

**MONTANA BOARD OF DENTISTRY
PO BOX 200513**

(301 S PARK, 4TH FLOOR - Delivery)

Helena, Montana 59620-0513

(406) 841-2331 or 2390 FAX (406) 841-2305

EMAIL: dlibsdden@mt.gov WEBSITE: www.dentistry.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED

(Please allow 14 days for processing from the date that the Board has a complete routine application)

**DENTISTS ARE NOT PERMITTED TO PRACTICE DENTISTRY IN MONTANA IN
ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE**

LICENSE REQUIREMENTS:

1. **LICENSURE BY EXAMINATION:**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant shall have passed a Board approved clinical examination within the last 5 years
- Applicant shall pass a Montana Jurisprudence examination
- Applicant shall possess a current CPR/ACLS/PALS certification

2. **LICENSURE BY CREDENTIALING:**

A. General Dental license:

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant shall have passed a Board approved clinical examination
- Applicant shall pass a Montana Jurisprudence examination
- Applicant shall possess a current CPR/ACLS/PALS certification
- Applicant shall be currently engaged in the practice of clinical, direct patient care dentistry, and shall document active practice within the last five years immediately preceding application, for a total accumulation of 3,000 hours of experience

B. General Dental License (Practicing as a Specialist):

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant shall have passed a Board approved general dentistry clinical practical examination
- Applicant shall have completed a specialty residency of at least two years accredited by CODA, or a specialty residency approved by the Board
- Applicant shall pass a Montana Jurisprudence examination
- Applicant shall possess a current CPR/ACLS/PALS certification
- Applicant shall be currently engaged in the practice of clinical, direct patient care dentistry, and shall document active practice within the last five years immediately preceding application, for a total accumulation of 3,000 hours of experience

3. **VOLUNTEER LICENSE:**

- Applicant shall have graduated from an accredited Commission on Dental Accreditation Dental School (CODA)
- Applicant shall have passed the National Board Dental Examination
- Applicant must have practiced within the last five years or;
 - ✓ Passed a Board approved regional or state examination within the last five years

or;

- ✓ Completed a Board approved clinical competency course or skills assessment analysis
- Applicant shall verify licensure in good standing for at least ten years in Montana, another state or jurisdiction, Canada or the United States Armed Forces
- Applicant shall be retired or not actively practicing
- Applicant shall possess a current CPR, ACLS, OR PALS certification

4. **RESTRICTED NON RESIDENT VOLUNTEER LICENSE** (Applicant is not a Montana resident)
- Applicant shall have graduated from an accredited Commission on Dental Accreditation School (CODA)
 - Applicant must hold an active license in good standing in another state
 - Applicant cannot receive monetary compensation for services provided under restricted temporary non resident volunteer license
 - Applicant can only work 14 days per license renewal cycle

FEES:

Examination Application Fees

Application Fee - \$100.00
Jurisprudence Exam Fee - \$85.00

Credentialing Application Fees

Application Fee - \$100.00
Credentialing Fee - \$500.00
Jurisprudence Exam Fee - \$85.00

Restricted Non Resident Volunteer Application Fee: \$10.00
Volunteer Application Fee \$5.00

****Make check or money order payable to the Montana Board of DENTISTRY
(Fees can be combined into one check)**

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application.

LICENSURE BY EXAMINATION DOCUMENTS:

- ✓ Verifications of successful passage of a Board approved clinical examination
- ✓ Copy of current CPR, ACLS, or PALS card
- ✓ **National Practitioner Data Bank (NPDB) self-query.** This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please send the original report to the Board office.
- ✓ Official transcripts sent directly from an approved dental school.
- ✓ Copy of diploma showing graduation from an accredited CODA approved school.
- ✓ Original National Board Examination Score Card sent directly from the Joint Commission on Examination. (If a card has not already been requested to be sent to Montana you may obtain one by calling (800)-232-1694 nlsexams@ada.org .
- ✓ License verification(s) sent directly from the state(s) where you have held or hold a license verifying status and any disciplinary action on your license sent directly to the Board office.
- ✓ Three reference letters of moral character (relatives may not be used as references). (Form can be found with the application material.)
- ✓ Check or money order for the appropriate fees.

LICENSURE BY CREDENTIALING DOCUMENTS:

- ✓ Must request a Professional Background Information Services (PBIS) packet. PBIS will assess the fee for the service and determine any refund policy for their service. Documentation required for all documentation for licensure by credentialing will be provided by this service. NO CREDENTIALING APPLICATION will be processed without this information. You must obtain their application to apply for the service by contacting them at:
Professional Background Information Services
23460 N 19th Ave. Ste. 225
Phoenix AZ 85027 (602) 861-5867 www.pbisonline.com
- ✓ All information and documentation required shall be supplied to the Board by Professional Background Information Services (PBIS) except for those noted below:
- ✓ National Practitioner Data Bank (NPDB) self-query. This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please send the original report to the Board office.
- ✓ Check or money order for the appropriate fees.

RESTRICTED NONRESIDENT VOLUNTEER DOCUMENTS

- Copy of official transcripts from a dental school accredited by CODA
- License verification(s) from all states where licensee currently holds a license
- Completed Volunteer License Statement included in application packet

NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS.

CLINICAL EXAM INFORMATION:

A Board approved clinical examination must be successfully passed. For licensure by examination exams are valid for five years.

The Board accepts the following clinical examinations:

CITA - COUNCIL OF INTERSTATE TESTING AGENCIES
(919) 460-7750 www.citaexam.com

CRDTS - CENTRAL REGIONAL DENTAL TESTING SERVICE
(785) 273-0380 www.crdts.org

NERB - NORTH EAST REGIONAL BOARD OF DENTAL EXAMINERS, INC
(301) 563-3300 www.nerb.org

SRTA - SOUTHERN REGIONAL TESTING AGENCY INC
(757) 318-9082 www.srta.org

WREB - WESTERN REGIONAL EXAMINING BOARD
(602) 944-3315 www.wreb.org

Application for clinical examination must be filed directly with the testing entity at the above address. The testing entity establishes the dates and testing sites. The clinical examination must be passed prior to making an application for licensure by examination in the State of Montana. Exam results are valid for five years.

THE ABOVE TESTING ENTITIES ARE NOT LICENSING AGENCIES

The Board also accepts clinical exams given by the following States:

California Delaware Florida Nevada

Please contact the State directly for exam results or information

APPLICATION PROCEDURES

- When a routine application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if the applicant will be required to appear before the Board during a regularly scheduled Board meeting.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting. Non-routine applications may take up to 120 days to process.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

JURISPRUDENCE EXAMINATION INFORMATION:

- ▶ ALL APPLICANTS WILL BE REQUIRED TO TAKE A MONTANA **JURISPRUDENCE EXAM AND PASS WITH A SCORE OF 75%. THE EXAM CAN BE TAKEN AFTER APPROVAL OF THE APPLICATION AND BEFORE RECEIVING A DENTAL LICENSE.** *Applicants will be notified when the application is approved and a jurisprudence exam will be sent with the notification. This is an open book exam and applicants are strongly encouraged to use the laws and rules for study and reference.*
- ▶ The examination covers the statutes and rules for the practice of dentistry, dental hygiene and dentistry.
- ▶ The copy of the laws and rules is on our web site at www.dentistry.mt.gov. **PLEASE DOWNLOAD ALL** the laws and rules on the Board of Dentistry's site.

PROCESSING PROCEDURES

- Processing time for a routine and complete application is approximately 14 days; the applicant will be sent the jurisprudence examination upon approval.
- The applicant will be notified in writing of any deficient or missing items in the application file. This delay may effect the processing time.
- When the examination has been corrected and passage is confirmed, a license may be issued to the applicant. Time for processing the final license depends on the applicant turnaround time on the jurisprudence take home examination.
- Please be sure the three individual references you listed on your application complete the reference questionnaire form and return the form directly to the Board office as soon as possible in order to complete your application.
- Credentialing applications will not be processed until the material from the Professional Background Information Services (PBIS) has been received
- Credentialing application that has been determined to be complete but must go before the full Board for review and can take up to 120 days for approval.
- The Montana Board does not have temporary licensure for dentists.

For information with regard to the processing of this application or other concerns please contact the Board of Dentistry at 406-841-2331 or 2390 or email us at dlibsdden@mt.gov.

PLEASE BE SURE TO DOWNLOAD THE MONTANA LAWS AND RULES FOR THE PRACTICE OF DENTISTRY FOR THE JURISPRUDENCE EXAMINATION
WEBSITE ADDRESS: www.dentistry.mt.gov

10. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method			Requested State Verification	
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO
				<input type="radio"/> EXAM	<input type="radio"/> ENDORSE	<input type="radio"/> OTHER	<input type="radio"/> YES	<input type="radio"/> NO

Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source.

Yes No

Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition.

Yes No

Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult.

Yes No

Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source.

Yes No

Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. Yes No

Have you ever been courts martial or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. Yes No

Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. Yes No

11. **PROFESSIONAL EDUCATION**

Name of University or College	City and State/Province/ Territory	Dates Attended	Degree Earned

12. Have you ever been certified by a Specialty Board? Yes No

Certifying Agency	Specialty	Date Awarded or Re-certified

13. **PRACTICE HISTORY:** List **all** practice after dental school in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, or residency program. Use additional paper if necessary.

Name & Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

14. **PROFESSIONAL & CHARACTER REFERENCES.
FOR EXAMINATION APPLICANTS ONLY**

Please type or print names and addresses of three references, Use these reference names to send the reference forms for your character references.

Name:	
Address:	
Telephone Number:	

Name:	
Address:	
Telephone Number:	

Name:	
Address:	
Telephone Number:	

DECLARATION

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Dentistry.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Signature of Applicant

Date

**VERIFICATION OF MORAL/PROFESSIONAL CHARACTER
FOR EXAMINATION APPLICANTS ONLY**

APPLICANT: Complete the upper portion of this form and mail to each of the character references you have listed in your application.

Legal Signature of Applicant _____
Date

(Please Type or Print)

Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to: Montana Board of Dentistry, PO Box 200513, Helena MT 59620. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does the applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes", please explain: Yes No

Do you consider this applicant worthy of approval to practice as a Dentist in Montana? Yes No

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed):

Signature of Reference _____
Date

The Applicant and the Board thank you for your assistance.

DEN/DEN
Revised 7/07, 09/07,
12/07, 3/08, 4/08,
7/08, 1/09, 2/09,
6/09, 02/10, 04/10,
6/10, 12/10, 11/11, 5/12

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PO BOX 200513**

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EMAIL: dlibsdden@mt.gov WEBSITE: www.dentistry.mt.gov

**REQUEST FOR OFFICIAL VERIFICATION OF LICENSURE
(THIS IS NOT AN ENDORSEMENT CERTIFICATION)**

APPLICANT: Do **NOT** send this form in with your application. This is to be used as necessary to request official license verification from states or licensing entities in which you currently hold, or ever have held a license.

COMPLETE THE FORM AND MAIL IT TO ANY STATE BOARD IN WHICH YOU ARE REQUESTING OFFICIAL LICENSE VERIFICATION BE SENT TO THE MONTANA BOARD. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. BE ADVISED THAT SOME BOARDS REQUIRE A FEE FOR THIS SERVICE. IT IS RECOMMENDED YOU CONTACT THE BOARDS BY PHONE PRIOR TO MAILING IN THIS FORM TO SEE IF YOU NEED TO INCLUDE PAYMENT.

LICENSEE INFORMATION

To Whom It May Concern:

I am applying for a license to practice Dentistry in the State of Montana and the Board of Dentistry requires official license verification. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to:

**Montana Board of Dentistry
PO Box 200513
Helena, MT 59620-0513.**

Your prompt response is appreciated.

Name (Please Print) _____ Signature _____

Address: _____

Street or PO Box # _____ City _____ State _____ Zip _____

My License Number from your State is: _____ License Type: _____

This form is to be used to request official verification from states where you hold or have ever held a license. Please **DO NOT** return this form to our office.

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number: _____ License Number: _____

Provide the name and address of the location you intend to provide services under this volunteer license to indigent or uninsured patients in underserved or critical needs areas.

Name _____

Address _____

VOLUNTEER LICENSE STATEMENT

I will not accept any fees, payment or other remuneration for any and all services that I provide while a holder of a Volunteer Dental License in Montana.

I hereby declare under penalty of perjury that I will abide by the above statement during the time I hold the Volunteer license. In signing this statement, I am aware that a false statement or accepting payment could result in revocation of my license based upon the board statute and rules. I have read and I am familiar with the applicable dental licensure laws and rules of the State of Montana and will abide by them.

Legal Signature of Applicant

Date

Subscribed and sworn to before me this _____ day of _____, _____ at

City/State

SEAL

Signature of Notary Public

Notary Public Printed Name

For the State of

My commission expires _____, _____

MONTANA BOARD OF DENTISTRY
PO BOX 200513
(301 S PARK, 4TH FLOOR - Delivery)
Helena, Montana 59620-0513
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EMAIL: dlibsdden@mt.gov WEBSITE: www.dentistry.mt.gov

CERTIFICATION OF HOURS
(Use for inactive to active practice, or volunteer license)
NOT FOR RESTRICTED NONRESIDENT VOLUNTEER

Applicant Name _____

Today's Date _____

Dates Worked: From _____ To: _____

Full-time or Part-time and Total hours worked: _____

Employer Signature _____ Date _____

If the applicant had more than one employer during this period of time, the applicant should make copies of this form and have each employer verify the work experience on this form.

Employer's Name _____
Please Print

Employer's Address _____

Employer's Telephone Number _____

I hereby declare under penalty of perjury that information submitted on this form is true and complete to the best of my knowledge. In signing this form, I am aware that a false statement or evasive answer may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

Applicant's Signature

Date

MONTANA BOARD OF DENTISTRY
PO BOX 200513
(301 South Park, 4th Floor – Delivery)
Helena MT 59620-0513
406-841-2390 Fax: 406-841-2305

E-Mail dlibsdden@mt.gov Web site: www.dentistry.mt.gov

TEMPORARY ANESTHESIA PERMIT APPLICATION FEE: \$200.00

(Make Checks payable to the Board of Dentistry - DO NOT SEND CASH)

THIS IS FOR A TEMPORARY PERMIT ONLY AND IS VALID FOR 120 DAYS OR UNTIL INSPECTION

Once approved, the Board office will contact you concerning your inspection when arrangements have been finalized. There is an additional inspection fee of \$200.00

1. Name:

Last First MI MT Dental License #

2. Current Mailing Address:

Address City State Zip Code

3. Location of Office for Inspection:

Street Address City Phone Number

4. Select the level of sedation you are applying for: * *

_____ Deep Sedation/Full General _____ Moderate Sedation

5. For Deep Sedation/Full General submit your **EDUCATION/TRAINING** required by **24.138.3221** (1) MINIMUM QUALIFYING STANDARDS

For Moderate Sedation submit a copy of your **ACLS** card, **EDUCATION/TRAINING** documentation and complete the following form of the **PATIENT LOGS** (See **24.138.3221** (2)(3) MINIMUM QUALIFYING STANDARDS) at www.dentistry.mt.gov under the "regulations" tab.

Please note: 37-4-511. Limitations regarding deep sedation or general anesthesia. (1) A person engaged in the practice of dentistry or oral surgery may not conduct any dental or surgical procedure upon another person under deep sedation or general anesthesia unless the vital signs of the patient are continually monitored by another trained health care professional.

(2) The facility in which deep sedation or general anesthesia is to be administered as part of a dental or surgical procedure must be equipped with proper drugs and equipment to safely administer anesthetic agents, to monitor the well-being of the patient under deep sedation or general anesthesia, and to treat the complications that may arise from deep sedation or general anesthesia.

24.138.3223 MINIMUM MONITORING STANDARDS: (4)

During dental procedures, the facility must be staffed by supervised monitoring personnel, all of whom are capable of handling procedures, problems, and emergency incidents, and have successfully completed the American Heart Association's Basic Life Support for Healthcare Providers, or its equivalent.

****MCA 37-4-101 Definitions -- practice of dentistry.** (1) Unless the context requires otherwise, in this chapter the following definitions apply:

(b) "Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(d) "General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

**** 24.138.3211 DEFINITIONS RELATED TO ANESTHESIA (8)**

"Moderate sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The drugs and/or techniques used for moderate sedation should render the unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing is obtained may result in a greater alteration of the state of consciousness than intended. A patient whose only response is reflex withdrawal from a painful stimulus is not in a state of moderate sedation.

THE COMPLETE ANESTHESIA STATUTES AND RULES ARE AVAILABLE AT www.dentistry.mt.gov under the "regulations" tab.

I hereby certify that the information supplied on this application and the documents attached to this application are true and correct to the best of my knowledge. I understand that any false or misleading information may result in refusal of a permit to administer moderate sedation, deep sedation/general anesthesia and could result in revocation of my dental license.

Signature of Applicant

Date

**MONTANA BOARD OF DENTISTRY
Moderate Sedation Permit Patient Log**

**Montana Board of Dentistry
301 South Park Avenue
PO Box 200513
Helena, Montana 59620-0513
Phone: (406) 841-2390
dlibsdden@mt.gov**

Applicant Name: _____
 Program: _____
 Applicant's Address: _____

 Email: _____
 Phone number: (____) _____

Moderate Sedation
 Moderate Sedation Program
 Address: _____

 Date started: ___/___/___ Date completed: ___/___/___

Instructions: As per rule MT rule 24.38.3221(3), twenty (20) patients must be sedated by any applicant pursuing a permit to provide moderate sedation in Montana. Please provide evidence of this requirement through completion of this patient log. Provide documentation of agents utilized for your sedations, dental procedure(s) performed, and time of sedation (start, finish and total time). Also, provide your initials as well as the initials of the doctor supervising your sedations. **All patients must be patients receiving dental treatment. Online simulation or sedation of non-dental procedures (i.e. colonoscopy procedures, etc.) is not considered appropriate to qualify.**

Date	Patient no.	Agents used ¹	Department or clinic	Procedure(s) (i.e. restorations, endodontic, extractions, implants, etc.)	Time start ²	Time end ²	Total time ³	Applicant initials ⁴	Observer's initials ⁵
/ /	1				:	:	h m		
/ /	2				:	:	h m		
/ /	3				:	:	h m		
/ /	4				:	:	h m		
/ /	5				:	:	h m		
/ /	6				:	:	h m		
/ /	7				:	:	h m		
/ /	8				:	:	h m		
/ /	9				:	:	h m		
/ /	10				:	:	h m		
/ /	11				:	:	h m		
/ /	12				:	:	h m		
/ /	13				:	:	h m		
/ /	14				:	:	h m		
/ /	15				:	:	h m		
/ /	16				:	:	h m		

/ /	17				:	:	h m		
/ /	18				:	:	h m		
/ /	19				:	:	h m		
/ /	20				:	:	h m		

1. Provide the agents used for the sedation as well as total doses (i.e. 2 mg midazolam, 100 mcg fentanyl)
2. Indicate start and finish times in military time (i.e. 1:27 pm would be recorded as 13:27)
3. Provide total time of the case in hours and minutes.
4. Provide your initials documenting completion of the sedation. In the chart below, provide your signature and initials for verification purposes.
5. Provide the initials of the doctor providing the supervision of your sedation(s) as well as their signature and initials.

Date	Applicant's name printed	Applicant's signature	Applicant's initials
/ /			
	Supervisor's name printed	Supervisor's signature	Supervisor's initials
/ /			
/ /			
/ /			
/ /			
/ /			