Washington State Department of Health

Application Packet for:

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

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Important Social Security Number Information:

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 read, complete, and return this **form** with your application.

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
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Quality Assurance Commission
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

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Washington State Department of Health

Application 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 printed clearly in blue or black ink on a correctly printed application. Applications must be printed in portrait, one page per sheet. Each page must print with the Department of Health footer displayed. Submit the application by regular mail, we cannot accept an application by email.

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

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **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.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

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 month, day, and year of your birth.

Birth place: 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. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. List all active, inactive, and expired credentials.

☐ **4. Moderate Sedation:**
List all education courses taken and provide documentation. Complete the following sections:

- Drug and Equipment for Moderate Sedation.
- Facilities and Equipment Requirements.
- Records for Moderate Sedation.

☐ **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 with Parenteral Agents.

☐ **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 Attestation:**
You must sign and date this in ink for us to process the application. Photo copies will not be accepted.

☐ **All applicants** must provide a copy of valid certification of Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or Pediatric Advanced Life Support (PALS).

Washington Administrative Code (WAC) Links Relating to Administration of Anesthetic Agents

WAC 246-817-755: Moderate sedation.

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

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

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Washington State Department of Health

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Revenue 0251070000

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

Applying For: (Mark only **one** level of sedation.)

☐ Moderate Sedation permit ☐ Moderate Sedation with Parenteral Agents permit
☐ General Anesthesia and Deep Sedation permit

Current Training Received: (Provide copy of valid certification.)

☐ Basic Life Support (BLS)
☐ Advanced Cardiac Life Support (ACLS)
☐ Pediatric Advanced Life Support (PALS)

Type of Practice:

☐ General Dentistry
☐ Oral and Maxillofacial Surgeon
☐ Other (specify)

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female

Name First	Middle	Last

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

Address			
City	State	Zip Code	County
Country			

Phone (Enter 10 digit #)	Fax (Enter 10 digit #)	Cell (Enter 10 digit #)

Email address			
Mailing address if different from above of record			
City	State	Zip Code	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):

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 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, intellectual disabilities, 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.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

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 any state or jurisdiction? ..... ☐ ☐

   Note: If you answered "yes" to question 5, 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 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? ..... ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ..... ☐ ☐

3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Please list all active, inactive, and expired credentials. Specifically list credentials granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if credential is current.

State/ Jurisdiction	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

4. Moderate Sedation—Method of Qualification WAC 246-817-755

(This portion is required to be completed only by Moderate Sedation 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. _____

_____

_____

Drugs 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.

Facilities and Equipment Requirements.

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) of appropriate size and stethoscope; or equivalent monitoring devices?	☐	☐
4. A pulse oximeter?	☐	☐

Records for Moderate Sedation.

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 blood 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	☐	☐

5. Moderate Sedation with Parenteral Agents—Method of Qualification

WAC 246-817-760

(This portion is required to be completed only by Moderate Sedation with Parenteral Agents 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). Provide copy of valid certification.

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. _____

_____

_____

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

1. Do you have an emergency kit with minimum contents of the following: ..... ☐ ☐
   - Alpha and Beta adrenergic stimulant
   - Anti-anaphylactic agent
   - Antihistamine
   - Aspirin
   - Bronchodilator
   - Coronary vasodilator
   - Intravenous fluids, tubing and infusion set
   - Narcotic antagonist
   - Parasympatholytic
   - Sedative antagonists for drugs used if available
   - Sterile needles, syringes and tourniquet
   - Sugar (glucose)
   - Vasopressor

Facilities and Equipment Requirements.

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) of appropriate size and stethoscope; or equivalent monitoring devices?..... ☐ ☐
4. A pulse oximeter? ..... ☐ ☐

Records for 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 blood 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 _____

_____

Address 2 _____

_____

6. General Anesthesia and Deep Sedation—Method of Qualification

WAC 246-817-770

(This portion is required to be completed only by General Anesthesia and Deep Sedation Applicants.)

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 anesthesiology 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.

Please indicate yes or no to the right:	Yes	No
I hold a current certificate in Advanced Cardiac Life Support. Provide a copy of valid certification.	☐	☐

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?	☐	☐

Do you provide the following: Yes No

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 connector
- 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
- End-Tidal CO2 Monitor
- Automated external defibrillator (AED) or 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
- Anti-anaphylactic ageny
- Aspirin
- Bronchodilator
- Coronary artery vasodilator
- Corticosteroid
- Intravenous medications for treatment of cardiac arrest
- Muscle relaxant
- Narcotic antagonist, Sedative antagonist, if available
- Sugar (glucose)
- 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 2 _____

_____

Complete the following questions, if you listed locations above.

		Yes	No
1.	For every person who assists me who has direct patient care, **I am providing copies** of his/her BLS, ACLS, or PALS training (Copies **MUST** be provided.)	☐	☐
2.	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
- Oral and nasopharyngeal airways
- Defibrillator
- Intravenous fluids administration set
- Bag-valve-mask resuscitation equipment

7. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington 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 have read all laws and rules related to my profession.

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_____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

Washington State Department of Health

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Standard of Professional Conduct Rules, WAC 246-16

Dental Professionals Laws, RCW 18.260

Dentistry Rules, WAC 246-817

Dentistry Laws, RCW 18.32

Online

AIDS Training Resources, Reference Page

Dental Quality Assurance Commission, Web page

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

Washington State Dental Association, www.wsda.org/

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

Listserv

To receive emails regarding important dental regulation information, please join our interested parties list at, Listserv

Required Continuing Education

Continuing education (CE) Training after permit has been issued see
WAC 246-817-755

WAC 246-817-760

WAC 246-817-770