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Montana Department of
LABOR & INDUSTRY

BOARD OF DENTISTRY
PO BOX 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513

Email: dlibsdhelp@mt.gov Web: www.dentistry.mt.gov Phone : (406) 444-6880

Dental Anesthesia Permit - Dentists Only

Full Name: ______________________________

Home Address: ______________________________

City: ______________________________

State: ____________________ Zip: __________

Office Address: ______________________________

City: ______________________________

State: ____________________ Zip: __________

E-Mail: ______________________________

Select the level of sedation or anesthesia: you are applying for:

☐ Moderate sedation
Complete Pages 1, 3, & 4

☐ Deep sedation/General anesthesia
Complete Pages 1 & 2

MT License# ____________________

Processing Notes:
(1) Applications are processed as efficiently as possible.
(2) Submitting all required information and the fee payment is the fastest way to ensure processing is completed.
(3) If you are applying for a Deep Sedation/General Anesthesia permit, upon qualification, you are also approved to provide moderate sedation.
(4) Questions about your application status should be directed to the contact information at the top of this page.
(5) Inspections are coordinated as quickly as possible. Once completed and approved your permit is valid for 120 days or until your inspection.

Fees

Total Fee: $400.00

Includes:
Application Fee - $200.00
Inspection Fee - $200.00

**Make check or money order payable to **
Montana Board of Dentistry

By providing your initials after each of the following statements you verify that you understand and agree:

(1) I have reviewed the Montana Board of Dentistry's rules for providing moderate sedation and deep sedation/general anesthesia. _____
(2) I agree that it is my responsibility to understand the requirements by rule to apply and be granted a moderate sedation or deep sedation/general anesthesia permit by the Montana Board of Dentistry. _____
(3) I agree that it is my responsibility to understand the requirements, by rule, for providing in-office sedation or anesthesia by the Montana Board of Dentistry. _____
(4) I understand that the Montana Board of Dentistry does not endorse, recommend, or support in any way, the qualifications of moderate sedation continuing education programs or courses. It is my responsibility to ensure that my moderate sedation training meets the rules of the Montana Board of Dentistry. _____

Signature: ______________________________ Date: ______________

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Only complete this page if you are applying for a deep sedation/general anesthesia permit.

Please mark which of the following you have completed:

A minimum of four years in an oral and maxillofacial surgery residency.

A minimum of two years in an advanced general dentistry education program in dental anesthesiology.

Name of Program:____

Address:____

Completion Dates: ________________ to ________________
MM/DD/YY MM/DD/YY

________________ Date of completion for advanced course in cardiac life support (ACLS)

Please provide, if not already supplied, proof of completion of your qualifying training. Evidence can include original transcripts from the program or a certificate.

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Only complete this section if you are applying for a moderate sedation permit. Moderate sedation applicants must provide a course syllabus and breakout of course hours, totaling 60 hours.

Moderate Sedation Permit Patient Log

Applicant Name: ____

Applicant's Address: ____

MT License Number: ____________________ E-mail: ______________________________

Phone number: ____________________

Moderate Sedation Program: ____

Moderate Sedation Program Address: ____

Date started: ________________ Date completed: ____________________

Date of completion for advanced course in cardiac life support (ACLS): ______________

Instructions: Twenty (20) patients must be sedated, intravenously, by any applicant pursuing a permit to provide moderate sedation in Montana. Please provide evidence of this requirement through completion of this patient log. Provide documentation of agents utilized for your sedations, dental procedure(s) performed, and time of sedation (start, finish and total time). Also, provide your initials as well as the initials of the doctor supervising your sedations.

All patients must be patients receiving dental treatment. Online simulation or sedation of non-dental procedures are not considered appropriate to qualify for the permit. (e.g. Colonoscopy Procedures, etc.)

1. Provide the agents used for the sedation as well as total doses (i.e. 2 mg midazolam, 100 mcg fentanyl)
2. Indicate start and finish times in hours and minutes (h:MMtt). (i.e. 8:03am)
3. Provide total time of the case in hours and minutes.
4. Provide your initials documenting completion of the sedation. In the chart below, provide your signature and initials for verification purposes.
5. Provide the initials of the doctor providing the supervision of your sedation(s) as well as their signature and initials.

(See next page)

Date	Patient no.	Agents used	Department or clinic	Procedure(s) (i.e. restorations, endodontic, extractions, implants, etc.)	Time start	Time end[2]	Total time	Applicant initials	Observer's initials
	1						h m		
	2						h m		
	3						h m		
	4						h m		
	5						h m		
	6						h m		
	7						h m		
	8						h m		
	9						h m		
	10						h m		
	11						h m		
	12						h m		
	13						h m		
	14						h m		
	15						h m		
	16						h m		
	17						h m		
	18						h m		
	19						h m		
	20						h m		

Date	Applicant's name printed	Applicant's signature	Applicant's initials
	Supervisor's name printed	Supervisor's signature	Supervisor's initials