Reset Form

APPLICATION FOR PERMIT TO ADMINISTER ANESTHESIA AND SEDATION FOR DENTISTS

State Form 46159 (R5 / 7-16)
Approved by State Board of Accounts, 2016

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.*

* 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

APPLICANT INFORMATION

I am applying for the following permit, *(Please check appropriate box below .)*

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

Name *(Last, first, middle, (maiden)*	Social Security number*

Address *(number and street or rural route)*

City, state, and ZIP code	E-mail address

Primary office address *(number and street or rural route)*

City, state, and ZIP code

Telephone number ( )	Date of birth *(month, day, year)*

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

EDUCATION AND TRAINING

(To be completed by applicants for General Anesthesia - Deep Sedation or Light Parenteral Conscious Sedation Permits)

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

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

WHERE DO YOU INTEND TO ADMINISTER GENERAL ANESTHESIA, DEEP SEDATION, LIGHT PARENTERAL CONSCIOUS SEDATION	
List all offices - hospitals where you currently intend to administer : *general anesthesia*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all offices - hospitals where you currently intend to administer : *deep sedation*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all offices - hospitals where you currently intend to administer: *light parenteral conscious sedation*	
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of office	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)
Name of hospital	Address (*number and street, city, state, and ZIP code*)

List all states in which you have been licensed to practice, including the license number and date of issuance.		
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)
Name of state	License number	Date of issuance (*month, day, year*)

ADVANCED CARDIAC LIFE SUPPORT INFORMATION	
List the date you were most recently certified in advanced cardiac life support or received certification as an instructor in advanced cardiac life support (*month, day, year*):	Date of issuance (*month, day, year*)
State the name and location of the entity where you received your training in advance cardiac life support	
Name	
Location	

PLEASE SUBMIT DOCUMENTATION VERIFYING YOUR CERTIFICATION WITH YOUR APPLICATION.

DISCIPLINARY INFORMATION

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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.

Has disciplinary action ever been taken regarding any dental license you hold or have held? ☐ Yes ☐ No

State	Charge
Date (*month, day, year*)	Disposition

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

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

I hereby swear under penalties of perjury that the above statements are true, complete and correct.

Signature	Date (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

To whom it may concern:

I hereby authorize, request and direct any person, firm officer, corporation, association, organization or institution to release to the Professional Licensing Agency or the Indiana State Board of Dental Examiners any files, documents, records or other information pertaining to the undersigned, requested by said Board, or any of its authorized representatives, in connection with the processing of my application for a permit to administer anesthesia or sedation.

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

I further authorize the Professional Licensing Agency and the Indiana State Board of Dental Examiners to disclose to the aforementioned organizations, persons, institutions any information which is material to my application, and I hereby specifically release said Agency and Board 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.

VERIFICATION

I hereby swear under penalties of perjury that the above statements are true, complete and correct.

Signature	Date (*month, day, year*)
Print name	

EMERGENCY EQUIPMENT SAMPLE AFFIDAVIT

This type of affidavit must be completed and submitted by all applicants for a permit. **This is a sample.** Please prepare your own affidavit. Your office must contain the listed emergency equipment. If your office contains additional emergency equipment please list it also. You must submit an equipment affidavit for each office location where you will administer *general anesthesia deep sedation or light parenteral conscious sedation.*

Photocopies of this sample will not be accepted by the board.

I, _____ ,

Indiana Dental License Number _____ being duly sworn upon my oath do hereby swear or affirm that

my dental office located at _____
(number and street, city, state, and ZIP code)

Contains the following emergency equipment:

(1) A portable oxygen system capable of delivering positive pressure highflow oxygen (i.e., ambu bag, Robert Shaw Demand valve, or equivalent), full face mask and oral and nasal airways.

(2) An emergency source of power which can be utilized in the event of a power failure and is sufficient to operate the equipment and provide an emergency source of light.

(3) A suction apparatus capable of aspirating gastric contents efficiently from the pharynx or mouth.

(4) An electrocardiograph.

(5) A laryngoscope and assorted blades.

(6) Endotracheal tubes in assorted sizes.

(7) Drugs necessary to follow advanced cardiac life support protocols.

(8) Equipment for continuous intravenous fluid infusion to facilitate drug administration.

(9) A stethoscope.

(10) A body temperature measuring device.

(11) A defibrillator.

(12) A pulse oximeter.

FURTHER AFFIANT SAYETH NAUGHT.

Signature

NOTARY CERTIFICATE

STATE OF _____ }
COUNTY OF _____ } SS:

I, _____, having been duly, say that I am the above-named applicant, that I have personally prepared the foregoing affidavit, and that the same is true to the best of my knowledge and belief.

Signature of applicant	Signature of Notary Public	
Printed or typed name of applicant	Printed or typed name of Notary Public	
Date subscribed and sworn to Notary Public (*month, day, year*)	County of residence	Date commission expires (*month, day, year*)