



Jeremiah W. (Jay) Nixon  
Governor  
State of Missouri

Kathleen (Katie) Steele Danner, Division Director  
DIVISION OF PROFESSIONAL REGISTRATION

Department of Insurance  
Financial Institutions  
and Professional Registration  
John M. Huff, Director

MISSOURI DENTAL BOARD  
3605 Missouri Boulevard  
P.O. Box 1367  
Jefferson City, MO 65102-1367  
573-751-0040  
573-751-8216 FAX  
800-735-2966 TTY  
800-735 2466 Voice Relay Missouri  
[dental@pr.mo.gov](mailto:dental@pr.mo.gov)  
<http://www.pr.mo.gov>

Brian Barnett  
Executive Director

Dear Applicant:

Please find the attached application for a Deep Sedation/General Anesthesia Permit. Pursuant to Board Rule 20 CSR 2110-4.040, no dentist shall administer deep sedation/general anesthesia unless the dentist possesses a permit issued by the Missouri Dental Board.

If you wish to apply for a deep sedation/general anesthesia permit, please complete the attached application form and return it to this office with the \$100 permit fee. To verify your education and training, please send the "Verification of Deep Sedation/General Anesthesia Requirements" form to your postgraduate program director to be completed and returned to this office. You will complete Section I of the form and your residency director completes Section II and returns it directly to this office. You must also document completion of an Advanced Cardiac Life Support (ACLS) course or its Board-approved equivalent during the past five (5) years.

Upon receipt of your completed application, \$100 fee, documentation of your education and training, and proof of current ACLS or its Board-approved equivalent, your application will be forwarded to our Deep Sedation/General Anesthesia Committee for review. Upon approval of your application, you will be contacted by a member of the Board staff and/or a Committee member to schedule an appointment for your on-site evaluation. On-site evaluations shall be conducted in accordance with guidelines in the current AAOMS *Office Anesthesia Evaluation Manual*.

In addition, the dental office(s) at which you intend to administer deep sedation/general anesthesia must have a site certificate issued by the Board. If the dental office(s) does not have a valid site certificate, the dentist-in-charge of the dental office(s) must secure a site certificate before the Board can issue you a deep sedation/general anesthesia permit.

If you have any questions regarding the application process for obtaining a deep sedation/general anesthesia permit, please contact the Board office at (573) 751-0040.

Sincerely,

A handwritten signature in cursive script that reads "Brian Barnett".

Brian Barnett  
Executive Director



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**APPLICATION FOR DEEP SEDATION /  
 GENERAL ANESTHESIA PERMIT**

**FEE: \$100**

MISSOURI DENTAL BOARD  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 1367  
 JEFFERSON CITY MO 65102-1367  
 TELEPHONE: (573) 751-0040  
 TTY: (800) 735-2966

**PLEASE TYPE OR PRINT  
 LEGIBLY IN BLACK INK**

**SECTION I – APPLICANT DATA**

|   |                           |                        |          |
|---|---------------------------|------------------------|----------|
| NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN) |                           | LICENSE NUMBER         |          |
| DATE OF BIRTH                                     | PLACE OF BIRTH            | SOCIAL SECURITY NUMBER |          |
| HOME TELEPHONE NUMBER                             | BUSINESS TELEPHONE NUMBER | FAX NUMBER             |          |
| MAILING ADDRESS                                   |                           |                        |          |
| CITY  |                           | STATE                  | ZIP CODE |

**SECTION II – EDUCATION AND TRAINING (PLEASE CHECK THE BOXES THAT APPLY TO YOUR EDUCATION AND TRAINING.)**

- Have you completed one of the following?
  - a) A postdoctoral training program in anesthesia and related subjects that satisfies the requirements described in Part II of the American Dental Association (ADA) Guidelines for Teaching Comprehensive Control of Pain and Anxiety in Dentistry, or;
  - b) An ADA accredited postdoctoral training program in oral and maxillofacial surgery; or
  - c) An anesthesia training program that is approved and accredited to teach postgraduate medical education by the Accreditation Council for Graduate Medical Education of the American Medical Association (AMA), or the Education Committee of the American Osteopathic Association (AOA)
- Have you completed one of the following during the past five (5) years?
  - a) An Advanced Cardiac Life Support (ACLS) course; or
  - b) A minimum of fifteen (15) hours of board-approved continuing education pertaining to medical emergencies, anesthesia complications, or patient management while under sedation.

**Please attach the appropriate documentation of your education and training with this application. Applicants who completed an approved or accredited training program must have their postgraduate program director complete the attached “Verification of Deep Sedation/General Anesthesia Requirements” form.**

**SECTION III – LOCATION(S) WHERE DEEP SEDATION/GENERAL ANESTHESIA SERVICES ARE PROVIDED.**

Please list below the locations of the dental office(s) at which you intend to offer deep sedation/general anesthesia services. Please understand that pursuant to 20 CSR 2110-4.040, the dentist-in-charge of each of the following dental offices must secure a site certificate. A separate permit is required for each dental office.

| BUSINESS NAME | ADDRESS | CITY | STATE | ZIP CODE | SITE CERTIFICATE NO. |
|---------------|---------|------|-------|----------|----------------------|
|               |         |      |       |          |                      |
|               |         |      |       |          |                      |
|               |         |      |       |          |                      |
|               |         |      |       |          |                      |
|               |         |      |       |          |                      |

**SECTION IV– NOTE: IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, ATTACH A FULL EXPLANATION.**

|   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do you now or have you ever held any professional license, other than dentistry, in any state or country? If yes, indicate profession, license number and whether active or inactive.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been suspended from practice, reprimanded, censured, or otherwise disciplined or disqualified as a dentist or a member of any profession? If so, provide the dates, facts and disposition of the matter and name and address of the authority in possession of the record thereof. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever voluntarily surrendered a professional license, including but not limited to a dental license, issued to you by any state or country?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are charges or an investigation currently pending relative to your dental license in any state or country?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has your employment, medical staff appointment or admitting or clinical privileges ever been denied, reduced, suspended, revoked or not renewed at any hospital, nursing home, clinic or other health care facility or are such actions currently pending?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been suspended, sanctioned or otherwise restricted from participation in any private, federal or state health insurance program, i.e., Medicare or Medicaid, or are such actions currently pending?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been denied a narcotic license or has your narcotic license ever been placed on probation, suspended, voluntarily surrendered or revoked or are such actions currently pending?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been charged with or been convicted, adjudged guilty by a court, pled guilty or nolo contendere to any crime, whether or not sentence was imposed (excluding traffic violations)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are there any malpractice judgements against you resulting from the practice of dentistry?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been adjudged insane or incompetent by a state or federal court within the past five years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol, whether or not sentence was imposed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you now or have you been within the past five years, addicted to or dependent upon any illegal or prescription drugs, controlled substances or alcohol?   | <input type="checkbox"/> | <input type="checkbox"/> |

**SWORN AFFIDAVIT**

I, the below named applicant, being duly sworn, hereby affirm under penalties of perjury that I am the applicant referred to in the proceeding application for a Deep Sedation/General Anesthesia permit in the state of Missouri, and that all statements and enclosures are true and accurate to the best of my knowledge, information and belief.

I submit for consideration, this application as required by the Missouri law governing the practice of dentistry and subject to the rules and regulations of the Missouri Dental Board. I subscribe and agree to abide by all applicable laws and rules regarding the practice of dentistry. I hereby certify that I have familiarized myself with Chapter 332, RSMo, known as the Dental Practice Act and applicable rules promulgated by the Missouri Dental Board.

Enclosed is the permit fee which is nonrefundable. I understand that the Board may require further information or evidence that it deems reasonable and proper.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications.

|   |                                       |                               |
|---|---------------------------------------|-------------------------------|
| <b>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</b> | SIGNATURE OF APPLICANT                |                               |
|   | STATE                                 | COUNTY (OR CITY OF ST. LOUIS) |
|   | SUBSCRIBED AND SWORN BEFORE ME, THIS  |                               |
|   | DAY OF                                | YEAR                          |
| <b>USE RUBBER STAMP IN CLEAR AREA BELOW.</b>  | NOTARY PUBLIC SIGNATURE               | MY COMMISSION EXPIRES         |
|   | NOTARY PUBLIC NAME (TYPED OR PRINTED) |                               |



**STATE OF MISSOURI**  
 DIVISION OF PROFESSIONAL REGISTRATION  
**VERIFICATION OF DEEP SEDATION /**  
**GENERAL ANESTHESIA REQUIREMENTS**

MISSOURI DENTAL BOARD  
 3605 MISSOURI BOULEVARD  
 P.O. BOX 1367  
 JEFFERSON CITY MO 65102-1367  
 TELEPHONE: (573) 751-0040  
 TTY: (800) 735-2966

**PLEASE TYPE OR PRINT**  
**LEGIBLY IN BLACK INK**

**SECTION I – APPLICANT INFORMATION**

**Instructions:** Complete Section I and mail this form to the Postgraduate Program Director for verification of your having met the qualifications for a permit to administer or supervise the administration of deep sedation/general anesthesia.

NAME (FIRST, MIDDLE, LAST, SUFFIX, FORMER/MAIDEN)

MAILING ADDRESS (STREET, CITY, STATE, ZIP)

The Missouri Dental Board requires that I submit evidence of my having met the requirements to obtain a permit to administer or supervise the administration of deep sedation/general anesthesia. You are hereby authorized to release any information in your possession pertaining to me, favorable or otherwise, directly to the Missouri Dental Board at the above address.

|                     |      |
|---------------------|------|
| APPLICANT SIGNATURE | DATE |
|---------------------|------|

**SECTION II – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR**

**Instructions:** Please indicate below if the above-named applicant has met the following requirements for a permit to administer deep sedation/general anesthesia and return this form directly to the Missouri Dental Board at the above address.

NAME OF POSTGRADUATE PROGRAM DIRECTOR

|   |                  |
|---|------------------|
| NAME AND LOCATION OF POSTGRADUATE PROGRAM | TELEPHONE NUMBER |
|---|------------------|

|  |                   |                 |                        |
|--|-------------------|-----------------|------------------------|
| DATES APPLICANT PARTICIPATED<br>IN THE ABOVE PROGRAM ▶ | FROM (MONTH/YEAR) | TO (MONTH/YEAR) | DATE PROGRAM COMPLETED |
|  |                   |                 |                        |

DID THE ABOVE APPLICANT SATISFACTORILY COMPLETE A MINIMUM OF ONE (1) YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS OR ITS EQUIVALENT, BEYOND THE UNDERGRADUATE DENTAL SCHOOL LEVEL?

YES     NO

IF THE ANSWER TO THE ABOVE QUESTION IS "NO," PLEASE ATTACH OR PROVIDE BELOW A DETAILED EXPLANATION.

|   |      |
|---|------|
| POSTGRADUATE PROGRAM DIRECTOR SIGNATURE | DATE |
|---|------|