The Commonwealth of Massachusetts
Division of Health Professions Licensure
Board of Registration in Dentistry
239 Causeway Street, 5th Floor, Suite 500
Boston, MA 02114
(617) 973-0971
www.mass.gov/dph/boards/dn

Facility Permit D-B2

(See 234 CMR 6.06 Effective August 20, 2010)

Administration of Minimal Sedation

Application Instructions

Facility Permit D-B2 authorizes the administration of minimal sedation at the specific site named on the Permit, as performed by a qualified dentist licensed to practice under MGL c. 112 s. 45 or by a medical anesthesiologist licensed by the Massachusetts Board of Registration in Medicine. Prior to the administration of minimal sedation in a dental office, a Facility Permit D-B2 must be obtained by the qualified dentist for each office site where minimal sedation is to be administered, including the offices of dentists who work with a qualified medical or dental anesthesiologist (234 CMR 6.03). Facility Permit D-B2 also authorizes the administration of nitrous oxide-oxygen at this site by qualified dentists with the proper individual anesthesia permits as issued by the Board.

Exemption: A Facility Permit D-B2 is not required for the administration of minimal sedation or nitrous oxide-oxygen at those hospital and/or dental school settings that have been approved by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of the Council on Education of the American Dental Association, or for hospitals and clinics licensed pursuant to M. G. L. c. 111, §§ 51 through 56**.** A private dental office of a licensed dentist that is located within a hospital or dental school facility, however, is subject to 234 CMR 6.00.

PLEASE NOTE:

1) A facility permit is issued by the Board in the name of a dentist currently licensed under MGL c. 112 s. 45 for the specific address named in the application and is not transferable to either another facility or another licensee. A facility permit immediately expires when the licensee in whose name it is issued ceases to practice at the facility.

2) A site inspection is required for completion of this application. Once the permit application is complete, a compliance officer will contact you to set up a time for the inspection. If you are a member of the Massachusetts Society of Oral and Maxillofacial Surgeons whose practice site named in the application has been inspected within the past five years you may submit a copy of the results of that inspection along with the application for a Facility Permit D-B2 in lieu of requesting a Board inspection.

3) Please consult Statutes, Rules, and Regulations pertaining to the administration of anesthesia and sedation (234 CMR 6.00) at www.mass.gov/dph/boards/dn for detailed descriptions of requirements for the Facility Permit D-B1 and Individual Anesthesia permits and go to www.osha.gov, www.ada.org and www.cdc.gov for up-to-date information on and requirements for the provision anesthesia in dental offices. Specific questions may be addressed to the Board by emailing dentistry.admin@state.ma.us

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Application -Facility Permit D-B2

1. APPLICANT NAME _____ MA DN Lic. # _____
Last First MI

2. FACILITY ADDRESS: _____
No. Street Unit #

_____
City/Town State Zip Code

3. BUSINESS NAME/DOING BUSINESS AS: _____

4. TELEPHONE NUMBER-DAY: _____ CELL: _____ FAX: _____

5. EMAIL ADDRESS: _____

6. **PRACTICE OWNER** (if different from applicant)

Name: _____ MA Dental Lic. # _____

Telephone: _____ Email: _____

7. **FACILITY DENTAL DIRECTOR** (if applicable – see 234 CMR 5.02 (3))

Name: _____ MA Dental Lic. # _____

Telephone: _____ Email: _____

8.**TYPE(S) OF ANESTHESIA AND/OR SEDATION TO BE ADMINISTERED AT THIS SITE (Check all that apply.)**

Nitrous Oxide- Oxygen Only _____
Nitrous Oxide-Oxygen + Oral Sedatives ____
Oral Sedation Only _____
I.V. Sedation _____
General Anesthesia and Deep Sedation _____
Other route of administration: _____

FACILITY PERMIT D-B2 APPLICATION ATTACHMENTS

- □ **Attachment 1**: Personal or business check or money order made payable to THE COMMONWEALTH OF MASSACHUSETTS in the amount of $180. **All fees are non-refundable and non-transferable**.
- □ **Attachment 2**: Required Equipment and Emergency Drugs (**see form attached**)
- □ **Attachment 3**: Documentation of most recent local fire department inspection of the application site within the past year.
- □ **Attachment 4**: Copy of current ACLS or PALS or BLS certificates for all individuals administering or assisting.
- □ **Attachment 5**: Copy of office's medical history form.
- □ **Attachment 6**: Copy of office's anesthesia chart form.
- □ **Attachment 7**: Copy of office's anesthesia consent form.
- □ **Attachment 8**: Copy of a schedule and log demonstrating the regular inspection of all emergency drugs and equipment for administration of minimal sedation at the office site, including the date(s) and name of person who last checked drugs and equipment and the results of the checks, including that of the condition of equipment according to manufacturers' specifications.
- □ **Attachment 9**: Copy of a written protocol for management of emergencies.
- □ **Attachment 10**: Copy of schedule and content of regular and routine office emergency drills.
- □ **Attachment 11**: Copy of WEEKLY spore testing results for the three (3) months prior to application for Facility Permit D-B2. If office has been open less than three months, submit the protocols and procedures for spore testing at the site and any and all WEEKLY spore testing results to date.
- □ **Attachment 12**: Copy of Federal DEA Controlled Substance Certificate and MA Controlled Substance Registration for the specific address listed on this application. (M.G.L. c. 94C, §10)
- □ **Attachment 13**: Request for on-site inspection of the site by the Board.
- □ **Attachment 14:** Copy of DPH Radiation Control Program Certification, (M.G. L. c. 111 §5N)
- □ **Attachment 15:** Copy of all current individual anesthesia permits of staff.

APPLICANT ATTESTATION: I _____HEREBY CERTIFY,

Print Full Name of Applicant

UNDER THE PAINS AND PENALTIES OF PERJURY, THAT:

- **ALL INFORMATION PROVIDED IN THIS APPLICATION IS ACCURATE AND TRUE;**
- **I HAVE READ AND UNDERSTOOD THE STANDARDS AND REQUIREMENTS FOR THE ADMINISTRATION OF ANESTHESIA AND SEDATION AS PROMULGATED BY THE BOARD ON AUGUST 20, 2010 AT 234.CMR 6.00, INCLUDING, BUT NOT LIMITED TO, THE REQUIREMENTS OF THIS PERMIT FOR:**
  - **AUXILIARY PERSONNEL REQUIRED AT 234 CMR 6.13 (2)**
  - **PATIENT EVALUATION REQUIRED AT 234 CMR 6.13 (3)**
  - **PRE-OPERATIVE PREPARATION REQUIRED AT 234 CMR 6.13 (4)**
  - **PATIENT MONITORING AND DOCUMENTATION REQUIRED AT 234 CMR 6.13 (5)**
  - **MANAGEMENT OF RECOVERY AND DISCHARGE OF PATIENTS AT 234 CMR 6.13 (6)**
  - **MANAGEMENT OF PEDIATRIC AND SPECIAL NEEDS PATIENTS AT 234 CMR 6.13 (7)**
  - **EMERGENCY MANAGEMENT AT 234 CMR 6.13 (8)**
  - **CURRENT ACLS, PALS AND BLS CERTIFICATION FOR ALL STAFF ADMINISTERING AND ASSISTING**
- **I UNDERSTAND THAT, UNDER THE TERMS OF THIS PERMIT, THE ADMINISTRATION OF MINIMAL CONSCIOUS SEDATION AND NITROUS OXIDE-OXYGEN SEDATION IS LIMITED SOLELY TO THE PRACTICE SITE WHERE THERE IS THE REQUISITE FACILITY D PERMIT FOR THE TYPE OF ANESTHESIA OR SEDATION TO BE ADMINISTERED.**
- **I AM CURRENTLY, AND WILL CONTINUE TO BE, IN COMPLIANCE WITH ALL STATUTES, RULES, AND REGULATIONS PERTAINING TO THE PRACTICE OF DENTISTRY IN THE COMMONWEALTH OF MASSACHUSETTS AS REQUIRED BY LAW.**

SIGNATURE OF APPLICANT: _____**DATE**:_____

Attachment 2

EQUIPMENT REQUIRED BY 234 CMR 6.06 TO BE PROVIDED AND MAINTAINED AT SITE

EQUIPMENT REQUIRED	DATE LAST INSPECTED
Alternative light source for use during power failure	
Automated or manual external defibrillator including batteries and other components	
Disposable CPR mask (pediatric and adult)	
Disposable syringes (assorted sizes)	
Equipment suitable for proper positioning of the patient for administration of cardiopulmonary resuscitation, including a back board	
Gas delivery system capable of positive pressure ventilation, which must include: ▪ Oxygen ▪ Safety-keyed hose attachments ▪ Capability to administer 100% oxygen in all rooms (operatory, recovery, examination, and reception) ▪ Gas storage in compliance with safety codes ▪ Adequate waste gas scavenging system ▪ Nasal hood or cannula.	
Latex free tourniquet	
Means of monitoring vital signs (pediatric and adult)	
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation including bag-valve-mask system	
Pulse oximeter with battery pack	
Sphygmomanometer and stethoscope (pediatric and adult)	
Suction	
Supervised area for recovery	

EMERGENCY DRUGS AND DRUG CLASSIFICATIONS REQUIRED BY 234 CMR 6.06 TO BE PROVIDED AND MAINTAINED AT SITE

REQUIRED DRUGS	NAME OF DRUG	DOSAGE	EXPIRATION DATE
Acetylsalicylic acid (rapidly absorbable form)	[redacted]		
Ammonia inhalants	[redacted]	[redacted]	[redacted]
Anticonvulsant			
Antihistamine			
Antihypoglycemic agent			
Bronchodilator			
Corticosteroid			
Epinephrine pre-loaded syringes			
Oxygen	[redacted]	[redacted]	
Reversal agents			
Two (2) epinephrine ampules			
Vasodilator			
Vasopressor			

Attachment 2 (page 2)

NAME(S) OF DENTIST(S)/ANESTHESIOLOGIST(S) WHO WILL BE ADMINISTERING ANESTHESIA AT THIS FACILITY	LICENSE NUMBER	ANESTHESIA PERMIT NUMBER	ACLS/BLS CERTIFICATION EXPIRATION DATE
Dental Director:			

NAME(S) OF DENTAL/SURGICAL ASSISTANT(S)	EXPIRATION DATE OF CPR/BLS CERTIFICATION

SIGN AND SEND THIS APPLICATION AND ALL REQUIRED ATTACHMENTS TO:

THE MASSACHUSETTS BOARD OF REGISTRATION IN DENTISTRY

239 CAUSEWAY STREET-SUITE 500, BOSTON, MA 02114

KEEP A COPY OF THIS APPLICATION AND ALL ATTACHMENTS FOR YOUR RECORDS