STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Dear Applicant:

Please be advised, pursuant to Section 17a-101 of the Connecticut General Statutes (see reverse side), certain health professions regulated by the Department of Public Health are mandated to report suspected child abuse or neglect to the Department of Children and Families (DCF) Child Abuse and Neglect Hotline or a law enforcement agency.

Reports must be made within twenty-four hours of the moment you suspect the abuse/neglect has occurred. Suspected child maltreatment of any kind, regardless of the identity of the alleged perpetrator must be reported. The Hotline number is 1-800-842-2288 and is available on a 24 hour 7 day a week basis. A copy of the child abuse reporting laws is enclosed. The Hotline can answer questions you may have regarding these laws.

It is important that you become familiar with Connecticut's reporting laws as failure to meet reporting responsibilities may subject you to criminal prosecution and possible action against your license or certificate.

Should you have any questions regarding your licensure or certification, please contact the Department of Public Health at the number in this application.

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue – MS # 12APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Connecticut General Statutes, Chapter 319a
Child Welfare
Child Abuse Reporting Laws

Sec.17a-101. (Formerly Sec. 17-38a). Protection of children from abuse. Mandated reporters. Educational and training programs. (a) The public policy of this state is: To protect children whose health and welfare may be adversely affected through injury and neglect; to strengthen the family and to make the home safe for children by enhancing the parental capacity for good child care; to provide a temporary or permanent nurturing and safe environment for children when necessary; and for these purposes to require the reporting of suspected child abuse, investigation of such reports by a social agency, and provision of services, where needed, to such child and family. (b) The following persons shall be mandated reporters: Any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, whether or not so licensed, any registered nurse, licensed practical nurse, medical examiner, dentist, dental hygienist, psychologist, coach of intramural or interscholastic athletics, school teacher, school principal, school guidance counselor, school paraprofessional, school coach, social worker, police officer, juvenile or adult probation officer, juvenile or adult parole officer, member of the clergy, pharmacist, physical therapist, optometrist, chiropractor, podiatrist, mental health professional or physician assistant, any person who is a licensed or certified emergency medical services provider, any person who is a licensed or certified alcohol and drug counselor, any person who is a licensed marital and family therapist, any person who is a sexual assault counselor or a battered women's counselor as defined in section 52-146k, any person who is a licensed professional counselor, any person paid to care for a child in any public or private facility, child day care center, group day care home or family day care home licensed by the state, any employee of the Department of Children and Families, any employee of the Department of Public Health who is responsible for the licensing of child day care centers, group day care homes, family day care homes or youth camps, the Child Advocate and any employee of the Office of Child Advocate. (c) The Commissioner of Children and Families shall develop an educational training program for the accurate and prompt identification and reporting of child abuse and neglect. Such training program shall be made available to all persons mandated to report child abuse and neglect at various times and locations throughout the state as determined by the Commissioner of Children and Families. (d) Any mandated reporter, as defined in subsection (b) of this section, who fails to report to the Commissioner of Children and Families pursuant to section 17a-101a shall be required to participate in an educational and training program established by the commissioner. The program may be provided by one or more private organizations approved by the commissioner, provided the entire costs of the program shall be paid from fees charged to the participants, the amount of which shall be subject to the approval of the commissioner.

Sec.17a-101a. Report of abuse, neglect or injury of child or imminent risk of serious harm to child. Penalty for failure to report. Any mandated reporter, as defined in section 17a-101, who in the ordinary course of such person's employment or profession has reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, as defined in section 46b-120, (2) has had nonaccidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, shall report or cause a report to be made in accordance with the provisions of sections 17a-101b to 17a-101d, inclusive. Any person required to report under the provisions of this section who fails to make such report shall be fined not less than five hundred dollars nor more than two thousand five hundred dollars and shall be required to participate in an educational and training program pursuant to subsection (d) of section 17a-101.

Sec.17a-101b. Oral report by mandated reporter. Notification of law enforcement agency when allegation of sexual abuse or serious physical abuse. Notification of person in charge of institution, facility or school when staff member suspected of abuse or neglect. (a) An oral report shall be made by a mandated reporter as soon as practicable but not later than twelve hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm, by telephone or in person to the Commissioner of Children and Families or a law enforcement agency. If a law enforcement agency receives an oral report, it shall immediately notify the Commissioner of Children and Families.

(b) If the commissioner or the commissioner's designee suspects or knows that such person has knowingly made a false report, the identity of such person shall be disclosed to the appropriate law enforcement agency and to the perpetrator of the alleged abuse.
(c) If the Commissioner of Children and Families, or the commissioner's designee, receives a report alleging sexual abuse or serious physical abuse, including, but not limited to, a report that: (1) A child has died; (2) a child has been sexually assaulted; (3) a child has suffered brain damage or loss or serious impairment of a bodily function or organ; (4) a child has been sexually exploited; or (5) a child has suffered serious nonaccidental physical injury, the commissioner shall, within twelve hours of receipt of such report, notify the appropriate law enforcement agency.
(d) Whenever a mandated reporter, as defined in section 17a-101, has reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for such child or a public or private school, the mandated reporter shall report as required in subsection (a) of this section. The Commissioner of Children and Families or the commissioner's designee shall notify the person in charge of such institution, facility or school or the person's designee, unless such person is the alleged perpetrator of the abuse or neglect of such child. Such person in charge, or such person's designee, shall then immediately notify the child's parent or other person responsible for the child's care that a report has been made.

17a-101c. Written report by mandated reporter. Within forty-eight hours of making an oral report, a mandated reporter shall submit a written report to the Commissioner of Children and Families or his representative. When a mandated reporter is a member of the staff of a public or private institution or facility that provides care for such child or public or private school he shall also submit a copy of the written report to the person in charge of such institution, school or facility or the person's designee. In the case of a report concerning a certified school employee, a copy of the written report shall also be sent by the person in charge of such institution, school or facility to the Commissioner of Education or his representative. In the case of an employee of a facility or institution that provides care for a child which is licensed by the state, a copy of the written report shall also be sent by the mandated reporter to the executive head of the state licensing agency.

Sec.17a-101d. Contents of oral and written reports. All oral and written reports required in sections 17a-101a to 17a-101c, inclusive, and section 17a-103, shall contain, if known: (1) The names and addresses of the child and his parents or other person responsible for his care; (2) the age of the child; (3) the gender of the child; (4) the nature and extent of the child's injury or injuries, maltreatment or neglect; (5) the approximate date and time the injury or injuries, maltreatment or neglect occurred; (6) information concerning any previous injury or injuries to, or maltreatment or neglect of, the child or his siblings; (7) the circumstances in which the injury or injuries, maltreatment or neglect came to be known to the reporter; (8) the name of the person or persons suspected to be responsible for causing such injury or injuries, maltreatment or neglect; and (9) whatever action, if any, was taken to treat, provide shelter or otherwise assist the child.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

CONSCIOUS SEDATION PERMIT APPLICATION

AN APPLICATION WILL NOT BE REVIEWED BY PROFESSIONAL STAFF OF THE DEPARTMENT UNTIL ALL REQUIRED DOCUMENTS HAVE BEEN RECEIVED.

- The fee for initial licensure covers the cost of eligibility determination and related administrative functions. At such time as an applicant is determined eligible for licensure, the process of licensure issuance will proceed immediately. The licensure renewal fee is separate and distinct from the application fee. Licenses are renewed annually during the licensee's month of birth. Renewal will be required in the **FIRST** birth month which immediately follows the issuance of licensure. The full renewal fee will be required regardless of the date of initial licensure.

- It is the responsibility of the applicant to arrange for submission of all required documentation for timely completion of the application. The Department does NOT notify applicants of incomplete documentation. It is recommended that applicants who are interested in expediting licensure contact the Department periodically to monitor the status of their file with regard to the receipt of supporting documents.

- Educational credentials earned in a country other than the United States (or Canada in some instances) must be evaluated by a credential evaluation service approved by the Department. Documents in a language other than English must be translated by a certified translation service in accordance with instructions from this office. Applicants to whom these provisions apply should request additional information from this office.

- No personal checks are accepted. Please remit the application fee, by CERTIFIED CHECK or MONEY ORDER ONLY, payable to "TREASURER, STATE OF CONNECTICUT", in United States dollars. All fees are non-refundable and non-transferable. The fee which accompanies an application covers the cost of reviewing and processing that specific application, IT CANNOT BE REFUNDED, EVEN IF THE APPLICANT IS FOUND INELIGIBLE FOR LICENSURE.

- Any incomplete application which has remained inactive for one year will be destroyed in accordance with the agency's record retention plan. To reactivate the application process, a completely new application and fee will be required.

- Licensure requirements are subject to change as a result of new legislation, new rules and regulations, or from new policies and procedures adopted by the Department of Public Health working, where appropriate, in cooperation with various Boards of Examiners. Applicants must meet current licensure requirements.

- Licensing examination questions are not included in the Freedom of Information Act as documents available for review. Whenever possible, however, this division will provide whatever feedback possible with regard to examination performance.

Phone: (860) 509-7603
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410 Capitol Avenue - MS # 12APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

CONSCIOUS SEDATION PERMIT REQUIREMENTS AND PROCEDURES

Pursuant to Section 20-123b, Chapter 379, Connecticut General Statutes, no licensed dentist may use general anesthesia or conscious sedation by intravenous injection on any patient unless such dentist has a permit. Two types of permits are available to applicants who can document fulfillment of requisite qualifications: Permit for the Administration of General Anesthesia and Conscious Sedation and Permit for the Administration of Parenteral Conscious Sedation. This is a permit application for the Administration of Parenteral Conscious Sedation.

ELIGIBILITY

In order to obtain a permit for conscious sedation, an applicant must satisfy the following requirements:

I. EITHER A, B, C, D, E, F OR G, below.

A) Graduate, within the two years prior to applying for the permit, from a dental school or post-doctorate dental residency program accredited by the ADA Commission on Dental Accreditation, which included:

(1) a didactic course in conscious sedation in dentistry with a curriculum that fulfills the minimum requirements set out in the ADA Council on Dental Education, "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry" **AND WHICH ALSO INCLUDED EITHER 2 OR 3 BELOW;**
(2) at least four weeks active participation in full-time rotation in hospital operating room anesthesia;
(3) ten documented clinical cases utilizing parenterally administered conscious sedation in the dental operatory.

OR

B) complete an "Intensive Course" or a "Supplemental or Refresher Course" in a post-doctoral continuing education program, structured in accordance with Part Three of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety;"

OR

C) document by patient anesthesia or sedation records the completion of a minimum of 12 parenterally administered conscious sedation procedures per year performed in the office, for each of the 3 one-year periods immediately preceding the date of application; and submit certification of completion of at least 24 hours of continuing education in one of the following areas within the 3 year period immediately preceding the issuance of the permit: anesthesia, parenterally administered conscious sedation, or emergency medicine.

OR

D) completion of a full course in a post-doctorate training program in Oral & Maxillofacial Surgery, approved by the ADA Commission on Dental Accreditation;

OR

E) completion of a minimum of one-year full-time training in a post-doctoral program in Anesthesiology, structured in accordance with Part Two of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry";

OR

F) hold current certification as a Diplomate of the American Board of Oral and Maxillofacial Surgery and have graduated from dental school or a post-doctoral dental residency training program no later than 1966;

OR

G) have been limiting practice to oral and maxillofacial surgery for a period of at least the ten years immediately preceding the date of application for a conscious sedation permit.

II. Applicant must hold current certification in Advanced Cardiac Life Support and Basic Cardiac Life Support; entire staff must hold current certification in Basic Cardiac Life Support.

III. Successfully complete an on-site evaluation. The on-site evaluation includes:

A) Observation of the parental conscious sedation technique employed by the practitioner during a minimum of two operative cases, the total time for both cases not to exceed two hours;
B) an exact simulation of the method of management of medical emergencies demonstrated by the practitioner with full participation of the office staff. For a listing of some of the medical emergencies which may be included in the simulation, please refer to Department of Public Health Regulations, Section 20-123-6(b);
C) review of the practitioner's office equipment, emergency drugs and anesthesia records to determine full compliance with the requirements established in Section 20-123b-9 of the Department of Public Health Regulations;
D) an exit interview between the practitioner and evaluation team for the purpose of reviewing deficiencies and making positive suggestions for improvement of the office facility and patient emergency management;
E) verification that the practitioner and his/her entire staff are currently certified in Basic or Advanced Cardiac Life Support. It is recommended that the practitioner be certified in Advanced Cardiac Life Support. Please enclose notarized copies of your and your staff member's certificates.

DOCUMENTATION REQUIRED

Individuals must arrange for submission of the following:

1) **A completed application form and fee of** $200.00, payable by certified check or money order to "Treasurer, State of Connecticut".
2) **Supporting documents**, verifying that all requirements have been met, must be submitted to this Department as outlined on the application.
3) In addition to the documentation required as outlined by “1” above, **reinstatement applicants** must ensure that the following documents be forwarded directly to this office:
   a) A brief written summary of your credentials to have your conscious sedation permit reinstated. Be sure to include information on your work experience as a licensed professional, including positions held, dates and major duties. If you have had any lapses in your active practice as a dentist, please explain the reason for any such lapses. If you are not currently working as a dentist, please explain your plans for employment and describe how you intend to bring your dental skills up-to-date.
   b) A letter directly from the appropriate authority confirming your most recent employment; including dates and evaluation of performance.
4) Once the initial review of the application is conducted and it has been determined that the preliminary requirements have been met, an on-site evaluation will be conducted. Further information about the on-site evaluation will be forwarded to applicants who qualify for this procedure.

All supporting documents must be submitted to:

DEPARTMENT OF PUBLIC HEALTH
DENTAL CONSCIOUS SEDATION PERMIT
410 CAPITOL AVE., **MS# 12APP**
P.O. BOX 340308
HARTFORD, CT 06134-0308
(860) 509-7603
www.ct.gov/dph

Privacy Act: The Privacy Act of 1974 requires any federal, state or local government agency that requires individuals to disclose their social security numbers to inform those individuals whether the disclosure is mandatory or voluntary, by what statutory or other authority the number is requested and how it will be used. The following information is provided to comply with these requirements.

Disclosure of the social security number is mandatory, pursuant to Public Law 104-193 and Sections 29-252a (b) and 4a-18, Connecticut General Statutes. The social security number is used in the administration and collection of taxes and is also used for child support collection.

Please note that the Department will **ONLY** disclose social security numbers to government entities. Your social security number will **NOT** be released to the general public.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

APPLICATION FOR DENTAL CONSCIOUS SEDATION PERMIT

First Name: _____ MI: ____ Last Name: _____ Maiden Name: _____

Social Security No.: _____-_____-_____ E-mail: _____

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: _____

Address: _____

_____

City, State, Zip: _____

Phone Number: (____) _____ Date of Birth: _____/_____/_____ Gender: _____

Connecticut dental license number: _____

I am applying for this permit based on: Check the appropriate category below (i.e., A through G) and follow the applicable instructions.

A. ☐ Graduation from a dental school or post-doctoral dental residency program accredited by the ADA Commission on Dental Accreditation within the last two years, satisfying the requirements of Section 20-123B-4 (a) of the Regulations for State Agencies. If checked, forward the enclosed **Dental School Verification Form or Residency Curriculum Report Form** to the institution for completion.

Name of dental school: _____

Name of post-doctoral residency program: _____

Location: _____

Dates of attendance: from: _____ to: _____

B. ☐ Completion of an "Intensive Course" or "Supplemental or Refresher Course" in a post-doctoral continuing education program, structured in accordance with part three of the ADA Council on Dental Education "Guidelines for Teaching The Comprehensive Control of Pain & Anxiety." If checked, forward the enclosed **Intensive, Supplemental, or Refresher Course Verification Form** to the program for completion.

C.

(1) ☐ Completion of at least twelve parenterally administered conscious sedation procedures per year for each of the last three years. If checked, please attach List of Procedures Performed on enclosed forms, to verify that this requirement has been met, and

(2) ☐ Completion of at least 24 hours of continuing education in the last three years in one of the following areas: anesthesia; parenterally administered conscious sedation, or emergency medicine. If checked, list courses completed, attaching additional sheets of course list if necessary, and submit **notarized certificates of completion**.

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

Course Title: _____

Offered By: _____

Location: _____

Date(s) _____ hours completed: _____

D. ☐ Completion of a post-doctoral training program in Oral & Maxillofacial Surgery approved by the ADA Commission on Dental Accreditation. If checked, forward the enclosed **Postdoctoral Training Verification Form** to your institution for completion.

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

E. ☐ Completion of one year of full-time training in a post-doctoral program in Anesthesiology. If checked, forward the enclosed **Postdoctoral Training Verification Form** to your institution for completion.

Name of Program: _____

Address: _____
NO. & STREET CITY STATE ZIP CODE

Dates of attendance. From: _____ to: _____

F. ☐ Current status as a Diplomate of the American Board of Oral and Maxillofacial Surgery and graduation from dental school or completion of a post-graduate training program no later than 1966. If checked, forward notarized copies of your current certificate and dental school diploma to this Department.

G. ☐ Limitation of practice to Oral and Maxillofacial surgery for at least the immediately preceding ten years. If checked, forward a notarized letter, on professional letterhead, to this office including the inclusive dates of such limitation of practice.

Are you currently certified in the following:

Certificate Type	**YES**	**NO**	**Expiration Date**
Advanced Cardiac Life Support			

Complete the attached list, indicating all staff members' names and their current Basic or Advanced Cardiac Life Support status. **Please enclose notarized copies of your and your staff member's certificates.**

PROFESSIONAL HISTORY: Answer 1-7 by checking YES or NO. If you answer Yes, follow directions below.

YES NO

1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: ☐ ☐

   -Any hospital, nursing home, clinic, or similar institution;
   -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public;
   -Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;
   -Any third party reimbursement program, whether governmental or private?

2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice? ☐ ☐

3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you? ☐ ☐

4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction? ☐ ☐

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. ☐ ☐

6. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, or fined by the responsible agency? ☐ ☐

If your answer is "yes" to any of the above questions (1-6), please give full details, names, addresses, etc. on a separate NOTARIZED statement.

7. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? ☐ ☐

If "yes", give full details, names, addresses, etc. on a separate, NOTARIZED statement. Also submit a NOTARIZED copy of the agreement.

8. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state? ☐ ☐

If "yes", give full details, dates, etc. on a separate NOTARIZED statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition.

PHOTOGRAPH:

Tape a recent photograph of applicant here.

DO NOT STAPLE

NOTARIZATION:

On this _____ day of _____ 20 ____,

_____ (**applicant's name**) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

_____

SIGNATURE OF APPLICANT

Sworn to before me this _____ day of _____ 20 ___.

_____ My commission expires _____

SIGNATURE OF NOTARY PUBLIC

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $200.00 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, "TREASURER, STATE OF CONNECTICUT" TO:

DEPARTMENT OF PUBLIC HEALTH
DENTAL CS PERMIT
410 CAPITOL AVE., **MS# 12MQA**
P.O. BOX 340308
HARTFORD, CT 06134-0308
(860) 509-7603
www.ct.gov/dph

IMPORTANT: The application packet for this profession consist of 24 pages, including instructions and eligibility requirements. Do not send this form and fee unless you have read and understood all pertinent information. No fees are refundable should you not be eligible for licensure.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY	
PERMIT NO.:	_____
DATE ISSUED:	_____
INITIAL ☐	REINST ☐

STAFF MEMBERS ACLS/BCLS VERIFICATION FORM

STAFF MEMBER	BCLS CERTIFICATION	EXPIRATION DATE

Please enclose notarized copies of your and your staff member's certificates.

Please return to:

DEPARTMENT OF PUBLIC HEALTH
DENTAL CONSCIOUS SEDATION PERMIT
410 CAPITOL AVE., **MS# 12APP**
P.O. BOX 340308
HARTFORD, CT 06134-0308
(860) 509-7603
www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

DENTAL SCHOOL VERIFICATION FORM

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

TO BE COMPLETED BY APPLICANT

Applicant: Enter your full name and birthdate on this form and forward it to the Program Director for completion. This form must be completed by the Director and returned directly to this office.

Applicant's Name _____ Date of Birth _____

TO BE COMPLETED BY PROGRAM DIRECTOR ONLY

DEAR DIRECTOR: Please provide the following verification of education for the above-named Connecticut dentist.

Name and location of institution where dental education was completed: _____

_____

Dates of Education: from _____ to _____

Degree _____ Date Degree Awarded _____

Did this individual complete, as part of his/her dental degree program, a minimum of four weeks active participation in full-time rotation in hospital operating room anesthesia? YES ☐ NO ☐.

Did this individual complete, as part of his/her dental degree program, the administration of conscious sedation in at least ten clinical cases in the dental operatory? YES ☐ NO ☐.

Did this individual complete, as part of his/her dental degree program, a didactic course in conscious sedation in dentistry with a curriculum that fulfills the minimum requirements set forth in the ADA Council on Dental Education, "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry"? YES ☐ NO ☐

I, _____, do certify that I am the program director at

_____, and that the information provided herein is true and correct to the best of my knowledge and belief.

_____ Date: _____

Signature of Program Director

Daytime telephone number: _____ **SEAL**

Please return to:

DEPARTMENT OF PUBLIC HEALTH • DENTAL CS PERMIT • 410 CAPITOL AVE., **MS# 12APP** • P.O. BOX 340308 • HARTFORD, CT 06134-0308 • (860) 509-7603 • www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

RESIDENCY CURRICULUM REPORT FORM

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

TO BE COMPLETED BY APPLICANT

Applicant: Enter your full name and birthdate on this form and forward it to the Program Director for completion. This form must be completed by the Director and returned directly to this office.

Applicant's Name _____ Date of Birth _____

TO BE COMPLETED BY PROGRAM DIRECTOR ONLY

DEAR DIRECTOR: Please provide the following verification of post-doctoral dental residency training for the above-named Connecticut dentist.

Name and location of facility/institution where residency training was completed:
_____

Dates of Training: from _____ to _____

In what specialty was residency training completed? _____

Did the residency program include a minimum of four weeks active participation in full-time rotation in hospital operating room anesthesia? YES ☐ NO ☐

Did the residency program include the administration of conscious sedation in at least ten clinical cases in the dental operatory? YES ☐ NO ☐

Did the residency program include a didactic course in conscious sedation in dentistry with a curriculum that fulfills the minimum requirements set forth in the ADA Council on Dental Education, "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry"? YES ☐ NO ☐

Did the applicant satisfactorily complete this period of residency training? YES ☐ NO ☐

I, _____, do certify that I am the program director at

_____, and that the information provided herein is true and correct to the best of my knowledge and belief.

_____ Date: _____
Signature of Program Administrator

SEAL

_____
Day time telephone number

Please return to:

DEPARTMENT OF PUBLIC HEALTH • DENTAL CS PERMIT • 410 CAPITOL AVE., **MS# 12APP** • P.O. BOX 340308 • HARTFORD, CT 06134-0308 • (860) 509-7603 • www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

CONSCIOUS SEDATION INTENSIVE, SUPPLEMENTAL OR REFRESHER COURSE VERIFICATION FORM

TO BE COMPLETED BY APPLICANT

Applicant: Enter your full name and birthdate on this form and forward it to the Program Administrator for completion. **THIS FORM MUST BE COMPLETED AND RETURNED BY THE PROGRAM ADMINISTRATOR DIRECTLY TO THIS OFFICE**.

Applicant's Name _____ Date of Birth _____

TO BE COMPLETED BY PROGRAM ADMINISTRATOR ONLY

DEAR ADMINISTRATOR: Please provide the following verification of completion of an "Intensive Course" or "Supplemental or Refresher Course" in Conscious Sedation for the above-named Connecticut dentist.

Name and location of facility/institution where residency training was completed: _____

_____

Dates of course: from _____ to _____

At the time of the applicant's attendance, was the course in conscious sedation structured in accordance with Part Three of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety"? YES ☐ NO ☐.

Did the applicant satisfactorily complete the course? YES ☐ NO ☐.

I, _____, do certify that I am the Program

Administrator at _____, and that the information provided herein is true and correct to the best of my knowledge and belief.

_____ Date: _____
Signature of Program Administrator

SEAL

_____
Day time telephone number

Please return to:

DEPARTMENT OF PUBLIC HEALTH • DENTAL CS PERMIT • 410 CAPITOL AVE., **MS# 12APP** • P.O. BOX 340308 • HARTFORD, CT 06134-0308 • (860) 509-7603 • www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

List of parenterally administered conscious sedation procedures performed in office.

Year 20 _____ - 20 _____

Name of Patient	Date of Procedure	Type of Procedure
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Year 20 _____ - 20 _____

Name of Patient	Date of Procedure	Type of Procedure
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

(OVER)

Year 20 _____ - 20 _____

Name of Patient	**Date of Procedure**	**Type of Procedure**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

_____ _____

Signature of Applicant ***Date***

PLEASE NOTE: The applicant must list 12 procedures performed during each of the three one year periods immediately preceding the date of application. Patient records documenting the procedures indicated on this list must be available for review by the evaluation team at the time of the on-site evaluation.

Please return to:

DEPARTMENT OF PUBLIC HEALTH • DENTAL CS PERMIT • 410 CAPITOL AVE., **MS# 12APP** • P.O. BOX 340308 • HARTFORD, CT 06134-0308 • (860) 509-7603 • www.ct.gov/dph

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

FOR OFFICE USE ONLY
PERMIT NO.: _____
DATE ISSUED: _____
INITIAL ☐ REINST ☐

POST-DOCTORAL TRAINING VERIFICATION FORM

TO BE COMPLETED BY APPLICANT

Applicant: Enter your full name and birthdate on this form and forward it to the Program Administrator for completion. **THIS FORM MUST BE COMPLETED BY THE PROGRAM ADMINISTRATOR AND RETURNED DIRECTLY TO THIS OFFICE.**

Applicant's Name _____ Date of Birth _____

TO BE COMPLETED BY PROGRAM ADMINISTRATOR ONLY

DEAR ADMINISTRATOR PLEASE PROVIDE THE FOLLOWING VERIFICATION OF POST-DOCTORAL TRAINING FOR THE ABOVE-NAMED CONNECTICUT DENTIST.

Name and location of facility/institution where post-doctoral training was completed: _____
_____

Dates of Training: From _____ To _____

In what specialty was residency training completed? _____

At the time of the applicant's training, was the training program approved by the ADA Commission on Dental Accreditation? YES ☐ NO ☐.

If in anesthesiology, was the program structured in accordance with Part Two of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry? YES ☐ NO ☐.

Did the applicant satisfactorily complete this period of post-doctoral training? YES ☐ NO ☐.

I, _____, do certify that I am the Program

Administrator at _____, and that the information provided herein is true and correct to the best of my knowledge and belief.

_____ Date: _____
Signature of Program Administrator

_____ **SEAL**
Day time telephone number

Please return to:
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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

DENTAL GENERAL ANESTHESIA/CONSCIOUS SEDATION EVALUATION FORM

Permit: General Anesthesia/Sedation ☐ ***Conscious Sedation*** ☐ Date of Site Evaluation _____

Name of Applicant: _____
Last *First* *Middle* *Maiden*

Office Address: _____
No. & Street *City* *State* *Zip Code*

Day time telephone number: _____ **Connecticut dental license number**: _____

Examiners (Please Print Name)

1 _____ Day Time Telephone _____

2 _____ Day Time Telephone _____

OFFICE EQUIPMENT

Except as specifically noted, all practitioners issued a permit shall demonstrate and maintain the following equipment. ***PLEASE CHECK IF EQUIPMENT PASSES INSPECTION AND LEAVE BLANK IF NOT.***

☐ Portable gas delivery system capable of positive pressure ventilation;

☐ Equipment capable of administering 100% oxygen in all rooms (operatory, recovery, examination, and reception);

☐ Portable bag-mask ventilator (ambu-bag);

☐ Full face mask:

- ☐ adult; and
- ☐ pediatric;

☐ Nasal hood or cannula;

☐ Oral airways (oropharyngeal airways):

- ☐ adult; and
- ☐ pediatric;

☐ Nasopharyngeal airways:

- ☐ adult; and
- ☐ pediatric;

☐ Endotracheal tubes with appropriate connectors and syringe for inflation, as follows: **(not required for conscious sedation permit)**

- ☐ adult endotracheal tubes;
- ☐ child endotracheal tubes;
- ☐ connectors;
- ☐ syringe; and
- ☐ stylet (pediatric and adult);

☐ Laryngoscope (straight or curved blade), as follows: **(not required for conscious sedation permit)**

- ☐ adult blade;
- ☐ pediatric blade;
- ☐ extra batteries; and
- ☐ extra bulb (or blade if fiberoptic blade);

☐ Combi tube (not required for general anesthesia permit);

☐ Portable suctioning equipment capable of use during electrical power failure;

☐ Equipment capable of suctioning the throat in all rooms;

☐ Nasopharyngeal suction catheter, for pulmonary lavage via endotracheal tube **(not required for conscious sedation permit);**

☐ Yankauer or similar suction;

☐ McGill forceps;

☐ Tongue grasping forceps;

☐ Equipment for emergency crico-thyrotomy or tracheotomy and the appropriate connectors for administering 100% oxygen;

☐ Blood pressure cuffs:

- ☐ adult; and
- ☐ pediatric;

☐ ECG;

☐ Defibrillator;

☐ Board or rigid surface for cardiopulmonary resuscitation (CPR);

☐ Light source capable of use during electrical power failure;

☐ Intravenous solutions and equipment for administration:

- ☐ 250 cc bags & 1000 cc bags of sterile saline;
- ☐ Sterile water for mixing or dilution of drugs;

☐ Appropriate intravenous needles, tubing and drips.

EQUIPMENT AND PERSONNEL FOR MONITORING DURING ADMINISTRATION OF DEEP SEDATION OR GENERAL ANESTHESIA

☐ means of monitoring heart rate:

- ☐ ECG; or
- ☐ pulsemeter; or
- ☐ pretracheal or precordial stethoscope; or
- ☐ direct palpation of pulse;

☐ means of following respirations and level of oxygenation:

- ☐ pretracheal or precordial stethoscope, or capnography; and
- ☐ pulse oximeter;

☐ means of monitoring blood pressure for child and adult.

EQUIPMENT AND PERSONNEL FOR CONTINUOUS MONITORING DURING THE ADMINISTRATION OF CONSCIOUS SEDATION:

☐ means of monitoring heart rate:

- ☐ ECG; or
- ☐ pulsemeter; or
- ☐ pretracheal or precordial stethoscope; or
- ☐ direct palpation of pulse;

☐ means of following respirations and level of oxygenation:

- ☐ pretracheal or precordial stethoscope, capnography or direct observation of chest; and
- ☐ pulse oximeter;

☐ means of monitoring blood pressure for child and adult.

EMERGENCY DRUGS

- ☐ Anticonvulsant drugs:
  - ☐ midazolam; or
  - ☐ diazepam;
- ☐ Antiemetic:
  - ☐ droperidol; or
  - ☐ odansetron; or
  - ☐ prochlorperazine; or
  - ☐ promethazine; or
  - ☐ metoclopramide;
- ☐ Beta agonist: albuterol inhaler;
- ☐ Cardiovascular medications:
  - ☐ Antiarrhythmics:
    - ☐ lidocaine or amiodarone; and
    - ☐ procainamide; and
    - ☐ diltiazem;
  - ☐ Atropine (either 0.4 mg/ml or 1.0 mg/ml);
  - ☐ Aspirin 160 or 325 mg dose;
  - ☐ Beta blocker:
    - ☐ esmolol; or
    - ☐ propranolol; or
    - ☐ atenolol; or
    - ☐ metoprolol;
  - ☐ Epinephrine 1 mg:
    - ☐ 1:1,000 solution; and
    - ☐ 1:10,000 solution;
  - ☐ Diuretic: furosemide 10mg/ml;
  - ☐ Nitroglycerin (tablet or spray);

☐ Vasodilators:

- ☐ labetalol; and
- ☐ hydrazaline or diazoxide;

☐ Vasopressors:

- ☐ ephedrine; and
- ☐ phenylephrine;

☐ Corticosteroids:

- ☐ dexamethasone; or
- ☐ hydrocortisone sodium succinate; or
- ☐ methylprednisolone sodium succinate;

☐ Dantrolene (must be in facility for offices in which agents causing malignant hypothermia are used);

☐ Dextrose 50%;

☐ Diphenhydramine;

☐ Reversal agents:

- ☐ naloxone; and
- ☐ flumazenil;

☐ Opioid: morphine;

☐ Procaine 10 mg/ml;

☐ Succinylcholine.

RECORDS

All practitioners who are being evaluated shall maintain anesthesia or conscious sedation records which include the date of procedure, nothing by mouth (NPO) status, availability of responsible adult escort, allergies, vital signs, drugs, and doses administered.

☐ DATE ☐ NPO ☐ ESCORT ☐ V/S ☐ ALLERGIES ☐ DRUGS ☐ DOSES

CASE OBSERVATIONS

CASE #1

General Anesthesia or Deep Sedation ☐ ***Conscious Sedation*** ☐

Anesthetics: _____

Procedure: _____

Time: _____

Pass ☐ **Fail** ☐

Basis for failure, if applicable: _____

_____

Other remarks: _____

_____

CASE #2

General Anesthesia or Deep Sedation ☐ ***Conscious Sedation*** ☐

Anesthetics: _____

Procedure: _____

Time: _____

Pass ☐ **Fail** ☐

Basis for failure, if applicable: _____

_____

Other remarks: _____

_____

MEDICAL EMERGENCIES

	PASS	***FAIL***		***PASS***	***FAIL***
Laryngospasm	☐	☐	Acute M.I.	☐	☐
Broncospasm	☐	☐	Acute Hypotension	☐	☐
Emesis	☐	☐	Hypertensive Crisis	☐	☐
Aspiration	☐	☐	Convulsions	☐	☐
FB in Airway	☐	☐	CPR	☐	☐
Angina	☐	☐	Allergic	☐	☐
Syncope	☐	☐	Hyperventilation	☐	☐

EXIT INTERVIEW

Name of Applicant: _____Date of Site Evaluation: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Practitioner: BCLS ☐ ACLS ☐

Staff: BCLS ☐ ACLS ☐

OUTCOME OF EVALUATION **PASS** ☐ **FAIL** ☐

EXAMINERS ***INITIALS***

1. _____License number _____ _____

2. _____License number_____ _____

PLEASE RETURN THIS EVALUATION FORM TO:

DEPARTMENT OF PUBLIC HEALTH
DENTAL LICENSURE
410 CAPITOL AVE., **MS# 12 APP**
P.O. BOX 340308
HARTFORD, CT 06134-0308
www.ct.gov/dph

Regulations of Connecticut State Agencies
Administration and Use of Anesthesia and Conscious Sedation in Dentistry

Sec. 20-123b-1. Definitions

(a) "OMFS" means an Oral and Maxillofacial Surgeon who has completed a full course in a post-doctoral training program in Oral and Maxillofacial Surgery approved by the American Dental Association Commission on Dental Accreditation.
(b) "ADA" means American Dental Association.
(c) "CSOMS" means Connecticut Society of Oral and Maxillofacial Surgeons.
(d) "BCLS" means a course in Basic Cardiac Life Support approved by the American Red Cross or the American Heart Association.
(e) "ACLS" means a course in Advanced Cardiac Life Support approved by the American Red Cross or the American Heart Association.
(f) "Commissioner" means Commissioner of Public Health or his designee.
(g) "On-Site Evaluation Team" means those individuals designated by the Commissioner to determine compliance with Section 20-123b-6 of the Regulations of Connecticut State Agencies.
(h) "Practitioner" means a person licensed to practice dentistry pursuant to Chapter 379 of the Connecticut General Statutes who is applying for a permit or being evaluated pursuant to Sections 20-123b-1 through 20-123b-9, inclusive, of the Regulations of Connecticut State Agencies.
(i) "Anesthesia Assistant" means a chairside assistant or a dentist licensed pursuant to Chapter 379 of the Connecticut General Statutes whose sole responsibility is to monitor the patient undergoing general anesthesia.
(j) "Calendar Quarter" means a period of three consecutive months beginning on January 1, April 1, July 1, or October 1.
(k) “Department” means the Connecticut Department of Public Health.

Sec. 20-123b-2. Permit application procedures

(a) A practitioner may apply to the Commissioner for one of the following:

(1) Permit for the Administration of General Anesthesia and Conscious Sedation; or
(2) Permit for the Administration of Parenteral Conscious Sedation.

(b) An applicant shall, at the time of application, submit such documentation of credentials as the Commissioner may require. The application and related documents shall be reviewed by the Commissioner or his designee. The Commissioner or his designee may, as necessary, consult with the Dental Commission concerning documentation of applicant credentials.

Sec. 20-123b-3. Qualifications for general anesthesia and conscious sedation permit

An applicant for a General Anesthesia and Conscious Sedation permit shall:

(a) Successfully complete one of the following:

(1) a full course in a post-doctoral training program in Oral and Maxillofacial Surgery, approved by the ADA Commission on Dental Accreditation, or

(2) a minimum of one-year full-time training in post-doctoral program in Anesthesiology, structured in accordance with Part Two of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry," or

(3) Certification as a diplomate of the American board of oral and maxillofacial surgery, provided the individual holding such certification graduated from dental school or a post-doctoral dental residency training program no later than 1966, or

(4) Designation of practice as limited to oral and maxillofacial surgery, in accordance with Section 20-106a of the Connecticut General Statutes, for a period of at least ten years prior to application for a general anesthesia and conscious sedation permit; and

(b) Demonstrate current certification in ACLS; and

(c) Successfully complete an on-site evaluation pursuant to Section 20-123b-6 of the Regulations of Connecticut State Agencies.

Sec. 20-123b-4. Qualifications for conscious sedation permit. An applicant for a Conscious Sedation permit shall:

(a) Comply with one of the following:

(1) document by patient anesthesia or sedation records the completion of a minimum of twelve parenterally administered conscious sedation procedures per year performed in the office, for each of the three one-year periods immediately preceding the date of application; and submit certification of completion of a minimum of twenty-four hours of continuing education in one of the following areas within the three year period immediately preceding the issuance of the permit; anesthesia, parenterally administered conscious sedation, or emergency medicine; or

(2) graduate from a dental school or post-doctoral dental residency program accredited by the ADA Commission on Dental Accreditation within two years prior to applying for the permit, which included either a minimum of four weeks active participation in full-time rotation in hospital operating room anesthesia, or ten documented clinical cases utilizing parenterally administered conscious sedation in the dental operatory; and which included a didactic course in conscious sedation in dentistry with a curriculum that fulfills the minimum requirements set forth in the ADA Council on Dental Education, "Guidelines or Teaching the Comprehensive Control of Pain and Anxiety in Dentistry"; or

(3) complete an "Intensive Course" or a "Supplemental (or Refresher) Course" (as applies) in a post-doctoral continuing education program, structured in accordance with Part Three of the ADA Council on Dental Education "Guidelines for Teaching the Comprehensive Control of Pain and Anxiety"; or

(5) satisfy the requirements of subsection (a) of Section 20-123b-3 of these regulations; and

(b) demonstrate current certification in ACLS; and

(c) successfully complete an on-site evaluation pursuant to Section 20-123b-6 of the Regulations of Connecticut State Agencies.

Sec. 20-123b-5. The evaluation team. The on-site evaluation team shall include, but not be limited to, the following:

(a) Two members recommended to the Commissioner by the Chairperson of the Anesthesia Committee of the CSOMS who have fulfilled the requirements of the CSOMS to be an office anesthesia evaluator; or

(b) one member who has fulfilled the requirements of the CSOMS to be an office anesthesia evaluator, and one member who is a fellow of the American Dental Society of Anesthesiology, both of whom shall be recommended to the Commissioner by the Chairperson of the Anesthesia Committee of the CSOMS.

Sec. 20-123b-6. Site evaluation

(a) In the case of a practitioner applying for the initial issuance of a permit, or the reinstatement of a lapsed permit, the on-site evaluation team shall observe the general anesthesia or parenteral conscious sedation technique (as appropriate) employed by the practitioner during a minimum of two operative cases, with the total time for both cases not to exceed two hours. During the on-site evaluation, an exact simulation of the method of management of medical emergencies shall be demonstrated by the practitioner with full participation of the office staff, and may include, but not be limited to, the management of: laryngospasm, bronchospasm, emesis, aspiration of vomitus, foreign body in airway, angina pectoris, acute myocardial infarction, acute hypotensive and hypertensive crises, cardiopulmonary resuscitation, acute allergic reactions, hyperventilation syndrome, syncope, and convulsions of unknown etiology.

(b) The on-site evaluation team shall review the practitioner's office equipment, emergency drugs and anesthesia records to determine full compliance with the requirements established in Section 20-123b-9 of the Regulations of Connecticut State Agencies.

(c) An exit interview between the practitioner and the evaluation team shall be conducted to review deficiencies and make positive suggestions for improving the office facility and patient emergency management.

(d) The on-site evaluation team shall verify that the practitioner is currently certified in BCLS and ACLS and that the practitioner’s entire staff is currently certified in BCLS.

Sec. 20-123b-7. Failure to successfully complete the site evaluation

(a) A practitioner who, in the opinion of the on-site evaluation team, fails to satisfactorily complete the requirement of subsection (a) of Section 20-123b-6 of the Regulations of Connecticut State Agencies shall be denied a permit and may reapply to be re-evaluated only after documenting the completion of a Continuing Education Course in ambulatory general anesthesia or parenteral conscious sedation (as appropriate) approved by the Commissioner in consultation with the on-site evaluation team.

(b) A practitioner who, in the opinion of the on-site evaluation team, fails to satisfactorily complete the requirements of subsection (b) of Section 20-123b-6 of the Regulations of Connecticut State Agencies shall be denied a permit and may reapply to be re-evaluated only after documenting the completion of a Continuing Education Course in the management of medical emergencies in the dental office approved by the Commissioner in consultation with the on-site evaluation team.

(c) A practitioner who, in the opinion of the on-site evaluation team, fails to satisfactorily complete the requirements of subsection (c) of Section 20-123b-6 of the Regulations of Connecticut State Agencies shall be denied a permit and may reapply to be re-evaluated.

(e) If any member of the on-site evaluation team has reason to believe that the practitioner being evaluated is unfit or incompetent or has been guilty of cruelty, incompetence, negligence or

indecent conduct towards a patient, such member shall file a petition with the Department of Public Health pursuant to Section 19a-14 of the Connecticut General Statutes.

Sec. 20-123b-8. Frequency of inspection

(a) Following initial issuance of the permit, the on-site evaluation specified in Section 20-123b-6 of the Regulations of Connecticut State Agencies shall be completed for each practitioner issued a permit pursuant to Sections 20-123b-1 through 20-123b-9 of the Regulations of Connecticut State Agencies in accordance with the following schedule:

(1) For each practitioner first issued a permit on or before December 31, 1989, the on-site evaluation shall be completed not later than December 31, 1995. Thereafter, the on-site evaluation shall be completed for each such practitioner not later than five years from the last day of the calendar quarter in which last evaluated.

(2) For each practitioner first issued a permit on or after January 1, 1990, the on-site evaluation shall be completed not later than five years from the last day of the calendar quarter in which last evaluated.

(b) A practitioner may request to schedule the on-site evaluation at a time earlier than specified in subsection (a) of this Section. However, in no event shall such alternative scheduling result in an interval longer than five years to the next on-site evaluation.

Sec. 20-123b-9. Office equipment, emergency drugs, and anesthesia records

(a) Except as specifically noted, all practitioners who are being evaluated pursuant to Sections 20-123b-1 through 20-123b-9, inclusive, of the Regulations of Connecticut State Agencies, or who have been issued a permit pursuant to Section 20-123b of the Connecticut General Statutes, shall demonstrate and maintain the following office equipment in any and all offices where they administer general anesthesia or conscious sedation:

(1) Portable gas delivery system capable of positive pressure ventilation;
(2) Equipment capable of administering 100% oxygen in all rooms (operatory, recovery, examination, and reception);
(3) Portable bag-mask ventilator (ambu-bag);
(4) Full face mask:
    (A) adult; and
    (B) pediatric;
(5) Nasal hood or cannula;
(6) Oral airways (oropharyngeal airways):
    (A) adult; and
    (B) pediatric;
(7) Nasopharyngeal airways:
    (A) adult; and
    (B) pediatric;
(8) Endotracheal tubes with appropriate connectors and syringe for inflation, as follows: (not required for conscious sedation permit)
    (A) adult endotracheal tubes;
    (B) child endotracheal tubes;
    (C) connectors;
    (D) syringe; and
    (E) stylet (pediatric and adult);

(9) Laryngoscope (straight or curved blade), as follows: (not required for conscious sedation permit)
  (A) adult blade;
  (B) pediatric blade;
  (C) extra batteries; and
  (D) extra bulb (or blade if fiberoptic blade);
(10) Combi tube (not required for general anesthesia permit);
(11) Portable suctioning equipment capable of use during electrical power failure;
(12) Equipment capable of suctioning the throat in all rooms;
(13) Nasopharyngeal suction catheter, for pulmonary lavage via endotracheal tube (not required for conscious sedation permit);
(14) Yankauer or similar suction;
(15) McGill forceps;
(16) Tongue grasping forceps;
(17) Equipment for emergency crico-thyrotomy or tracheotomy and the appropriate connectors for administering 100% oxygen;
(18) Blood pressure cuffs:
  (A) adult; and
  (B) pediatric;
(19) ECG;
(20) Defibrillator;
(21) Board or rigid surface for cardiopulmonary resuscitation (CPR);
(22) Light source capable of use during electrical power failure;
(23) Intravenous solutions and equipment for administration:
  (A) 250 cc bags & 1000 cc bags of sterile saline; and
  (B) Sterile water for mixing or dilution of drugs; and
(24) Appropriate intravenous needles, tubing and drips.

(b) Except as specifically noted, all practitioners who are being evaluated pursuant to sections 20-123b-1 to 20-123b –9, inclusive, of the Regulations of Connecticut State Agencies, or who have been issued a permit pursuant to Section 20-123b of the Connecticut General Statutes, shall demonstrate and maintain the following equipment and personnel for continuous monitoring during the administration of anesthesia in any and all offices where they administer general anesthesia or conscious sedation:

(1) Equipment and personnel for continuous monitoring during the administration of deep sedation or general anesthesia:
  (A) means of monitoring heart rate:
    (i) ECG;
    (ii) pulsemeter;
    (iii) pretracheal or precordial stethoscope; or
    (iv) direct palpation of pulse;
  (B) means of following respirations and level of oxygenation:
    (i) pretracheal or precordial stethoscope, or capnography; and
    (ii) pulse oximeter;
  (C) means of monitoring blood pressure for child and adult.
(2) Equipment and personnel for continuous monitoring during the administration of conscious sedation:
  (A) means of monitoring heart rate:
    (i) ECG;
    (ii) pulsemeter;

(iii) pretracheal or precordial stethoscope; or
(iv) direct palpation of pulse;
(B) means of following respirations and level of oxygenation:
(i) pretracheal or precordial stethoscope, capnography or direct observation of chest; and
(ii) pulse oximeter;
(C) means of monitoring blood pressure for child and adult.

(c) All practitioners who are being evaluated pursuant to Sections 20-123b-1 through 20-123b-9, inclusive, of the Regulations of Connecticut State Agencies, or who have been issued a permit pursuant to Section 20-123b of the General Statutes, shall maintain the following emergency drugs in any and all offices where they administer general anesthesia or conscious sedation:

(1) anticonvulsant drugs:
(A) midazolam; or
(B) diazepam;
(2) antiemetic:
(A) droperidol;
(B) odansetron;
(C) prochlorperazine;
(D) promethazine; or
(E) metoclopramide;
(3) beta agonist: albuterol inhaler;
(4) cardiovascular medications:
(A) antiarrhythmics:
(i) lidocaine or amiodarone;
(ii) procainamide; and
(iii) diltiazem;
(B) atropine (either 0.4 mg/ml or 1.0 mg/ml);
(C) aspirin 160 or 325 mg dose;
(D) beta blocker:
(i) esmolol;
(ii) propranolol;
(iii) atenolol; or
(iv) metoprolol;
(E) epinephrine 1 mg:
(i) 1:1,000 solution; and
(ii) 1:10,000 solution;
(F) diuretic: furosemide 10mg/ml;
(G) nitroglycerin (tablet or spray);
(H) vasodilators:
(i) labetalol; and
(ii) hydrazaline or diazoxide;
(I) vasopressors:
(i) ephedrine; and
(ii) phenylephrine;
(J) corticosteroids:
(i) dexamethasone;
(ii) hydrocortisone sodium succinate; or
(iii) methylprednisolone sodium succinate;

(K) dantrolene (must be in facility for offices in which agents causing malignant hypothermia are used);
(L) dextrose 50%;
(M) diphenhydramine;
(N) reversal agents:
    (i) naloxone; and
    (ii) flumazenil;
(O) opioid: morphine;
(P) procaine 10 mg/ml; and
(Q) succinylcholine.

(d) All practitioners who are being evaluated pursuant to Sections 20-123b-1 through 20-123b-9, inclusive, of the Regulations of Connecticut State Agencies, or who have been issued a permit pursuant to Section 20-123b of the Connecticut General Statutes, shall maintain anesthesia or conscious sedation records which include the date of procedure, nothing by mouth (NPO) status, availability of responsible adult escort, allergies, vital signs, drugs, and doses administered.

Statement of Purpose: To update standards regarding the administration of anesthesia and conscious sedation in dental practices.