



APPLICATION FOR  
**GENERAL ANESTHESIA PERMIT**  
LOUISIANA STATE BOARD OF DENTISTRY  
365 CANAL STREET, SUITE 2680  
NEW ORLEANS, LOUISIANA 70130  
TELEPHONE (504) 568-8574 FAX (504) 568-8598

**ENCLOSE APPROPRIATE FEES AND DOCUMENTATION—INCLUDING COPY OF CURRENT BLS AND ACLS AND/OR PALS CARD—WITH YOUR COMPLETED APPLICATION**

All information **must** be completed (including DEA and Louisiana controlled substance license numbers).

**INCOMPLETE APPLICATIONS WILL BE RETURNED TO THE APPLICANT.**

ARE YOU APPLYING FOR A PERSONAL PERMIT OR AN OFFICE PERMIT OR BOTH?

PERSONAL PERMIT (\$400.00 fee)

A *personal* permit indicates the dentist has the required training to administer general anesthesia. A dentist wishing to administer general anesthesia may only do so in an office in which there exists an *office* permit for the same or higher level of anesthesia.

OFFICE PERMIT (\$400.00 fee **per office**)

An *office* permit indicates that the office location has been inspected by the Louisiana State Board of Dentistry. The office permit allows any of the following to administer general anesthesia in that location:

A licensed Louisiana dentist holding a personal permit for general anesthesia;

A licensed Louisiana physician specializing in anesthesiology; or

A licensed Louisiana certified registered nurse anesthetist.

WILL GENERAL ANESTHESIA BE ADMINISTERED TO ADULT OR PEDIATRIC PATIENTS?

ADULTS ONLY (attach copy of current BLS and ACLS certification)

ADULTS AND/OR PEDIATRIC PATIENTS (attach copy of current BLS, ACLS, and PALS certification)

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle initial \_\_\_\_\_

LA Dental License # \_\_\_\_\_ DEA License # \_\_\_\_\_ LA Controlled Substance License # \_\_\_\_\_

\_\_\_\_\_  
Mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Indicate below ALL office addresses where you (or a qualified third party) intend to administer anesthesia. **If you are applying for an office permit, check the box below the address for which you are applying.** Please list any additional offices on a separate sheet and attach it to this application.

*NOTE: There **must** be an office permit in every office where anesthesia is administered to dental patients. If our records indicate you hold a personal permit and are practicing in an office location without an office permit, you must either apply for an office permit at that location **or** send us written notification that you will not be administering the applicable level of anesthesia in said location.*

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Office address	City	State	Zip	Telephone
<input type="checkbox"/> I am applying for an office permit for this location.				

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Office address	City	State	Zip	Telephone
<input type="checkbox"/> I am applying for an office permit for this location.				

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Office address	City	State	Zip	Telephone
<input type="checkbox"/> I am applying for an office permit for this location.				

### QUALIFICATIONS FOR A PERSONAL PERMIT

Enclose a copy of documentation of your completion of a training program which was in compliance with the guidelines and policy statements published by the American Dental Association pertaining to training recommended for general anesthesia.

### FACILITIES, PERSONNEL, AND EQUIPMENT

By your signature and completion of this application you are certifying that any location where you administer general anesthesia meets the board's requirements set forth in regulations.

### RECORDS

1. Adequate medical history and physical evaluation update prior to each administration.
  - a. Name, age, sex, and weight;
  - b. ASA Risk Assignment (American Society of Anesthesiologists Classification);
  - c. Rationale for the sedation/anesthesia of the patient;
  - d. Written informed consent of patient or guardian.
2. General anesthesia records will include the following:
  - a. Baseline vital signs. If obtaining vital signs is prevented by the patient's physical resistance or emotional condition, the reason or reasons must be documented;
  - b. Intermittent quantitative monitoring of oxygen saturation, partial pressure of carbon dioxide, heart and respiratory rate, blood pressure and ECG as appropriate for specific techniques;
  - c. IV site, drug amounts and time or times administered, including local and inhalation anesthetics;
  - d. Proper maintenance of drug log;
  - e. Length of procedure;
  - f. Any complications;
  - g. Statement of patient's condition at time of discharge.

\*PER R.S. 37:793 E (1) ALL ANESTHESIA INCIDENTS RESULTING IN MORTALITY, OR TEMPORARY OR PERMANENT PHYSICAL OR MENTAL INJURY TO A PATIENT REQUIRING HOSPITALIZATION OF THE PATIENT DURING OR AS A RESULT OF ANY TYPE OF ANESTHESIA MUST BE REPORTED TO THE BOARD WITHIN TEN DAYS.

**INFORMATION AUTHORIZATION**

I hereby authorize release of any information requested by the Louisiana State Board of Dentistry.

DATE \_\_\_\_\_

LICENSEE SIGNATURE \_\_\_\_\_

**ACKNOWLEDGMENT**

**BEFORE ME** \_\_\_\_\_, **Notary Public**, duly commissioned and qualified within and for the state of Louisiana, Parish of \_\_\_\_\_.

**PERSONALLY CAME AND APPEARED,** \_\_\_\_\_ (applicant/affiant), who declared and acknowledged to me, Notary, under oath, after being by me duly sworn, that affiant swears that all information provided in this application is correct and true, and in the case of affiant’s application for an office permit that affiant has or will have the equipment required for the administration of anesthesia/analgesia pertaining to the requested permit(s) on location wherein said permit is requested.

\_\_\_\_\_  
**AFFIANT/APPLICANT’S SIGNATURE**

**SWORN TO AND SUBSCRIBED BEFORE ME,** this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
**NOTARY PUBLIC**