

# STATE OF MAINE

## BOARD OF DENTAL PRACTICE

### APPLICATION FOR PERMIT

- Moderate Sedation Level I Permit
- Moderate Sedation Level II Permit
- Deep Sedation / General Anesthesia Permit



Maine Board of Dental Practice  
143 State House Station  
Augusta, ME 04333-0143

Office Telephone: (207) 287-3333  
Office Facsimile: (207) 287-8140  
TTY users call Maine Relay 711  
Website: [www.maine.gov/dental](http://www.maine.gov/dental)

## **APPLICANT INFORMATION GUIDE**

The application material you have requested from the Board of Dental Practice is enclosed. It contains all the relevant materials you need to complete your application for sedation/anesthesia permit in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

### **FURNISHED TO APPLICANT**

- Application Information Guide
- Renewal Application
- Maine's Prescription Monitoring Program website
- Maine's Mandated Reporter Requirements for Suspected Child Abuse website
- Maine's Medical Professionals Health Program website

### **ADDITIONAL RESOURCES**

- Board of Dental Practice Statute, Title 32, Chapter 143

**Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.**

Available: <http://legislature.maine.gov/legis/statutes/32/title32ch143sec0.html> or call (207) 287-3333

- Board of Dental Practice Rules

**Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.**

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#313> or call (207) 287-3333

- Statutory Authority, Titles 5 & 10

Available: <http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

<http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html>

## **APPLICATION INFORMATION GUIDE**

- **Mandated Reporter Requirements for Suspected Child Abuse:** Maine law requires that dentists and dental hygienists immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the licensee knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. Mandated Reporter Training and additional information regarding mandated reporting can be found at: <https://www.maine.gov/dhhs/ocfs/provider-resources/reporting-suspected-child-abuse-and-neglect/mandated-reporter-information>
- **Maine's Prescription Monitoring Program (PMP):** The PMP is a tool created to prevent and detect prescription drug misuse and diversion, and improve patient care through better coordination of care. PMP maintains a database of all transactions for schedule II, III and IV controlled substances dispensed in the State of Maine. This database is available free online to prescribers and dispensers by the Office of Substance Abuse and Mental Health Services (SAMHS) in the Maine Department of Health and Human Services. Clinicians can use the program to check the history of a new patient and to monitor on-going treatment. PMP is another tool clinicians can add to their toolkit for preventing and intervening against misuse and diversion of prescription drugs. FMI about the program visit: <https://www.maine.gov/dhhs/obh/providers/prescription-drug-monitoring-program>
- **Maine's Medical Professionals Health Program (MPHP):** The MPHP works cooperatively with six Maine boards of licensure, hospitals, medical staffs, and professional associations to ensure that professionals in need of treatment and services get the help they need. The MPHP is not a treatment program, but their staff will help professionals to find the resources they need, to better understand the treatment and recovery process, and to implement strategies for return to safe practice. <https://www.mainemphp.org/>
- **10 Day Reporting Requirement:** Please be advised, pursuant to 32 MRS §18352, licensees and applicants are to report to the Office, in writing, any change of name or address on file with the Office, any criminal conviction, any revocation, suspension or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held, or any material change set forth in this application within ten (10) days:
- **Please submit your application materials to the Board by USPS mail to our office. Faxed submissions will not be accepted.** Your application will be reviewed and processed in the order that it was received. Application reviews generally take at least two weeks, barring any action required by the full Board, or any high volume renewal of licensure periods.
- Pursuant to M.R.S. Chapter 143 §18341 (3), An applicant has 90 days after being notified of the materials needed to complete the application to submit those materials to the board. You will be notified by mail if there are deficiencies with your application. You may also check the Board's website at [www.maine.gov/dental](http://www.maine.gov/dental). It is the responsibility of the applicant to see that all documentation is completed and returned to the Board for consideration. Failure to complete the application within that 90-day period may result in a denial of the application.

### **STANDARD APPLICATION – Check List**

Qualifying dentists who are issued a sedation and/or general anesthesia permit are limited to administer sedation at the practice location identified on the application only. Permits are NON-TRANSFERABLE. A separate permit application must be submitted and approved by the Board before practicing in the administration of moderate sedation, deep sedation and/or general anesthesia at a new or second location.

- Completed and signed Application and Certification Form (pgs. 1-13)
- Payment of the required fees; application fee \$100.00; permit fee \$750.00
- Copy of current, valid life support certification (BLS, ACLS, and PALS - required for pediatric sedation), including copy of BLS certification for each personnel listed in Section 4 of the Certification Form.

STATE OF MAINE / BOARD OF DENTAL PRACTICE

**Mailing Address:** 143 State House Station, Augusta, Maine 04333-0143

Phone: (207) 287-3333 Fax: (207) 287-8140 TTY users call Maine Relay 711 Website: [www.maine.gov/dental](http://www.maine.gov/dental)

## Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 143 State House Station, Augusta, Maine 04333- 0143.
- **Can I come to Augusta to pick up my license?** No. Your permit will be sent electronically to your email address provided on the application.
- **How can I check the status of my application?** You can check the Board's website: [www.maine.gov/dental](http://www.maine.gov/dental)
- **Can I fax my application?** No.

### NOTICES

**BACKGROUND CHECK:** Pursuant to 5 M.R.S.A. §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Maine Board of Dental Practice requires a criminal history records check as part of the application process for all applicants.

**PUBLIC RECORD:** This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

**SOCIAL SECURITY NUMBER:** The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Before you seal the envelope, did you:

- Complete every item on the application?
- Sign and date your application?
- Include the required fee(s). Make checks payable to "Maine State Treasurer" or complete the credit card section on the application. **DO NOT SEND CASH.**
- Make a copy of your application to keep for your records?



STATE OF MAINE
BOARD OF DENTAL PRACTICE

143 State House Station, Augusta, ME 04333-0143

PERMIT APPLICATION

(Revised 12/2022)

APPLICANT INFORMATION (please print)
FULL LEGAL NAME FIRST MIDDLE INITIAL LAST
ANY OTHER NAMES EVER USED
DATE OF BIRTH mm/ dd/ yyyy SOCIAL SECURITY NUMBER
MAILING ADDRESS
CITY STATE ZIP CODE COUNTY
PHONE ( ) FAX ( ) E-MAIL

BACKGROUND CHECK and 10 DAY REPORTING NOTICE

Pursuant to 5 MRS §5301 - 5303, the State of Maine, Board of Dental Practice is granted the authority to take into consideration an applicant's criminal history record. In addition, the Board of Dental Practice requires licensees to report to the Board criminal convictions within 10 days.

Board of Dental Practice

Required Fee: \$850.00

Office Use Only

1446 - \$100.00
1421 - \$750.00

Please Select Permit Type:

- Moderate Sedation - Level I (Enteral)
Moderate Sedation - Level II (Parenteral)
Deep Sedation / General Anesthesia

Office Use Only

Check #
Amount:
Cash #:
License #:

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" - if you wish to pay by credit or debit card, fill out the following:

NAME OF CARDHOLDER (please print) FIRST MIDDLE INITIAL LAST
ADDRESS OF CARDHOLDER (please print)
I authorize the Maine Board of Dental Practice to charge my card the following amount: \$
VISA M/C Discover AMEX
I understand that fees are non-refundable
Card number: Expiration Date: mm/ yyyy
SIGNATURE DATE

**Undergraduate Education**

Name of Academic Institution:

Mailing Address:

City:	State:	Zip Code:
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Major:	Degree Granted:	Date Conferred:
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**Dental Education**

Name of Dental School Attended:

Mailing Address:

City:	State:	Zip Code:
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Degree Granted:	Date Conferred:
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**Sedation Training / Certification**

Name of Training Program or Certification Program:

Mailing Address:

City:	State:	Zip Code:
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Title of course and date completed (attach curriculum/certification of completion):

**Residency Training (If applicable)**

Name of School or Program Affiliation:

Mailing Address:

City:	State:	Zip Code:
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Dates:

## Licensure / Disciplinary Questions

The following questions must be answered. If you circle "YES" to any question numbered 1 through 19, then please provide additional information such as a written explanation regarding the disclosure, along with additional documentation relevant to the disclosure.

### **Since your last application filed with the Board:**

1. Have you submitted an application for a professional or occupational license, certification, registration, or permit to any authority, other than the Maine Board of Dental Practice, that was not approved or that was approved subject to a condition, limitation, or restriction?

YES                      NO

2. Has any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, disciplined or otherwise imposed any sanctions, fines, probation, limitations, or restrictions on any license, certification, registration, or permit held by you?

YES                      NO

3. Have you entered into any type of settlement agreement with any professional or occupational licensing, registration, or certifying authority other than the Maine Board of Dental Practice?

YES                      NO

4. Are you aware of any complaints filed with any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, against any license, certification, registration, or permit held by you, for which you have not received a notice of final dismissal?

YES                      NO

5. Are you aware of any investigations or inquiries undertaken by any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, that involve, to any extent, any license, certification, registration, or permit held by you, for which you have not received a notice of final closure or dismissal?

YES                      NO

6. Have your practice privileges been restricted?

YES                      NO

7. Have you ever left a dental licensing jurisdiction, other than the Maine Board of Dental Practice, while a complaint or allegation was pending?

YES                      NO

8. Have you ever been denied registration or had your ability to administer, prescribe, or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended?

YES                      NO

9. Have you ever received a sanction from the Center for Medicare and Medicaid Services or any state Medicaid program?

YES                      NO

**Licensure / Disciplinary Questions (Cont.)**

10. Have you rendered any dental services illegally?

YES                      NO

11. Are you currently dependent on the use of alcohol or habituating drugs?

YES                      NO

12. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

YES                      NO

13. Are you currently participating in a substance abuse and/or alcohol or drug treatment program, or have you been diagnosed with a substance abuse disorder that in any way currently affects or limits your ability to practice safely and in a competent and professional manner?

YES                      NO

14. Do you currently use any chemical substance(s), including alcohol or drugs, which in any way impairs or affects your ability to practice your dental profession with reasonable skill and safety?

YES                      NO

15. Do you have or have you been diagnosed with or treated for a medical, mental, physical, emotional, nervous, or behavioral disorder or condition that in any way currently limits or impairs your ability to practice safely or to function as a dental professional?

YES                      NO

16. Have you asserted any condition or impairment as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

YES                      NO

17. Have you been named in any lawsuit involving your practice as a dental professional that was adjudicated to any degree in favor of the other party?

YES                      NO

18. Have you been named in any lawsuit involving your practice as a dental professional that was settled by the parties?

YES                      NO

19. Are you currently in default on payment of student loans?

YES                      NO

**Maine Statutes and Rules**

20. Have you read the statutes and rules governing dental practices in Maine?

YES

NO

**Attest and Agree**

I have read and completed this application and attest that all information is true to the best of my knowledge. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice in the state of Maine.

I hereby authorize all hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies and instrumentalities (local, state, federal or foreign) to release to the Maine Board of Dental Practice, my references and information, files, or records requested by the Board in connection with processing of this application. I hereby authorize the Maine Board of Dental Practice to use photocopies of this authorization and waiver in lieu of the original.

I further authorize the Maine Board of Dental Practice to release to the organizations, individuals and groups listed above, any information which is material to my application.

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

Date: \_\_\_\_\_

**Notices**

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**STATE OF MAINE  
BOARD OF DENTAL PRACTICE**

143 State House Station, Augusta, ME 04333-0143

**CERTIFICATION FORM  
SEDATION AND/OR GENERAL ANESTHESIA (Rev. 12/2020)**

This certification form is required pursuant to Board Rule, Chapter 14 for qualifying dentists seeking a permit from the Board to administer sedation and/or general anesthesia. Complete this form and submit it to the Board along with the application and payment of the required fee.

**IMPORTANT REMINDERS:**

**NOTIFICATIONS REQUIRED:**

- 1) 10 day notification law pursuant to 32 MRS §18352:
  - a. Change of name or address;
  - b. Criminal Conviction;
  - c. Revocation, suspension or other disciplinary action taken in this State or any other jurisdiction against any occupational or professional license held by the licensee or applicant; or
  - d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the board.
- 2) 14 day notification pursuant to Board Rule, Chapter 14:
  - a. If providing sedation and/or general anesthesia services in agreement with an operating dentist, a 14 Day Notification Form must be submitted and approved by the Board prior to providing services.
- 3) 72 hour notification pursuant to Board Rule, Chapter 12 (I)(E) "Dental Adverse Occurrence Report":
  - a. Death of a patient within 48 hours after the administration of a dental practice procedure.
  - b. Activation of an emergency response of a patient or emergent transport of a patient to another facility.

**PERMITS ARE NON-TRANSFERABLE**

All moderate level permits and deep sedation/general anesthesia permits are non-transferable. Permits issued are dentist specific and dental practice location specific.

**SAMPLE FORMS**

Attached to the certification form are the following anesthesia related documents:

- 1) Anesthesia Record and Modified Aldrete Scoring System
- 2) Common Dental Practice Emergency cases

**DENTIST RESPONSIBILITIES**

- 1) Levels of Anesthesia. The permit holder must be prepared to manage deeper than intended levels of sedation and/or anesthesia. If a patient enters a deeper level of sedation than the provider is qualified to provide, then the dental procedure must stop until the patient returns to the intended level of sedation.
- 2) Completeness/Accuracy. The dentist applying for a permit is responsible for completing the certification form. Failure to complete the form may result in a preliminary denial of the permit application, and failure to accurately complete the form may result in disciplinary action.





**SECTION 5 – Moderate Sedation Permit Applicant Only**

**A. Equipment Requirements – Moderate Level I (Enteral) and Moderate Level II (Parenteral) Permits.**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. EMERGENCY EQUIPMENT</b>	<b>INITIAL</b>
a) Bag-valve-mask apparatus (appropriate size) or equivalent with an oxygen hook up	
b) Oral and nasopharyngeal airway device	
c) External defibrillator – manual or automatic	
d) ACLS algorithms card	
e) Broselow pediatric measuring tape	
f) Emergency medications	
<b>2. EQUIPMENT TO MONITOR VITAL SIGNS AND OXYGENATION/VENTILATION</b>	
a) Continuous pulse oximeter	
b) Blood pressure cuff (appropriate size) and stethoscope, or equivalent blood pressure monitoring device	
<b>3. RECOVERY – Must be immediately available during recovery period</b>	
a) Oxygen	
b) Suction	
c) Pulse oximeter	
<b>4. BACK UP EQUIPMENT</b>	
a) Back up suction equipment	
b) Back up lighting system	
<b>5. ACCESS EQUIPMENT (at least one is needed)</b>	
a) Equipment to establish intravenous (IV) access	
b) Equipment to establish intraosseous (IO) access	
c) Equipment to establish sublingual (SL) access	
<b>6. OTHER</b>	
a) Electrocardiograph (only if patients with classification of ASA III or higher)	
b) Ventilation monitoring system – capnography required by 7/1/2018	

**B. Drugs – Moderate Level I (Enteral) and Moderate Level II (Parenteral) Permits.**

**Applicant must identify expiration date of drug and initial each of the following boxes to indicate compliance.**

<b>1. CARDIAC DRUGS</b>	<b>EXPIRATION DATE</b>	<b>INITIAL</b>
Moderate Level I and Moderate Level II		
a) Vasopressor (e.g. Epinephrine)		
b) Nitroglycerin (spray or tablets)		
c) Anticoagulant (aspirin)		
d) Glucose (D50 or liquid glucose)		

Moderate Level II only		
e) Lidocaine		
f) Atropine		
g) Adenosine		
h) Diltiazem		
i) Beta Blocker (e.g. Labetalol, Esmolol)		
<b>2. REVERSAL AGENTS – AS APPLICABLE (Required only for the administration of benzodiazepines or narcotics)</b>		
Moderate Level I and Moderate Level II		
a) Flumazenil (benzodiazepine reversal agent)		
b) Narcan (narcotic reversal agent)		
Moderate Level II only		
c) Dantrolene, Ryanodex (volatile gas reversal agent)		
<b>3. OTHER</b>		
Moderate Level I and Moderate Level II		
a) Antihistamine (e.g. Benadryl IV or PO)		
b) Bronchodilator (e.g. Albuterol inhaler)		
Moderate Level II only		
c) Corticosteroid (e.g. Solu-Medrol)		
d) Muscle Relaxant (e.g. Succinylcholine)		
e) Narcotics (e.g. morphine, fentanyl)		
f) Antihypertensive drugs (e.g. Propranolol, Verapamil)		

**SECTION 6 – Deep Sedation / General Anesthesia Permit Applicant Only**

**A. Equipment Requirements – Deep Sedation / General Anesthesia Permit**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. EMERGENCY EQUIPMENT</b>	<b>INITIAL</b>
a) Bag-valve-mask apparatus (appropriate size) or equivalent with an oxygen hook up	
b) Oral and nasopharyngeal airway device	
c) External defibrillator – manual or automatic	
d) ACLS algorithms card	
e) Broselow pediatric measuring tape	
f) Emergency medications	
<b>2. EQUIPMENT TO MONITOR VITAL SIGNS AND OXYGENATION/VENTILATION</b>	
a) Continuous pulse oximeter	
b) Blood pressure cuff (appropriate size) and stethoscope, or equivalent blood pressure monitoring device	
<b>3. RECOVERY – Must be immediately available during recovery period</b>	
a) Oxygen	
b) Suction	
c) Pulse oximeter	

<b>4. BACK UP EQUIPMENT</b>	
a) Back up suction equipment	
b) Back up lighting system	
<b>5. ACCESS EQUIPMENT (at least one is needed)</b>	
a) Equipment to establish intravenous (IV) access	
b) Equipment to establish intraosseous (IO) access	
c) Equipment to establish sublingual (SL) access	
<b>6. EMERGENCY EQUIPMENT TO MANAGE DIFFICULT AIRWAYS</b>	
a) Laryngeal mask airway; and/or endotracheal tubes; and/or LMA suitable for patients	
b) Laryngoscope with reserve batteries and bulbs	
c) Endotracheal tube forceps (e.g. Magill)	
d) One additional airway management device	
e) Equipment to establish surgical airway	
<b>7. OTHER</b>	
a) Electrocardiograph	
b) Ventilation monitoring system – capnography required by 7/1/2018	

**B. Drugs – Deep Sedation / General Anesthesia Permit.**

**Applicant must identify expiration date of drug and initial each of the following boxes to indicate compliance.**

<b>1. CARDIAC DRUGS</b>	<b>EXPIRATION DATE</b>	<b>INITIAL</b>
a) Vasopressor (e.g. Epinephrine)		
b) Nitroglycerin (spray or tablets)		
c) Anticoagulant (aspirin)		
d) Glucose (D50 or liquid glucose)		
e) Lidocaine		
f) Atropine		
g) Adenosine		
h) Diltiazem		
i) Beta Blocker (e.g. Labetalol, Esmolol)		
<b>2. REVERSAL AGENTS – AS APPLICABLE (Required only for the administration of benzodiazepines, narcotics, or triggering agents of malignant hypothermia)</b>		
a) Flumazenil (benzodiazepine reversal agent)		
b) Narcan (narcotic reversal agent)		
c) Dantrolene, Ryanodex (volatile gas reversal agent)		
<b>3. OTHER</b>		
a) Antihistamine (e.g. Benadryl IV or PO)		
b) Bronchodilator (e.g. Albuterol inhaler)		
c) Corticosteroid (e.g. Solu-Medrol)		
d) Muscle Relaxant (e.g. Succinylcholine)		
e) Narcotics (e.g. morphine, fentanyl)		
f) Antihypertensive drugs (e.g. Propranolol, Verapamil)		

**SECTION 7 – All Permit Applicants**

**A. Anesthesia Gas Delivery Systems –**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. Anesthesia Gas Delivery Systems</b>	<b>INITIAL</b>
a) Deliver oxygen under positive pressure, including a back-up oxygen system	
b) Gas outlets that meet safety standards; prevent accidental administration of inappropriate gases or gas mixture	
c) Fail-safe mechanism for inhalation of nitrous oxide analgesia	
d) Inhalation equipment with appropriate scavenging system	
e) Gas storage facilities that meet safety standards	
f) Engineering controls and maintenance procedures to ensure safety of inhalation equipment	

**B. Emergency Protocols –**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. Emergency Protocols – Must have written emergency protocols for the following clinical emergencies. Annual training to personnel required.</b>	<b>INITIAL</b>
a) Laryngospasm	
b) Bronchospasm	
c) Emesis and aspiration	
d) Airway blockage by foreign body	
e) Angina pectoris	
f) Myocardial infarction	
g) Hypertension/Hypotension	

**C. Patient Documentation –**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. PATIENT DOCUMENTATION</b>	<b>INITIAL</b>
a) Medical history – current and comprehensive	
b) Height and Weight	
c) ASA Classification	
d) Dental Procedure(s)	
e) Informed Consent	
f) Physical examination <ul style="list-style-type: none"> <li>i. Airway assessment</li> <li>ii. Baseline heart rate, blood pressure, respiratory rate, oxygen saturation</li> </ul>	
g) Time oriented anesthesia record, which includes <ul style="list-style-type: none"> <li>i. Time anesthesia commenced and ended</li> <li>ii. 5 minute intervals of recording blood pressure, heart rate, oxygen saturation, and respiratory rate</li> <li>iii. Continuous ECG and documentation of changes in rhythm if clinically indicated</li> <li>iv. Parenteral access site and method, if utilized</li> <li>v. Medications administered – including oxygen, dosage, route, and time given</li> </ul>	

vi. Vital signs before and after anesthesia is utilized	
vii. Intravenous fluids, if utilized	
viii. Response to anesthesia – including complications	
h) Condition of patient at discharge charted with objective data (Modified Aldrete scoring system)	

**D. PATIENT MONITORING**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. PATIENT MONITORING -</b>	<b>INITIAL</b>
Moderate Level I and Moderate Level II Permit Applicant	
a) Continuous heart rate, respiratory status, and oxygen saturation	
b) Intermittent blood pressure taken at least every 5 minutes	
c) Continuous electrocardiograph of patients with significant cardiovascular disease	
d) End-tidal carbon dioxide monitoring (capnography required by 7/1/2018)	
e) Continuous monitoring of level of consciousness	
Deep Sedation / General Anesthesia Permit Applicant	
f) Continuous heart rate, respiratory status, and oxygen saturation	
g) Intermittent blood pressure taken at least every 5 minutes	
h) Continuous electrocardiograph	
i) End-tidal carbon dioxide monitoring (capnography required by 7/1/2018)	
j) Continuous monitoring of level of consciousness	

**E. MISCELLANEOUS/PERSONNEL**

**Applicant must initial each of the following boxes to indicate compliance.**

<b>1. MISCELLANEOUS/PERSONNEL-</b>	<b>INITIAL</b>
a) Life Support – all dental personnel must successfully complete BLS certification to monitor minimal, moderate, and deep sedation/general anesthesia	
b) Moderate Sedation – When providing moderate sedation at a dental practice location, the dentist and at least one other individual who is experienced in patient monitoring and documentation, and trained to handle emergency situations must be present.	
c) Deep Sedation / General Anesthesia - During the administration of deep sedation or general anesthesia, the operating dentist and at least two other individuals, one of whom is experienced in patient monitoring and documentation, and trained to handle emergency situations, must be present.	

**F. SIGNATURE/ATTESTATION**

By my signature, I hereby attest to adhering to the requirements of Board Rule, Chapter 14 and that the information provided on this certification form is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Maine Board of Dental Practice will rely upon this information for issuance of my permit and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

\_\_\_\_\_   
 Date

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

## ANESTHESIA RECORD

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Escort Present:     Yes     No        Name: \_\_\_\_\_        NPO:    NA    Y    N

Weight \_\_\_\_\_ lbs    Height \_\_\_\_\_        Airway Class    I    II    III    IV  
 Consent form reviewed and signed:

Past Medical History: \_\_\_\_\_  
ASA (circle)    I    II    III    IV

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_  NKDA

Pregnant:    NA    Y    N

**Times**

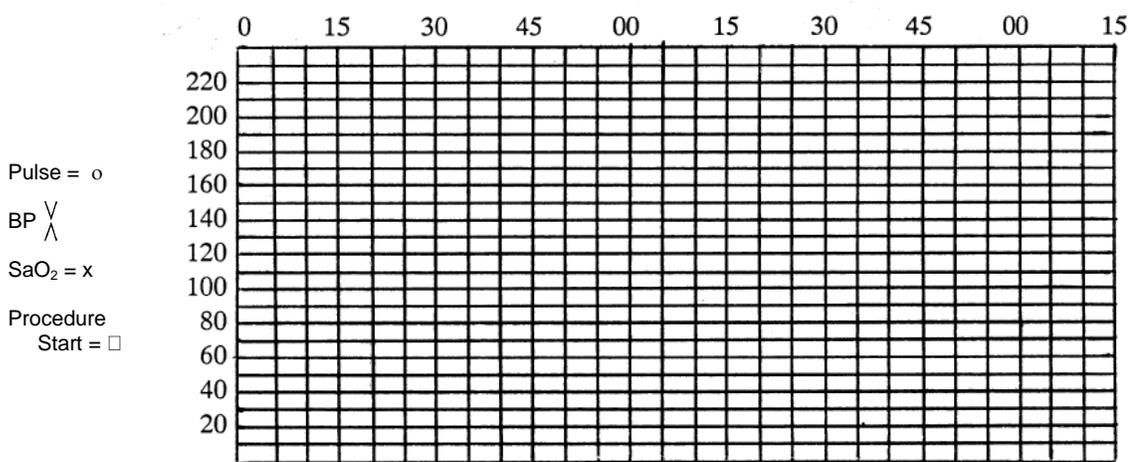
Pt arrived in office \_\_\_\_:\_\_\_\_        Procedure Start \_\_\_\_:\_\_\_\_        Procedure Finish \_\_\_\_:\_\_\_\_

**Oral Premedication:** Medication: \_\_\_\_\_        Dose: \_\_\_\_\_        Time: \_\_\_\_:\_\_\_\_

**Pre-op vitals:**        P \_        BP \_\_\_ / \_\_\_        SaO<sub>2</sub>% \_\_\_\_\_

**Monitors:**         Pulse Oxim.     BP     ECG (cardiac issues)     Capnography

**Staff:**        Assistant #1: \_\_\_\_\_        Assistant #2: \_\_\_\_\_



**Medications**

- Oxygen L/min
- Nitrous Oxide L/min

**LIST OTHER MEDICATIONS GIVEN**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Sedation Complications:** \_\_\_\_\_  None

**Modified Aldrete Score for Discharge to Home**

**Aldrete scoring system**

<b>Respiration</b>
Able to take deep breath and cough = 2
Dyspnea/shallow breathing = 1
Apnea = 0
<b>Oxygen saturation</b>
S <sub>a</sub> O <sub>2</sub> >95 percent on room air = 2
S <sub>a</sub> O <sub>2</sub> = 90-95 percent on room air = 1
S <sub>a</sub> O <sub>2</sub> <90 percent even with supplemental O <sub>2</sub> = 0
<b>Consciousness</b>
Fully awake = 2
Arousable on calling = 1
Not responding = 0
<b>Circulation</b>
BP ± 20 mm Hg baseline = 2
BP ± 20-50 mm Hg baseline = 1
BP ± 50 mm Hg baseline = 0
<b>Activity</b>
Able to move 4 extremities = 2
Able to move 2 extremities = 1
Able to move 0 extremities = 0

Monitoring may be discontinued and patient discharged to home or appropriate unit when Aldrete score is 9 or greater.

*Reproduced with permission from: Aldrete JA, Kroulik D. A postanesthetic recovery score. Anesth Analg 1970; 49:924. Copyright © 1970 Lippincott Williams & Wilkins.*



Time Pt discharged home \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

## Common Dental Emergency Cases

### HYPOVENTILATION / AIRWAY OBSTRUCTION

Ask patient to take deep breath at the same time check your pulse oximeter to ensure it is properly placed.

Turn off the nitrous oxide if it is being used, and increase the oxygen flow rate to 10L/min

If the patient does not respond to the request to take a deep breath, apply a painful stimulus (i.e. local anesthesia in the palate if they have not had local anesthesia applied in that area or pinch their ear lobe).

Change the mask to a full face mask with an oxygen flow rate of 10L/min

Is there spontaneous breathing? If the patient is breathing, and the oxygen saturation continues to be low reposition the patient's jaw with a jaw thrust. Allow patient to lighten enough to be able to follow commands

If there is NO spontaneous breathing turn off the nitrous oxide, ensure the oxygen tanks are full and delivering oxygen (especially if the tanks are portable).

Recheck vital signs at this point.

If oxygen is flowing and the patient is not breathing perform jaw thrust or chin head lift. Assess for chest rise and airflow.

Get your positive pressure oxygen bag mask ready to use and hooked up to oxygen if not already attached.

If there is no chest rise or you cannot feel breath on the back of your hand perform positive ventilation until the oxygen saturation returns to normal. Once normal reassess the patient and ensure that you now have spontaneous ventilation. If you do not have spontaneous ventilation, continue ventilating the patient.

If you need to continue to perform positive ventilation then consider reversal agents naloxone or flumazenil to correct over sedation. Be aware flumazenil is contraindicated in a patient with seizure disorder since it may precipitate grand mal seizures.

It may take a minute or two for the reversal agent to work before patient is spontaneously breathing. Be prepared to continue to ventilate the patient. If you are not seeing chest rise, reposition the patient and reattempt the positive pressure ventilation.

If you are needing to ventilate this patient beyond 5 minutes or if the oxygen saturation is persistently low after trying repositioning or 2 person mask ventilation. CALL 911.

Sources: [www.uptodate.com](http://www.uptodate.com)

Office Anesthesia Manual. American Association of Oral and Maxillofacial Surgeons. 2006. Rosemont, IL.

## ALLERGIC REACTION

These reactions are rare. It could be from the antibiotic premedication, latex rubber if your office is not latex free, or possibly the local anesthetic.

The mild form with only a skin reaction can be treated with benadryl and albuterol.

ANAPHYLAXIS is a true medical emergency do not hesitate to call 911 or give epinephrine. Delay in recognition or treatment can lead to cardiac arrest.

### Signs and Symptoms

1. Cutaneous symptoms, which occur in up to 90 percent of episodes, including flushing, itching, urticaria, and angioedema (including periorbital edema and conjunctival swelling)
2. Respiratory symptoms, which occur in up to 70 percent of episodes, including nasal discharge, nasal congestion, change in voice quality, sensation of throat closure or choking, cough, wheeze, and dyspnea
3. Gastrointestinal symptoms, which occur in up to 40 percent of episodes, including nausea, vomiting, diarrhea, and cramping abdominal pain

Cardiovascular symptoms, which occur in up to 35 percent of episodes, including dizziness, tachycardia, hypotension, and collapse.

### Treatment

Give the patient full oxygen:

**Dosing and administration** – There is persistent confusion among clinicians regarding the optimal epinephrine dose and route of administration for the treatment of anaphylaxis.

**Intramuscular injection** – Intramuscular injection is recommended over subcutaneous injection because it provides a more rapid increase in the plasma and tissue concentrations of epinephrine. Epinephrine is commercially available in several dilutions, and great care must be taken to use the correct dilution. The epinephrine dilution for intramuscular injection contains 1 mg per mL and may also be labeled as 1:1000 or 0.1 percent. For adults, the recommended dose of epinephrine (1 mg per mL) is 0.3 to 0.5 mg per single dose, injected intramuscularly into the mid-anterolateral thigh (vastus lateralis muscle). This treatment may be repeated at 5 to 15 minute intervals, based upon clinical experience and consensus opinion. For infants and children, the recommended dose of epinephrine (1 mg per mL) is 0.01 mg per kilogram (up to 0.5 mg per dose), injected intramuscularly into the mid-anterolateral thigh (vastus lateralis muscle). The dose should be drawn up using a 1 mL syringe. This treatment may be repeated at 5 to 15 minute intervals. Epinephrine can also be administered into the mid-anterolateral thigh using an auto-injector. These are available in 0.15 mg and 0.3 mg doses. Children weighing less than 25 to 30 kilograms should receive the 0.15 mg dose EpiPen® 0.3 mg or EpiPen Jr® 0.15 mg (pediatric dose).

**Benadryl** - For adults: diphenhydramine 25 to 50 mg intravenously; may be repeated up to a maximum daily dose of 400 mg per 24 hours. For children: 1 mg per kg (maximum 50 mg) intravenously, which may be repeated up to a maximum daily dose of 5 mg per kg or 300 mg per 24 hours

**Bronchodilators** – For the treatment of bronchospasm not responsive to epinephrine, inhaled bronchodilators, such as albuterol should be administered by nebulizer/compressor as needed. They are adjunctive treatment to epinephrine because they do not prevent or relieve mucosal edema in the upper airway or shock, for which the alpha-1 adrenergic effects of epinephrine are required.

**Glucocorticoids** – The onset of action of glucocorticoids takes hours; therefore, these medications do not relieve the initial symptoms and signs of anaphylaxis. They are given on an empirical basis with the rationale that they may help to prevent the biphasic or protracted reactions that occur in up to 23 percent of individuals, although there is no satisfactory published evidence that they actually have this effect.

If given, a dose of methylprednisolone of 1 to 2 mg per kilogram per day is sufficient. If glucocorticoid treatment is instituted, it can be stopped after three or four days without a taper.

## Hypoglycemia

In the general dental office this patient is usually being treated for diabetes by their physician. I would ask the patient to bring their glucometer to the office and document the blood sugar prior to starting the case. The blood sugar could be low (less than 100 mg/dl ) if they took their full AM does of insulin or oral agent.

### Signs and Symptoms

Confusion, agitation, anxiety, diaphoresis, cold clammy skin

Mildly elevated blood pressure or heart rate, changes in mental status

May progress to loss of consciousness or seizures.

### Treatment

Recognize early so patient can cooperate to take oral concentrated glucose or drink orange juice. Recheck blood glucose when the patient reports they feel better. Consider consultation with the patient's physician for decision if they need to be referred on for care. Consider ending treatment at this point.

If patient uncooperative call 911.

If unable to cooperate start IV if available and give 50% dextrose.

Be prepared to treat seizures if the patient remains unconscious.

## Myocardial infarction

This is due to blockage of one of coronary arteries. Once this happens the heart muscle is deprived of oxygen and the patient starts to complain of chest pain. Remember many advanced diabetic patients might not complain of chest pain.

### Signs and Symptoms

Pallor, ashen look, nausea vomiting, diaphoretic

Weak pulse (you might not feel a radial pulse), irregular beats.

Chest pain, arm, back or jaw pain.

### Treatment

911 to be called first then:

100% oxygen by full face mask rebreather if available. Make sure the flow is at least 10L/min.

Nitroglycerin tablet under the tongue 1-2 tablets every 5 minutes. Until chest pain gone. Warn patient that they will have a terrible headache. Make sure you take regular blood pressures while giving nitroglycerin since the patient can drop their pressure.

Make sure the nitro tablets are not expired. If the patient's personal tablets are being used ensure that they have not been open for more than a couple of months. Once the tablets are exposed to air they degrade, and lose potency and efficacy.

Have the patient chew a full 4 chewable baby aspirin tablets if they are not allergic to it.

If you have morphine give it by IM injection or IV if available monitor for respirator depression especially if the patient is elderly.

The patient might pull off the oxygen mask saying they can't catch their breath reassure them that they are getting oxygen with the mask and to keep it on.

Bring your AED/defibrillator to the area since this patient could go into cardiac arrest awaiting EMS.

If you have considered an EKG and have one available apply it. Capture rhythm strips; this is helpful for cardiologists or ER treating providers.

## Seizure

Seizures may result from underlying systemic disease, occur in reaction to various anesthetic agents, or be in reaction to a combination of factors. The most common seizure in the dental office is related to syncope. Patients often have seizure like activity after full vasovagal episode. Epilepsy is the next most common cause. The other causes can be tumor, prior head trauma, hypoglycemia, or intravascular injection of local anesthesia.

If this is related to vasovagal the trendelenburg position and oxygen will quickly resolve this.

### Treatment

CALL 911 if not short and syncope related

Ensure the patient is safe by clearing the area.

Give 100% oxygen by mask

Start IV

Give Diazepam

Once the patient is post-ictal they may need airway support with ventilation have a bag mask available.

## Syncope

Occurs as a result of a strong emotional stimulus. The vagus nerve over corrects slowing the body down, hence the term vasovagal. The patients often become bradycardic.

### Signs and Symptoms

Rapid deep breathing, Dizzy light headed or nauseated

Loss of color pallor

Loss of consciousness possible seizure like activity.

### Treatment

Place the patient supine and elevate the legs

Give 100% oxygen by mask.

Reassure patient and remove stressful stimulus.