South Dakota State Board of Dentistry
P.O. Box 1079, 1351 N. Harrison Ave. Pierre, SD 57501-1079
Ph: 605-224-1282 Fax: 1-888-425-3032
E-mail: contactus@sdboardofdentistry.com www.sdboardofdentistry.org

REGISTERED DENTAL ASSISTANT APPLICATION TO ADMINISTER NITROUS OXIDE SEDATION AND ANALGESIA

Pursuant to ARSD § 20:43:09:06 you must submit the following:

1. $45 Application Fee (check or money orders only, do not send cash);
2. A copy of your current Board approved cardiopulmonary resuscitation (CPR) card. A Board approved CPR course is a course intended for a Healthcare Provider that meets the required knowledge and objectives outlined in the American Heart Association guidelines for BLS or American Heart Association Guidelines for CPR and ECC, and includes a hands-on skills assessment.
3. Proof of successful completion of a nitrous oxide course taken through an American Dental Association Commission on Dental Accreditation (CODA) accredited dental, dental hygiene or dental assisting school, and proof that you:
    a. Completed the course within thirteen months prior to application; or
    b. Completed the course more than thirteen months prior to application, have legally administered nitrous oxide sedation and analgesia for a period of time during the three years preceding application, and provide written documentation from a dentist that has employed or supervised you, attesting to your current clinical proficiency to administer nitrous oxide sedation and analgesia. *(Please have a dentist that has employed or supervised you complete the attached document if you completed the course more than thirteen months prior to application.)*

Name: _____ Registration #: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Employer Office: _____ Phone: _____

Address:_____ City, State, Zip: _____

Satellite Office: _____ Phone: _____

Address: _____City, State, Zip: _____

If you have more than one satellite office, please include that information on another page.

I hereby certify that when I administer nitrous oxide, I will have equipment for administering nitrous oxide inhalation analgesia with fail-safe features, a 30% minimum oxygen flow and a scavenger system.

I declare and affirm under the penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct.

Signature: _____ Date: _____

Printed Name: _____

Mail completed application and $45.00 application fee to:
South Dakota State Board of Dentistry
PO Box 1079
Pierre, SD 57501

For Office Use Only:
Check # _____
Amount _____
Date _____

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Registered Dental Assistant Application to Administer Nitrous Oxide Sedation and Analgesia Verification of Clinical Proficiency

This form is to be submitted with the *Registered Dental Assistant Application to Administer Nitrous Oxide Sedation and Analgesia* only if the applicant completed a board approved course in nitrous oxide sedation and analgesia more than thirteen months prior to application and is currently authorized to provide this service in a state other than South Dakota.

To be completed by the applicant:

Applicant's Name: _____

Date of Completion of Board approved course: _____

State, other than South Dakota, in which you provided this service: _____

License/ Registration # for that state: _____

Signature of Applicant: _____ Date: _____

To be completed by the supervising dentist:

The applicant named above is applying for a permit to administer nitrous oxide sedation and analgesia in the State of South Dakota. Written documentation from a dentist that has employed or supervised the applicant, attesting to the current clinical proficiency of the applicant to administer nitrous oxide sedation and analgesia, is required. Please provide your professional assessment of the applicant's current clinical proficiency to administer nitrous oxide sedation and analgesia by completing below.

Supervising Dentist Name: _____ License #: _____

Office Name: _____

City, State, Zip Code: _____ Phone: _____

During the previous three years, I supervised or employed the above named applicant from: _____/_____ (month/year) through _____/_____ (month/year).

During that timeframe, he/she legally administered nitrous oxide sedation and analgesia in the state of _____.

I hereby certify the above named applicant is ***currently*** clinically proficient to administer nitrous oxide sedation and analgesia.

_____ _____
Dentist Signature Date