NOTE: In order for your application to be considered complete, all applicants MUST also submit a copy of the following documents:

1. ☐ Age: Evidence of at least 19 years of age (i.e.: driver's license, birth certificate, marriage license, school transcript, US State ID card, Military ID, or similar documentation);
2. ☐ Adverse Action: If you have had any disciplinary actions taken against your credential, you must submit a copy of the disciplinary action(s), including charges and disposition; and
3. ☐ Certification: Provide a copy of your current certification in basic life-support skills for health care providers and , if providing minimal sedation for persons twelve years of age and under, provide proof of current certification in pediatric advanced life support.

Any documents written in a language other than English must be accompanied by a complete translation into the English language. The translation must be an original document and contain the notarized signature of the translator. An individual may not translate his/her own documents.

This form may be completed online and mailed to the address listed below.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

DHHS - Licensure Unit
P.O. Box 94986
Lincoln NE 68509-4986
Telephone #: 402-471-2118

APPLICATION FOR A CHANGE OF ADDRESS FOR MINIMAL SEDATION
(Please print or type application)

SECTION A – PERSONAL INFORMATION (All applicants must complete this entire section) **This section is public information and will be displayed on the INTERNET http://www.nebraska.gov/LISSearch/search.cgi** ***Items 1, 7 & 8 are displayed on the Internet.***

NOTE: To expedite notification of any pending requirements, the notification will sent to the e-mail address or mailing address you provide. If you change your address, you must advise this office.

1	Legal Name	First:	Middle/MI:	Last:	
	Maiden Name	Name:	Other Names you are known as (AKA):		
2	Current Office Address:	Street/PO/Route:			
		City:	State or Country:	Zip:	
3	Date of Birth:	Month/Day/Year:	Place of Birth:	City/State or Country:	
4	Check the Appropriate Box(s):	☐ Social Security Number (SSN); ☐ Alien Registration Number ("A#") with VISA Status; or ☐ Form I-94 (Arrival-Departure Record) number with VISA Status ***If you have both a SSN and an A# or I-94 number, you must report both.***	SSN#: A#: I-94 #:		
	Social Security Numbers obtained are not public information but may be shared by the Department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to this information.				
5	Phone #:		Fax #: (optional)		
6	E-Mail Address:				
7	Nebraska Dental License Number:				
8	Inhalation Number:				

SECTION B – NEW Office Address Where Minimal Sedation will be Administered (All applicants must complete this section) Applicants will need separate permits for each location where administration will take place.

NEW Office Address: Must provide physical address of the office	Street/PO/Route:		
	City:	State:	Zip:

PLEASE NOTE: There are separate applications for new anesthesia/sedation permits available on our website at the following address:
http://www.dhhs.ne.gov/licensure/pages/Dentist.aspx

Separate anesthesia permits are required at each location you will be administering anesthesia/sedation. This change of address will not affect your expiration date on this permit.

☐ I have submitted a copy of a current certification in basic life-support skills for health care providers and if providing minimal sedation for persons under twelve (12) years of age and under, I have submitted a copy of a current certification in pediatric advanced life-support. **(REQUIRED)**

SECTION C – QUESTIONS ABOUT THE OFFICE WHERE MINIMAL SEDATION WILL BE ADMINISTERED. – Individuals wishing to administer minimal sedation must answer the following questions. Please explain any NO answers.

Operating Room	**Yes**	**No**
1. Is operating room large enough to adequately accommodate the patient on a table or in an operating chair?	☐	☐
2. Does the operating room permit an operating team of at least two individuals to freely move about the patient?	☐	☐
Suction Equipment	**Yes**	**No**
1. Does suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
Oxygen Delivery System	**Yes**	**No**
1. Does oxygen delivery system have full-face masks and connectors?	☐	☐
2. Is it capable of delivering 100% oxygen to the patient under positive pressure?	☐	☐
3. Is there a backup oxygen delivery system available?	☐	☐

Recovery Area (Recovery area can be the operating room)	Yes	No
1. Does recovery area have oxygen available	☐	☐
2. Does recovery area have suction available?	☐	☐
3. Does recovery area have lighting?	☐	☐
4. Does recovery area have available electrical outlets?	☐	☐
5. Can the patient be observed by a member of the staff at all times during the recovery period?	☐	☐
Ancillary Equipment	**Yes**	**No**
1. Are there oral pharyngeal airway(s)?	☐	☐
2. Is there a sphygmomanometer?	☐	☐
3. Is there a stethoscope?	☐	☐
RECORDS – ARE THE FOLLOWING RECORDS MAINTAINED?	**Yes**	**No**
1. A medical history of the patient prior to the administration of minimal sedation and physical evaluation records?	☐	☐
2. Does the record include the name and dosage of the medication administered?	☐	☐
3. Does the record include a listing of the name(s) of those assisting the dentist?	☐	☐
4. Does the record include verification that the dentist and any person who assists the dentist in the administration of minimal sedation has a current certification in basic life-support and if providing minimal sedation for persons under twelve (12) years of age and under, has current certification in pediatric advanced life-support?	☐	☐

SECTION D – PRACTICE PRIOR TO CREDENTIAL

An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of $10 per day up to $1,000, or such other action as provided in the statutes and regulations governing the credential.

1	I have administered minimal sedation at this location prior to being issued a permit?	YES ☐	NO ☐
2	If yes, what are the actual number of days you administered minimal sedation in Nebraska and what is the business name, location and telephone number of the practice:	# of days: _____	
		Name of Business:	
		City:	
		Telephone #:	

SECTION E - ATTESTATION

Attestation: For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114 and 38-129 (*check **ONE** of the boxes below):*

I attest that:

☐ I am a citizen of the United States.

OR

☐ I am a qualified alien under the Federal Immigration and Nationality Act.

☐ I am a nonimmigrant lawfully present in the United States.

☐ Check this box if you are **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

NOTE: You may still be eligible for a credential if you provide a photocopy of your unexpired Employment Authorization Document (EAD) and evidence of meeting section 202(c)(2)(B)(i) through (ix) of the Federal REAL ID Act of 2005.

Application Attestation: I attest that:

1. I have read the application or have had the application read to me; and
2. All statements on this application are true and complete.

Print Name: _____

Signature: _____ Date: _____