



**APPLICATION FOR  
NITROUS OXIDE INHALATION ANALGESIA 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 CPR CARD—WITH YOUR COMPLETED APPLICATION**

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

**NEW LICENSEES:** You may NOT apply for any anesthesia permit unless and until you have been granted a Louisiana dental license number, DEA number, and a Louisiana controlled substance license number.

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

TYPE OF ANESTHESIA PERMIT YOU ARE REQUESTING (at least one box **must** be checked)

- PERSONAL PERMIT (\$50.00 fee)  
 OFFICE PERMIT (\$50.00 fee per office)

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

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

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Mailing Address	City	State	Zip	Telephone
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Indicate below ALL office addresses where you 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 you intend to administer anesthesia. If our records indicate you 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

Indicate under which method listed below you qualify for a nitrous oxide inhalation analgesia certificate. Enclose a copy of documentation of completion with your application.

- 1. Successful completion of courses prescribed by a dental school demonstrating proficiency pertaining to use with documentation of a minimum of six (6) successful cases of induction and recovery.
- 2. Post-doctoral training which includes a minimum of fourteen (14) hours during which proficiency is demonstrated.
- 3. Completion of a board approved course which conforms to American Dental Association guidelines.

## FACILITIES PERSONNEL AND EQUIPMENT

By your signature and completion of this application you are certifying that any location where you administer nitrous oxide inhalation analgesia 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. Nitrous oxide inhalation equipment 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 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. Bronchodilator;
  - d. Dextrose or other antihypoglycemic;
  - e. Appropriate drug antagonists;
  - f. Antihistaminic;
  - g. Anticholinergic;
  - h. Anticonvulsant;
  - i. Oxygen.
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.
9. All persons directly involved with the care of a patient will be certified in basic cardiac life support (CPR) and certified biennially.
10. A dentist who administers, or who orders the administration of, nitrous oxide inhalation analgesia to a patient shall be physically present in the treatment facility until the patient is adequately recovered and discharged from the facility.

## RECORDS

1. Adequate medical history and physical evaluation update prior to each administration of nitrous oxide inhalation analgesia.
  - a. Name, age, sex, and weight;
  - b. ASA Risk Assignment (American Society of Anesthesiologists classification);
  - c. Rationale for nitrous oxide analgesia;
  - d. Written informed consent of patient, parent or guardian.

2. Nitrous oxide inhalation analgesia 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. Duration and concentration of nitrous oxide/oxygen administration;
  - c. Any complication of nitrous oxide inhalation analgesia;
  - d. 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 \_\_\_\_\_ 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**