Dental Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Application Packet for:

- **Moderate Sedation Permit**
- **Moderate Sedation with Parenteral Agents Permit**
- **General Anesthesia and Deep Sedation Permit**

Contents:

1. 646-142.... Contents List/SSN Information/Mailing Information .... 1 page
2. 646-147.... General Instructions Checklist ....2 pages
3. 646-103.... Moderate Sedation, Moderate Sedation with Parenteral Agents, General Anesthesia and Deep Sedation – Dentistry Application ....10 pages
4. 646-144.... Inspection/Evaluation Form...4 pages
5. RCW Links, AIDS Courses, and Online Web Sites .... 1 page

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application.

If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your application:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

Include this blank page when printing two-sided.
Do **not** remove.

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PO Box 47877
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360.236.4700

General Instructions Checklist

You should be using this application to acquire a:

- Moderate Sedation permit.
- Moderate Sedation with Parenteral Agents permit.
- General Anesthesia and Deep Sedation permit.

All information should be typed or printed clearly. It is your responsibility to submit the correct forms required.

☐ **Application Fee**. (This fee is non-refundable). You can check the **fee page** for current fees.

☐ **#1: Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state and country where you were born.

Address: List the address we should use to send any information on your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change.
See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **#2: Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority..

- [ ] **#3: Previous Licensure:**
List all states where licenses are or were held. List all active, inactive, and expired licenses. (Previous credential to include license, certification, or registration.) Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

- [ ] **#4: Moderate Sedation:**
List all education courses taken and provide documentation. Complete the following sections:
  - Drug and Emergency kit for Moderate Sedation.
  - Facilities and Equipment Requirements.
  - Records for Moderate Sedation and Moderate Sedation with Parenteral Agents.

  These portions must be completed by all applicants.

- [ ] **#5: Moderate Sedation with Parenteral Agents:**
List all education courses taken and provide documentation. Complete the following sections:
  - Drug and Equipment for Moderate Sedation with Parenteral Agents.
  - Facilities and Equipment Requirements.
  - Records for Moderate Sedation and Moderate Sedation with Parenteral Agents.

  These portions must be completed by all applicants.

- [ ] **#6: General Anesthesia and Deep Sedation:**
List anesthesia training and provide documentation. Complete the following sections:
  - Facilities and Equipment Requirements for General Anesthesia and Deep Sedation.
  - Drugs for General Anesthesia and Deep Sedation.
  - Records for General Anesthesia and Deep Sedation.

- [ ] **#7: Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up, and a front view. Your application will not be processed without a current photograph.

- [ ] **#8: Applicant's Attestation:**
You must sign and date this for us to process the application. Read to ensure you understand this section.

Applicants for general anesthesia permits: Prior to issuance of a general anesthesia permit, an on-site inspection must be conducted at all practice locations where you will be administering anesthesia. **Inspections may be conducted by yourself or by a peer.**

Mobile Anesthesia Services: A completed inspection form must be submitted for each facility where anesthesia services are provided.

Washington Administrative Code (WAC) Links Relating to Conscious Sedation/General Anesthesia

WAC 246-817-755: Moderate sedation.

WAC 246-817-760: Moderate sedation with parenteral agents.

WAC 246-817-770: General anesthesia with deep sedation.

Dental Quality Assurance Commission
PO Box 1099
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360.236.4700

Background Check Stamp Here

Date Stamp Here

Revenue 0251070000

Moderate Sedation, Moderate Sedation with Parenteral Agents, General Anesthesia and Deep Sedation – Dentistry Application

Applying For:
☐ Moderate Sedation permit
☐ Moderate Sedation with Parenteral Agents permit
☐ General Anesthesia and Deep Sedation permit

Current Training Received:
☐ Basic Life Support (BLS)
☐ Advanced Cardiac Life Support (ACLS)
☐ Pediatric Life Support (PLS)

Type of Practice:
☐ General ☐ Oral Surgery ☐ Other (specify ________
____

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)
— —

Name ☐ Male ☐ Female First Middle Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone ( )	Fax ( )	Cell ( )

Email address

Mailing address if different from above of record

City	State	Zip	County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

Credential # ________________________ Issue Date ________________
Validation Date ________________________ Received ________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach an explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction? ☐ ☐

Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?.. ☐ ☐
   b. Diverted controlled substances or legend drugs? .... ☐ ☐
   c. Violated any drug law? .... ☐ ☐
   d. Prescribed controlled substances for yourself?.. ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? . ... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .... ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?.. ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?......................... ☐ ☐

3. Previous Licensure

List all states where licenses are or were held. Please list all active, inactive, and expired licenses. (Previous credential to include license, certification, or registration.) Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

State	Profession	Certificate		Permanent or Temporary	License Received by		Currently in force
		Yr Issued	Number		Exam	Other	
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

4. Moderate Sedation - Method of Qualification WAC 246-817-755 (This portion must be completed by all Moderate Sedation & Moderate Sedation with Parenteral Agents and/or General Anesthesia applicants.)

Attach documented proof of your education qualification such as a letter from the school or course completion.

You **MUST** have completed 21 hours in **minimal sedation**:

- predoctoral dental school.
- postgraduate instruction.
- continuing education.

– And –

You **MUST** have completed 7 hours in **moderate sedation**:

- predoctoral dental school.
- postgraduate instruction.
- continuing education.

List course(s) taken, course sponsor, dates attended, and course hours. ______________________________

____

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____

Drug and Equipment for Moderate Sedation .... Yes No

Do you have an emergency kit with minimum contents of the following: .... ☐ ☐

☐ Bronchodilator.
☐ Sugar (glucose).
☐ Aspirin.
☐ Antihistaminic.
☐ Coronary artery vasodilator.
☐ Anti-anaphylactic agent.

5. Moderate Sedation with Parenteral Agents – Method of Qualification WAC 246-817-760: (This portion must be completed by all Moderate Sedation & Moderate Sedation with Parenteral Agents and/or General Anesthesia applicants.)

You **MUST** have completed a postdoctoral course(s) of sixty clock hours or more which includes training in basic moderate sedation, physical evaluation, venipuncture, technical administration, recognition and management of complications and emergencies, monitoring, and supervised experience in providing moderate sedation to fifteen or more patients.

– And –

You **MUST** also have a current and documented proficiency in advanced cardiac life support (ACLS) or pediatric advanced life support (PALS).

Attach documented proof of your postdoctoral qualification such as a letter from the school program attended. This must include hours and patients.

List course(s) taken, course sponsor, dates attended, and course hours. ______________________________

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Drug and Equipment for Moderate Sedation with Parenteral Agents .... Yes No

1. Do you have an emergency kit with minimum contents of the following: .... ☐ ☐

- Sterile needles, syringes and tourniquet
- Narcotic antagonist
- A and B adrenergic stimulant
- Vasopressor
- Coronary vasodilator
- Antihistamine
- Parasympatholytic
- Intravenous fluids, tubing and infusion set
- Sedative antagonists for drugs used if available

This portion must be completed by all Moderate Sedation & Moderate Sedation with Parenteral Agents and/or General Anesthesia applicants.

Facilities and Equipment Requirements. If there are multiple locations, provide serial numbers for equipment at each location.

Do you provide the following: .... Yes No

1. Suction equipment capable of aspirating gastric contents from the mouth and pharynx? .... ☐ ☐
2. A portable oxygen delivery system including full face masks and bag-valve-mask combination with appropriate connectors capable of delivering positive pressure, oxygen-enriched ventilation and oral and nasal pharyngeal airways of appropriate size? .... ☐ ☐
3. A blood pressure cuff (sphygmomanometer) or appropriate size and stethoscope; or equivalent monitoring devices? .... ☐ ☐

Please indicate what the equivalent monitoring device is including make, model, and serial number:

____

4. A pulse oximeter? Please indicate make, model and serial number. ____________________

____

Records for Moderate Sedation and Moderate Sedation with Parenteral Agents

Do you maintain records in the following manner: .... Yes No

1. Appropriate medical history and patient evaluation. Dosage and forms of medications dispensed are noted. .... ☐ ☐
2. The pulse, respiration and blood pressure and/or blood oxygen saturation noted and recorded whenever possible prior to the procedure unless prevented by the patient's physical or emotional condition. .... ☐ ☐
3. The pulse, respiration and blood pressure and/or bloody oxygen saturation noted and recorded at the conclusion of the procedure. .... ☐ ☐
4. Blood oxygen saturation continuously monitored and recorded at appropriate intervals throughout any period of time in which purposeful response of the patient to verbal command cannot be maintained. .... ☐ ☐
5. The patient's level of consciousness recorded prior to the dismissal of the patient. .... ☐ ☐

Provide a list of addresses of all locations of practice utilizing moderate sedation with parenteral agents.

Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Address 1 ______________________________

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Attention

If you are only applying for a Moderate Sedation or Moderate Sedation with Parenteral Agents permit, please do **NOT** complete this section.

If you are applying for a General Anesthesia permit, please continue and complete all other portions of this application.

6. General Anesthesia and Deep Sedation – Method of Qualification WAC 246-817-770

You must have two years of continuous full-time anesthesia training if you:

- ☐ Began training prior to 2008, training must include two full years of continuous full-time training in anesthesiology beyond the undergraduate dental school level.
- ☐ Began training January 2008 or after, you must have a certificate of completion from one of the following:
  - ☐ A dental aneshtesioloy program accredited by CODA.
  - ☐ A dental anesthesiology program approved by the Dental Quality Assurance Commission.
  - ☐ Two years of full-time anesthesia residency training at a medical program accredited by ACGME.

– OR –

An applicant who has completed a residency training in oral and maxillofacial surgery must meet at least one of the following:

- ☐ Be a diplomate of the American Board of Oral and Maxillofacial Surgery.
- ☐ Be a fellow of the American Association of Oral and Maxillofacial Surgeons.
- ☐ Be a graduate of an Oral and Maxillofacial Residency Program accredited by CODA.

You MUST also have a current and documented proficiency in advanced cardiac life support (ACLS).

Please indicate yes or no to the right:	**Yes**	**No**
1. I hold a current certificate in Advanced Cardiac Life Support or equivalent. (Please explain equivalent on separate sheet of paper.)	☐	☐
2. For every person who assists me who has direct patient care, **I am providing copies** of his/her BLS, ACLS, or PLS training (Copies **MUST** be provided.)	☐	☐
3. In addition to those individuals necessary to assist me in performing the procedure, I do have a trained individual to be present to monitor the patient's cardiac and respiratory functions. This individual monitoring patients receiving deep sedation or general anesthesia has received a minimum of fourteen hours of documented training in a course specifically designed to include instruction and practical experience in use of all equipment required in WAC 246-817-770. This must include, but not be limited to, the following equipment:	☐	☐

- Sphygmomanometer
- Pulse oximeter
- Electrocardiogram
- Bag-valve-mask resuscitation equipment
- Oral and nasopharyngeal airways
- Defibrillator
- Intravenous fluids administration set

Facilities and Equipment Requirements for General Anesthesia / Deep Sedation

Do you provide the following: .... **Yes No**

1. An operating theater large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to freely move about the patient? .... ☐ ☐

2. An operating table or chair which permits the patient to be positioned so the operating team can maintain the airway, quickly alter patient position in an emergency, provide a firm platform for the administration of basic life support? .... ☐ ☐

3. A lighting system which is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit conclusion of any operation underway at the time of general power failure? .... ☐ ☐

4. Suction equipment capable of aspirating gastric contents from the mouth and pharyngeal cavities and a backup suction device? .... ☐ ☐

5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate portable backup system? .... ☐ ☐

   List serial number ____

   Manufacture_______________________________Model Number__________________________________

6. A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating theater. During the recovery phase the patient is monitored continually by an individual trained to monitor patients recovering from general anesthesia or deep sedation. .... ☐ ☐

7. Ancillary equipment, which must include **all** of the following: .... ☐ ☐

   Laryngoscope complete with adequate spare batteries and bulb
   Endotracheal tubes with appropriate connectors
   Oral airways
   Tonsillar or pharyngeal suction tip adaptable to all office outlets
   Endotracheal tube forceps
   Sphygmomanometer and stethoscope
   Adequate equipment to establish an infusion
   Pulse oximeter
   Electrocardiographic monitor
   Synchronized defibrillator available on premises

Drugs for General Anesthesia / Deep Sedation .... **Yes No**

Are all of the following emergency drugs available in your facility: .... ☐ ☐

- Antiarrhythmic
- Anticholinergic
- Anticonvulsant
- Antihistaminic
- Antihypertensive
- Bronchodilator
- Coronary artery vasodilator
- Corticosteroid
- Intravenous medications for treatment of cardiac arrest
- Muscle relaxant
- Narcotic antagonist, Sedative antagonist, if available
- Vasopressor

Records for General Anesthesia / Deep Sedation

Do you maintain records in the following manner:..Yes No

1. Appropriate medical history and patient evaluation records.. ☐ ☐
2. Anesthesia records recorded during the procedure in a timely manner and must include: blood pressure, heart rate, respiration, blood oxygen saturation, drugs administered including amounts and time administered, length of procedure, any complications of anesthesia. (The patient's blood pressure, heart rate, and respiration is recorded at least every five minutes.) .... ☐ ☐
3. A discharge entry made in the patient's record indicating the patient's condition upon discharge and the responsible party to whom the patient was discharged.. ☐ ☐

Provide a list of addresses of all locations of practice utilizing general anesthesia/deep sedation: (excluding hospital and surgery center locations):

Address 1 ____

____

____

Address 1 ____

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Address 1 ____

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Address 1 ____

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7. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

8. Applicant's Attestation

I, ________________________________ , declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated __________________in __________________________ (city, state)

By:_________________________________
Signature of applicant

Subscribed and sworn to before me this _________________________day of ______ , 20___________

Notary in and for the State of____

Residing at____

Signature of Notary ____

My Commission Expires ____

Dental Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

General Anesthesia On-site Inspection/Evaluation form
(To be completed by General Anesthesia applicants only)

Name of practitioner:	
Location/Address Inspected:	
Additional office locations and/or sites where anesthesia services are performed (attach additional sheet, if necessary):	
General anesthesia permit number:	Telephone number at location evaluated:
Date of evaluation:	Time:
Name of evaluator(s):	

A. Personnel

	Yes	No
1. Valid ACLS Certificate of Equivalent (Please have Dr.'s ACLS Certification available)	☐	☐
2. Evidence of:		
a. 1 year advanced training in anesthesiology or Fellow of the American Dental Society of Anesthesiology	☐	☐
b. Diplomat of American Board of Oral and Maxillofacial Surgery or	☐	☐
c. Eligible for examination by American Board of Oral and Maxillofacial Surgery or	☐	☐
d. Fellow of the American Association of Oral and Maxillofacial Surgery.	☐	☐

3. List assisting staff's credentials/CV/training: (Attach documentation.)
   a. ______________________________
   b. ______________________________
   c. ______________________________
4. Evidence that monitoring personnel have a certificate of adequate training under WAC 246-817-770(1). **(Attach documentation.)** ☐ ☐

B. Records

Have available three (3) charts of patients who have been treated in your office with IV sedation or general anesthesia.

	Yes	No
1. An adequate medical history of the patient.	☐	☐
2. An adequate physical evaluation of the patient.	☐	☐

		Yes	No
3.	Anesthesia Records showing:	☐	☐
	Continual monitoring of heart rate, blood pressure, respiration and oximetry. These should be recorded every 5 minutes.		
4.	Evidence of continual recovery monitoring with a notation of patient's condition upon discharge and to whom patient was discharged.	☐	☐
5.	Accurate recording of mediations administered including amounts and time administered.	☐	☐
6.	Records illustrating length of procedure.	☐	☐
7.	Records reflecting any complications of anesthesia.	☐	☐

C. Office Facility And Equipment

(Make a list of (a) brand name/type of equipment and (b) serial numbers.)

BP/Dynamap a. ______________________________

b. ______________________________

EKG a. ______________________________

b. ______________________________

Defibrillator a. ______________________________

b. ______________________________

Oximeter a. ______________________________

b. ______________________________

		Yes	No
1.	Operating Theater		
a.	Is the operating theater large enough to adequately accommodate the patient on a table or in an operating chair?	☐	☐
b.	Does the operating theater permit an operating team consisting of at least three individuals to freely move about the patient?	☐	☐
2.	Operating Chair or Table		
a.	Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway?	☐	☐
b.	Does the operating chair or table permit the team to quickly alter the patient's position in an emergency?	☐	☐
c.	Does the operating chair or table provide a firm platform for the management of CPR?	☐	☐
3.	Lighting System		
a.	Does the lighting system permit evaluation of the patient's skin and mucosal color?	☐	☐
b.	Is there a battery powered backup lighting system?	☐	☐
c.	Is the backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?	☐	☐
4.	Suction Equipment		
a.	Does the suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
b.	Is there a backup suction device available?	☐	☐

5. Oxygen Delivery System

	Yes	No
a. Does the oxygen delivery system have adequate full face masks and appropriate connectors and is it capable of delivering oxygen to the patient under positive pressure?	☐	☐
b. Is there an adequate backup oxygen delivery system?	☐	☐

6. Recovery Area (Recovery Area can be the operating theater)

	Yes	No
a. Does the recovery area have available oxygen?	☐	☐
b. Does the recovery area have adequate suction available?	☐	☐
c. Does the recovery area have adequate lighting?	☐	☐
d. Does the recovery area have adequate electrical outlets?	☐	☐
e. In accordance with WAC 246-817-770(2), can the patient be observed by a member of the staff at all times during the recovery period?	☐	☐

7. Ancillary Equipment

	Yes	No
a. Is there a working laryngoscope complete with an adequate selection of blades, spare batteries and bulbs?	☐	☐
b. Are there endotracheal tubes and appropriate connectors?	☐	☐
c. there a backup suction device available?	☐	☐
d. Is there a tonsillar or pharyngeal type suction tip adaptable to all office outlets?	☐	☐
e. Are there endotracheal tube forceps?	☐	☐
f. Is there a sphygmomanometer and stethoscope?	☐	☐
g. s there a pulse oximeter?	☐	☐
h. Is there an electrocardioscope and defibrillator?	☐	☐
i. Is there adequate equipment for the establishment of an intravenous infusion?	☐	☐

D. Drugs

	Yes	No
1. Vasopressor drug available?	☐	☐
2. Corticosteroid drug available?	☐	☐
3. Bronchodilator drug available?	☐	☐
4. Muscle relaxant drug available?	☐	☐
5. Intravenous medication for treatment of cardiopulmonary arrest?	☐	☐
6. Narcotic antagonist drug available?	☐	☐
7. Antihistaminic drug available?	☐	☐
8. Antiarrhythmic drug available?	☐	☐
9. Anticholinergic drug available?	☐	☐
10. Coronary artery vasodilator drug available?	☐	☐
11. Antihypertensive drug available?	☐	☐

Overall Equipment/Facility: ☐ Adequate ☐ Inadequate

Comments: ____________________

____

Recommendations: ____________________

Signature of Evaluators | **Date** | **Print Name**

____________________ ________ ____________________

____________________ ________ ____________________

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Affidavit for practitioners providing anesthesia services at multiple site locations:

“I hereby attest that **all sites** or facilities in which I perform general anesthesia services meet the criteria indicated in this inspection form. (A separate survey form may be completed in lieu of signing this affidavit.)”

____________________ ________ ____________________

Signature of Practitioners Evaluated | **Date** | **Print Name**

____________________ ________ ____________________

____________________ ________ ____________________

Dental Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Health Professions Reference Numbers and Links

RCW Links

UDA RCW 18.130 .... Uniform Disciplinary Act

APA RCW 34.05 .... Administrative Procedure Act

WAC 246-12 .... Administrative procedures and requirements

RCW Dentistry .... http://apps.leg.wa.gov/RCW/default.aspx?cite=18.29

WAC Dentistry .... http://apps.leg.wa.gov/WAC/default.aspx?cite=246-817

On-Line

AIDS Training .... http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/training.htm

Dental Quality Assurance Commission ....http://www.doh.wa.gov/hsqa/Professions/Dental/default.htm

Drug Enforcement Administration (DEA)..www.deadiversion.usdoj.gov

Washington State Dental Association...www.wsda.org

American Association of Dental Examiners..www.aadexam.org/

Western Regional Examining Board (WREB) ....www.wreb.org/

Southern Regional Testing Agency (SRTA) .... www.srta.org/

North East Regional Board (NERB) .... www.nerb.org/

Central Regional Dental Testing Service (CRDTS) .... www.crdts.org/

American Dental Association (ADA)..www.ada.org/

Required Hours of Training

Continuing education (CE) Training after license has been issued.........................21 hours annually