

APPLICATION FOR A PHYSICIAN TO ADMINISTER SEDATION AND/OR GENERAL ANESTHESIA IN A DENTAL OFFICE

All physicians who wish to treat patients in a dental facility (which holds a Facility Permit issued by this College) using oral moderate sedation, parenteral conscious sedation (IV sedation), deep sedation and/or general anesthesia must apply and submit the following information:

TYPE OF PRIVILEGES BEING SOUGHT

- Non-visiting physician** – I will administer sedation and/or general anesthesia in a Type A dental facility that provides all necessary sedation and/or general anesthetic equipment and emergency drugs
- Visiting physician** – I will administer sedation and/or general anesthesia in a Type B dental facility and I bring all necessary sedation and/or general anesthetic equipment and emergency drugs to the dental facility

APPLICANT NAME AND PRIMARY ADDRESS (please print)

FULL NAME:	CPSO #:	
STREET:	SUITE:	
CITY:	PROVINCE:	POSTAL CODE:
TEL:	FAX:	EMAIL:

MODALITIES OF SEDATION AND/OR GENERAL ANESTHESIA TO BE ADMINISTERED

- (i) Deep Sedation Y N
- (ii) General Anesthesia Y N

PROFESSIONAL TRAINING/QUALIFICATIONS

- (i) Are you currently registered to practice medicine in Ontario? Y N
- (ii) Do you hold a fellowship in anesthesiology from the Royal College of Physicians and Surgeons of Canada? Y N
- (iii) If you answered "No" to question (ii) above, have you successfully completed a post-graduate program in anesthesiology recognized by a Canadian Faculty of Medicine? Y N

If "yes", please provide details about this program (duration, where taken) and the date when you completed the program.

- (iv) Do you hold active hospital privileges to administer deep sedation and/or general anesthesia in a public hospital in Ontario? Y N **If "yes", please include a letter from the hospital.**
- (v) If you do not hold active hospital privileges to administer deep sedation and/or general anesthesia, please provide details of your recent anesthesiology practice in the space below.

(vi) PLEASE CONTACT THE CPSO, ORDER A "CERTIFICATE OF PROFESSIONAL CONDUCT" AND ASK THAT IT BE SENT TO THE RCDSO.

(vii) If you will be administering deep sedation and/or general anesthesia you must provide evidence to this College of current BLS, ACLS, and PALS (if applicable) certification as required by the *Standard of Practice* of the RCDSO.

DENTAL FACILITY WHERE YOU INTEND TO ADMINISTER SEDATION AND/OR GENERAL ANESTHESIA:

FACILITY:

STREET:

SUITE:

CITY:

PROVINCE:

POSTAL CODE:

TEL:

FAX:

EMAIL:

AGREEMENT TO CEASE ADMINISTRATION UPON NOTICE

1. I agree to immediately cease to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia at a dental facility in the event the College's Registrar notifies the facility permit holder of that dental facility that the Registrar has determined, either as a result of an inspection or by any other means, that there is a risk of harm to the public should I continue to administer sedation and/or general anesthesia.

Name (please print)

Witness Name (please print)

Signature

Signature

Date

ATTESTATION

1. I acknowledge that I have read and fully understand the College's *Standard of Practice for the Use of Sedation and General Anesthesia in Dental Practice* ("Standard of Practice") and the College's By-Laws governing Sedation and General Anesthesia, (College By-Law No. 21), which forms part of the *Standard of Practice*.
2. I understand that I may only administer the modality or modalities of oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia, for which I have been qualified by the College of Physicians and Surgeons of Ontario ("CPSO").
3. I understand that I must comply with the College's *Standard of Practice*, all applicable CPSO Standards and Guidelines, and the CPSO's Out-of-Hospital Premises Inspection Program.
4. I understand that the facility permit holder is required to file a Tier I or Tier II report with the College if an adverse event, as defined by the *Standard of Practice*, occurs following the administration of sedation or general anesthesia. I understand that if I am the responsible sedation or general anesthesia provider in such a case, I must cooperate with the facility permit holder to ensure the appropriate Tier report is filed with the College and I understand that the Tier report may be shared with CPSO.
5. I understand that it is my responsibility to ensure that the equipment and emergency drugs required for the administration of oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia are in compliance with the *Standard of Practice* and present at all times when I am administering any modality of sedation and/or general anesthesia in a dental facility. I further understand that I may only administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia in a dental facility that has a valid Facility Permit issued by this College.
6. I understand that it is my responsibility to ensure that the information contained on this form is accurate and complete and to ensure that I comply fully with the *Standard of Practice*. I further understand and acknowledge that the College has the right to forward information to the attention of the CPSO's Registrar if the College is not satisfied that I am in full compliance with the *Standard of Practice*, and that a copy of that communication will be provided to me.
7. **I understand that by signing this attestation I am declaring that the information contained on this form is accurate and complete, and that I am agreeing that I will comply fully with the *Standard of Practice*.**

Name (please print)

Witness Name (please print)

Signature

Signature

Date

Please sign and return this form to the college by email sedation@rcdso.org