# Dental Anesthesia/Sedation Certification Form 2A

## Dental General Anesthesia

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

**DEPARTMENT USE ONLY**

Approved: _____

Date: _____

# VERIFICATION OF APPROVED POST-DOCTORAL/GRADUATE LEVEL EDUCATION IN ANESTHESIA OR EDUCATION IN APPROVED SPECIALTY PROGRAM OR RESIDENCY

## APPLICANT INSTRUCTIONS

1. Complete Section I. Enter your name as it appears on your application Form 1. Please be sure to sign and date item 8.
2. Send this form to the institution you attended. See informational materials for requirements and additional information. Be sure to include any fee required by the institution.
3. The institution which completes Section II must send this form directly to the Division of Professional Licensing Services. It will not be accepted if submitted by the applicant.

## SECTION I: APPLICANT INFORMATION

**1** **Social Security Number:** _____
*(Leave this blank if you do not have a U.S. Social Security Number)*

**2** **Birth Date:** _____ _____ _____
*mo . day yr.*

**3** _____
**New York State License Number**

**4** **Print Your Full Name Exactly As It Appears On Your Certification Application (FORM 1)**

Last _____

First _____

Middle _____

**5** **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 _____

Line 2 _____

Line 3 _____

City _____

State _____ Zip Code _____

Country/ Province _____

**6** Name of Institution: _____

Dates of attendance: from _____ / _____ / _____ to _____ / _____ / _____
*mo. day yr. mo. day yr.*

**7** Print name under which program was completed: _____

**8** I request and give my permission to the institution listed in item 6 above to complete the information on this form and send any documentation requested by the NYS State Education Department including that listed on page 2 of this form (e.g. an official transcript) to the New York State Education Department's Office of the Professions.

Applicant's signature: _____ Date: _____ / _____ / _____
*mo. day yr.*

## SECTION II: VERIFICATION OF POST-DOCTORAL/GRADUATE LEVEL EDUCATION IN ANESTHESIA OR EDUCATION IN APPROVED SPECIALTY PROGRAM OR RESIDENCY

**INSTRUCTIONS TO INSTITUTION:** Please complete this section and return this form directly to the Office of the Professions at the address at the end of the form. It will **not** be accepted if it is incomplete or if it is returned by the applicant.

I hereby certify that _____
(Dentist's Name)

Attended:

- ☐ a. 2 year post doctoral education program in anesthesia, or
- ☐ b. Completion of three (3) years of post-doctoral education in anesthesia acceptable to the Department and accredited by an acceptable accrediting body.
- ☐ c. Completion of a graduate level program in oral and maxillofacial surgery acceptable to the Department and accredited by an acceptable accrediting body (completion of a CODA accredited residency in OMFS)

at _____, accredited by _____
(Dentist's School) (Accrediting body such as CDA)

from _____ through _____ and that the above named dentist successfully completed this

program on _____.
(Date)

☐ **Please check and attach a letter of explanation with this form if this dentist did not successfully complete the training program.**

### ATTESTATION

**I hereby attest that to the best of my knowledge and belief the foregoing is a true statement.**

Signature:_____ Date: _____ / _____ / _____
mo. day yr.

Print or type name: _____

Title or official position: _____

Institution: _____ (INSTITUTION SEAL)

(If seal not available, attach explanation)

Address: _____

Telephone number: ( _____ ) _____

Fax: ( _____ ) _____

E-mail: _____

**Return Directly to:** **New York State Education Department, Office of the Professions, Dentistry Unit, 89 Washington Avenue, Albany, NY 12234-1000.**