to the coursework, ten (10) clinically oriented experiences in the use of enteral conscious sedation techniques on dental patients who shall be 13 years of age or older.

Institution attended: _____

Location: _____ Attended _____ - _____
From To

Type of residency program completed (if applicable): _____
(e.g. GPR, AEGD, OMS, etc.)

Dental Enteral Conscious Sedation 12 years old & younger [authorizes a licensed dentist to employ conscious sedation (enteral route only with or without inhalation agents)]

Complete Form 2C

- a. pre-doctoral education or post-doctoral education consisting of a specialty program or residency accredited by an acceptable accrediting body, and which shall include a formal course in Pediatric Advanced Life Support (PALS) and Advanced Cardiac Life Support (ACLS) and additional coursework consisting of at least 60 clock hours of coursework. In addition to the coursework, fifteen (15) clinically oriented experiences in the use of enteral conscious sedation techniques on dental patients who shall be 12 years of age or younger and **five (5) patients 13 years old or older.**
- b. post-doctoral coursework approved by the Department which has equivalent rigor as coursework approved by an acceptable accrediting body which includes coursework in Advance Cardiac Life Support and additional coursework consisting of at least 60 clock hours of coursework. In addition to the coursework, ten (10) clinically oriented experiences in the use of enteral conscious sedation techniques on dental patients who shall be 13 years of age or older.

Institution attended: _____

Location: _____ Attended _____ - _____
From To

Type of residency program completed (if applicable): _____
(e.g. GPR, AEGD, OMS, etc.)

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Please check only one of the following:

- I am applying for licensure based on successful completion of a residency program approved by an acceptable national accrediting body; such as the Commission on Dental Accreditation.
- I am applying for licensure by endorsement of a license held in another jurisdiction of the United States.

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CHILD SUPPORT OBLIGATION:

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must file a written statement that, as of the date of the filing, she or he is, or is not, under an obligation to pay child support*. **Individuals who are four months or more in arrears in child support or who have failed to comply with a summons, subpoena or warrant relating to a paternity or child support proceeding may be subject to suspension of their business, professional, drivers and/or recreational licenses and permits.** The intentional submission of false written statements for the purpose of frustrating or defeating the lawful enforcement of support obligations is punishable under section 175.35 of the Penal Law.

You must complete this section before we can issue the credential for which you have applied. Individuals who are not in compliance with their obligation to pay child support can be issued a credential for no more than six months in order to comply with their child support obligations.

Check only A or B below. If you check B, you must check one of the five statements listed below it.

A I am **not** under an obligation to pay child support:

OR

B I am under an obligation to pay child support *and* (please check only one of the following)

- I am current and **am not** four months or more in arrears in the payment of child support; or,
- I am making payments by income execution or by court agreed payment plan or by a plan agreed to by the parties; or,
- The child support obligation is the subject of a pending court proceeding; or,
- I am receiving public assistance or supplemental security income; or,
- None of the above four statements apply.

*New York State General Obligations Law, Section 3-503

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AFFIDAVIT WITH ACKNOWLEDGMENT (Notarization required.)

APPLICANT

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution. **This form must be signed and dated in the presence of a Notary Public.**

Signature of the applicant: _____

Date: _____ / _____ / _____
Month Day Year

NOTARY

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signed, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date: _____ / _____ / _____
Month Day Year

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.