Reset Form

APPLICATION FOR PERMIT TO ADMINISTER ANESTHESIA AND SEDATION FOR DENTISTS

State Form 46159 (R6 / 5-21)

INDIANA STATE BOARD OF DENTISTRY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2054
E-mail: pla8@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $50.00, payable to the Indiana Professional Licensing Agency, in accordance with 828 IAC 0.5-2-3.*
2. *All fees are non-refundable and non-transferable.*
3. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*
4. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

FOR OFFICE USE ONLY		
Date application received (*month, day, year*)	Application fee	Date fee paid (*month, day, year*)
Receipt number	Permit number	

DO NOT WRITE ABOVE THIS LINE

BASIS FOR LICENSURE

Indiana dentist license number

I am applying for the following permit: *(Check only one.)*

☐ General Anesthesia and Deep Sedation *(includes authorization to administer Light Parenteral Conscious Sedation)*

☐ Light Parenteral Conscious Sedation *(only)*

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)	
Social Security number *	Date of birth (*month, day, year*)
Address of applicant (*number and street or rural route*)	City, state, and ZIP code
Primary office address (*number and street or rural route*)	City, state, and ZIP code
Telephone number (*daytime*) ( )	E-mail address

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No	Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

DENTAL DEGREE(S) GRANTED

Name of school	Dates attended (*month, day, year*)	
Location of school		Degree granted

EDUCATION AND TRAINING

General Anesthesia - Deep Sedation Permits / Advanced Education Program

Name of school	Dates attended (*month, year to month, year*)
Location of school	Degree received
Date certification / degree was granted (*month, day, year*)	Program title

EDUCATION AND TRAINING *(continued)*

Light Parenteral Conscious Sedation Permit / Training and Education

*To be completed by applicants if **predoctoral training was obtained.***

Name of school	Dates attended (*month, year to month, year*)
Location of school	

*To be completed by applicants if **postdoctoral training was obtained.***

Name of school - hospital	Dates attended (*month, year to month, year*)
Location of school - hospital	

Program title	Number of hours of instruction	Number of patients managed

LOCATION WHERE YOU WILL ADMINISTER GADS OR LPCS

Name of office

Address of office (*number and street, city, state, and ZIP code*)

To add an additional office and/or hospital where you intend to administer general anesthesia, deep sedation, or light parenteral conscious sedation (in addition to the above address) you will be required to submit the following:

1. *A written request for an additional office and/or hospital with the dentist name, additional location, license, and permit number.*
2. *A new Emergency Equipment Affidavit.*
3. *A fee of $25.00 for each additional office and/or hospital.*

LIST ALL STATES, INCLUDING INDIANA, IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE ANY REGULATED HEALTH OCCUPATION, REGARDLESS OF STATUS.

STATE	TYPE OF LICENSE / CERTIFICATE	NUMBER	DATE ISSUED *(month, day, year)*	CURRENT STATUS

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice veterinary medicine or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
4. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No
5. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restriction, probation or other type of discipline or limitations? ☐ Yes ☐ No
6. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility In which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
7. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date (*month, day, year*)