



**NEVADA STATE BOARD OF DENTAL EXAMINERS**

2651 N Green Valley Parkway, Suite 104,

Henderson, Nevada 89014

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Phone(702) 486-7044 | (800) DDS-EXAM | Fax (702)486-7046

**OFFICE USE ONLY**

Date Received: \_\_\_\_\_

Payment Amount: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

**MODERATE ANESTHESIA ADMININSTRATIVE PERMIT APPLICATION**

(administration of Moderate Sedation to patients 13 years of age or older)

**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:
<p>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.</p> <p><b>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</b></p>			
Name/Practice Name/DBA:		Office Address:	
City:	State:	Zip Code:	Office Phone: Office Fax:
<b>OFFICE SITE PERMIT</b>			
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)			<input type="checkbox"/>

**B. EDUCATION INFORMATION**

1. Highest Degree Earned:	<input type="checkbox"/> Certificate <input type="checkbox"/> Bachelors <input type="checkbox"/> Doctoral (DDS)	<input type="checkbox"/> Associates <input type="checkbox"/> Masters <input type="checkbox"/> 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

<b>*Specialty Education</b>		
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. APPLICANT ATTESTATIONS**

1. <b>By selecting this box,</b> I attest that I have received and attached said certification to this application proving I have completed no less than sixty (60) hours of course study as subject to the approval of the Board, dedicated exclusively to the administration of moderate sedation to patients 13 years of age or older and proof of successful management as the operator of moderate sedation to not less than twenty (20) patients who are 13 years of age or older	<input type="checkbox"/>
2. <b>By selecting this box,</b> I hereby attest that I have attached a valid copy of Advanced Cardiac Life Support by the American Heart Association or the completion of a course approved by the Board that provides instruction on medical emergencies and airway management	<input type="checkbox"/>

	<b>CONTINUE TO PAGE 3 AND COMPLETE THE MODERATE SEDATION ADMINISTRATION FORM. APPLICATIONS THAT DO NOT HAVE THE COMPLETED MODERATE SEDATION ADMINISTRATION FORM ARE NOT COMPLETE AND WILL NEED TO BE RESUBMITTED.</b>	
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## D. MODERATE SEDATION - CASE LOG COVER SHEET

List cases in chronological order by date and label all supporting case/chart records by patient name or number corresponding:

	Date	Time	Patient Name/Case	Medication Administered	Office Use
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

	<p><b>CONTINUE TO PAGE 4 TO SIGN AND ATTEST TO THE APPLICATION. APPLICATIONS THAT ARE NOT SIGNED ARE NOT COMPLETE AND WILL NEED TO BE RESUBMITTED.</b></p>	
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**E. FEES**

**APPLICATION FEES ARE NON-REFUNDABLE. DENIAL OF AN APPLICATION IS NOT GROUNDS FOR A REFUND**

<input type="checkbox"/> Moderate Sedation	\$750.00	<input type="checkbox"/> Site Permit	\$500.00
<b>OPTIONAL REQUEST FEES</b>			
<input type="checkbox"/> Duplicate Anesthesia Permit	\$25.00	Quantity: _____	
<input type="checkbox"/> Duplicate DH Local Anesthesia/N20 Permit	\$25.00	Quantity: _____	
<input type="checkbox"/> Name Change	\$25.00		

I hereby submit my application for a Moderate Sedation Permit to administer moderate sedation *to patients 13 years of age or older* from the Nevada State Board of Dental Examiners. I understand that if this permit is issued, I am authorized to administer moderate sedation **ONLY** *to patients 13 years of age or older* at the address listed above. If I wish to administer moderate sedation *to patients 13 years of age or older* at another location, I understand that each site must be inspected, and a “Moderate Sedation Site Permit” must be issued by the Board prior to administration of moderate sedation *to patients 13 years of age or older*. I understand that this permit, if issued, allows only *me* to administer moderate sedation *to patients 13 years of age or older*.

Furthermore, I understand that this permit does **NOT** allow for the administration of *moderate sedation to patients 12 years of age or younger* or the administration of deep sedation or *general anesthesia* by me, a physician, nurse anesthetist, or any other person. I have read and am familiar with the provisions and requirements of NRS 631 and NAC 631 regarding the administration of moderate sedation.

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 the 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

Licensee Signature:

Date:

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