THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Permit to Administer Moderate or Minimal Sedation Application Instructions

A dentist may not administer moderate sedation to patients over 13 years of age or moderate or minimal sedation to a patient younger than 13 years of age without a permit issued by the Alaska Board of Dental Examiners.

A moderate sedation permit is renewed biennially in conjunction with the renewal of the permittee's license to practice dentistry in the State of Alaska.

The following must be received by the division before your application to administer moderate or minimal sedation can be reviewed by the board:

1. APPLICATION
A completed application, signed and notarized (#08-4172, pages 1-3).

2. FEES
Fees made payable to "State of Alaska."

Nonrefundable Application Fee:	$ 100.00
Moderate Sedation Permit Fee:	$1,000.00
Total Fees Due:	$1,100.00

3. ADVANCED CARDIOVASCULAR LIFE SUPPORT AND/OR PEDIATRIC ADVANCED LIFE SUPPORT
Copy of current American Heart Association Advanced Cardiovascular Life Support (ACLS) card, or other certification that meets the requirements of 12 AAC 28.015(d)(5). Copy of current Pediatric Advanced Life Support (PALS) for Health Professionals if providing sedation to patients younger than 13. Both are required if providing sedation to patients of all ages.

4. COURSE VERIFICATION

a. If providing moderate or minimal sedation to patients younger than 13 years of age <u>ONLY</u>, documentation of either:

- Completion of a CODA accredited residency in pediatric dentistry;

  - OR -

- Completion of at least 30 hours of continuing education coursework in pediatric moderate sedation approved by the board (form #08-4172c);

  - AND -

  Provide proof of administration of sedation for at least 20 individually managed patients younger than 13 years of age (form #08-4172e).

b. If providing moderate sedation to patients at least 13 years of age, documentation of either:

- Training in moderate sedation consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students while enrolled in a dental program accredited by CODA or, a post-doctoral university or teaching hospital program (form 08-4172a);

  - OR -

- A board approved continuing education course in sedation consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. The course must consist of a minimum of 60 hours of instruction plus administration of sedation for a least 20 individually managed patients per participant (form 08-4172b).

c. If providing moderate or minimal sedation to patients younger than 13 years of age <u>AND</u> patients 13 years of age and older, documentation of either:

- Completion of a CODA accredited residency in pediatric dentistry; (form #08-4172a);

  - OR -

- An additional 30 hours of board-approved coursework in pediatric moderate sedation (form #08-4172d).

  - AND -

  Provide proof of administration of sedation for at least 20 individually managed patients younger than 13 years of age while under the supervision of a sedation provider holding a current moderate or deep sedation permit in good standing for patients under 13 years of age or an anesthesiologist or certified registered nurse anesthetist licensed in this state or another jurisdiction (form #08-4172e).

If providing moderate sedation to patients 13 years of age and older, and moderate or minimal sedation to patients younger than 13, the applicant must show proof of training under b. and c. in this section.

IN ADDITION TO MEETING THE REQUIREMENTS OF #4 ABOVE, THE DOCUMENTATION MUST:

a. Have been completed within three years immediately before application;

   - OR -

b. If training was obtained three years but less than five years before submitting the application, document four hours of continuing education that focuses on one or more of the following:
   - Venipuncture
   - Intravenous Sedation
   - Enteral Sedation
   - Physiology
   - Pharmacology
   - Nitrous Oxide Analgesia
   - Patient Evaluation, Patient Monitoring or Medical Emergencies

   - OR -

   If training was obtained three years but less than five years before application, document completion of a comprehensive review course in moderate sedation approved by the board;

   - OR -

c. If more than five years have elapsed since completion of the training required and the applicant holds a permit for moderate sedation from another jurisdiction where the applicant is also licensed to practice dentistry, you may submit documentation of at least 25 cases at the moderate sedation level not earlier than the 24 months immediately preceding application (form #08-4172e);

   - OR -

d. Demonstrate current competency to the satisfaction of the board that the applicant has skill in moderate sedation to safely deliver moderate sedation services to the public.

ON-SITE INSPECTION

Before issuance of a moderate sedation permit and during the term of the permit, the board may require an on-site inspection of the permittee's facilities and equipment, and an evaluation of the ancillary staff.

General Information

APPLICATION PROCESSING:
The average processing time varies by program. When the application is complete and correct, all supporting documents have been received and all fees have been paid, the permit may be issued. Start the process far enough in advance to allow for processing time. Applications are reviewed in order of receipt in our office, and walk-in customers should not expect immediate review.

PERMIT TERM:
Permits are issued for a two-year period and expire on February 28 of odd-numbered years, regardless of the date of issuance, except permits issued within 90 days of the expiration date which are issued to the next biennial expiration date. One renewal notice will be sent via email or mail at least 30 days before license expiration to the last known email or mailing address of record. Failure to receive a renewal notice does not relieve a licensee from the responsibility of renewing a license or permit on time.

DENIAL OF APPLICATION:
Be aware that the denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local governmental agency, or other entity making a relevant inquiry or as may be required by law.

ADDRESS OR NAME CHANGE:
In accordance with 12 AAC 02.900, it is the applicant's responsibility to notify the division, in writing, of changes of address or name. Name and address change notification forms are available on the division's website. The address of record with the division will be used to send renewals and all other official notifications. The name appearing on the license must be your current legal name.

CERTIFIED TRUE COPIES:
If any of the required documents will be issued under a former name, indicate on the application and submit marriage license and/or court documents that are notarized as a "certified true copy of the original document". To obtain a certified true copy, you must present the notary with the original document along with the photocopy. You must write, "I certify this is a true copy of the original document" and sign your name. The notary will compare the original document with the copy and then notarize your signature.

SOCIAL SECURITY NUMBERS:
AS 08.01.060 requires a U.S. Social Security Number be on file with the division before a professional license is issued. If you do not have a U.S. Social Security Number, complete the Request for Exemption from Social Security Number Requirement form located at *ProfessionalLicense.Alaska.Gov.*

PUBLIC INFORMATION:
All information on the application will be available as public record, unless required to be kept confidential by state or federal law.

ABANDONED APPLICATIONS:
Under 12 AAC 02.910, an application is considered abandoned when 12 months have elapsed since correspondence was last received from or on behalf of the applicant. An abandoned application is denied without prejudice. At the time of abandonment, the division will send notification to the last known address of the applicant, who has 30 days to submit a written request for a refund of biennial license and other fees paid. The application fee will not be refunded. If no request for refund is received within that timeframe, no refund will be issued, and all fees will be forfeited.

BUSINESS LICENSES:
The status of a professional license will directly impact the status of an associated business license. Renewal applications for business licenses are mailed separately. For more information about business licenses, (907) 465-2550 or *BusinessLicense.Alaska.Gov.*

STALE DOCUMENTS:
Application forms, authorizations and verifications older than 12 months from the date the document was received by the division will be considered stale; the document must be resubmitted as appropriate before the application will be considered by the division or a licensing board. Application documents include the application documents and verifications of licensure from other licensing jurisdictions. (12 AAC 02.915)

PAYMENT OF CHILD SUPPORT:
If the Alaska Child Support Enforcement Division has determined that you are in arrears on child support, you may be issued a nonrenewable temporary license valid for 150 days. Contact Child Support Services at (907) 269-6900 to resolve payment issues.

STATUTES AND REGULATIONS:
The complete set of statutes and regulations for this program are available by written request or online at the division's website: *ProfessionalLicense.Alaska.Gov*. To receive notification of all proposed regulation changes, send a request with your name, preferred contact method (mail or email), and the program you want to be updated on to the regulation specialist at the following email: *RegulationsAndPublicComment@Alaska.Gov.*

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

DEN

FOR DIVISION USE ONLY

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Permit to Administer Moderate or Minimal Sedation Application

PART I Age of Patients

Select ONE (1) of the following:

- ☐ I will ONLY be providing moderate or minimal sedation to patients younger than 13 years of age.
- ☐ I will ONLY be providing moderate sedation to patients 13 years of age and older.
- ☐ I will be providing moderate or minimal sedation to patients younger than 13 years of age AND providing moderate sedation to patients 13 years of age and older.

PART II Payment of Fees

Required Fees:	☐ Application and Permit Fee ($100 is Non-Refundable)	**$1100.00**

PART III Personal Information

Full Legal Name:			

Provide all other names used (maiden, nicknames, aliases). If any documentation will be received in a prior name, you must provide a certified true copy of the documentation showing proof of legal name change(s).

- ☐ Not Applicable
- ☐ Other Names Used: _____

Mailing Address:	P.O. Box or Street	City	State	Zip
Contact Phone:		**Date of Birth:**		

EMAIL AGREEMENT: By choosing to receive correspondence on any matter affecting my license or other business with the Alaska Division of Corporations, Business and Professional Licensing, I agree to maintain an accurate email address through the MY LICENSE web page. I understand that failure to check my email account or to keep the email address in good standing may result in an inability to receive crucial information, potentially resulting in my inability to obtain or maintain licensure.

Email Address:		**Select One:**	☐ Send my Correspondence Electronically ☐ Send my Correspondence by Mail

Note: If both boxes are selected above, you will receive correspondence electronically.

SOCIAL SECURITY NUMBER: AS 08.01.060 requires you to provide your United States Social Security Number. It is considered confidential information and will not be publicly disclosed; it may be used to verify inter-state licensure.	

PART IV Alaska License

AK Dental License Number:		**Years of Clinical Practice as a Dentist:**	
DEA Registration Number:		**Expiration Date:**	

PART V Dental Education

Name of Dental School:			
Location: (City, State)			
Date Attended From:		**Date Attended To:**	
Degree Awarded:			

PART VI Sedation Training

Name of College or University:			
Location: (City, State)			
Date Attended From:		**Date Attended To:**	
Program Name:			

PART VII Professional License(s)

List the license number and name of the jurisdiction for all dental licenses you hold or have ever held in any jurisdiction (i.e., states, territories, provinces, or foreign countries). Continue on a separate page, if necessary.

State or Jurisdiction	Licensed By (Exam, Credential, Other)	License Number	Issue Date	Dates of Practice

PART VIII Alaska Law

☐ I hereby certify I have reviewed, understand and will abide by the statutes and regulations applicable to my profession (AS 08.36, AS 08.32 and 12 AAC 28).

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

DEN

FOR DIVISION USE ONLY

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Notary Signature Page

Applicant Name:		
Alaska License Number (if known):		☐ *Application in Process*

PART IX Notarized Signature

By my signature below, I certify I have read and will comply with all of the equipment, facility, and staff requirements of Article I of the dental regulations regarding the facility compliance in the administration of moderate and minimal sedation.

I understand, before issuance of a moderate sedation permit and during the term of the permit, the board may require an on-site inspection of the permittee's facilities and equipment, and an evaluation of the ancillary staff.

I hereby certify I am the person herein named and subscribing to this application. I further certify I have read the complete application, and I know the full content thereof. I declare all of the information contained herein, and evidence or other documents submitted herewith are true and correct.

I understand any falsification or misrepresentation of any item or response in this application, or any attachment hereto, or falsification or misrepresentation of documents to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license, registration, certificate, or permit to practice in the state of Alaska.

I further understand it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification. A person who makes a false statement on this application may be subject to civil and criminal penalties, including prosecution for perjury (AS 11.56.200 & AS 11.56.230).

Notary Stamp	**Applicant Printed Name:**			
	Applicant Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Program Verification

This form is used to provide proof of the following:

- Completion of a CODA accredited residency in pediatric dentistry.
  - AND/OR -
- Training in moderate sedation consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students while enrolled in a dental program accredited by CODA or, a post-doctoral university or teaching hospital program.

→ Applicant:

Complete this top section, then forward to the institution where you received training in administering moderate sedation.

Applicant Name:			
Applicant Signature:		**Date Signed:**	

→ Institution Use Only:

Complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead address.

Institution Name:			
Address:	P.O. Box or Street City State Zip		
Program Name:		**Completion Date:**	

☐ I have attached a course description or course outline.

1. Is the program accredited by the Commission on Dental Accreditation (CODA).	☐ Yes ☐ No
2. Is the program a post-doctoral university or teaching hospital?	☐ Yes ☐ No
3. Is the program a CODA-approved residency in pediatric dentistry?	☐ Yes ☐ No
***If yes*, did the student perform at least 20 sedations on patients younger than 13?**	☐ Yes ☐ No
4. Is the training consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students as adopted by the October 2016 American Dental Association House of Delegates?	☐ Yes ☐ No

Signature

I hereby certify the above information regarding the training in moderate/minimal sedation for the above-named applicant is true and correct to the best of my knowledge, and they have acquired the necessary knowledge and proficiency to perform moderate sedation, or minimal sedation to patients younger than 13 years of age.

School Seal				
	Signature:		**Date Signed:**	
	Printed Name:		**Title:**	
	Email:		**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Continuing Education Course Verification

If providing moderate sedation to patients at least 13 years of age:
This form is used to provide proof of a board approved continuing education course in sedation consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. The course must consist of a minimum of 60 hours of instruction plus administration of sedation for a least 20 individually managed patients per participant.

→ Applicant:

Complete this top section, then forward to the institution where you received training in administering moderate sedation.

Applicant Name:			
Applicant Signature:		**Date Signed:**	

→ Institution Use Only:

Complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead address.

Institution Name:			
Address:	P.O. Box or Street City State Zip		
Course Title:		**Completion Date:**	

☐ I have attached a course description or course outline.

1. Does the course consist of at least 60 hours of instruction?	☐ Yes ☐ No
2. Did the student perform sedation on at least 20 individually managed patients?	☐ Yes ☐ No
3. Is the training consistent with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students as adopted by the October 2016 American Dental Association House of Delegates?	☐ Yes ☐ No

Signature

I hereby certify the above information regarding the training in moderate sedation for the above-named applicant is true and correct to the best of my knowledge, and they have acquired the necessary knowledge and proficiency to perform moderate sedation.

Instructor Printed Name:			
Instructor Signature:		**Date Signed:**	
Email:		**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Continuing Education Course Verification

Use this form if you are providing moderate or minimal sedation to patients younger than 13 years of age AND patients 13 years of age and older. You must show completion of an additional 30 hours of continuing education coursework in pediatric moderate sedation approved by the board and proof of administration of sedation for at least 20 individually managed patients younger than 13 years of age while under the supervision of a sedation provider holding a current moderate or deep sedation permit in good standing for patients under 13 years of age or an anesthesiologist or certified registered nurse anesthetist licensed in this state or another jurisdiction.

→ Applicant:

Complete this top section, then forward to the institution where you received training in administering moderate/minimal sedation.

Applicant Name:			
Applicant Signature:		**Date Signed:**	

→ Institution Use Only:

Complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead address.

Institution Name:			
Address:	P.O. Box or Street / City / State / Zip		
Course Title:		**Completion Date:**	

☐ I have attached a course description or course outline.

1. How many hours of instruction pertained to pediatric sedation?	
2. Did the student perform sedation on pediatric patients?	☐ Yes ☐ No
***If yes*, how many were individually managed?**	
3. Is the training consistent with the Guideline for Monitoring and management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures endorsed by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry?	☐ Yes ☐ No

Signature

I hereby certify the above information regarding the training in moderate sedation for pediatric patients for the above-named applicant is true and correct to the best of my knowledge, and they have acquired the necessary knowledge and proficiency to perform moderate/minimal sedation for pediatric patients.

Instructor Printed Name:			
Instructor Signature:		**Date Signed:**	
Email:		**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Continuing Education Course Verification

Use this form if you are providing moderate or minimal sedation to patients younger than 13 years of age ONLY. You must show completion of at least 30 hours of continuing education coursework in pediatric moderate sedation approved by the board and proof of administration of sedation for at least 20 individually managed patients younger than 13 years of age.

→ Applicant:

Complete this top section, then forward to the institution where you received training in administering moderate/minimal sedation.

Applicant Name:			
Applicant Signature:		**Date Signed:**	

→ Institution Use Only:

Complete this bottom part for the applicant identified above and return the form directly to the Alaska State Board of Dental Examiners at the letterhead address.

Institution Name:			
Address:	P.O. Box or Street City State Zip		
Course Title:		**Completion Date:**	

☐ I have attached a course description or course outline.

1. Does the course consist of at least 30 hours of instruction?	☐ Yes ☐ No
2. Did the student perform sedation on at least 20 individually managed pediatric patients?	☐ Yes ☐ No
3. Is the training consistent with the Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures endorsed by the American Academy of Pediatrics and the American Academy of Pediatric Dentistry?	☐ Yes ☐ No

Signature

I hereby certify the above information regarding the training in moderate sedation for pediatric patients for the above-named applicant is true and correct to the best of my knowledge, and they have acquired the necessary knowledge and proficiency to perform moderate sedation for pediatric patients.

Instructor Printed Name:			
Instructor Signature:		**Date Signed:**	
Email:		**Phone:**	

THE STATE of ALASKA
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

Board of Dental Examiners
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *BoardOfDentalExaminers@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/BoardOfDentalExaminers*

Anesthesia Documentation

If you qualify for a moderate sedation permit under 12 AAC 28.015(e)(2) or (f), complete this form documenting 20 anesthesia cases, or 25 cases if applying under (g)(4).

Applicant Name:	

Date	Patient Date of Birth	Sedation Duration	Name of Medication	Dose	Sedation Level
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

Date	Patient Date of Birth	Sedation Duration	Name of Medication	Dose	Sedation Level
21.					
22.					
23.					
24.					
25.					

Signature

I hereby certify the above information is true and correct to the best of my knowledge. I understand that it is a Class A misdemeanor under Alaska Statute 11.56.210 to falsify an application and commit the crime of unsworn falsification.

Applicant Printed Name:			
Applicant Signature:		**Date Signed:**	
Email:		**Phone:**	

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

FOR DIVISION USE ONLY

State of Alaska
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee:			
Profession Type *(e.g., Acupuncture)*:		**License Number *(if applicable)*:**	
I wish to make payment by credit card for the following *(check all that apply):*			**AMOUNT**
☐ **Application Fee:**			
☐ **License or Renewal Fee:**			
☐ **Other *(fine, exam, etc.)*:**			
1.			
2.			
		TOTAL:	0

Name *(as shown on credit card)*:			
Mailing Address:			
Phone Number:		**Email *(Optional)*:**	
Signature of Credit Card Holder:	X		

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed.

1. Credit Card Number:		**All 3 fields MUST be completed.**
2. Expiration Date:		**This section will be destroyed after the payment is processed.**
3. Security Code:		