Dental Anesthesia/Sedation Certification Form 2C

Dental Enteral 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 PRE-DOCTORAL OR POST-DOCTORAL EDUCATION IN USE OF ENTERAL 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 or provider where you received your training for completion of Section II on page 2
3.
4. 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 Enteral Conscious Sedation 13 Years & Older** ☐ **Dental Enteral Conscious Sedation 12 Years & Younger**

2 **Social Security Number:** _____ *(Leave this blank if you do not 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 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 Division of Professional Licensing Services.

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

SECTION II: VERIFICATION OF TRAINING

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

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

of pre-doctoral or post-doctoral education in the use of enteral conscious sedation in a program accredited/approved by

_____ at _____
(Accrediting body) (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:

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 enteral conscious sedation on at least 10 patients 13 years of age or older and at least 5 patients 12 years of age or younger.

☐ This individual successfully administered or observed enteral conscious sedation on at least 15 patients 12 years of age or younger and at least 5 patients 13 years of age or older.

☐ **Please check here and attach a letter of explanation with this form if this dentist did not successfully complete the pre-doctoral or 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: _____

Institution or provider: _____

(INSTITUTION SEAL)
(If seal not available, attach explanation)

Telephone: (_____) _____

Fax: (_____) _____

E-mail: _____

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