



APPLICATION FOR  
**ENTERAL CONSCIOUS SEDATION (ECS)**  
LOUISIANA STATE BOARD OF DENTISTRY  
365 CANAL STREET, SUITE 2680  
NEW ORLEANS, LOUISIANA 70130  
TELEPHONE (504)568-8574 FAX (504)568-8598

**PLEASE ENCLOSE APPROPRIATE FEES AND DOCUMENTATION WITH YOUR COMPLETED APPLICATION**

**PERSONAL PERMIT FEE \$100.00**

**OFFICE PERMIT FEE/PER OFFICE \$100.00**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Primary Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

Secondary Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone \_\_\_\_\_

**QUALIFICATIONS**

Indicate under which method listed below you qualify for an Enteral Conscious Sedation certificate

- 1. Postgraduate program in oral and maxillofacial surgery, pediatric dentistry or periodontics program approved by the Commission of Dental Accreditation or comparable organization approved by the Board.
- 2. General Practice Residency or other advanced education in a General Dentistry program approved by the Board.
- 3. A Board approved educational program on enteral conscious sedation.

**PLEASE INDICATE TYPE OF ANESTHESIA PERMIT YOU ARE REQUESTING:**

- 1. Adult
- 2. Pediatric

**FACILITIES PERSONNEL AND EQUIPMENT**

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

- 1. An operatory large enough to adequately accommodate the patient and permit a team consisting of at least three individuals to freely move about the patient.
- 2. A table or dental chair that permits positioning so the attending team can maintain the airway, and that provides a firm platform for the management of cardiopulmonary resuscitation.
- 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a battery powered backup system of sufficient intensity to permit completion of at the time of a power failure.
- 4. An appropriate functional suctioning device that permits aspiration of the oral and pharyngeal cavities. A backup suction device that can function at the time of a power failure.
- 5. A positive-pressure oxygen delivery system capable of administering greater than 90% oxygen at a 10 liter/minute flow for at least sixty minutes (650 liter "E" cylinder), even in the event of a power failure. All equipment must be capable of accommodating patients of all ages and sizes.
- 6. Inhalation sedation equipment, if used in conjunction with oral sedation, must have the capacity for delivering 100%, and never less than 25%, oxygen concentration at a flow rate appropriate for any patient's size and have a fail-safe system. The equipment must be maintained and checked for accuracy at least annually.
- 7. Ancillary equipment maintained in good operating condition, which must include all of the following:
  - (a) Oral airways capable of accommodating patients of all ages and sizes;
  - (b) Sphygmomanometer with cuffs of appropriate size for patients of all ages and sizes;
  - (c) Pulse oximeter;

- (d) Accurate scale – (for minors only).
- 8. Equipment appropriate for the age and size of the patient to resuscitate a non-breathing and unconscious patient and provide continuous support while the patient is transported to a medical facility.
  - 1. Vasopressor;
  - 2. Corticosteroid;
  - 3. Bronchodilator;
  - 4. Dextrose or other antihypoglycemic;
  - 5. Appropriate drug antagonists;
  - 6. Antihistaminic;
  - 7. Anticholinergic;
  - 8. Anticonvulsant;
  - 9. Oxygen.
- 9. All persons directly involved with the care of a patient will be certified in basic cardiac life support (CPR) and certified biennially.
- 10. Pursuant to Rule 1506 a dentist who administers, or who orders the administration of oral conscious sedation to a patient shall be physically present in the treatment facility while the patient is sedated and shall be present until the patient is discharged from the facility.

**RECORDS**

- 1. Adequate medical history and physical evaluation update prior to each administration of ECS.
  - (a) Name, age, sex, and weight;
  - (b) ASA Risk Assignment (American Society of Anesthesiologists Classification);
  - (c) Rational for the sedation of the patient;
  - (d) Written informed consent of patient, parent or guardian.
- 2. ECS records will include:
  - (a) Baseline vital signs, If obtaining vital signs is prevented by the patients physical resistance or emotional condition, the reason or reasons must be documented;
  - (b) Intermittent quantitative monitoring of oxygen saturation, heart and respiratory rate and blood pressure as appropriate for specific techniques;
  - (c) Drug amounts and time or times administered, including local and inhalation anesthetics;
  - (d) Length of procedure;
  - (e) Any complication of ECS;
  - (f) Statement of patient’s condition at time of discharge.

**INFORMATION AUTHORIZATION**

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

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

I attest that all information provided in this application is correct and true.

\_\_\_\_\_  
Signature

**ACKNOWLEDGMENT**

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

**PERSONALLY CAME AND APPEARED**, \_\_\_\_\_, 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)**

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

**NOTARY PUBLIC**

\_\_\_\_\_  
Anesthesia Chairman  
Date \_\_\_\_\_

\_\_\_\_\_  
LSBD Inspector  
Date \_\_\_\_\_

Approved \_\_\_\_\_ Denied \_\_\_\_\_