Dental Anesthesia/Sedation Certification Form 2B

Dental Parenteral Conscious Sedation

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 POST-DOCTORAL EDUCATION IN USE OF PARENTERAL CONSCIOUS SEDATION

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 9.
2. Send this form to the institution at which you received your training or served your residency for completion of Section II on page 2.
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 **Check what you are applying for:**

☐ **Dental Parenteral Conscious Sedation 13 Years & Older**

☐ **Dental Parenteral Conscious Sedation 12 Years & Younger**

2 **Social Security Number:** ☐☐☐ ☐☐ ☐☐☐☐

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

3 **Birth Date:** ☐☐ ☐☐ ☐☐☐☐
mo . day yr.

4 ☐☐☐☐☐☐
New York State License Number

5 **Print Your Full Name Exactly As It Appears On Your Certification Application (Form 1)**

Last

First

Middle

6 **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

7 Name of Institution: ____

Dates of attendance: from _________ / _________ / _________ to _________ / _________ / _________
mo. day yr. mo. day yr.

8 Print name under which program was completed: ____

9 I request and give my permission to the institution listed in item 7 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 Division of Professional Licensing Services.

Applicant's signature: ____ Date: _______ / _______ / _______
mo. day yr.

SECTION II: VERIFICATION OF POST-DOCTORAL EDUCATION IN USE OF PARENTERAL CONSCIOUS SEDATION

INSTRUCTIONS TO INSTITUTION: Please complete this section and return directly to the Division of Professional Licensing Services. It will **not** be accepted if incomplete or if returned by the applicant.

I hereby certify that ____ completed ____________ hours
(Dentist's Name)

of post-doctoral education in the use of parenteral conscious sedation in a program accredited/approved by ______________________
(Accrediting body such as CDA)

______________________________ at ____
(Name and location of institution)

____

Inclusive dates of training _____________ to _____________

Type of residency program completed (if applicable): ____
(e.g. GPR, AEGD, OMS, etc.)

The training included instruction in all of the following **required** subjects:

Subject		
Patient evaluation and Monitoring	☐ Yes	☐ No
Rescue Patients from Deep Sedation	☐ Yes	☐ No
IV Access and Placement	☐ Yes	☐ No
Pediatric and Adult Cardiac and Pulmonary Anatomy and Physiology	☐ Yes	☐ No
Pediatric and Adult Pharmacology	☐ Yes	☐ No
Control of Pain and Anxiety	☐ Yes	☐ No
Management of Pediatric and Adult Airways	☐ Yes	☐ No

On the chart below, list other subjects included in training (attach additional sheets if necessary).

Other Subjects	
Total Clock Hours (Minimum 60 hours): ___________	

In addition,

☐ This individual successfully administered or observed parenteral conscious sedation on no fewer than 20 live dental patients via intravenous route who shall be 13 years of age or older.

☐ This individual successfully administered or observed parenteral conscious sedation on no fewer than 15 live dental patients via intravenous route who shall be 12 years of age or younger and 5 live dental patients who shall be 13 years old or older.

☐ **Please check and attach a letter of explanation with this form if this dentist did not successfully complete the post-doctoral 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)

Address: ____ (If seal not available, attach explanation)

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.**