



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
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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
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DATES APPLICANT PARTICIPATED 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
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