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.com

APPLICATION FOR A PERMIT TO MONITOR PATIENTS UNDER GENERAL ANESTHESIA, DEEP SEDATION, OR MODERATE SEDATION

Pursuant to § 20:43:09:10 you must submit the following:

1. 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; and
2. Verification that you have successfully completed at least an eight-hours board approved course in anesthetic assisting and either:
    a. Completed the course within thirteen months prior to application; or
    b. Completed the course more than thirteen months prior to application, have legally monitored patients receiving analgesic or anesthetic agents for a period of time during the two years preceding application, and provide written documentation from a dentist that has employed or supervised you, attesting to your current clinical proficiency to monitor patients under general anesthesia, deep sedation, or moderate sedation. *(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: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Email: _____ Social Security Number: _____

I am a (please check one):

- ❑ Dental Hygienist -- License # _____
- ❑ Registered Dental Assistant -- Registration # _____
- ❑ Dental Assistant

I will be monitoring patients in the following office(s):

Primary Office: _____ Phone: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Satellite Office: _____ Phone: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

If you have more than one satellite offices where these services will be provided, please include that information on another page.

Course Information: *You must attach verification of completion of a Board approved course (listed below).* If the course is not Board approved, your application may be denied. If a course that you are interested in attending is not listed below, please contact our office.

I have attached verification of completion of the following course (please check one):

- ☐ Dental Anesthesia Assistant National Certification Examination (DAANCE) -- Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS). Hours: 36.
- ☐ Anesthesia Assistants Review Course -- Sponsor: American Association of Oral and Maxillofacial Surgeons (AAOMS). Hours: 12.
- ☐ Assistant Sedation/Anesthesia Course -- Sponsor: American Dental Society of Anesthesiology (ADSA). Hours: 12.
- ☐ Assistant Sedation/Anesthesia On Demand Course (Online Course) -- Sponsor: American Dental Society of Anesthesiology (ADSA). Hours: 12. Twelve individual one hour assistant courses must be completed. All twelve certificates must be submitted with the application. If ADSA offers more than 12 courses, you can choose the 12 you would like to complete.
- ☐ Conscious Sedation Consulting Online Sedation Course -- Sponsor: Conscious Sedation Consulting. Hours: 8. Eight individual one hour courses must be completed: A Culture of Safety; Patient Assessment; Sedation; Pain; Patient Monitoring; Adverse Events – Airway & Respiratory; Adverse Events – Cardiac & Neurological; and Recovery and Discharge. All eight certificates must be submitted with the application.
- ☐ Sedation and Anesthesia in the Dental Practice -- Sponsor: South Dakota Dental Association. Hours: 8.
- ☐ Intravenous Conscious Sedation Course, GRU, College of Dental Medicine -- Sponsor: Georgia Regents University. Hours: 40
- ☐ Assisting on the Sedated Patient – Sponsor: Dentinomics. Hours: 8
- ☐ Monitoring of Sedation/ General Anesthesia Patients for Dental Procedures and intravenous catheter insertion – Sponsor: Saint Louis University Center for Advanced Dental Education. Hours: 24

Course Location: _____

Dates of Course: _____

Course Contact – Name: _____

Telephone: _____ Email: _____

By initialing below, I hereby attest that the CPR course I am submitting a card for meets the following requirements:

_____ Is a Basic Life Support course intended for a Healthcare Provider; and
_____ Included knowledge and objectives in accordance with the American Heart Association Guidelines for BLS or American Heart Association Guidelines for CPR and ECC; and
_____ Included a hands-on skill assessment.

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: _____

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VERIFICATION OF COMPETENCY

This form is to be submitted with the *Application for a Permit to Monitor Patients Under General Anesthesia, Deep Sedation or Moderate Sedation* only if the applicant completed a board approved course in anesthetic assisting more than thirteen months prior to application and is currently authorized to provide this service in a state other than South Dakota.

To Whom It May Concern:

The South Dakota State Board of Dentistry is conducting a review of an applicant for a permit to monitor patients under general anesthesia, deep sedation, or moderate sedation in the State of South Dakota. One of the requirements for that permit is written documentation from a dentist that has employed or supervised the applicant, attesting to the current clinical proficiency of the applicant to monitor patients under general anesthesia, deep sedation, or moderate sedation. Please provide your professional assessment of the applicant's current clinical proficiency to monitor patients under general anesthesia, deep sedation, or moderate sedation by completing the form below.

Applicant's Name: _____

Date of Completion: _____

I supervised or employed the above named applicant during the following timeframe _____/_____ (month/year) through _____/_____ (month/year). During that timeframe, he/she legally monitored patients under general anesthesia, deep sedation, or moderate sedation in the state of _____. I hereby certify the above named applicant is ***currently*** clinically proficient to monitor patients under general anesthesia, deep sedation, or moderate sedation.

_____ _____
Signature of Dentist Date

_____ _____
Name of Office Address

_____ (_____)_____
City, State, Zip Office Phone Number

_____ _____ _____
Dentist Name (Print) Dentist License # State