Application for Moderate Sedation Permit

Board *of* Dentistry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasdentistry.gov
Email: MQA.Dentistry@flhealth.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH-MQA 1204, Revised 5/2025, Rule 64B5-14.0025, F.A.C.

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Do Not Write in this Space
For Revenue Receipting Only

Review Rule chapter (ch.) 64B5-14, Florida Administrative Code (F.A.C.), prior to completing your application.
https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B5-14

Moderate Sedation Permit **$300.00**

Total fee includes the following:

Application Fee (non-refundable)	$100.00
Permit Fee	$200.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Requests to withdraw or for a refund must be made in writing. The permit fee may be refunded if the application is denied without inspection of the applicant's facilities.

1. PERSONAL INFORMATION

Florida Dental License Number: _____

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Name: _____

2. APPLICANT BACKGROUND

A. Do you currently hold, or have you ever held an anesthesia permit, license, and/or certificate?
Yes No

If you responded "Yes," complete the following:

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

3. TRAINING PROGRAM

Refer to Rules 64B5-14.0025 and 64B5-14.003(2)(a), F.A.C., which establish the criteria for issuance of a moderate sedation permit.

A. Have you completed a formal training course **in the use of moderate sedation** offered through a Commission on Dental Accreditation accredited dental school or program or through an accredited teaching hospital (clinical training must take place at the accredited dental school or accredited teaching hospital)?
Yes No

If you responded "Yes," complete the following:

Training Program or Institution	Date of Certification (MM/DD/YYYY)	Training Dates: From-To (MM/DD/YYYY)
		to
		to
		to

Applicants must provide the following:

A copy of certification or letter from the dean of the dental school or head of the teaching hospital attesting to and describing the formal training.

A patient chart or log containing type(s) and concentration of medication used for sedation.

Documentation of actual clinical administration of anesthetics to 20 patients within two years of this application.

B. Have you completed clinical administration of anesthetics to 20 dental or oral and maxillofacial patients within two years prior to application of the particular type of anesthetics for the permit applied for?
Yes No

Location Where Moderate Sedation was Administered	# of Administrations Given

C. Have you experienced any mortality or other incident resulting in temporary or permanent physical or mental injury requiring hospitalization or emergency room treatment of a dental patient that occurred during or as a direct result of the use of general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation, minimal sedation, nitrous oxide, or local anesthesia? Yes No

If you responded "Yes" to C, you must provide the following:

A description of **dental procedure(s).**

A description of **preoperative physical condition of patient(s).**

A detailed **list of the drugs administered** and the **dosage administered.**

A detailed description of the **techniques utilized** in administering the drugs.

A detailed description of the **adverse occurrence**, to include 1) the onset and type of **complications** and the onset and type of **symptoms experienced** by the patient; 2) the onset and type of **treatment rendered** to the patient; 3) the onset and type of **response of the patient** to the treatment rendered; and 4) **final disposition** of the patient.

4. FACILITY INFORMATION (Attach additional pages for any additional facilities.)

List each location where anesthesia or sedation will be administered. The locations you provide will be inspected prior to issuance of your moderate sedation permit.

Facility Name: _____

Facility Address:

_____ _____ _____
Street/P.O. Box Suite No. City

_____ _____ _____
State ZIP Country

Contact Information:

_____
Telephone

5. FACILITY OPERATIONS

A. Is your anesthesia/sedation location(s) properly equipped as outlined in Rule 64B5-14.009, F.A.C.? Yes No

B. At your anesthesia/sedation location(s), do you employ two or more qualified assistants/dental hygienists who, working under the direct supervision of the dentist, assist the dentist, and assist in emergency care of the patient as defined in Rule 64B5-14.001(9), F.A.C.? Yes No

All locations at which you administer sedation must be provided in writing to the board office. The holder of any general anesthesia, moderate sedation, or pediatric moderate sedation permit is authorized to practice pursuant to such permit only at the location or locations previously identified to the board office.

Official notification must be provided to the board office at MQA.Dentistry@flhealth.gov for any additions, deletions, or changes of locations.

Name: _____

6. DISCIPLINE HISTORY

A. Have there been any disciplinary actions initiated against your license in any state? Yes No

B. Has any action been initiated against your license, permit, or certificate to administer anesthesia or sedation in any state? Yes No

C. Is there any pending litigation or dental malpractice proceeding being conducted against your license, permit, or certification related to the practice of dentistry or the administration of anesthesia/sedation?
Yes No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				Y N
				Y N
				Y N

If you responded "Yes" to any of the questions in this section, you must provide the following:

A written self-explanation, describing in detail the circumstances surrounding the disciplinary action.

A copy of the **Administrative Complaint** and **Final Order**.

7. CARDIOPULMONARY RESUSCITATION

Review Rule 64B5-14.003(2)(e), F.A.C., to view requirements for a dentist utilizing moderate sedation. https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64B5-14.

List staff available when moderate sedation is being administered.

Name	Currently CPR Certified?
	Y N
	Y N
	Y N

Effective March 1, 2022, if treating a patient 7 years of age or under, a dentist utilizing any level of sedation must be currently trained in Pediatric Advanced Life Support (PALS).

Provide proof of your Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) certification, and PALS certification, if required.

Provide proof of BLS certification for each support staff listed above.

CPR certification must be from the American Heart Association or American Red Cross or an equivalent agency sponsored CPR course at the basic life support level to include one person CPR, two person CPR, infant resuscitation, and obstructed airway. Note: The **"Heartsaver"** course **does not** meet this requirement.

Name: _____

8. APPLICANT RELEASE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I understand that Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed. Failure to do so may result in action by the board including denial of licensure.

Applicant Signature _____ Date _____

You may print out this application and sign it or sign digitally. MM/DD/YYYY

Board *of* Dentistry
Anesthesia Credentialing Supplement
Rule 64B5-14.003(2)(b), F.A.C.

This form is to be completed and signed by the program director or instructor, and the school or hospital seal embossed on this certification. Failure to comply may delay approval of your moderate sedation or pediatric moderate sedation application. Rule 64B5-14.003(2)(b), F.A.C., specifically requires certification that the dentist is competent in the administration of moderate sedation or pediatric moderate sedation and that the dentist completed at least 60 didactic hours and personally administered this anesthesia to at least 20 patients in a competent manner.

I _____, hereby certify that _____,
(Name and Title of Director/Instructor) *(Name of Applicant)*

completed at least 60 didactic hours as described in the above rule, including 4 hours in Airway Management, and personally administered moderate sedation or pediatric moderate sedation to at least 20 patients while completing this program and has been trained to competency.

_____ _____
Print Name of Director/Instructor MM/DD/YYYY

_____
Signature of Director/Instructor

_____
School Name

_____
School Address

Dates of Training: Start: _____ End: _____
(MM/DD/YYYY) (MM/DD/YYYY)

(School/Hospital Seal)