Dental Anesthesia/Sedation Certification Form 4

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

Morbidity and Mortality Report Form

Under Part 61.10 of the Commissioner's Regulations, a dentist must submit a morbidity or mortality report to the Department if he/she:

- has had any mortality or irreversible morbidity occurring during or within 48 hours following, or otherwise related to, the administration of conscious (moderate) sedation or deep sedation or general anesthesia, such report must be submitted to the Department within 30 days of the occurrence; or
- is applying for an anesthesia certificate via endorsement and he/she has ever had any patients with irreversible morbidity or mortality due to the sedation provided by him/her.

Instructions: Complete this form. Be sure to sign and date the certification before sending the completed form along with any other documentation to the Office of the Professions at the address at the end of the form.

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

2 **Birth Date** Month Day Year

3 **Print Name As It Appears On Your Application for Licensure (Form 1)**

Last
First
Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1
Line 2
Line 3
City
State Zip Code
Country/ Province

5 **Dentist License number**:

Jurisdiction(s) where licensed as a Dentist:

6 **Anesthesia Certificate Number:**

Anesthesia Certificate Type:

- ☐ General
- ☐ Parenteral
- ☐ Enteral

7 **Date and time of incident:** _____

8 **Name and address where the incident took place:** _____

9 **Name of Operating Dentist(s):** _____

License Number of Operating Dentist(s) : _____

Name of Patient: _____ **Patient's date of birth:** _____

Name of Patient's Parent or Guardian (if applicable): _____

10 **Names and titles of office staff present in the office on the date of the incident. (Attach additional sheets if necessary.)**

Name: _____ **Title:** _____

Name: _____ **Title:** _____

Name: _____ **Title:** _____

Name: _____ **Title:** _____

11 **Dental Procedure involved:** _____

Type of sedation/anesthesia administered:

- ☐ Enteral Conscious (Moderate) Sedation
- ☐ Parenteral Conscious (Moderate) Sedation
- ☐ Deep Sedation
- ☐ General Anesthesia

Description of incident (please note whether a death, permanent organic brain dysfunction, or hospitilazation of the patient occured. (Attach additional sheets if necessary):

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Please be advised that depending on the circumstances, the Department may require you to:

1. **submit a time oriented anesthesia record of the incident(s) referenced in this form; and/or**
2. **complete remedial education before a dental parenteral or enteral conscious sedation certificate of any category may be issued.**

Certification

I declare and affirm that the statements made in this report form, including accompanying documents, are true, complete and accurate. I further understand that any false or misleading information made in, or in connection with, this report form, may be cause for denial or loss of anesthesia certificate(s) and/or licensure and may result in criminal prosecution.

Signature _____

Date _____ / _____ / _____
mo. day yr.

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