NEVADA STATE BOARD OF DENTAL EXAMINERS
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OFFICE USE ONLY	
Date Received:	
Payment Amount:	
Staff Initials:	

GENERAL ANESTHESIA ADMININSTRATIVE PERMIT APPLICATION

THE FOLLOWING INFORMATION AND DOCUMENTATION MUST BE RECEIVED BY THE BOARD OFFICE PRIOR TO CONSIDERATION OF A PERMIT. ALL APPLICATIONS MUST BE COMPLETED IN FULL AND SIGNED BY THE APPLICANT

A. CONTACT INFORMATION

First Name:	Middle Name:	Last Name:	License Number:

Pursuant to NAC 631.150, all licensees are required to keep the Board informed of their current address(es). Changes to any address must be reported to the Board office in writing via the Address Change Form (or updated online) within thirty (30) days of such change. All addresses are treated individually.

PROVIDE THE ADDRESS OF THE PRACTICE YOU ARE APPLYING FOR AN ANESTHESIA PERMIT BELOW. IF YOU ARE APPLYING FOR MORE THAN ONE (1) OFFICE, LIST OTHERS ON A SEPARATE SHEET

Name/Practice Name/DBA:	Office Address:

City:	State:	Zip Code:	Office Phone:	Office Fax:

OFFICE SITE PERMIT

Check this box if you are applying for a Site Permit for the same office location as listed above. (If your practice office is already site-permitted, DO NOT select this box)	☐

B. EDUCATION INFORMATION

1. Highest Degree Earned:	☐ Certificate ☐ Bachelors ☐ Doctoral (DDS)	☐ Associates ☐ Masters ☐ Doctoral (DMD)

2. Educational Institution Name:			
3. Institution City:	Institution State:	Did you Graduate?	○ Yes ○ No
4. *If Yes, Graduation Date:	**If No, Expected Graduation Date:		
5. Did you attend a Postdoctoral program in a specialty or advanced education in dentistry?		○ Yes*	○ No

*Specialty Education		
7. Educational Program Name:		
9. Institution City:	Institution State:	Did you Graduate? ◯ Yes ◯ No
10. *If Yes, Graduation Date:	Did you receive Specialty Certificate/Diploma? ◯ Yes ◯ No Certificate/Diploma: _____	

C. ANESTHESIA RELATED EDUCATION

All permit holders MUST show the completion of a Board approved program, of advanced training in anesthesiology and related academic subjects beyond the level of undergraduate dental school in training program as described in the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students or the completion of a graduate program in oral and maxillofacial surgery or dental anesthesiology approved by CODA

Have you completed one (1) year advanced training in Anesthesiology? ◯ Yes* ◯ No

**If yes, provide the name of the facility and when the training occurred:*

Facility Name	Start Date	End Date

Have you completed a residency program in General Anesthesia of not less than one (1) calendar year approved by the Board of Directors of the American Dental Society of Anesthesiology? ◯ Yes* ◯ No

**If yes, provide the name of the facility and when the training occurred:*

Facility Name	Start Date	End Date

Have you completed a graduate program in Oral and Maxillofacial Surgery approved by the Commission of Accreditation of the American Dental Association? ◯ Yes* ◯ No

**If yes, provide the name of the facility and when the training occurred:*

Facility Name	Start Date	End Date

By selecting this box, I hereby attest that I have attached a valid copy of Advanced Cardiac Life Support or a course providing similar instruction that is approved by the Board with this application ☐

CONTINUE TO PAGE 3 AND SIGN AND ATTEST TO THE APPLICATION TO COMPLETE APPLICATION. APPLICATIONS THAT ARE NOT SIGNED ARE NOT COMPLETE AND WILL NEED TO BE RESUBMITTED.

D. FEES			
APPLICATION FEES ARE NON-REFUNDABLE. DENIAL OF AN APPLICATION IS NOT GROUNDS FOR A REFUND			
☐ General Anesthesia	$750.00	☐ Site Permit	$500.00
OPTIONAL REQUEST FEES			
☐ Duplicate Anesthesia Permit	$25.00	Quantity: _____	
☐ Duplicate DH Local Anesthesia/N20 Permit	$25.00	Quantity: _____	
☐ Name Change	$25.00		

By signing below, I hereby request a General Anesthesia Permit from the Nevada State Board of Dental Examiners. I understand that if this permit is issued, I am authorized to administer to a patient of any age general anesthesia, deep sedation, or moderate sedation ONLY at the address(es) provided in this application. If I wish to administer general anesthesia, deep sedation, or moderate sedation at another location, I understand that each site must be inspected and issued a general anesthesia site permit, allows only me to administer general anesthesia, deep sedation, or moderate sedation. I have read and am familiar with the provisions and requirements of NRS 631 and NAC 631 regarding the administration of general anesthesia.

I hereby acknowledge the information contained on this application is true and correct, and I further acknowledge any omissions, inaccuracies, or misrepresentations of information on this application are grounds for revocation of a permit which may have been obtained through this application. It is understood and agreed that the title of all certificates shall remain in the Nevada State Board of Dental Examiners and shall be surrendered by order of said Board.

Licensee Signature: _____ Date: _____