

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-H

(See 234 CMR 6.08 Effective August 20, 2010)

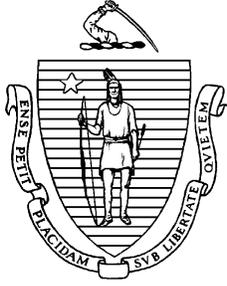
Facility Requirements for Dental Offices Using Mobile and/or Portable Anesthesia Services

Application Instructions

Each dental facility or practice site utilizing mobile or portable anesthesia services is required to have a Facility Permit D-H. The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper individual anesthesia permit and a current facility permit D-P (see.6.09) issued by the Board, and that the portable anesthesia service is appropriately permitted and equipped in accordance with 234 CMR 6.00 for the level of pain control and/or sedation to be provided.

The operating dentist shall be responsible for ensuring that the qualified dental anesthesiologist has the proper anesthesia permit and that the portable anesthesia service is appropriately permitted for the level of pain control and/or sedation to be provided.

If you already hold a current Facility Permit D for the level of anesthesia you plan to have administered by a Portable Dental Operation, please do not submit this application.



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

If you already hold a current Facility Permit D for the level of anesthesia you plan to have administered by a Portable Dental Operation, please do not submit this application.

Application -Facility Permit D-H

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. TYPES OF ANESTHESIA

**TYPE(S) OF ANESTHESIA AND/OR SEDATION
TO BE ADMINISTERED**

(Check all that apply.)

Nitrous Oxide- Oxygen Only _____

Nitrous Oxide-Oxygen + Oral Sedative(s) _____

Oral Sedation Only _____

I.V. Sedation _____

General Anesthesia and Deep Sedation _____

Other route of administration: _____

Attachment 2

AT A MINIMUM, A FACILITY THAT HOSTS A MOBILE OR PORTABLE DENTAL ANESTHESIA SERVICE WILL BE REQUIRED TO HAVE THE FOLLOWING EQUIPMENT AND DRUGS

EQUIPMENT REQUIRED	DATE LAST INSPECTED
Alternative light source for use during power failure	
Ambu-bag or portable bag-mask ventilator	
Automated or manual external defibrillator, including batteries and other components	
Disposable CPR mask (pediatric and adult)	
Disposable syringes (assorted sizes)	
Latex free tourniquet	
Oxygen (portable Cylinder E tank) pediatric and adult masks capable of giving positive pressure ventilation including bag-valve-mask system	
Sphygmomanometer and stethoscope (pediatric and adult)	
Suction	

EMERGENCY DRUGS AND DRUG CLASSIFICATIONS REQUIRED BY 234 CMR 6.08 TO BE PROVIDED AND MAINTAINED AT SITE

REQUIRED DRUGS	NAME OF DRUG	DOSAGE	EXPIRATION DATE
Acetylsalicylic acid (rapidly absorbable form)			
Ammonia inhalants			
Antihistamine			
Bronchodilator			
Epinephrine pre-loaded syringes (pediatric and adult)			
2 Epinephrine ampules			
Oxygen			
Vasodilator			
Vasopressor			

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:			

