



Nevada State Board of Dental Examiners

6010 S. Rainbow Blvd., Bldg. A, Ste. 1

Las Vegas, NV 89118

(702) 486-7044 • (800) DDS-EXAM • Fax (702) 486-7046

MODERATE SEDATION PROGRAM PROVIDER APPROVAL REQUEST (Patients 13 years of age or older) SUBMISSION GUIDELINES

Please comply with the following:

I certify that the program if granted Board approval will be conducted as an education program and will meet the following minimum requirements:

- 1) That instruction shall be conducted on the same educational standards of scholarship and teaching as that required of a true university discipline.
- 2) The course or topic of instruction shall conform to the purpose and method of higher education.
- 3) The completion of a course of study, subject to the approval of the Board, of not less than 60 Hours dedicated exclusively to the administration of moderate sedation, and the successful administration as the operator of moderate sedation to no less than 20 patients

FEE (FOR "FOR PROFIT" ORGANIZATIONS): \$150.00 FOR THE FIRST CREDIT HOUR REQUESTED, \$50.00 FOR EACH ADDITIONAL CREDIT HOUR. THIS FEE IS FOR THE PROCESSING AND REVIEW OF YOUR REQUEST FOR PROVIDER APPROVAL AND MUST ACCOMPANY THIS FORM UPON SUBMISSION OF THE REQUEST.

ALL PROVIDER APPROVAL REQUESTS MUST BE SUBMITTED TO THE BOARD FOR REVIEW NO LATER THAN 45 DAYS PRIOR TO THE BEGINNING DATE OF THE COURSE.



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MODERATE SEDATION PROGRAM PROVIDER APPROVAL REQUEST (Patients 13 years of age or older)

Pursuant to NAC 631.2213(2)(a) which states: The completion of a course of study, subject to the approval of the Board, of not less than 60 Hours dedicated exclusively to the administration of moderate sedation, and the successful administration as the operator of moderate sedation to no less than 20 patients:

Business Name: _____

Business Address: _____

City, State & Zip: _____

Business Telephone: _____

Comprehensive Course Materials and Objectives: **Please submit copies of all course materials.**

Hours of Actual Instruction: _____

Location/Facility Name, Address and instructors Name: _____

Date(s) of Course: _____

Individual Submitting Request: _____

Business Address: _____

City, State & Zip: _____

Business Telephone: _____

Date of Request: _____

Signature of Person Authorized to Represent Program Provider

PLEASE ATTACH NAMES AND BRIEF BIOGRAPHICAL SKETCHES OF INSTRUCTORS AND OUTLINE OF COURSE, INCLUDING METHOD OF PRESENTATION TO THIS FORM.

FOR OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE.

Approved by: _____

Number of Hours Approved: _____

Effective Date of Approval: _____

Disapproved [Explanation]: _____