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

PEDIATRIC SEDATION ENDORSEMENT APPLICATION

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

Electronic Mail Address *(E-Mail address required)* _____

Pursuant to Minnesota Rule 3100.3600, a licensed dentist **who holds a conscious sedation or general anesthesia certificate** may administer to patients **8 years and younger** for the purpose of PEDIATRIC SEDATION after obtaining endorsement from the Board by completing Section 1 (if applicable), Section 2 and Section 3 on this form and returning this completed form and supporting documentation listed in Section 4 to the Board office.

GA Certification Number _____**OR**

Conscious Sedation Certification Number_____

Cost: There is no cost to add the pediatric endorsement to either sedation/ anesthesia certification.

SECTION 1

CONSCIOUS SEDATION CERTIFICATE HOLDERS ONLY: Please complete the information requested below relating to the program you completed to become competent for the administration of pediatric sedation. The program **MUST** be a pediatric program accredited by the Commission on Dental Accreditation (CODA) or an equivalent residency program that requires clinical competency in the administration of moderate sedation on pediatric patients.

Name of Institution _____

Address of Institution _____

City, State, Zip code _____

Date Program Completed _____

(_____)_____
Phone Number of Institution

SECTION 2

ATTESTATION OF CASES:

I certify that I have completed at least 12 cases of moderate and/or deep sedation [general anesthesia] on patients who are **8 years old or younger** within the last 12 months.

_____ _____

Signature Date

*Note: A dentist administering pediatric sedation must have two additional licensed personnel who are currently certified in CPR and allied sedation monitoring present [in-office] during administration.

If you are applying for the pediatric endorsement with your *initial* conscious sedation or general anesthesia certification application, you do NOT need to complete Section 3 of this application.

SECTION 3

Please name all practices and list the addresses of all facilities where you plan to administer pediatric sedation. (Please attach additional pages as needed.)

_____ _____

Name of Practice Name of Practice

_____ _____

Address Address

_____ _____

City, State & Zip City, State & Zip

(_____)_____ (_____)_____

Phone Number Phone Number

Please Check

- ❑ All clinical dental professionals have applicable training.
- ❑ Emergency protocols are written and routinely reviewed by all dental professionals.
- ❑ All office facilities are equipped with the following equipment:
  - * Automated external defibrillator or full function defibrillator (immediately accessible)
  - * Positive pressure oxygen delivery system and a back up system
  - * Functional suction device and a back up suction device
  - * Auxiliary lighting
  - * Gas storage facility
  - * Recovery area
  - * Method to monitor respiratory function
  - * Method to continuously monitor cardiac activity
  - * Emergency cart or kit (readily accessible)
- ❑ Complete and accurate record keeping procedures.

ATTESTATION OF COMPLIANCE:

I certify that I am in compliance with the aforementioned requirements at the office locations I plan to administer pediatric sedation pursuant to Minnesota Rules 3100.3600.

Name (*Please Print)*	License Number
Signature	Date
Email address *(mandatory)*	

SECTION 4

In addition to completing Sections 1 (if applicable), 2 and 3 you **MUST** submit the following with this form:

1. Official documentation (if applicable) from the institution listed in Section 1, verifying your successful completion of the program.