MINNESOTA BOARD OF DENTISTRY

Minnesota Board of Dentistry
335 Randolph Ave, Suite 250
St. Paul, MN 55102
Office: (612) 617-2250
MN Relay Service: (800) 627-3529
www.mn.gov/boards/dentistry

ALLIED SEDATION MONITORING CERTIFICATION APPLICATION

Name (*Please Print)* _____ MN License Number _____

For Licensed Dental Assistants and Dental Hygienists:
Before monitoring patients under sedation or recovering from sedation, and before performing any or all approved intravenous (IV) sedation procedures (limited to initiating, maintaining, monitoring and removing IV lines and/or aiding in administration of medications into an existing IV line), a licensed dental assistant or dental hygienist must successfully complete a Board-approved course on these specific sedation procedures and become certified by the Minnesota Board of Dentistry in these procedures. Licensee must follow all provisions for anesthesia and sedation procedures under Minnesota Rule 3100.8500, Subp.1a (N)(O), 1b (J) and Subp.1c or Minnesota Rule 3100.8700, Subp.2b (A) (B) and (C).

In addition to completing the attestations in Sections 1, 2 and 3 (if applicable), you MUST submit the following supportingdocumentation to the Board:

1. This original application form
2. A copy of your CPR card
3. A copy of your completion certificate from the sponsoring organization listed in section 2
4. If you hold active DAANCE certification, a copy of your DAANCE certificate. You can obtain a copy of your certificate by emailing daanceinquiries@aaoms.org

SECTION 1

I certify that I have completed and am current in a Healthcare Provider CPR course, pursuant to Minnesota Rule 3100.0100, subpart 9a.

Signature _____ Date _____

I certify that I have completed a course on the administration of nitrous oxide inhalation analgesia from an institution accredited by the Commission on Accreditation, and I am currently Board certified to administer nitrous oxide, pursuant to Minnesota Rule 3100.3600, subpart 14 and subpart 15.

Signature _____ Date _____

SECTION 2

I certify that I have successfully completed an **Allied Sedation Monitoring Course** approved by the Minnesota Board of Dentistry for Allied staff.

Name *(Please Print)*	License Number
Name of Institution/Sponsoring Org.	Address of Institution/Sponsoring Org.
Date of Completion	City, State, Zip Code
Signature	Date

SECTION 3

I certify that I hold current DAANCE certification through the AAOMS.

Name *(Please Print)*	
Date of Completion	
Signature	Date