MINNESOTA
BOARD OF DENTISTRY

Minnesota Board of Dentistry
335 Randolph Ave, Suite 250
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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.2(B)(C),2a(H), and 2b.

In addition to completing the attestations in Sections 1, 2 and 3, you MUST submit the following supporting documentation 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 sections 2 and 3
4. If you participated in the 8-hour clinical portion, a copy of your dAANCE certificate

SECTION 1

I certify that I have completed and am current in a Healthcare Provider CPR course recognized by the American Heart Association, or American Red Cross Professional Rescuer with AED course, pursuant to Minnesota Rule 3100.3600, subpart 4, Item C.

_____ _____
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 4, Item E.

_____ _____
Signature Date

SECTION 2

I certify that I have successfully completed a *didactic* **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 have successfully completed a *hands-on* **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