

# Dental Anesthesia/Sedation Certification Form 1 Application for Certification

**All applicants for certification** must complete this form and submit it with the appropriate fee (\$100) directly to the Office of the Professions at the address at the end of this form. You must answer all questions **in ink** (pen or printer) and provide all information requested unless otherwise indicated. Failure to complete all required parts of the application will delay its review. **You must sign and date the Affidavit on this form in the presence of a Notary Public.**

Check what you are applying for (check one):

- |   |   |    |       |    |
|---|---|----|-------|----|
| <input type="checkbox"/> Dental General Anesthesia                                  | <table border="1"><tr><td>82</td><td>\$100</td><td>ER</td></tr></table> | 82 | \$100 | ER |
| 82  | \$100   | ER |       |    |
| <input type="checkbox"/> Dental Parenteral Conscious Sedation 13 Years and Older    | <table border="1"><tr><td>81</td><td>\$100</td><td>ER</td></tr></table> | 81 | \$100 | ER |
| 81  | \$100   | ER |       |    |
| <input type="checkbox"/> Dental Parenteral Conscious Sedation 12 Years and Younger* | <table border="1"><tr><td>81</td><td>\$100</td><td>ER</td></tr></table> | 81 | \$100 | ER |
| 81  | \$100   | ER |       |    |
| <input type="checkbox"/> Dental Enteral Conscious Sedation 13 Years and Older       | <table border="1"><tr><td>83</td><td>\$100</td><td>ER</td></tr></table> | 83 | \$100 | ER |
| 83  | \$100   | ER |       |    |
| <input type="checkbox"/> Dental Enteral Conscious Sedation 12 Years and Younger*    | <table border="1"><tr><td>83</td><td>\$100</td><td>ER</td></tr></table> | 83 | \$100 | ER |
| 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.

- |   |               |       |  |      |
|---|---------------|-------|--|------|
| 1. Social Security Number<br><i>(Leave this blank if you do not have a U.S. Social Security Number)</i> | 2. Birth Date | Month | Day  | Year |
| 3. Print Name   | Last          |       |  |      |
|   | First         |       |  |      |
|   | Middle        |       |  |      |
|   |               |       | 5. Telephone/Email Address   |      |
|   |               |       | Daytime Phone  |      |
|   |               |       | <input type="checkbox"/> Home or <input type="checkbox"/> Business |      |

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

- |  |  |   |
|--|--|---|
| 4. Mailing Address <input type="checkbox"/> Home or <input type="checkbox"/> Business<br><i>(You must notify the Department within 30 days of any address or name changes)</i> | 5. Telephone/Email Address   |   |
| Line 1   | Daytime Phone  |   |
| Line 2   | <input type="checkbox"/> Home or <input type="checkbox"/> Business |   |
| Line 3   |  |   |
| City   | Area Code  | Phone   |
| State  | 6. New York State DMV ID Number<br>(Driver or Non-Driver ID)       |   |
| Country/<br>Province   | ZIP Code   | <i>(Leave this blank if you do not have a<br/>New York State DMV ID Number)</i> |

7. I am applying for (check one):

- Certification based on successful completion of a residency program approved by an acceptable national accrediting body; such as the Commission on Dental Accreditation **and** the Department; or a Department approved program.
- Certification by endorsement of a license held in another jurisdiction of the United States or Canadian province (you must complete item 10).
- Certification based on completion of a pre or post-doctoral program acceptable to the Department.

8. New York State dentistry license number \_\_\_\_\_ Registration expiration date \_\_\_\_\_  
mo. day yr.

9. 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

10. Do you now hold, or have you ever held, a license or certificate to practice any profession in any state or jurisdiction?  Yes  No  
**If yes, you must list all licenses/certificates, states or jurisdictions and provide appropriate information in the columns below or your application will be delayed. A Form 3 must be submitted for each professional license/certificate listed unless it is a license/certificate issued by the New York State Education Department. See the Applicant instructions on Form 3 for specific information about completing and submitting the form.**

| Professional Title | State or Jurisdiction | Date License/Certificate Issued | License/Certificate Number | Limitations on License/Certificate |
|--------------------|-----------------------|---------------------------------|----------------------------|------------------------------------|
|                    |                       |                                 |                            |                                    |
|                    |                       |                                 |                            |                                    |
|                    |                       |                                 |                            |                                    |

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

- 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 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 and 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 and older** [authorizes a licensed dentist to employ conscious sedation (enteral route only with or without inhalation agents)]

**Complete Form 2C**

Completion of pre-doctoral education or post-doctoral education accredited by an acceptable accrediting body and previously approved by the department, which shall include at least 60 clock hours of didactic 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 and younger** [authorizes a licensed dentist to employ conscious sedation (enteral route only with or without inhalation agents)]

**Complete Form 2C**

Completion of pre-doctoral education or post-doctoral education accredited by an acceptable accrediting body and previously approved by the department, which shall include at least 60 clock hours of didactic 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.**

Institution attended \_\_\_\_\_

Location \_\_\_\_\_ Attended \_\_\_\_\_  
From \_\_\_\_\_ To \_\_\_\_\_

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

12. Child Support Obligation

Everyone applying for a professional license, permit, or registration, or any renewal thereof, must certify 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

13. Affidavit with Acknowledgement (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.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**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's Signature

Notary Stamp

\_\_\_\_\_  
Notary ID number

\_\_\_\_\_  
Expiration Date

**If you are submitting an initial Form 1, mail this form and appropriate fee to:** New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201, U.S.A.. **DO NOT SEND CASH.** Make check or money order payable to the New York State Education Department.