South Dakota State Board of Dentistry
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FORM 1
PRACTITIONER ANESTHESIA INSPECTION CHECKLIST
FULL INSPECTION

Mail completed form and $500 inspection fee to the address above

Name of Practitioner _____ License Number _____

Name of Office _____ Date _____

Address _____

Telephone _____

Email _____

- THIS FORM MUST BE COMPLETED BY THE PRACTITIONER LISTED ABOVE – PRACTITIONER MUST INITIAL EACH QUESTION

PERMIT – Please check only one:	
General Anesthesia and Deep Sedation	
Moderate Sedation (Patients 12 years and Older)	
Pediatric Moderate Sedation	
Host	

STAFF – Please verify the following by initialing each:	**YES**	**NO**
I delegate duties in accordance with Board Administrative Rules and Laws and verify that all individuals that monitor patients under moderate sedation, deep sedation or general anesthesia hold the appropriate permit issued by the Board or are otherwise authorized by law to monitor.		
I delegate injection of medication through an intravenous site per ARSD 20:43:09:10.01.		
If yes, I certify compliance with ARSD 20:43:09:10 and 20:43:09:10.01 and I have verified current certification of staff (DAANCE). *If you do not delegate injection, please leave blank.*		

OFFICE FACILITY AND EQUIPMENT - Please verify, by initialing each and supplying the requested information, that the following are operational and available, *in appropriate sizes where applicable*, when moderate sedation, deep sedation or general anesthesia is being administered to a patient:	**YES**	**NO**
MONITORING AND EMERGENCY EQUIPMENT		
Automated blood pressure monitor (and appropriately sized cuffs)		
Manual blood pressure cuffs (appropriately sized) and stethoscope		
Electrocardiograph		
Automated External Defibrillator (AED) and pads (unexpired)		
Pulse Oximeter		
Measurement of EtCO2/Capnography		
Precordial Stethoscope		
Emergency medications organized and labeled, located within or near operating theater.		
OPERATING THEATER(S)		
Allow at least three individuals to move freely about the patient.		
Permit easy access to emergency equipment and for emergency personnel.		
OPERATING CHAIR OR TABLE		
Permits the patient to be positioned so the operating team can maintain the airway.		
Permits the team to alter the patient's position quickly in an emergency.		
Provides a firm platform for the management of cardiopulmonary resuscitation.		
LIGHTING SYSTEM		
There is a backup lighting system.		
The backup lighting system is of sufficient intensity to permit completion of any operation underway at the time of general power failure.		
SUCTION EQUIPMENT		
The suction equipment permits aspiration of the oral and pharyngeal cavities.		
There is a backup suction device available.		
OXYGEN DELIVERY SYSTEM		
There is an adequate backup oxygen delivery system available.		
The oxygen delivery system has appropriately sized full-face masks for patients, appropriate connectors, and is it capable of delivering oxygen to the patient under positive pressure.		
RECOVERY AREA *(Recovery Area can be the Operating Theater)*		
Has available oxygen.		
Has available adequate suction.		
Has adequate lighting.		
Has adequate electrical outlets.		
Has monitoring equipment in recovery area including pulse oximeter and blood pressure.		
Recovery area allows for adequate movement of personnel and use of equipment.		

ANCILLARY EQUIPMENT	YES	NO
Laryngoscope complete with an adequate selection of blades, spare batteries and bulbs.		
Appropriately sized endotracheal tubes and appropriate connectors.		
Appropriately sized oral and nasal airways		
Appropriately sized supraglottic airways		
Tonsillar or pharyngeal type suction tip adaptable to all office outlets		
Endotracheal tube forceps (McGill)		
Equipment adequate to establish an intravenous infusion		
Printed emergency algorithms: ACLS and anesthesia emergencies. PALS, if applicable.		
Glucometer and test strips (unexpired)		
Intraosseous Vascular Access Kit		
Equipment available to perform a cricothyroidotomy or surgical airway		
Ability to communicate within the office in case of emergency and quickly call 911		

DRUGS - Please verify, by initialing each and supplying the requested information, that these drugs are available when moderate sedation, deep sedation or general anesthesia is being administered to a patient:	YES	NO	NAME OF DRUG:	**Expiration Date:** *(MM/DD/YY)*
Vasopressor drug				
Corticosteroid drug				
Bronchodilator drug				
Muscle relaxant drug				
Intravenous medication for treatment of cardiopulmonary arrest				
Narcotic antagonist drug				
Benzodiazepine antagonist drug				
Antihistamine drug				
Antiarrhythmic drug				
Anticholinergic drug				
Coronary artery vasodilator drug				
Antihypertensive drug				
Anti-Emetic drug				

Please list any drugs that have been ordered, but are on backorder:	**Anticipated ship date:**

Inhalation Anesthetics (other than nitrous oxide) – Please verify by initialing and supplying the requested information.	**YES**	**NO**
Inhalation anesthetics other than nitrous oxide are used		
If yes, please list the following: a. Mechanism of response for Malignant Hyperthermia Drug: _____ Expiration Date: _____ b. Method used to continuously monitor temperature: _____		

EMERGENCIES - Please verify the following by initialing each:	**YES**
I have a written emergency response protocol in place for all patients undergoing moderate sedation, deep sedation, or general anesthesia.	
Within the prior 12 months, the individuals involved in caring for a patient undergoing moderate sedation, deep sedation, or general anesthesia completed a review of appropriate emergency scenarios and were able to demonstrate knowledge and ability in recognition and treatment of these emergencies, including all of the following: Respiratory: Laryngospasm, Bronchospasm, Emesis and Aspiration, and Airway Obstruction Cardiovascular: Angina/Myocardial Infarction, Hypotension, Hypertension Other: Syncope, Hyperventilation Syndrome, Seizures, Malignant Hyperthermia, and Severe Allergic Reaction	

ANESTHESIA RECORDS - Please verify the following by initialing each:	**YES**
I have attached to this form in hard copy three anesthesia records, corresponding anesthesia consent forms, and corresponding patient evaluation records from my patients that have undergone moderate sedation, deep sedation, or general anesthesia in the last 12 months. *Please do not include the operative report.*	
The anesthesia records have been redacted and do not contain any protected health information (HIPAA PHI).	

LICENSED ANESTHESIA PROVIDER (LAP) - Please verify the following by initialing each:	**YES**	**NO**
I utilize a LAP to administer moderate sedation, deep sedation, or general anesthesia to dental patients.		
If yes, I certify compliance with ARSD 20:43:09:04.01 and have a written contract or agreement that satisfies the criteria outlined in this rule. *If you do not utilize a LAP, please leave blank.*		

MISCELLANEOUS - Please verify the following by initialing each:	**YES**
I can proficiently start an intravenous line.	
I have reviewed and am compliant with the requirements of ARSD 20:43:09 in all offices in which I administer or utilize a licensed anesthesia provider to administer moderate sedation, deep sedation, or general anesthesia.	
All emergency equipment is inspected and maintained on a prudent and regularly scheduled basis, according to manufacturer specifications where applicable.	
All emergency drugs are inspected on a prudent and regularly scheduled basis.	
I understand that per ARSD 20:43:09:09 I must notify the Board within 72 hours after any death or any incident that results in a temporary or permanent physical or mental injury requiring medical treatment of a patient during, or as a result of, the administration of general anesthesia, deep sedation, moderate sedation, or nitrous oxide and failure to comply with this reporting requirement may result in a suspension of my host, moderate, or general anesthesia and deep sedation permit. I further understand that this reporting requirement applies if I am administering anesthesia or sedation or if I am utilizing a licensed anesthesia provider to administer sedation or anesthesia to my patient.	
I can competently administer the level of sedation or anesthesia authorized by my permit. *If host permit evaluation, please leave blank.*	

ADDITIONAL LOCATIONS: I administer or utilize a licensed anesthesia provider to administer moderate sedation, deep sedation or general anesthesia in the following offices *(Attach additional sheets if necessary)*.

Office Name:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Level of Sedation or Anesthesia Provided at this Location:_____

Office Name:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Level of Sedation or Anesthesia Provided at this Location:_____

Office Name:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Level of Sedation or Anesthesia Provided at this Location:_____

Office Name:_____

Phone: _____

Physical Address:_____

Mailing Address:_____

Level of Sedation or Anesthesia Provided at this Location:_____

I, _____(print name), being first duly sworn, certify that I am the person referred to in this inspection form and that under penalty of perjury all the information contained in this inspection form and in any attachments or additional documents submitted herewith are true and correct. I attest that each practice location where moderate sedation, deep sedation, or general anesthesia services are provided are compliant with ARSD § 20:43:09 and any applicable state or federal regulations. I understand that falsification or omission of information, including intentional failure to provide complete information or concealment of relevant information, may result in revocation of a permit or license, or may be considered as the basis for discipline.

Practitioner Signature: _____ Date: _____

Subscribed and sworn to before me this _____ day of _____ 20_____

My commission expires _____

_____
Notary Public

Mail completed form, attachments, and $500 Inspection Fee to:	South Dakota State Board of Dentistry PO Box 1079 Pierre, SD 57501