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. ☐ **Education:** You must submit one of the following:
   (1) Proof of being a fellow of the American Dental Society of Anesthesiology; or
   (2) Proof of completing an advanced education program approved by the board that affords at least 60 didactic/clinical hours of comprehensive and appropriate training necessary to administer and manage moderate sedation.
3. ☐ **CPR:** Proof of current certification in basic life-support skills for health care providers and either advanced cardiac life support or current certification from an appropriate emergency management course for anesthesia and dental sedation; and
4. ☐ **Conviction Information:** If you have been convicted of a felony or misdemeanor, you must submit:
   (1) A copy of the court record, which includes charges and disposition;
   (2) Explanation from the applicant of the events leading to the conviction (what, when, where, why) and a summary of actions you have taken to address the behaviors/actions related to the convictions;
   (3) All addiction/mental health evaluations and proof of treatment, if the conviction involved a drug and/or alcohol related offense and if treatment was obtained and/or required; and
   (4) A letter from the probation officer addressing probationary conditions and current status, if you are currently on probation;
5. ☐ **Adverse Action:** If you have had any adverse actions taken against any credential you have held or currently hold, you must submit a copy of the adverse action(s), including charges and disposition;
7. ☐ **Fee:** The required fee.

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

APPLICATION FOR A PERMIT TO ADMINISTER MODERATE SEDATION
(Please print or type application)

#_____

Date:_____

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

Fee $200.00

SECTION A – PERSONAL INFORMATION (All applicants must complete this section) **This section is public information and will be displayed on the INTERNET https://www.nebraska.gov/LISSearch/search.cgi** ***Items 1-2 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	Mailing 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#"); or ☐ Form I-94 (Arrival-Departure Record) number: ***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:				

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

Office Address:	Street/PO/Route:		
	City:	State:	Zip:

SECTION C –LICENSURE INFORMATION (All applicants must complete this section) Direct source verification/certification of any dental license that you hold or have held is required. You will need to request that each state or jurisdiction sends a verification/certification of your license directly to our office.

License Number	State	Issue Date	Expiration Date

SECTION D – CONVICTION AND LICENSURE INFORMATION (All applicants must complete this section)
Failure to disclose any such conviction or disciplinary action, regardless of when the action occurred, could result in disciplinary action, including, but not limited to, payment of a civil penalty.

- If you have any criminal charges or license adverse actions pending that results in conviction or license discipline, you are required to report such actions to the Investigations Unit within 30 days https://dhhs.ne.gov/pages/Investigations.aspx or by telephone at 402-471-0175.

Answer each of the following questions by placing a (✓) in the appropriate box (yes or no) and completing the information requested. All 'yes' responses MUST be explained in detail and you must submit the requested documentation and you may attach a separate page if needed.

The following questions relate to any credential that you hold or have held in health services, health-related services or environmental services in another jurisdiction.			
1	Have you ever had any disciplinary or adverse action imposed against a professional credential in any state or jurisdiction?	YES ☐	NO ☐
2	Have you ever voluntarily surrendered or voluntarily limited in any way a credential issued to you by a licensing or disciplinary authority?	YES ☐	NO ☐
3	Have you ever been requested to appear before any licensing agency?	YES ☐	NO ☐
4	Have you ever been notified of any charges, complaints or other actions filed against you by any licensing or disciplinary authority?	YES ☐	NO ☐
5	Are you aware of any pending disciplinary actions or of any on-going investigations of a complaint against your credential in any jurisdiction?	YES ☐	NO ☐
6	Have you ever been asked to and/or permitted to withdraw an application for a credential with any Board or jurisdiction?	YES ☐	NO ☐
7	Has any state or jurisdiction refused to issue, refused to renew or denied you a credential to practice?	YES ☐	NO ☐

8	Are you currently, or have you ever been, addicted to, dependent upon or chronically impaired by alcohol, narcotics, barbiturates, or other drugs which may cause physical and/or psychological dependence?	YES ☐	NO ☐
9	Within the past 5 years, have you received any therapy/treatment or been admitted to any hospital or other in-patient care facility for reasons relating to your use/abuse of alcohol, narcotics, barbiturates, or other drugs?	YES ☐	NO ☐
10	Do you currently, or have you ever had, any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?	YES ☐	NO ☐
11	Within the past 5 years, has any licensing agency or credentialing organization initiated any inquiry into your physical, mental or emotional health?	YES ☐	NO ☐
12	Have you ever been restricted, suspended, terminated, requested to voluntarily resign, place on probation, counseled, received a warning or been subject to any remedial or disciplinary action during dental school or postgraduate training?	YES ☐	NO ☐
13	Have you ever had hospital or institutional privileges denied, reduced, restricted, suspended, revoked, terminated or placed on probation?	YES ☐	NO ☐
14	Have you ever been requested to voluntarily resign or suspend hospital or institutional privileges while under investigation from a hospital, clinic, institution, or other dental related employment?	YES ☐	NO ☐
15	Have you ever been notified that any action against your hospital or institutional privileges is pending or proposed?	YES ☐	NO ☐
16	Have you ever been allowed to withdraw your staff privileges from a hospital or institution?	YES ☐	NO ☐
17	Have you ever been subject to staff disciplinary action or non-renewal of an employment contract?	YES ☐	NO ☐
18	Have you ever been convicted of a felony? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES ☐	NO ☐
19	Have you ever been convicted of a misdemeanor? **Failure to disclose any such convictions regardless of when the conviction occurred could result in disciplinary action, including but not limited to a minimum of $500 civil fine.**	YES ☐	NO ☐
20	Have you ever been notified of any charges, complaints or other actions filed against you by any criminal prosecution authority?	YES ☐	NO ☐
21	Have you ever been denied a Federal Drug Enforcement Administration (DEA) Registration or state controlled substances registration?	YES ☐	NO ☐
22	Have you ever been called before any licensing agency or lawful authority concerned with DEA controlled substances?	YES ☐	NO ☐
23	Have you ever surrendered your state or federal controlled substances registration?	YES ☐	NO ☐
24	Have you ever had your state or federal controlled substances registration restricted or disciplined in any way?	YES ☐	NO ☐
25	Have you ever been notified of any professional liability claim that resulted in an adverse judgment, settlement, or award, including settlements made prior to suit in which the patient releases any professional liability claim against the applicant?	YES ☐	NO ☐
26	Are you aware of any professional liability claims currently pending against you?	YES ☐	NO ☐

PLEASE NOTE: There is a separate application for anesthesia/sedation permits available on our website at the following address:

Separate anesthesia/sedation permits are required at each location you will be administering anesthesia/sedation.

SECTION E – EDUCATIONAL QUALIFICATIONS TO ADMINISTER MODERATE SEDATION (This permit will also you to administer minimal sedation) – To be filled out by individuals wishing to administer Moderate Sedation.
PLEASE NOTE THAT INSPECTION OF THE OFFICE WHERE YOU WILL BE ADMINSTERING MODERATE SEDATION NEEDS TO OCCUR PRIOR TO ISSUANCE OF THE PERMIT.

☐ I am a fellow of the American Dental Society of Anesthesiology.
☐ I have submitted the required affidavit for proof of being a fellow of the American Dental Society of Anesthesiology. (Attachment A).

OR

☐ I have completed an advanced education program approved by the board that affords at least 60 didactic/clinical hours of comprehensive and appropriate training necessary to administer and manage moderate sedation.
☐ I have submitted the required proof on completing an advanced education program approved by the Board that affords comprehensive and appropriate training necessary to administer and manage moderate sedation. (Attachment B)

AND

☐ I have submitted a copy of current certification in basic life-support skills for health care providers and either advanced cardiac life support or current certification from an appropriate emergency management course for anesthesia and dental sedation **(REQUIRED)**

SECTION F – QUESTIONS ABOUT THE OFFICE WHERE MODERATE SEDATION WILL BE ADMINISTERED. - Individuals wishing to administer Moderate Sedation must answer the following questions. Please explain any NO answers.

Operating Room	**Yes**	**No**
1. Is the 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?	☐	☐
Operating Chair or Table	**Yes**	**No**
1. Does the operating chair or table permit the patient to be positioned to allow the operating team to maintain the airway?	☐	☐
2. Does the operating chair or table permit the team to quickly alter the patient's position in an emergency?	☐	☐
3. Does the operating chair or table provide a firm platform for management of cardiopulmonary resuscitation?	☐	☐
Lighting System	**Yes**	**No**
1. Does lighting system permit evaluation of the patient's skin and mucosal color?	☐	☐
2. Is there a backup lighting system which is battery powered or on-site generator powered?	☐	☐
3. Is backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure?	☐	☐

Suction Equipment	**Yes**	**No**
1. Does suction equipment permit aspiration of the oral and pharyngeal cavities?	☐	☐
2. Is there a backup suction device available?	☐	☐
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. Is there a working laryngoscope complete with a selection of blades, spare batteries, and bulb?	☐	☐
2. Are there endotracheal tubes and connectors?	☐	☐
3. Are there oral airway(s)?	☐	☐
4. Are there endotracheal tube forceps?	☐	☐
5. Is there a CO2 monitor or a pre cardio-stethoscope?	☐	☐
RECORDS – ARE THE FOLLOWING RECORDS MAINTAINED?	**Yes**	**No**
1. A medical history and physical evaluation of the patient?	☐	☐
2. Sedation records showing blood pressure readings?	☐	☐
3. Sedation records showing pulse readings?	☐	☐
4. Sedation records listing the drugs and amounts administered?	☐	☐
5. Sedation records reflecting the length of procedure?	☐	☐
6. Does the record include a listing of the name(s) of those assisting the dentist?	☐	☐
7. Does the record include verification that the dentist and any person who assists the dentist in the administration of general anesthesia/deep sedation has a current certification in basic life-support skills for health care providers and either advanced cardiac life support or an appropriate emergency management course for anesthesia and dental sedation?	☐	☐
ARE THE FOLLOWING DRUGS WITH CURRENT DATES AVAILABLE FOR TREATMENT OF THE FOLLOWING MEDICAL EMERGENCIES?	**Yes**	**No**
1. Laryngopasm (general anesthesia/deep sedation only)	☐	☐
2. Bronchospasm	☐	☐
3. Angina Pectoris	☐	☐
4. Myocardial Infarction (general anesthesia/deep sedation only)	☐	☐
5. Hypotension	☐	☐
6. Hypertension	☐	☐
7. Cardiac Arrest	☐	☐
8. Allergic Reactions	☐	☐
9. Convulsions	☐	☐
10. Respiratory Arrest	☐	☐
11. Medication for reversal of anesthesia/sedation agents	☐	☐

SECTION G – 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. (When answer question 1, answer the one that applies to the permit you are applying for.)

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

SECTION H – 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: _____

LETTER OF VERIFICATION THAT AS A FELLOW OF THE AMERICAN DENTAL SOCIETY OF ANESTHESIOLOGY
Attachment A

Applicants must complete #1

1. I, _____, being first duly sworn say that I
(Print Name)

am the person referred to in this letter and that I am a fellow of the American Dental Society of Anesthesiology.

_____
(Legal Signature of Applicant)

_____
(Month-Day-Year)

****

This section must be completed by the American Dental Society of Anesthesiology, 211 East Chicago Avenue, Suite 780, Chicago, IL, 60611.

2. This is to certify that _____ is a fellow of the American
(Name of Applicant)
Dental Society of Anesthesiology.

_____
(Signature of Authorized Representative) (No Stamp)

(EXECUTIVE DIRECTOR SEAL)

_____
(Type or printed name and title)

_____
(Date Signed, Month-Day-Year)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986

AFFIDAVIT FOR COMPLETING AN ADVANCED EDUCATION PROGRAM OF AT LEAST 60 DIDACTIC/CLINICAL HOURS OF COMPREHENSIVE AND APPROPRIATE TRAINING NECESSARY TO ADMINISTER AND MANAGE MODERATE SEDATION

Attachment B

All applicants must complete #1

1. I, _____, being first duly sworn say that I
(Print Name)

am the person referred to in this affidavit and that I have completed at least an advanced education program of at least 60 didactic/clinical hours of comprehensive and appropriate training necessary to administer and manage moderate sedation.

_____
(Legal Signature of Applicant)

_____
(Month-Day-Year)

****

This section must be completed by course provider from where you received your education.

2. This is to certify that _____ has completed an advanced
(Name of Applicant)

education program of comprehensive and appropriate training necessary to administer and manage moderate sedation.

_____
(Name of Advanced Education Program)

_____
(Date signed, Month-Day-Year)

NAME AND ADDRESS
ADVANCED EDUCATION
PROGRAM

_____
(Signature of Authorized person) (No stamp)

_____
(Type or printed name and title)

(SEAL, if applicable)

_____
(Address)

_____
(City) (State) (Zip)

Please return this completed form to:

State of Nebraska
Department of Health and Human Services
Division of Public Health
Licensure Unit
P O Box 94986
Lincoln NE 68509-4986