Oklahoma State Board of Dentistry
2920 N Lincoln Blvd., Ste B
Oklahoma City, OK 73105
Phone: (405)522-4844 Fax: (405)522-4614

$100 Application Fee- Non-Refundable

FACILITY USE PERMIT APPLICATION
****ONLY AN OWNER MAY SUBMIT A FACILITY APPLICATION AND EACH OWNER NEEDS TO BE LISTED ON THE APPLICATION****

APPLICATION AND CHECKLIST TO AUTHORIZE THE ADMINISTRATION OF (Circle one)
PEDIATRIC CONSCIOUS SEDATION PARENTERAL CONSCIOUS SEDATION OR
GENERAL ANESTHESIA BY ANOTHER DENTIST WHO HOLDS A VALID PROVIDER PERMIT OR CRNA LICENSE

Name of Owner and License Number:

Name of Location and Address:

Contact Person or Office Manager:

Contact Email:

Phone Number:

Dentist Provider /CRNA Name and License Numbers:

1. _____ License Type: _____ License #: _____
2. _____ License Type: _____ License #: _____
3. _____ License Type: _____ License #: _____

(If there are more providers, please list them on the back of this sheet)

List all staff members who are CPR/BLS certified:
(You must attach a copy of each employee BLS certification with this application)

1.
2.
3.
4.

Is there a drug locker for the facility? Yes No
Is there a current Dispensing Permit for the facility? Yes No
Is there a current Professional Entity on File? Yes No
**The checklist the inspector will be using is attached to this application. We have attached this for your knowledge to be prepared for the inspection. Please do not send the checklist back to the Board.*

Required CE:

(a) **Direct supervision of a Certified Registered Nurse Anesthetist (CRNA).** A dentist is permitted to directly supervise the administration of general anesthesia (including deep sedation) to patients by a CRNA provided that the following requirements are satisfied:

(1) Current certification in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) or Pediatric " Advanced Life Support (PALS) by the American Heart Association.

(2) Complete every three (3) years at least eighteen (18) hours of courses related to the administration of anesthesia, sedation or medical emergencies in the dental office. Hours accrued completing certification or re-certification in BLS and ACLS or PALS shall be accepted towards completion of this eighteen (18) hour requirement.

(3) Hold a valid facility permit as described in 195:20-1- 4(d).

AFFIDAVIT OF DENTIST

I do hereby attest that all information or statements made on this form, or any information given in connection therewith, to be true and correct. I also understand and agree that this is a State of Oklahoma official document and any misrepresentation or fraudulent statement on any part of this form may be grounds for disciplinary action as set forth by the Oklahoma State Dental Act 59 O.S. § Section 328.32(A)(2), as well as other laws under the State of Oklahoma.

_____ _____

Dentist Signature Date Signed

Inspection Checklist on next page

CHECKLIST- FOR INSPECTOR USE ONLY (SUBMIT WITH APPLICATION)

1. EQUIPMENT / FACILITY
   A. Airway Management Equipment:

1. Portable emergency O_2 and appropriate connectors	YES ☐	NO ☐
2. Minimum of two tanks of oxygen connected to the common oxygen supply so that one can be activated should line pressure drop in the other.	YES ☐	NO ☐

   B. Facility:

1. Is of adequate size and design to permit physical access of emergency equipment and personnel and to permit effective emergency management.	YES ☐	NO ☐
2. Is equipped with adequate lighting to permit evaluation as well as emergency lighting in the event of a power outage.	YES ☐	NO ☐
3. Is equipped with adequate central or portable suction with back up suction in the event of a power outage or loss of water pressure.	YES ☐	NO ☐
4. Scavenging equipment utilized with N_2O/O_2 administration.	YES ☐	NO ☐
5. Recovery area (if separate from above) includes all the above.	YES ☐	NO ☐
6. Operating low pressure oxygen alarm or oxygen analyzer within hearing distance of the operating room.	YES ☐	NO ☐
7. Fire extinguisher available with current inspections.	YES ☐	NO ☐
8. Office has emergency procedures posted	YES ☐	NO ☐
9. Written list of all monitors, emergency equipment, drugs, and And other materials which the mobile or portable anesthesia provider agrees to have available.	YES ☐	NO ☐

Initial Inspection ☐ 5 Year Inspection ☐

Permit to use Facility to Authorize General Anesthesia by another Dentist or Dental Anesthesiologist who holds a valid provider permit or a CRNA is:

CIRCLE ONE→ SATISFACTORY UNSATISFACTORY

Evaluator _____
PRINT NAME

Signature of Evaluator _____
Date

IF THE PERMIT IS NOT RECOMMENDED, THEN ENUMERATION OF DEFICIENCIES SHALL BE PROVIDED TO CANDIDATE WITHIN 21 DAYS AND RECOMMENDATIONS FOR RESOLUTION OF THE DEFICIENCY(S) WILL BE MADE.