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Certificate Number _____
Date Issued _____
Applicant No. _____

GEORGIA BOARD OF DENTISTRY

237 Coliseum Drive • Macon, Georgia 31217 • (478) 207-2440

www.sos.ga.gov/plb/dentistry

APPLICATION FOR CONSCIOUS SEDATION/GENERAL ANESTHESIA ADDITIONAL SITE/CHANGE IN LOCATION

Application Fee \$100 (non-refundable)

License Type: CONSCIOUS SEDATION/GENERAL ANESTHESIA ADDITIONAL SITE/CHANGE IN LOCATION

Method Obtained by:

Applicant is applying for above referenced license by application.

Name as desired on License _____
First Middle Last

Social Security Number **Date of Birth**

Dental License # **Anesthesia Permit #**

Address for Present Permit *P.O. Box not acceptable*

Number and Street

City/State Zip

Mailing Address (if different)

Number and Street

City/State Zip

Telephone Number Day Telephone Number Evening FAX Number

E-mail Address (required field) _____

Your e-mail address is not public information and will not be shared with any third parties.



Georgia Board of Dentistry

237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440
(866) 888-1308 FAX
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INSTRUCTIONS AND REQUEST FORM FOR PERMITS FOR ADDITIONAL CONSCIOUS SEDATION/GENERAL ANESTHESIA SITES/CHANGE IN LOCATION

Checks returned for insufficient funds will be assessed a \$40 service charge pursuant to O.C.G.A. § 16-9-20

Please complete this form if you currently hold an active conscious sedation or general anesthesia permit issued by the Georgia Board of Dentistry, and are requesting a permit for a **secondary or additional** site(s) **or** a **change in location** where you wish to provide Conscious Sedation/General Anesthesia services. This form must be accompanied by a **non-refundable \$100.00** permit fee/per site (subject to change). **NOTE: The permit fee of \$100.00 includes one site. An additional \$100 fee is incurred for each additional site.** Personal checks or money orders are acceptable, payable to the order of Georgia Board of Dentistry. **ALL FEES ARE NON-REFUNDABLE.**

CHECK APPLICABLE BOXES:

CHANGE IN LOCATION REQUESTED, LIST NEW ADDRESS:

Number and Street

City/State Zip

Telephone: () _____ Fax: () _____

SECONDARY OFFICE LOCATION(S) REQUESTED, LIST ADDRESS(ES):

(1) _____

Number and Street

City/State Zip

Telephone: _____ Fax: _____

(2) _____

Number and Street

City/State Zip

Telephone: () _____ Fax: () _____

I hereby certify that each additional site and/or change in site is a properly equipped facility for the administration of general anesthesia/deep sedation and/or conscious sedation and is staffed with a supervised team of certified support personnel (In accordance with the Laws and Rules of the State of Georgia with respect to the practice of dentistry).

YES NO

I certify that all of the following equipment and supplies are present and stationary at each facility for which I am applying:

- equipment capable of delivering positive pressure oxygen ventilation including ancillary airway devices
- pulse oximeter
- suction equipment
- operating table or chair that allows for patient positioning to maintain airway
- firm platform for CPR
- fail-safe nitrous oxide/oxygen inhalation system, **if used**
- equipment necessary to establish intravascular access
- equipment to continuously monitor blood pressure and heart rate
- EKG (**required for general anesthesia/deep sedation only**)
- defibrillator (AED or manual)
- emergency drugs per ACLS or PALS protocol
- if a separate recovery area**, oxygen and suction are available
- applicant and support personnel have current certification in BLS CPR. **Submit copy of cards.**
- applicant has current certification in ACLS and/or PALS. **Submit copy of card(s).**
- I understand that each additional site and/or change in site may be subject to an on-site inspection

Print name _____

Signature _____

Date _____