

SECTION II: VERIFICATION OF TRAINING

INSTRUCTIONS TO INSTITUTION OR PROVIDER : Please complete this section and return directly to the Division of Professional Licensing Services. It will **not** be accepted if it is incomplete or if it is returned by the applicant.

I hereby certify that _____ completed _____ hours
(Dentist's Name)
of pre-doctoral or post-doctoral education in the use of enteral conscious sedation in a program accredited/approved by
_____ at _____
(Accrediting body) (Name and location of institution)

Inclusive dates of training _____ to _____

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

The training included instruction in all of the following **required** subjects:

Nitrous oxide use Yes No
Emergency management Yes No

On the chart below, list other subjects included in training.

Other Subjects	
Total Clock Hours (Minimum 18 hours): _____	

If necessary, attach additional sheets.

In addition, this individual successfully administered or observed enteral conscious sedation on _____ patients (minimum 20)
(number of patients)

Please check here and attach a letter of explanation with this form if this dentist did not successfully complete the pre-doctoral or post-doctoral training program.

ATTESTATION

I hereby attest that to the best of my knowledge and belief the foregoing is a true statement.

Signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print or type name: _____

Title: _____

Institution or provider: _____

(INSTITUTION SEAL)
(If seal not available, attach explanation)

Telephone: (_____) _____

Fax: (_____) _____

E-mail: _____

Return Directly to: New York State Education Department, Office of the Professions, Dentistry Unit, 89 Washington Avenue, Albany, NY 12234-1000.