



**APPLICATION FOR GENERAL ANESTHESIA PERMIT**

**FEES**

Application Fee: \$500.00  
 (Must be enclosed with application)

**APPLICATION FEES  
 ARE NON-REFUNDABLE**

*For Office Use Only*

Rec # \_\_\_\_\_

FeePd \_\_\_\_\_

Date  
 Cashiered \_\_\_\_\_

Entity# \_\_\_\_\_

File# \_\_\_\_\_

*For Office Use Only*

Date Received

(PLEASE PRINT CLEARLY OR TYPE)

1. SSN/ITIN:	2. BIRTH DATE (MM/DD/YYYY):
3. LEGAL NAME: LAST	FIRST
MIDDLE	
4. MAILING ADDRESS:	
5. EMAIL ADDRESS:	
6. TELEPHONE NUMBER:	
7. FAX NUMBER:	
8. DENTAL OR MEDICAL LICENSE NUMBER:	
9. METHOD OF QUALIFICATION - INDICATE UNDER WHICH METHOD LISTED BELOW YOU QUALIFY FOR A GENERAL ANESTHESIA PERMIT. ATTACH DOCUMENTED PROOF OF YOUR QUALIFICATION.	
<p><b><u>DENTIST APPLICANT</u></b></p> <p>COMPLETION OF A RESIDENCY PROGRAM IN GENERAL ANESTHESIA OF NOT LESS THAN ONE CALENDAR YEAR, THAT IS APPROVED BY THE BOARD OF DIRECTORS OF THE AMERICAN DENTAL SOCIETY OF ANESTHESIOLOGY FORELIGIBILITY FOR FELLOWSHIP IN GENERAL ANESTHESIA.</p> <p>COMPLETION OF A GRADUATE PROGRAM IN ORAL AND MAXILLOFACIAL SURGERY WHICH HAS BEEN APPROVED BY THE COMMISSION ON ACCREDITATION OF THE AMERICAN DENTAL ASSOCIATION.</p> <p>HAVE A FELLOWSHIP IN ANESTHESIA APPROVED BY THE BOARD OF DIRECTORS OF THE AMERICAN DENTAL SOCIETY OF ANESTHESIOLOGY.</p>	
<p><b><u>PHYSICIAN APPLICANT</u></b></p> <p>ATTACH A COPY OF YOUR ABMS CERTIFICATE IN ANESTHESIOLOGY.</p> <p>SUCCESSFULLY COMPLETED A POSTGRADUATE RESIDENCY TRAINING PROGRAM IN ANESTHESIOLOGY RECOGNIZED BY THE AMERICAN COUNCIL ON GRADUATE MEDICAL EDUCATION.</p>	

10. DO ANY OF THE FOLLOWING STATEMENTS APPLY TO YOU:

Yes   
No

- YOU WERE ADMITTED TO THE UNITED STATES AS A REFUGEE PURSUANT TO SECTION 1157 OF TITLE 8 OF THE UNITED STATES CODE;
- YOU WERE GRANTED ASYLUM BY THE SECRETARY OF HOMELAND SECURITY OF THE UNITED STATES ATTORNEY GENERAL PURSUANT TO SECTION 1158 OF TITLE 8 OF THE UNITED STATES CODE; OR,
- YOU HAVE A SPECIAL IMMIGRANT VISA AND WERE GRANTED A STATUS PURSUANT TO SECTION 1244 OF THE PUBLIC LAW 110-181, PUBLIC LAW 109-163, OR SECTION 602(b) OF TITLE VI OF DIVISION F OF PUBLIC LAW 111-8, RELATING TO IRAQUI AND AFGHAN TRANSLATORS/INTERPRETERS OF THOSE WHO WORKED FOR OR ON BEHALF OF THE UNITED STATES GOVERNMENT.

IF YOU SELECTED YES, YOU MUST ATTACH EVIDENCE OF YOUR STATUS AS A REFUGEE, ASYLEE, OR SPECIAL IMMIGRANT VISA HOLDER. FAILURE TO DO SO MAY RESULT IN APPLICATION REVIEW DELAYS.

ACCEPTABLE DOCUMENTATION

- FORM I-94, ARRIVAL/DEPARTURE RECORD, WITH AN ADMISSION CLASS CODE SUCH AS "RE" (REFUGEE) OR "AY" (ASYLEE) OR OTHER INFORMATION DESIGNATING THE PERSON A REFUEE OR ASYLEE.
- SPECIAL IMMIGRANT VISA THAT INCLUDES THE "SI" OR "SQ"
- PERMANENT RESIDENT CARD (FORM I-551), COMMONLY KNOWN AS A "GREEN CARD," WITH A CATEGORY DESIGNATION INDICATING THAT THE PERSON WAS ADMITTED AS A REFUGEE OR ASYLEE.
- AN ORDER FROM A COURT OF COMPETENT JURISDICTION OR OTHER DOCUMENTARY EVIDENCE THAT PROVIDES REASONABLE ASSURANCE THAT THE APPLICANT QUALIFIES FOR EXPEDITED LICENSURE.

11. ARE YOU REQUESTING EXPEDITING OF THIS APPLICATION FOR SPOUSES OR DOMESTIC PARTNERS OF AN ACTIVE DUTY MEMBER OF THE U.S. ARMED FORCES?

Yes   
No

MILITARY SPOUSE OR DOMESTIC PARTNER REQUIREMENTS

NOTE: IF YOU MEET MILITARY SPOUSE OR DOMESTIC PARTNER REQUIREMENTS PLEASE SCAN AND ATTACH THE FOLLOWING DOCUMENTATION ON THE ATTACHMENTS PAGE OF THIS APPLICATION (YOU MAY BE ASKED TO SUBMIT ORIGINAL DOCUMENTATION):

- CERTIFICATE OF MARRIAGE OR DOMESTIC PARTNERSHIP OR OTHER LEGAL UNION WITH AN ACTIVE DUTY MEMBER OF THE ARMED FORCES OF THE UNITED STATES WHO IS ASSIGNED TO A DUTY STATION IN THIS STATE UNDER OFFICIAL ACTIVE DUTY MILITARY ORDERS.
- VERIFICATION OF CURRENT LICENSE IN ANOTHER STATE, DISTRICT, OR TERRITORY OF THE UNITED STATES IN THE PROFESSION OF VOCATION FOR WHICH YOU ARE SEEKING LICENSURE.

12. ARE YOU REQUESTING EXPEDITING OF THIS APPLICATION FOR HONORABLY DISCHARGED MEMBERS OF THE U.S. ARMED FORCES?

Yes   
No

MILITARY HONORABLE DISCHARGE REQUIREMENTS

NOTE: IF YOU MEET THE U.S. ARMED FORCES EXPEDITE REQUIREMENT, PLEASE SCAN AND ATTACH A COPY OF THE FOLLOWING DOCUMENTATION ON THE ATTACHMENTS PAGE OF THIS APPLICATION:

- DD214 OR OTHER SUPPORTING DOCUMENTATION.

<b>FACILITIES AND EQUIPMENT REQUIREMENTS - ARE THE FOLLOWING AVAILABLE IN ALL PLACES OF PRACTICE WHERE YOU ADMINISTER GENERAL ANESTHESIA?</b>	
13. AN OPERATING THEATER LARGE ENOUGH TO ADEQUATELY ACCOMMODATE THE PATIENT ON A TABLE OR IN AN OPERATINGCHAIR AND PERMIT AN OPERATING TEAM CONSISTING OF AT LEAST THREE INDIVIDUALS TO FREELY MOVE ABOUT THE PATIENT?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. AN OPERATING TABLE OR CHAIR THAT PERMITS THE PATIENT TO BE POSITIONED SO THE OPERATING TEAM CAN MAINTAIN THE AIRWAY, QUICKLY ALTER PATIENT POSITION IN AN EMERGENCY, AND PROVIDE A FIRM PLATFORM FOR THE MANAGEMENT OF CARDIOPULMONARY RESUSCITATION?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. A LIGHTING SYSTEM THAT IS ADEQUATE TO PERMIT EVALUATION OF THE PATIENT'S SKIN AND MUCOSAL COLOR AND A BACKUP LIGHTING SYSTEM WHICH IS BATTERY POWERED AND OF SUFFICIENT INTENSITY TO PERMIT COMPLETION OF ANY OPERATION UNDERWAY AT THE TIME OF GENERAL POWER FAILURE?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. SUCTION EQUIPMENT THAT PERMITS ASPIRATION OF THE ORAL AND PHARYNGEAL CAVITIES AND A BACKUP SUCTION DEVICE THAT CAN OPERATE AT THE TIME OF GENERAL POWER FAILURE?	Yes <input type="checkbox"/> No <input type="checkbox"/>
17. AN OXYGEN DELIVERY SYSTEM WITH ADEQUATE FULL FACE MASKS AND APPROPRIATE CONNECTORS THAT IS CAPABLE OF DELIVERING OXYGEN TO THE PATIENT UNDER POSITIVE PRESSURE, TOGETHER WITH AN ADEQUATE BACKUP SYSTEM THAT CAN OPERATE AT THE TIME OF GENERAL POWER FAILURE?	Yes <input type="checkbox"/> No <input type="checkbox"/>
18. A RECOVERY AREA THAT HAS AVAILABLE OXYGEN, ADEQUATE LIGHTING, SUCTION, AND ELECTRICAL OUTLETS? THE RECOVERY AREA CAN BE THE OPERATING THEATER.	Yes <input type="checkbox"/> No <input type="checkbox"/>
19. ANCILLARY EQUIPMENT MAINTAINED IN GOOD OPERATING CONDITION, WHICH MUST INCLUDE ALL OF THE FOLLOWING: (a) LARYNGOSCOPE COMPLETE WITH ADEQUATE SELECTION OF BLADES AND SPARE BATTERIES AND BULB. (b) ENDOTRACHEAL TUBES AND APPROPRIATE CONNECTORS. (c) ORAL AIRWAYS. (d) TONSILLAR OR PHARYNGEAL TYPE SUCTION TIPS ADAPTABLE TO ALL OFFICE OUTLETS. (e) ENDOTRACHEAL TUBE FORCEPS. (f) SPHYGMOMANOMETER AND STETHOSCOPE. (g) ELECTROCARDIOSCOPE AND DEFIBRILLATOR. (h) ADEQUATE EQUIPMENT FOR THE ESTABLISHMENT OF AN INTRAVENOUS INFUSION. (i) PRECORDIAL/PRETRACHEAL STETHOSCOPE. (j) PULSE OXIMETER.	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>RECORDS - DO YOU MAINTAIN THE FOLLOWING RECORDS?</b>	
20. ADEQUATE MEDICAL HISTORY AND PHYSICAL EVALUATION RECORDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ANESTHESIA RECORDS THAT SHOW: (a) MULTIPLE BLOOD PRESSURE AND PULSE READINGS (b) DRUGS ADMINISTERED, AMOUNTS ADMINISTERED, AND TIME ADMINISTERED. (c) LENGTH OF PROCEDURE. (d) ANY COMPLICATIONS OF ANESTHESIA. (e) STATEMENT OF PATIENT'S CONDITION AT TIME OF DISCHARGE.	Yes <input type="checkbox"/> No <input type="checkbox"/>
22. WRITTEN INFORMED CONSENT OF THE PATIENT, OR IF THE PATIENT IS A MINOR, THE PARENT OR GUARDIAN.	Yes <input type="checkbox"/> No <input type="checkbox"/>

**23. DRUGS - DO YOU MAINTAIN EMERGENCY DRUGS OF THE FOLLOWING TYPES AT ALL TIMES IN CONNECTION WITH THE ADMINISTRATION OF GENERAL ANESTHESIA?**

- |  |  |                              |
|--|--|------------------------------|
| • VASOPRESSOR  | • ANTICHOLINERGIC                        | Yes <input type="checkbox"/> |
| • CORTICOSTEROID   | • ANTIARRHYTHMIC                         |                              |
| • BRONCHODILATOR   | • CORONARY ARTERY VASODILATOR            | NO <input type="checkbox"/>  |
| • MUSCLE RELAXANT  | • ANTIHYPERTENSIVE                       |                              |
| • INTRAVENOUS MEDICATION FOR TREATMENT OF CARDIOPULMONARY ARREST | • ANTICONVULSANT                         |                              |
| • APPROPRIATE DRUGS ANTAGONISTS                                  | • OXYGEN                                 |                              |
| • ANTIHISTAMINIC   | • 50% DEXTROSE OR OTHER ANTIHYPOGLYCEMIC |                              |

**24. EMERGENCIES - ARE YOU COMPETENT TO TREAT ALL OF THE FOLLOWING EMERGENCIES?**

- |                         |                          |                              |
|-------------------------|--------------------------|------------------------------|
| • AIRWAY OBSTRUCTION    | • HYPOGLYCEMIA           | Yes <input type="checkbox"/> |
| • CARDIAC ARREST        | • MYOCARDIAL INFARCTION  |                              |
| • BRONCHOSPASM          | • SYNCOPE                | No <input type="checkbox"/>  |
| • ALLERGIC REACTION     | • HYPOTENSION            |                              |
| • EMESIS AND ASPIRATION | • RESPIRATORY DEPRESSION |                              |
| • CONVULSIONS           | • HYPERTENSION           |                              |
| • ANGINA PECTORIS       |                          |                              |

PROVIDE THE ADDRESSES OF ALL LOCATIONS OF PRACTICE WHERE YOU ADMINISTER OR ORDER THE ADMINISTRATION OF GENERAL ANESTHESIA. ALL OFFICES SHALL MEET THE STANDARDS SET FORTH IN REGULATIONS ADOPTED BY THE BOARD. IF YOU ARE A PHYSICIAN AND SURGEON APPLYING FOR THIS PERMIT, PROVIDE THE NAMES OF ANY HOSPITALS WHERE YOU HAVE MEMBERSHIP ON THE MEDICAL STAFF.

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IF NECESSARY, CONTINUE ON BACK OF THIS PAGE.

**Certification** - I certify under the penalty of perjury under the laws of the State of California that the foregoing is true and correct and I hereby request a permit to administer or order the administration of general anesthesia in my office setting(s) as specified by the Dental Practice Act and regulations adopted by the Board. Falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying or revoking this permit.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

**INFORMATION COLLECTION AND ACCESS**

The information requested herein is mandatory and is maintained by Dental Board of California, 2005 Evergreen Street, Ste 1550, Sacramento, CA 95815, Executive Officer, in accordance with Business & Professions Code, §1600 et seq. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted will be release to the public upon request and may be posted on the Internet.