MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Suite 100, 600 East Amite Street • Jackson, Mississippi 39201-2801 • (601) 944-9622 • www.msbde.state.ms.us

M E M O R A N D U M

TO: **APPLICANTS FOR A GENERAL ANESTHESIA PERMIT**

FROM: **CHRIS L. HUTCHINSON, EXECUTIVE DIRECTOR**

SUBJECT: **INSTRUCTIONS**

IMPORTANT INFORMATION
PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION FORM

Enclosed is an application for a permit to administer General Anesthesia (includes Enteral Conscious Sedation and Parenteral Conscious Sedation) on an outpatient basis. Please complete the items that apply to you. If an item is not applicable to you, please type "N/A" in the blank. **ALL QUESTIONS MUST BE ANSWERED.**

The completed application should be returned by certified mail, return receipt requested to:

Mississippi State Board of Dental Examiners
Suite 100, 600 East Amite Street
Jackson, MS 39201-2801

Application fee in the amount of $300.00 and photocopies of current ACLS certification for you and CPR certification for your auxiliaries should accompany the application. Credentials and other documents substantiating the information on Page 2 of the application form must be forwarded to the Board office directly from the institution or organization involved.

Upon receipt of your application, the Board office will contact you to schedule an on-site visit.

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Suite 100, 600 East Amite Street ● Jackson, Mississippi 39201-2801 ● (601) 944-9622 ● www.msbde.state.ms.us

APPLICATION FOR PERMIT TO ADMINISTER GENERAL ANESTHESIA ON AN OUTPATIENT BASIS

DATE_____

INSTRUCTIONS: This Form Must Be **TYPEWRITTEN.** If More Space is Required, Attach Additional Sheets.

IDENTIFYING INFORMATION

Last Name	First Name	Middle Name	Birth Date
License No.	Specialty License No.	D.E.A. No.	

Primary Office Street Address	City	State	Zip	Telephone
Second Office Street Address	City	State	Zip	Telephone
Home Street Address	City	State	Zip	Telephone

Type of Practice

Practicing with Whom and Nature of Affiliation

EDUCATION

Pre-Dental:	Name of Institution		Degree	Dates
Dental School:	Name of Institution		Degree	Dates
Other Degrees:	Name of Institution		Degree	Dates
Internship:	Name of Institution		Type	Dates
Residency:	Name of Institution			Dates
Certification:	Specialty Board			Dates

CHECK CATEGORIES OF TRAINING AND EDUCATION CRITERIA QUALIFYING YOU FOR PERMIT (CREDENTIALS AND/OR SUBSTANTIATING DOCUMENTS MUST BE SENT DIRECTLY TO THE BOARD OFFICE FROM THE INSTITUTION OR ORGANIZATION.)

_____ A. Completed minimum of one year of advanced training in anesthesiology and related academic subjects (or its equivalent) beyond the undergraduate dental school level in a training program as described in Parts I, II, and III of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry. On a separate sheet include a detailed explanation, i.e., institution, dates, courses taken, etc.

_____ B. Diplomate of American Board of Oral and Maxillofacial Surgery.

_____ C. Member of American Association of Oral and Maxillofacial Surgeons.

_____ D. Eligible for examination by the American Board of Oral and Maxillofacial Surgery. (List date of any expected examination to be taken and dates of any previous examinations taken.)

_____ E. Employment or work in conjunction with a qualified anesthesiologist or certified nurse anesthetist who is a member of the anesthesiology staff in an accredited hospital, provided that such anesthesiologist or certified nurse anesthetist must remain on the premises of the dental facility until any patient given any level of anesthetic regains consciousness and is discharged. (Give details of your association with anesthesiologist or nurse anesthetist including names, license numbers, hospital affiliations, and type of employment contract. Use separate sheet, if necessary.)

DID YOU USE GENERAL ANESTHESIA PRIOR TO JULY 1, 1987? _____Yes _____No

GIVE A RÉSUMÉ OF YOUR GENERAL ANESTHESIA QUALIFICATIONS INCLUDING TRAINING AND EXPERIENCE.

ALL 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

LICENSES HELD FROM OTHER STATES

State	License No.	Date of Issue
State	License No.	Date of Issue
State	License No.	Date of Issue

List All Instances of Mortality or Morbidity in Connection with Your Use of General Anesthesia, Parenteral Conscious Sedation, or Enteral Conscious Sedation, Including a Detailed Explanation of Any Such Occurrence. Use a Separate Sheet if Necessary.

INFORMATION ABOUT YOUR OUTPATIENT FACILITY

What Anesthetic Techniques Do You Employ? (General, I.V., N2 O, Inhalation, Etc.) Give details.

What Major Drugs Do You Employ Relating to Sedation?

List Drugs and Equipment on Hand in Your Office Available for Resuscitation of a Patient (Use Separate Sheet if Necessary):

_____

_____

_____

_____

Your ACLS Certification _____
Name of Course Date

ATTACH A SEPARATE SHEET LISTING NAMES OF AUXILIARIES AND DATES OF THEIR CPR CERTIFICATION.

PRACTICE HISTORY

List in Chronological Order Ending with Most Current. Include Military.

_____
Address Date

_____
Address Date

_____
Address Date

_____
Address Date

_____
Address Date

_____
Address Date

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET.

Have You Ever Been Suspended from Staff Membership or Denied Staff Privileges by a Hospital?

No_____ Yes _____

Have Your Hospital Privileges Ever Been Curtailed or Revoked or Has Your Application for Any Hospital Privileges Been Denied?

No_____ Yes _____

Have You Ever Been Denied Membership or a Renewal Thereof or Been Subject to Disciplinary Proceedings in Any Dental Organization or Jurisdiction?

No_____ Yes _____

CONTINUING DENTAL EDUCATION

List on a Separate Sheet All Professional Meetings, Seminars, Etc., Attended in the Past Two (2) Years.

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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.

_____ _____

Date Signature of Applicant

NOTE: Enclose the Following with Application Form:

1. **Application Fee in the Amount of $300.00.**
2. **Photocopies of Current ACLS Certification for You and Current CPR Certifications for Your Auxiliaries.**

Documents and/or Credentials Substantiating Items on Page 2 Must be Sent Directly to the Board Office from the Institution or Organization.

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.

_____ _____

Date Signature of Applicant

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Print Form