

FOR OFFICE USE ONLY	
PERMIT NO.:	_____
DATE ISSUED:	_____
INITIAL <input type="checkbox"/>	REINST <input type="checkbox"/>

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

APPLICATION FOR GENERAL ANESTHESIA 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: _____

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

NO. & STREET	CITY	STATE	ZIP CODE
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I am applying for this permit based on: Check A, B, C or D below and follow the applicable instructions.

Document by patient anesthesia or sedation records the completion of a minimum of twelve parenterally administered conscious sedation procedures per year performed in the office, for each of the three one-year periods immediately preceding the date of application; and submit certification of completion of a minimum of twenty-four hours of continuing education in one of the following areas within the three year period immediately preceding the issuance of the permit; anesthesia, parenterally administered conscious sedation, or emergency medicine.

Graduate from a dental school or post-doctoral dental residency program accredited by the ADA Commission on Dental Accreditation within two years prior to applying for the permit, which included either a minimum of four weeks active participation in full-time rotation in hospital operating room anesthesia, or ten documented clinical cases utilizing parenterally administered conscious sedation in the dental operator; and which included a didactic course in conscious sedation in dentistry with a curriculum that fulfills the minimum requirements set forth in the ADA Council on Dental Education, "Guidelines or Teaching the Comprehensive Control of Pain and Anxiety in Dentistry";

Name of Program: _____

Address: _____

NO. & STREET	CITY	STATE	ZIP CODE
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Complete an "Intensive Course" or a "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 and Anxiety".

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 _____

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 _____.

SIGNATURE OF NOTARY PUBLIC

My commission expires _____

Please return this application and the fee for \$160.00 to:

DEPARTMENT OF PUBLIC HEALTH
 DENTAL GACS PERMIT
 410 CAPITOL AVE., MS# 12MQA
 P.O. BOX 340308
 HARTFORD, CT 06134-0308
 (860) 509-7603
www.dph.state.ct.us