



# State of Utah

## DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741  
Salt Lake City, Utah 84114-6741  
Telephone (801) 530-6628  
[www.dopl.utah.gov](http://www.dopl.utah.gov)

- DENTAL CLASS I ANESTHESIA AND ANALGESIA PERMIT** (\$110.00 Non Refundable Application Fee)
- DENTAL CLASS II ANESTHESIA AND ANALGESIA PERMIT** (\$110.00 Non Refundable Application Fee)
- DENTAL CLASS III ANESTHESIA AND ANALGESIA PERMIT** (\$110.00 Non Refundable Application Fee)
- DENTAL CLASS IV ANESTHESIA AND ANALGESIA PERMIT** (\$110.00 Non Refundable Application Fee)
- UTAH CONTROLLED SUBSTANCE LICENSE** (\$100.00 Non Refundable Application Fee)

*(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)*

<b>***Please list your full legal name as it appears on your driver's license, Social Security Card, etc.***</b>				
Last Name:		First Name:		Middle Name:
Social Security Number:    -    -			Maiden Name:	
I certify under penalty of perjury that:				
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: __				
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.				
<input type="checkbox"/> I am a foreign national not physically present in the United States.				
Mailing Address:				
City:			State:	ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone #:	E-Mail:	
<input type="checkbox"/> Female				
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>				
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	
Profession:		Issuing State:		
License Number:		License Status:	Issue Date:	

**DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY**

License/Certificate Number: \_\_\_\_\_

Date License/Certificate Approved/Denied: \_\_\_ / \_\_\_ / \_\_\_ by \_\_\_\_\_

Reason for Denial/Other Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Bureau Manager Review: QQ Yes answers or Education or Exam     Approve     Deny

**AFFIDAVIT and RELEASE AUTHORIZATION FOR APPLICANT**

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**DENTAL SCHOOL** *(Use additional sheets if necessary.)*

<b>Name of School:</b>	Dates Attended:	To:
Location:	Date of Graduation:	
Mailing Address:		
City:	State:	ZIP:
<b>Name of School:</b>	Dates Attended:	To:
Location:	Date of Graduation:	
Mailing Address:		
City:	State:	ZIP:

**PROFESSIONAL EXAMINATION REQUIREMENT**

- National Board, Date(s) Taken:
- Western Regional Examination, Date(s) Taken:
- Northeast Regional Board Examination, Date(s) Taken:
- Southern Regional Testing Agency Examination, Date(s) Taken:
- Central Regional Dental Testing Service Examination, Date(s) Taken:
- State Examination, State \_\_\_\_\_ Date(s) Taken: \_\_\_\_\_

**CPR/BCLS/ACLS CERTIFICATION**

<input type="checkbox"/> CPR <input type="checkbox"/> BCLS <input type="checkbox"/> ACLS	Source: _____	Expiration Date: _____
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**RECORD OF PROFESSIONAL EXPERIENCE AS A DENTIST** *(If Applying By Endorsement)*

**Yes** I have worked as a licensed dentist for 6,000 or more hours in the 5 years immediately preceding the date of this application.

From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:
From Date	To Date:	Practice Experience & Location:

## UTAH CONTROLLED SUBSTANCES LAW AND RULES EXAMINATION

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah's controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 <http://dopl.utah.gov/laws/58-37.pdf>

Utah Controlled Substances Act Rule, R156-37 <http://dopl.utah.gov/laws/R156-37.pdf>

Answer “**True**” or “**False**” for each statement. Submit this completed examination with your application for licensure.

<input type="checkbox"/> True <input type="checkbox"/> False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
<input type="checkbox"/> True <input type="checkbox"/> False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
<input type="checkbox"/> True <input type="checkbox"/> False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
<input type="checkbox"/> True <input type="checkbox"/> False	7. A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed.
<input type="checkbox"/> True <input type="checkbox"/> False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incidence to the local police, and send copies of the filed DEA forms to DOPL.
<input type="checkbox"/> True <input type="checkbox"/> False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
<input type="checkbox"/> True <input type="checkbox"/> False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
<input type="checkbox"/> True <input type="checkbox"/> False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
<input type="checkbox"/> True <input type="checkbox"/> False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
<input type="checkbox"/> True <input type="checkbox"/> False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.
<input type="checkbox"/> True <input type="checkbox"/> False	14. The Division may: refuse to issue a license, refuse to renew a license, or revoke, suspend, restrict, or place on probation the license of an individual who does not register with the controlled substance database and take the controlled substance tutorial and examination.


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## QUALIFYING QUESTIONNAIRE

**Read thoroughly, and answer the questions. Do not leave any question blank.**

*(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)*

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you ever been denied the right to sit for a licensure examination?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Have you been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug use or abuse within the past five (5) years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Are you currently using or have you recently ( <i>within 90 days</i> ) used any drugs ( <i>including recreational drugs</i> ) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?

<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed ( <i>i.e. plea-in-abeyance or deferred sentence</i> )?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
	<p><b>If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered “yes” to Questions 21, 22, 23, 24, 25, 26 or 27 you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</b></p> <p><b>If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</b></p> <p><b>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</b></p> <p><b>A “Yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.</b></p>

## REQUEST FOR A CLASS II ANESTHESIA AND ANALGESIA PERMIT

Applicant Name:

### ANESTHESIA TRAINING

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

### AFFIDAVIT:

I declare under penalty of perjury as follows:

1. My anesthesia courses conform to the American Dental Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, Parts I or III, October 2007.
2. I have and will maintain current BCLS or ACLS certification.
3. My patient care staff will maintain current CPR or BCLS certification.
4. Every patient under nitrous oxide administration will have continuous in-operatory observation by a member of the dental patient care staff.
5. Nitrous oxide and oxygen flow rates and sedation duration and clearing times will be appropriately documented in patient record.
6. Reasonable and prudent controls and equipment are in place and followed in regard to nitrous oxide to ensure the health and safety of patients, dental office personnel, and the general public.
7. The dental facility is equipped with adequate and appropriate equipment, in good working order, to assess vital signs.
8. Equipment used in the administration of nitrous oxide has a scavenging system and all gas delivery units have an oxygen fail-safe system.
9. I certify that I will comply with the scope of practice as set for in rule Subsection [R156-69-601\(2\)](#).

Signature of Applicant:

Signature Date:

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## REQUEST FOR A CLASS III ANESTHESIA AND ANALGESIA PERMIT

Applicant Name:

### ANESTHESIA TRAINING

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

### AFFIDAVIT:

I declare under penalty of perjury as follows.

1. My anesthesia courses conform to the American Dental Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, Parts I or III of the American Dental Association, October 2007.
2. I have and will maintain current ACLS certification.
3. My patient care staff will maintain current CPR or BCLS certification.
4. I have, or am applying for, and will maintain a Utah controlled substance license.
5. Every patient under nitrous oxide administration will have continuous in-operatory observation by a member of the dental patient care staff.
6. Reasonable and prudent controls and equipment are in place or are exercised over all nitrous oxide administration, equipment and tanks to ensure the health and safety of patients, dental office personnel and the general public.
7. Equipment used in the administration of nitrous oxide has a scavenging system and all gas delivery units have an oxygen fail-safe system.
8. The facility in which I work has adequate and appropriate monitoring equipment, including pulse oximetry, current emergency drugs, and equipment capable of delivering oxygen under positive pressure.
9. The patient's heart rate, blood pressure, respiratory rate and responsiveness will be checked at specific intervals during the anesthesia and recovery period and such observations will be appropriately recorded in the patient record.
10. Inhalation agents' flow rates and sedation duration and clearing times are appropriately documented in the patient record.
11. A minimum of two qualified persons as defined by rule will be present during the administration of parenteral conscious sedation.
12. I certify that I will comply with the scope of practice as set for in rule Subsection [R156-69-601\(3\)](#).

Signature of Applicant:

Signature Date:

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## REQUEST FOR A CLASS IV ANESTHESIA AND ANALGESIA PERMIT

Applicant Name:

### ANESTHESIA TRAINING

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

Program Name / Institution:

Certificate Awarded:

From Date

To Date:

### AFFIDAVIT:

I declare under penalty of perjury as follows.

1. I have successfully completed at least one year of advanced training in administration of general anesthesia and deep sedation. All courses conform to the American Dental Association's Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, Part II, October 2007.
2. I have successfully completed advanced training in obtaining a health history, performing a physical examination and diagnosis of a patient consistent with the administration of general anesthesia or deep sedation.
3. I have and will maintain current ACLS certification and a current Utah controlled substance license.
4. My patient care staff will maintain current CPR or BCLS certification.
5. Every patient under nitrous oxide administration will have continuous in-operatory observation by a member of the dental patient care staff.
6. Reasonable and prudent controls and equipment are in place or are exercised over all nitrous oxide administration, equipment and tanks to ensure the health and safety of patients, dental office personnel and the general public.
7. Equipment used in the administration of nitrous oxide has a scavenging system and all gas delivery units have an oxygen fail-safe system.
8. Inhalation agents' flow rates and sedation duration and clearing times are appropriately documented in the patient record.
9. The facility in which I will practice is equipped with precordial stethoscope for continuous monitoring of cardiac function and respiratory work, electrocardiographic monitoring and pulse oximetry, means of monitoring blood pressure, and temperature monitoring; the preceding or equivalent monitoring of the patient will be used for all patients during all general anesthesia or deep sedation procedures with temperature monitoring used for children.
10. Equipment will be immediately available to treat emergencies, including advanced airway equipment, resuscitation medications, and defibrillator.
11. Monitoring and emergency equipment is inspected annually by a certified technician and is calibrated and in good working order.
12. A minimum of two qualified persons as defined by rule will be present during the administration of parenteral conscious sedation.
13. Three qualified and appropriately trained individuals, as set forth in rule will be present during the administration of general anesthesia or deep sedation.
14. I certify that I will comply with the scope of practice as set for in rule Subsection [R156-69-601\(4\)](#).

Signature of Applicant:

Signature Date:

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# REQUEST FOR VERIFICATION OF LICENSE

(Use this form to verify licensure from another state, if applicable.)

## PART 1 - TO BE COMPLETED BY THE APPLICANT:

Complete the first section of the form and submit it to a state in which you are **currently** licensed. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.

Last Name:	First Name:	Middle Name:	
Maiden Name:	Social Security Number:    -    -		
Mailing Address:	City:	State:	ZIP:
Date of Birth:	E-Mail:	Date of Graduation:	
I am requesting licensure in the <b>State of Utah</b> as a <b>Dentist</b> .			
I am/have been licensed in your state under the name:		License nr in your state is/was:	
I have enclosed the necessary license verification fee in the amount of \$			
Signature of Applicant:		Date of Signature:	

## PART 2 - TO BE COMPLETED BY THE VERIFYING AGENCY:

Please furnish the information requested, sign and verify the document, and mail it directly to DOPL, or place the completed form in a sealed envelope and provide it to the applicant in person or by mail. The applicant will include the sealed verification of licensure with his/her Utah application. Thank you.

Name of Verifying State: \_\_\_\_\_

Name of Licensee (as it appears in verifying state's records): \_\_\_\_\_

Classification of License Issued: \_\_\_\_\_

License Number: \_\_\_\_\_ Current Status: \_\_\_\_\_

Original Date of Licensure: \_\_\_/\_\_\_/\_\_\_ Expiration Date: \_\_\_/\_\_\_/\_\_\_

Continuously Licensed:

Yes  No, please explain: \_\_\_\_\_

Licensed By:

Exam, Type: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Endorsement: from what state? \_\_\_\_\_

Examination Scores: \_\_\_\_\_

Education Required for Licensure: \_\_\_\_\_

Disciplinary Action or Pending Disciplinary Action:

No  Yes, please provide certified copies of all Petitions, Orders, etc.

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

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# DENTAL LICENSE

<b>Application Checklist</b> <i>(Applications with incomplete attachments will not be considered and may be denied.)</i>	
<input type="checkbox"/>	Submit an official transcript from a dental school accredited by the Commission on Dental Accreditation of the ADA, which includes your date of graduation and degree earned. <i>Have the school send the transcript directly to DOPL. You may also have the school send the transcript to you for inclusion with your application so long as it is in a sealed envelope, bearing the school's stamp/seal on the envelope flap.</i>
<input type="checkbox"/>	Submit an official passing score report on the National Board Examination as administered by the Joint Commission on National Dental Examinations of the ADA.
<input type="checkbox"/>	Submit an official score report or a duplicate certificate from WREB, NERB, SRTA, or CRDTS verifying your having passed a regional practical examination.
If you are applying for a <b><u>Class II Anesthesia and Analgesia permit</u></b> , complete the following:	
<input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. Submit a "Request for a Class II Anesthesia and Analgesia Permit" form.</li> <li>2. Submit a copy of your current Basic Life Support course certification</li> <li>3. Submit an official letter from your anesthesia course director certifying the amount and type of anesthesia training received, the dates you received the training, and a statement that the course <b>conforms</b> to the Guidelines for Teaching Pain Control and Sedation to Dentist and Dental Students published by the American Dental Association, October 2007.</li> </ol>
If you are applying for a <b><u>Class III Anesthesia and Analgesia permit</u></b> , complete the following:	
<input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. Submit a "Request for a Class III Anesthesia and Analgesia Permit" form.</li> <li>2. Submit a copy of your current ACLS certification.</li> <li>3. Submit an official letter from your anesthesia course director certifying :               <ol style="list-style-type: none"> <li>a. you have successfully completed comprehensive pre-doctoral or post doctoral training in the administration of conscious sedation which conforms to the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, published by the American Dental Association, October 2007; and</li> <li>b. documenting your competency in performing conscious sedation; and 60 hours of didactic education in sedation and successful completion of 20 cases.</li> </ol> </li> <li>4. Submit certification that you will comply with the scope of practice as set forth in Subsection R156-69-601(3). <i><b>NOTE:</b> You must have a current Utah Controlled Substance license in good standing or have applied and have met the requirements.</i></li> </ol>
If you are applying for a <b><u>Class IV Anesthesia and Analgesia permit</u></b> , complete the following:	
<input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. Submit a "Request for a Class IV Anesthesia and Analgesia Permit" form.</li> <li>2. Submit a copy of your current ACLS certification.</li> <li>3. Submit an official letter from your anesthesia course director certifying:               <ol style="list-style-type: none"> <li>a. you have successfully completed advanced training in the administration of general anesthesia and deep sedation consisting of not less than one year in a program which conforms to the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, published by the American Dental Association, October 2007;</li> <li>b. documenting your competency in performing general anesthesia and deep sedation; and</li> <li>c. documenting your successful completion of advanced training in obtaining a health history, performing a physical examination and diagnosis of a patient consistent with the administration of general anesthesia or deep sedation.</li> </ol> </li> <li>4. Submit certification that you will comply with the scope of practice as set forth in Subsection R156-69-601(3). <i><b>NOTE:</b> You must have a current Utah Controlled Substance license in good standing or have applied and have met the requirements.</i></li> </ol>
<input type="checkbox"/>	Submit a copy of your current CPR, BCLS or ACLS "hands on" course certification card.
<input type="checkbox"/>	If you have been licensed in another state, use the "Request for Verification of License" form <i>(attached to this application)</i> , obtain verification of licensure from a state in which you are currently licensed. Request that the verifying state complete the form and mail it directly to DOPL or return it to you for submission with your application.
<input type="checkbox"/>	Complete and submit the Qualifying Questionnaire <i>(submit with application)</i>
If you are <b>applying by endorsement</b> , additionally submit the following:	
<input type="checkbox"/>	Documentation that you are currently licensed in another state.
<input type="checkbox"/>	Documentation that you have successfully engaged in practice as a dentist for not less than 6,000 hours in the last five years.
<input type="checkbox"/>	Submit non refundable application fee for a Dental License of \$110.00
<input type="checkbox"/>	Submit non refundable application fees for a Controlled Substance License \$100.00

**You must hold** a Utah controlled substance license and a Drug Enforcement Administration (DEA) registration to administer possess or prescribe a controlled substance in your practice of medicine in Utah. **Contact the DEA at Salt Lake District Office 348 East South Temple Salt Lake City UT 84088. Telephone (801) 524-4389.**

1. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
2. **Address of Record:** The address you provide on this application will be your address of record. You are responsible to directly notify DOPL of any change to your address of record.
3. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov).
4. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to “DOPL.” Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL’s main office – but not over the telephone.
5. **Mail Complete Application to:**

<b>By U.S. Mail</b>	Division of Occupational & Professional Licensing P.O. Box 146741 Salt Lake City UT 84114-6741
<b>By Express Mail or In Person</b>	Division of Occupational & Professional Licensing 1 <sup>st</sup> Floor Lobby 160 E 300 S Salt Lake City UT 84111-2305

6. **Telephone Numbers:** (801) 530-6628  
(866) 275-3675 – Toll-free in Utah