STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

APPLICATION FOR GENERAL ANESTHESIA/DEEP SEDATION PERMIT

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

Social Security No.: _____-_____-_____ E-mail: _____

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: _____

Phone Number: (____) _____ Date of Birth: _____/_____/_____ Gender: _____

Connecticut dental license number: _____

Primary professional address **(site at which evaluation will be conducted)** _____

_____
NO. & STREET CITY STATE ZIP CODE

I am applying for this permit based on: Check A, B, C or D below and follow the applicable instructions.

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

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

B. ☐ Completion of one year of full-time training in a post-doctoral program in Anesthesiology. If checked, forward the enclosed Post-Doctoral Training Verification Form to the appropriate institution for completion.

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

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

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

Do you hold a current certificate in Basic Cardiac Life Support? YES ☐ NO ☐. Expiration Date _____

Do you hold a current certificate in Advanced Cardiac Life Support? YES ☐ NO ☐. Expiration Date _____

STATEMENT OF 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:

Tape a recent photograph of applicant here.

DO NOT STAPLE

NOTARIZATION:

On this _____ day of _____ 20_____,

_____ **(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 _____ 20_____.

_____ 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:

THE DEPARTMENT OF PUBLIC HEALTH
GACS PERMIT
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134-0308
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

STAFF MEMBERS ACLS/BCLS VERIFICATION FORM

STAFF MEMBER	**BCLS CERTIFICATION**	**EXPIRATION DATE**

Please enclose copies of your and your staff members' certificates.

PLEASE RETURN TO:

DEPARTMENT OF PUBLIC HEALTH
DENTAL SEDATION PERMIT
410 CAPITOL AVE., **MS# 12APP**
P.O. BOX 340308
HARTFORD, CT 06134-0308