Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

6 Crescent Road, Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814 Toll Free: 1.800.565.4591 www.rcdso.org

Checklist and Information Sheet for Member Authorization and Visiting Member Authorization

A Member's Authorization is the authorization issued by the College to permit a member to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia in a dental facility (which holds a Type A Facility Permit issued by the College) where the facility provides all necessary sedation and/or general anesthetic equipment and emergency drugs and, unless the context otherwise requires, includes an authorization which has been provisionally issued.

A Visiting Member's Authorization is the authorization issued by the College to permit a member to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia in a dental facility (which holds a Facility Permit issued by the College) where the member provides all necessary sedation and/or general anesthetic equipment and emergency drugs and, unless the context otherwise requires, includes an authorization which has been provisionally issued.

Please note that all Provisional Authorizations will expire within three months of issuance. Please also note that all Annual Authorizations expire March 31st of each year regardless of the initial date of issuance.

CHECKLIST OF REQUIREMENTS

- ☐ Completed application form
- ☐ Documentation of formal training and continuing education
- ☐ Current life support certification (CPR level HCP as a minimum)
- ☐ Payment

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Application for Member Authorization to Administer Sedation and General Anesthesia

All members who wish to treat patients using oral moderate sedation, parenteral conscious sedation (IV sedation), deep sedation and/or general anesthesia must apply and be authorized by the College to do so.

TYPE OF AUTHORIZATION BEING SOUGHT

☐ Member authorization – I will administer sedation and/or general anesthesia in a dental facility that provides all necessary sedation and/or general anesthetic equipment and emergency drugs.

☐ Visiting member authorization – I will provide all necessary sedation and/or general anesthetic equipment and emergency drugs to the dental facility.

NAME AND DENTAL FACILITY WHERE YOU INTEND TO ADMINISTER

YOUR NAME: _____

STREET: _____ SUITE: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

TEL: _____ FAX: _____ EMAIL: _____

MODALITIES OF SEDATION AND/OR GENERAL ANESTHESIA TO BE ADMINISTERED

(i) Oral Moderate Sedation	☐ Yes	☐ No
(ii) Parenteral Conscious Sedation (intravenous, intramuscular, subcutaneous, submucosal or intra-nasal)	☐ Yes	☐ No
(iii) Deep Sedation	☐ Yes	☐ No
(iv) General Anesthesia	☐ Yes	☐ No

INDICATE ALL DRUGS YOU INTEND TO ADMINISTER TO ACHIEVE THE ABOVE MODALITIES OF SEDATION AND/OR GENERAL ANESTHESIA

- ☐ Triazolam (Halcion™)
- ☐ Midazolam (Versed™)
- ☐ Lorazepan (Ativan™)
- ☐ Diazepam (Valium™)
- ☐ Chloral Hydrate
- ☐ Hydroxyzine (Atarax™)
- ☐ Promethazine (Phenergan™)
- ☐ Diphenhydramine (Benadryl™)
- ☐ Fentanyl (Sublimaze™)
- ☐ Remifentanil (Ultiva™)
- ☐ Meperidine (Demerol™)
- ☐ Nalbuphine (Nubain™)
- ☐ Propofol (Diprivan™)
- ☐ Ketamine (Ketalar™)
- ☐ Thiopental (Pentothal™)
- ☐ Pentazocine (Talwin™)
- ☐ Butorphanol (Stadol™)
- ☐ Nitrous Oxide
- ☐ Halothane (Fluothane™)
- ☐ Isoflurane (Forane™)
- ☐ Sevoflurane (Ultane™)
- ☐ Desflurane (Suprane™)
- ☐ Other (please list below)

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PROFESSIONAL TRAINING/QUALIFICATIONS

DETAILS OF FORMAL TRAINING AND COMPETENCY IN SEDATION AND/OR GENERAL ANESTHESIA

(i) Please list the name of the University and/or Hospital where you obtained your training **and attach a copy of your certificate of completion**.

SCHOOL/HOSPITAL: _____ CITY: _____

(ii) Please indicate the type of program you completed:

- ☐ Continuing Education Course
- ☐ Dental Internship/Residency
- ☐ Dental Specialty Program

  Name of Specialty Program: _____
- ☐ Dental Anesthesiology Training/Residency
- ☐ Oral and Maxillofacial Surgery Training/Residency

(iii) Name of Program/Course Director: _____

(iv) Date of Program or Course Completion: _____

If you completed a residency program or continuing education program, please attach a copy of your certificate of completion.

If you completed a Diploma/Degree Program in Dental Anesthesiology or Oral and Maxillofacial Surgery, a copy of your diploma/degree is required for our records.

All dentists administering oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia must provide, as a minimum, evidence of current BLS certification at the Health Care Professional (HCP) level. In addition, all dentists administering deep sedation and/or general anesthesia must provide evidence of completion of a provider course in ACLS. If providing care for patients under the age of 12 years, training in PALS is recommended.

CONTINUING EDUCATION

HAVE YOU TAKEN ANY CONTINUING EDUCATION PROGRAMS ON THE SUBJECT OF SEDATION AND/OR GENERAL ANESTHESIA IN THE PAST YEAR?

☐ Yes ☐ No

If yes, please list below:

COURSE NAME: _____

DATE: _____

LOCATION: _____

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") and the College's By-Laws governing Sedation and General Anesthesia, which form part of the Standard.

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 authorized by the College.

3. I understand that it is my responsibility to ensure that the sedation and/or general anesthetic 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 and present at all times when I am administering any modality for which I have been authorized by the College. I further understand that any deficiency observed in the course of any inspection will be posted on the Public Register.

4. I understand that, unless extended, my Provisional Authorization expires in three months from the date of its issuance or upon the issuance of an Annual Authorization whichever first occurs. I further understand and acknowledge that an Annual Authorization will not be issued unless and until the Registrar is satisfied by an inspection that my sedation and/or general anesthetic records are in full compliance with all aspects of the Standard.

5. I agree to immediately cease to administer oral moderate sedation, parenteral conscious sedation, deep sedation and/or general anesthesia at any dental facility in the event the Registrar notifies me 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 do so.

6. I understand and agree that the Registrar may rescind my authorization where the Registrar is satisfied that the issuance of the authorization was based upon information or representations that were inaccurate, false or misleading or where I no longer meet the requirements of the Authorization issued 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.**

Name (please print)	**Witness Name (please print)**
Signature	**Signature**
Date	

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Authorization Sedation and/or General Anesthesia Application Fee Payable to RCDSO

PLEASE PRINT

NAME

SURNAME: _____ GIVEN NAMES: _____

ADDRESS

STREET: _____ CITY/TOWN: _____

POSTAL CODE: _____ TEL: _____

TYPE OF AUTHORIZATION

☐ Member Authorization – $150

☐ Visiting Member Authorization – $600

PLEASE COMPLETE THIS SECTION FOR METHOD OF PAYMENT

You may elect to pay your fees by any one of the following methods:

A) CERTIFIED Cheque or Money Order.

B) Credit Card. If you pay by credit card, the form below must be completed. While we are pleased that we are able to accept payment by credit card, we are unable to do so by telephone.

☐ CERTIFIED CHEQUE ☐ MONEY ORDER ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

CREDIT CARD #: _____ EXPIRY DATE: _____

SIGNATURE: _____

FOR OFFICE USE ONLY - AUTHORIZATION APPROVED - COMMENTS

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