FOR OFFICE USE ONLY
Dental Anestheia Facility Checklist

- ☐ App. & Fee
- ☐ Attestation

Anesthesia Checklist

- ☐ Anesthesia Training

Gen Anesthesia/Deep Sedation

- ☐ BLS
- ☐ ACLS
- ☐ PALS

ModerateSedation

- ☐ BLS
- ☐ ACLS or PALS

Minimal Sedation/Nitrous Oxide

- ☐ BCLS

*****FOR OFFICE USE ONLY*****

Receipt #

ID #

Issue Date

License #

Rhode Island
Board of Examiners in Dentistry

Room 104 - 3 Capitol Hill
Providence, RI 02908-5097

License # _____

Name _____

Instructions and License/Permit Application for Anesthesia Facility Permits:

- ☐ **Nitrous Oxide Facility**
- ☐ **Minimal Sedation Facility**
- ☐ **Moderate Sedation Facility**
- ☐ **General Anesthesia/Deep Sedation Facility**
- ☐ **Facility Host Permit (H Permit)**
- ☐ **Pediatric Facility Permit**

Applicant - Print Name (Full Name)

Phone: (401) 222-2837 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 04/29/2025 jcp

PERMIT REQUIREMENTS

☐ Completed, Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application.

Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$40.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.

☐ **Nitrous Oxide Facility Permit - Supporting official transcripts of verification of the qualification requirements listed below submitted directly to the Department.**

a. Current license as a dentist in this state
b. Nitrous Oxide Individual Anesthesia permit
c. Duly executed nitrous oxide sedation self-assessment form (Part A, B)

☐ **Minimal Sedation Facility Permit - Supporting official transcripts of verification of the qualification requirements listed below submitted directly to the Department.**

a. Current license as a dentist in this state
b. Minimal Sedation Individual permit
c. Duly executed nitrous oxide sedation self-assessment form (Part A, B)

☐ **Moderate Sedation Facility Permit - Supporting official transcripts of verification of the qualification requirements listed below submitted directly to the Department.**

a. Current license as a dentist in this state
b. Moderate Sedation Individual permit
c. Successful completion of an on-site office evaluation performed by an office evaluation team approved by the Board and the Director
   1. An office evaluation team shall consist of two or more persons chosen and approved by the Board and the Director. At least one of the evaluators must hold an Individual General Anesthesia Permit. At least one member of the team must have substantial experience in the administration of the method of delivery of ansesthesia or sedation used by the dentist being evaluated.
   2. The board may appoint a licensee member of the board to serve as a consultant at any evaluation.
   3. Equipment in Attachment 2
   4. Emergency Drugs as listed

☐ **General Anesthesia/Deep Sedation Facility Permit - Supporting official transcripts of verification of the qualification requirements listed below submitted directly to the Department.**

a. Current license as a dentist in this state
b. General Anesthesia/Deep Sedation Individual permit
c. Successful completion of an on-site office evaluation performed by an office evaluation team approved by the Board and the Director (See Sections A, C for self-attestation)
   1. Required equipment
   2. Required Emergency Drugs
   3. Office forms
      - Medical History
      - Anesthesia chart
      - Anesthesia consent

☐ **Facility Host Permit**

a. Attestation to the safety of all equipment used in connection with the administration of anesthesia
b. Successful completion of an on-site office evaluation performed by an office evaluation team approved by the Board and the Director (See Sections A, C for self-attestation)

☐ **Pediatric Facility Permit**

a. Current license as a dentist in this state
b. General anesthesia/deep sedation individual permit.
c. Successful completion of an on-site office evaluation performed by an office evaluation team appointed by the Board and the Director.

State of Rhode Island
Board of Examiners in Dentistry
Application for Anesthesia Permit

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Dental Facility:

Facility Name

2. Owner Name:

Provide the name of the owner.

First Name | Middle Name | Surname, (Last Name)

3. Name of Responsible Dentist

Provide the name of the licensed individual who is responsible for the day-to-day operations. NOTE: A change requires written notification to the BOARD.

Dentist License Number

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III) | Area Code | Phone Number | Extension | ☐ Unlisted?

4. Facility Mailing Information:

Please provide the mailing information for all communication regarding this license. It is your responsibility to notify the board of all address changes.

This information will NOT appear on the RIDOH Web site.

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Mailing Address Phone | Extension | Mailing Address Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

5. Facility Location Information:

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

This information will appear on the RIDOH Web site.

Facility Phone | Extension | Facility Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Type of Ownership

Please Check ONE

- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Limited Partnership
- ☐ Governmental Entity
- ☐ Partnership

7. Ownership Information:

Provide the name address and telephone number(s) of the facility owner in the spaces provided
If necessary, continue below, or on a separate of
8 1/2 X 11" sheet of paper.

Name of Owner

D.B.A. (Doing Business As)

First Line Address

Second Line Address

Third Line Address

City | State/Province | Zip Code

Country, If NOT U.S. | Postal Code, If NOT U.S.

Phone | Extension | Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

8. Federal Employer Identification Number (FEIN)

Mandatory

Federal Employer Identification Number (FEIN)

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Federal Employer Identification Number (FEIN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

9. Affidavit of Applicant

Complete this section and sign

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. 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 Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Examiners in Dentistry of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant | Date of Signature (MM/DD/YY

Section A: Staff-For completion for any facility permit

NAME(S) OF DENTIST(S)/ ANESTHESIOLOGIST(S) WHO WILL BE ADMINISTERING ANESTHESIA AT THIS FACILITYANESTHESIOLOGIST(S) WHO WILL BE ADMINISTERING ANESTHESIA AT THIS FACILITY	LICENSE NUMBER	ANESTHESIA PERMIT NUMBER	BLS CERTIFICATION EXPIRATION DATE (NITROUS AND MINIMAL)	ACLS/PALS CERTIFICATION EXPIRATION DATE (MODERATE, GENERAL, HOST)
Dental Director:				

NAME(S) OF DENTAL/ SURGICAL ASSISTANT(S)	BLS CERTIFICATION EXPIRATION DATE (NITROUS AND MINIMAL)	ACLS/PALS CERTIFICATION EXPIRATION DATE (MODERATE, GENERAL, HOST)

Section B: Nitrous and Minimal Sedation

RECORDS REQUIRED	SELF-ATTEST AVAILABLE NITROUS	SELF-ATTEST AVAILABLE MINIMAL
Consent for nitrous oxide/oxygen	Initial _____	
Documentation of delivered amount/duration/recovery of nitrous oxide/oxygen	Initial _____	
Monitoring of vital signs	Initial _____	Initial _____
FACILITY		
Device has O2 capacity of 100% never less than 25%	Initial _____	
Device allows adjustable flow rates and concentrations appropriate for size and weight of the patient	Initial _____	
Delivery systems that cover the mouth and nose must be used in conjunction with a calibrated and functional oxygen analysis	Initial _____	
Device calibrated and inspected scavenging of waste gases as per NIOSH standards	Initial _____	
Piped in nitrous oxide and oxygen systems compliant with state and or local inspections	Initial _____	
Oxygen reserve tank(s)	Initial _____	
Biannual NIOSH approved testing and occupational exposure	Initial _____	
Automated external defibrillator including batteries and other components	Inspection Date _____	Inspection Date _____
Suction-tonsil/Yankauer		Initial _____
Sphygmomanometer and stethoscope (pediatric and adult)		Initial _____
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation including bag-valve-mask system	Inspection Date _____	Inspection Date _____
Gas delivery system capable of positive pressure ventilation, which must include: • Oxygen • Safety-keyed hose attachments • Capability to administer 100% oxygen in all rooms (operatory, recovery, examination, and reception) • Gas storage in compliance with safety codes • Adequate wast gas scavenging system • Nasal hood or cannula	Inspection Date _____	Inspection Date _____

Part C: In office inspection. Inspection will be performed by an evaluation team appointed by the Board and the RIDOH Director and will include a review of forms, protocols, monitoring equipment, emergency equipment and drugs, and any other relevant items related to safe performance of anesthesia. Applicants may obtain a copy of the inspection form by visiting www.health.ri.gov/forms/DentalAnesthesiaInspectionForm.pdf