APPLICANT NAME _____

AFFIDAVIT OF APPLICANT APPLICATION
MODERATE ENTERAL SEDATION, MODERATE PARENTERAL,
DEEP SEDATION/GENERAL ANESTHESIA PERMITS

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such an act shall constitute cause for denial, suspension, or revocation of my license or personal/ facility permit to provide Moderate Enteral, Moderate Parenteral, or Deep Sedation/General Anesthesia permanently and without recourse for reapplication. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I understand that I have no legal authority to administer Moderate Enteral, Moderate Parenteral, or Deep Sedation/General Anesthesia until a permit has been granted.

I certify that I am trained and capable of administering Basic Life Support and certify that I am trained and capable of administering Advanced Cardiac Life Support if I provide Moderate Parenteral Sedation or Deep Sedation/General Anesthesia exclusively for adult patients and certify that I am trained and capable of administering Pediatric Advanced Life Support if I provide Moderate Parenteral Sedation or Deep Sedation/General Anesthesia for children under twelve (12) years of age or younger.

I certify that I employ qualified auxiliary personnel that are trained in and are capable of monitoring vital signs, assisting in emergency procedures, and administering basic life support.

I understand that if a patient enters a deeper level of sedation than what I am qualified to provide, I must stop the dental procedure until the patient returns to the intended level of sedation. I understand that I am responsible for the sedative management, outside personnel providing sedation/anesthesia, adequacy of the facility and staff, diagnosis and treatment of emergencies and providing the equipment and protocols for patient rescue. I understand that I must be able to rescue patients who enter a deeper state of sedation than intended and must be prepared to treat emergencies that may arise.

I understand that if I perform a procedure for which Moderate Enteral, Moderate Parenteral, is being employed I shall not administer the pharmacologic agents prohibited in TITLE 16. OCCUPATIONAL AND PROFESSIONAL LICENSING, CHAPTER 5. DENTISTRY. PART 15. DENTISTS, ANESTHESIA ADMINISTRATION - 16.5.15.14 (J) and shall not administer pharmacologic agents or monitor the patient without the presence and assistance of at least one additional person trained in Basic Life Support for Healthcare Providers.

I understand that if I perform a procedure for which Deep Sedation/General Anesthesia is being employed that I shall not administer the pharmacologic agents and monitor the patient without the

presence and assistance of two additional individuals who have current certification in Basic Life Support for Healthcare Providers.

I am aware that in signing this form, I declare that the appropriate (defined by current standards of care set by the AAOMS, Office Anesthesia Evaluation Manual, current edition, ASDA, ADA, ASA) equipment, emergency supplies, and conditions are met for each facility in which anesthesia is performed, including but not limited to:

- Appropriate history and pre-sedation preparation of each patient
- Appropriate vital monitors for each patient with direct writing capability
- Appropriate agents used, including non-expired drugs and Controlled Substance logs in compliance with TITLE 16. OCCUPATIONAL AND PROFESSIONAL LICENSING, CHAPTER 5.
- Appropriate infection control techniques
- Appropriate monitoring for patient recovery and transport
- Adequate knowledge of emergencies related to anesthesia administration and associated age/size appropriate rescue equipment and reserve oxygen in working order and easily accessible
- Appropriate logs kept of regular equipment checks
- Appropriate safety and fire rescue equipment per Code of Federal Regulations, OSHA Standards, OSHA 3187- 09R, Title 29.
- Appropriate compressed gases safety per OSHA Safety Regulations, 29CFR, Part 1910, Subpart: H, Hazardous Materials, 1910.101, Compressed gases
- Appropriate office emergency protocols, including Emergency Procedure Record form and emergency phone numbers

I understand that all aspects of the facility and provider that pertain to the use of anesthesia, including previous sedation records, are subject to inspection, scheduled or unannounced.

I am aware that pursuant to TITLE 16. OCCUPATIONAL AND PROFESSIONAL LICENSING, CHAPTER 5. DENTISTRY. PART 15. DENTISTS, ANESTHESIA ADMINISTRATION 16.5.15.13 REPORTING ADVERSE INCIDENTS, I must report any adverse occurrences related to the use of sedation.

I hereby authorize the release of any and all information and records the Board shall deem pertinent to the evaluation of this application, and shall supply to the Board such records and information as requested for evaluation of my qualifications for a permit to administer Moderate Enteral, Moderate Parenteral, Deep Sedation/General Anesthesia in the State of New Mexico.

I understand that based on evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit, or revoke the personal/facility anesthesia permit(s) or dental license entirely.

I further state that I have read the rules related to the use of anesthesia and sedation, as described in TITLE 16, CHAPTER 5, of the New Mexico Occupational and Professional Licensing Code. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and anesthesia/sedation in the State of New Mexico and that failure to do so may result in the Board placing restrictions on the permit, or revocation of my personal/facility anesthesia permit(s) or dental license entirely.

MUST BE SIGNED

IN THE PRESENCE

OF A NOTARY PUBLIC

SIGNATURE OF APPLICANT: _____

SUBSCRIBED AND SWORN BEFORE ME, THIS

_____ DAY OF _____,

YEAR _____.

(NOTARY SEAL)

NOTARY PUBLIC SIGNATURE: _____

NOTARY PUBLIC NAME

(TYPED OR PRINTED):_____

MY COMMISSION EXPIRES: _____