STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

APPLICATION FOR DENTAL CONSCIOUS SEDATION PERMIT

Last Name: _____ First Name: _____ MI: _____ Maiden Name: _____

Date of Birth: _____/_____/_____ Social Security No.: _____-_____-_____ Gender: _____

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: _____

Address: _____

_____

City, State, Zip: _____

Daytime Phone Number: (____) _____ E-mail: _____

Connecticut dental license number: _____

I am applying for this permit based on: Check the appropriate category below (i.e., A through G) and follow the applicable instructions.

A. ☐ Graduation from a dental school or post-doctoral dental residency program accredited by the ADA Commission on Dental Accreditation within the last two years, satisfying the requirements of Section 20-123B-4 (a) of the Regulations for State Agencies. If checked, forward the enclosed **Dental School Verification Form or Residency Curriculum Report Form** to the institution for completion.

Name of dental school: _____

Name of post-doctoral residency program: _____

Location: _____

Dates of attendance: from: _____ to: _____

B. ☐ Completion of an "Intensive Course" or "Supplemental or Refresher Course" in a post-doctoral continuing education program, structured in accordance with part three of the ADA Council on Dental Education "Guidelines for Teaching The Comprehensive Control of Pain & Anxiety." If checked, forward the enclosed **Intensive, Supplemental, or Refresher Course Verification Form** to the program for completion.

C.

(1) ☐ Completion of at least twelve parenterally administered conscious sedation procedures per year for each of the last three years. If checked, please attach List of Procedures Performed on enclosed forms, to verify that this requirement has been met, and

(2) ☐ Completion of at least 24 hours of continuing education in the last three years in one of the following areas: anesthesia; parenterally administered conscious sedation, or emergency medicine. If checked, list courses completed, attaching additional sheets of course list if necessary, and submit **notarized certificates of completion**.

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

D. ☐ Completion of a post-doctoral training program in Oral & Maxillofacial Surgery approved by the ADA Commission on Dental Accreditation. If checked, forward the enclosed **Postdoctoral Training Verification Form** to your institution for completion.

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

E. ☐ Completion of one year of full-time training in a post-doctoral program in Anesthesiology. If checked, forward the enclosed **Postdoctoral Training Verification Form** to your institution for completion.

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

F. ☐ Current status as a Diplomate of the American Board of Oral and Maxillofacial Surgery and graduation from dental school or completion of a post-graduate training program no later than 1966. If checked, forward notarized copies of your current certificate and dental school diploma to this Department.

G. ☐ Limitation of practice to Oral and Maxillofacial surgery for at least the immediately preceding ten years. If checked, forward a notarized letter, on professional letterhead, to this office including the inclusive dates of such limitation of practice.

Are you currently certified in the following:

Certificate Type	**YES**	**NO**	**Expiration Date**
Advanced Cardiac Life Support			

Complete the attached list, indicating all staff members' names and their current Basic or Advanced Cardiac Life Support status. **Please enclose notarized copies of your and your staff member's certificates.**

PROFESSIONAL HISTORY: Answer 1-7 by checking YES or NO. If you answer Yes, follow directions below.

YES NO

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: ☐ ☐

   -Any hospital, nursing home, clinic, or similar institution;
   -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
   -Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;
   -Any third party reimbursement program, whether governmental or private?

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice? ☐ ☐

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you? ☐ ☐

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction? ☐ ☐

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. ☐ ☐

6. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, or fined by the responsible agency? ☐ ☐

If your answer is "yes" to any of the above questions (1-6), please give full details, names, addresses, etc. on a separate NOTARIZED statement.

7. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? ☐ ☐

If "yes", give full details, names, addresses, etc. on a separate, NOTARIZED statement. Also submit a NOTARIZED copy of the agreement.

8. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state? ☐ ☐

If "yes", give full details, dates, etc. on a separate NOTARIZED statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition.

PHOTOGRAPH:

NOTARIZATION:

On this _____ day of _____ 200 ____,

_____ (**applicant's name**) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

_____
SIGNATURE OF APPLICANT

Sworn to before me this _____ day of _____ 200 ___.

_____ My commission expires _____
SIGNATURE OF NOTARY PUBLIC

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $200.00 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, "TREASURER, STATE OF CONNECTICUT" TO:

DEPARTMENT OF PUBLIC HEALTH
DENTAL CS PERMIT
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134-0308
(860) 509-7603