INSTRUCTION SHEET

DENTAL SEDATION PERMIT
Conscious Sedation - Permit A
Deep Sedation and General Anesthesia - Permit B

In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.

BEFORE COMPLETING THE APPLICATION PACKAGE, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in accurately completing your application and eliminate any delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT. Every permit issued under the Dental Practice Act expires on September 30 every three (3) years.

Step 1. Use the REFERENCE SHEET (CHART I) to select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, and record that information in PART I (page one) of the Application for Licensure and/or Examination.

Step 2. Proceed with PART II (page one) and complete all applicable information requested on all 4 pages of the Application for Licensure and/or Examination.

NOTE: a) Indicate both Pre-Dental and Dental Education in PART III, number 6 on the Application for Licensure and/or Examination.

b) Indicate Specialty Training or Residency in PART III, number 7, on the Application for Licensure and/or Examination.

c) Indicate Anesthesiology Training in PART III, number 7, on the Application for Licensure and/or Examination.

Step 3. The remainder of this form contains specific instructions for each Licensure Method. Locate the instructions for the Licensure Method you recorded in PART I (page one) of the Application for Licensure and/or Examination and follow those instructions only.

NOTE: a) An applicant for Dental Sedation Permit must be currently licensed as a general dentist in Illinois.

b) Licensees qualified to administer deep sedation and general anesthesia (Permit B) may administer conscious sedation without a Permit A.

Step 4. If needed, a telephone number for assistance in completing the Application Package is provided on the Reference Sheet.

SPECIAL NOTICE:
DENTISTS WHO ADMINISTER NITROUS OXIDE ONLY, ARE NOT REQUIRED TO HOLD A DENTAL SEDATION PERMIT.
CONSCIOUS SEDATION--PERMIT A

In order for your application to be processed,

ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED

with the application and required fee unless otherwise directed in the instructions.

1. Supporting Document CCA must be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document TN-DEN must be completed by the Director/Administrator of the Anesthesiology Program with school seal affixed showing successful completion of a course of study that includes a minimum 75 hours of didactic and clinical study that includes training in conscious sedation (both light and deep), physical evaluation, venipuncture, technical administration, recognition and management of complications and emergencies, and monitoring with additionally supervised experience in providing conscious sedation to 20 or more patients over and above the undergraduate dental school level. The anesthesiology training program must have been an organized sequence of study operated by one entity and completed in less than one calendar year. It is suggested that you request that the Director/Administrator verify only the anesthesia training. Please request the Director/Administrator to return TN-DEN directly to you for inclusion with application.

3. Supporting Document AF-DEN must be appropriately completed.


5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. See REFERENCE SHEET (CHART I) for fee payment.

6. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

RESTORATION--PERMIT A

In order for your application to be processed,

ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED

with the application and required fee unless otherwise directed in the instructions.

These Restoration Instructions apply only to those dentists whose Conscious Sedation licenses have been expired for five or more years.

1. Supporting Document CCA must be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document RS must be completed (if this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 217-782-0458).

3. Submit one of the following documents:
   a. Supporting Document CT must be completed by the U.S. jurisdiction of current licensure where you have most recently been practicing. You must direct the licensing agency/board to return completed form CT directly to you for inclusion with the application; or
   b. Submit copy of DD214 if restoring after military service; or
   c. Verification of completion of an approved training program taken two years prior to application.


5. Fee payment amount is indicated in the Official Use Only Box on Supporting Document RS. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.

6. Forward four-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.
DEEP SEDATION AND GENERAL ANESTHESIA--PERMIT B

**In order for your application to be processed,**

**ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED**

with the application and required fee unless otherwise directed in the instructions.

1. Supporting Document **CCA** must be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document **TN-DEN** completed by the Director/Administrator of the Anesthesiology Program with school seal affixed showing successful completion of an approved training program in anesthesiology to administer deep sedation or general anesthesia shall be 2 calendar years that includes a minimum of 200 hours of didactic and 2,000 hours of clinical training. It is suggested that you request that the Director/Administrator verify only the training program in anesthesiology. Please request the Director/Administrator to return **TN-DEN** directly to you for inclusion with application.

The didactic aspect may precede the clinical training or it may be offered in an integrated manner. The trainee must receive the equivalent of 2 calendar years on a consecutive basis, not to exceed 3 years, as the minimum required to provide an acceptable clinical and didactic program in comprehensive pain control.

3. Submit certification from one or more of the following:
   a) a diplomate of the American Board of Oral and Maxillofacial Surgery;
   b) completion of a minimum of 2 years of advanced training in anesthesiology or related academic subjects, or its equivalent, beyond the pre-doctoral level, in a training program as outlined in Part 2 of Teaching the Comprehensive Control of Pain and Anxiety in an Advanced Education Program, published by the American Dental Association, Council on Dental Education, dated December 2007;
   c) a specialty license in oral and maxillofacial surgery issued by the Department; or
   d) a current valid permit for deep sedation or general anesthesia administration issued by Department.

4. Supporting Document **AF-DEN** must be appropriately completed.


6. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. See **REFERENCE SHEET (CHART I)** for fee payment.

6. Forward four-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

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RESTORATION--PERMIT B

**In order for your application to be processed,**

**ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED**

with the application and required fee unless otherwise directed in the instructions.

*If your license has been expired for less than five years, you should contact the Department of Financial and Professional Regulation at 1-800-560-6420 for detailed instructions on how to restore it to active status.*

These Restoration Instructions apply only to those dentists whose Conscious Sedation licenses have been expired for five or more years.

1. Supporting Document **CCA** must be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Supporting Document **RS** must be completed (if this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 217-782-0458).

3. Submit one of the following documents:
   a. Supporting Document **CT** must be completed by the U.S. jurisdiction of current licensure where you have most recently been practicing. You must direct the licensing agency/board to return completed form **CT** directly to you for inclusion with the application; or
   b. Submit copy of DD214 if restoring after military service; or
   c. Verification of completion of an approved training program in anesthesiology to administer deep sedation or general anesthesia taken two years prior to application.


5. Fee payment amount is indicated in the Official Use Only Box on Supporting Document **RS**. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.

6. Forward four-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.
LICENSURE METHODS AND DEFINITIONS

Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.

<table>
<thead>
<tr>
<th>Licensure Methods</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.</td>
</tr>
<tr>
<td>Endorsement of License</td>
<td>Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.</td>
</tr>
<tr>
<td>Acceptance of Examination</td>
<td>Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.</td>
</tr>
<tr>
<td>Restoration</td>
<td>Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.</td>
</tr>
<tr>
<td>Grandfather/Waiver</td>
<td>Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).</td>
</tr>
<tr>
<td>Non-examination</td>
<td>Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.</td>
</tr>
</tbody>
</table>
IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to DEPARTMENT ON AGING AT 1-800-252-8966."

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse."
REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change fees if prevailing circumstances necessitate such action.

<table>
<thead>
<tr>
<th>CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD &amp; FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROFESSION NAME</td>
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<tr>
<td>Dental Sedation Permit</td>
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</table>

<table>
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<tr>
<th>CHART II - EXAMINATION CODES AND FEES</th>
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<tbody>
<tr>
<td>NOT APPLICABLE FOR DENTAL SEDATION PERMIT</td>
</tr>
<tr>
<td>ENTER N/A IN PART VII a) OF APPLICATION FOR LICENSURE AND/OR EXAMINATION</td>
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</table>

<table>
<thead>
<tr>
<th>CHART III - EXAMINATION DATES AND LOCATION</th>
</tr>
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<tbody>
<tr>
<td>NOT APPLICABLE FOR DENTAL SEDATION PERMIT</td>
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<tr>
<td>ENTER N/A IN PART VII b) OF APPLICATION FOR LICENSURE AND/OR EXAMINATION</td>
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<tr>
<th>CHART IV - SCHOOL CODES</th>
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<tbody>
<tr>
<td>NOT APPLICABLE FOR DENTAL SEDATION PERMIT</td>
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<tr>
<td>ENTER N/A IN PART VII c) OF APPLICATION FOR LICENSURE AND/OR EXAMINATION</td>
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* * * * * REQUEST FOR ASSISTANCE * * * * *

If assistance is needed, direct your request to the following telephone number:

1-800-560-6420
TTY - 1-866-325-4949

Please allow 3 weeks from mailing your application before making an inquiry concerning its status.
APPLICATION FOR LICENSURE AND/OR EXAMINATION

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

PART I: Application Category Information

A. Check the box indicating the appropriate information regarding your application. [ ] Military [ ] Military Spouse [ ] Not Military [ ] Decline to Answer

Military service member is defined as. “Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application.” The following will be considered proof of you or your spouse’s active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember’s electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official court order.

B. SEE INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for this profession in Illinois.
☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
☐ Other:

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., M.D., D.D.S., etc.)

3. UNITED STATES SOCIAL SECURITY NO.

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. MOTHER’S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY

9. DATE OF BIRTH Month / Day / Year

10. AGE [ ] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (_______) ______-________ Home: (_______) ______-________
Fax: (_______) ______-________ Fax: (_______) ______-________

12. REQUIRED E-MAIL ADDRESS

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.
B. FEES ARE NOT REFUNDABLE.
C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

Note: Statement of violent crimes

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.
**PART III: Education Information**

1. **PRELIMINARY EDUCATION** (Elementary and High School or G.E.D. Circle number of years completed)

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<td>Graduated High School?</td>
<td>Yes</td>
<td>No</td>
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<td>Received or G.E.D.?</td>
<td>Yes</td>
<td>No</td>
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2. **NAME OF LAST PRELIMINARY SCHOOL ATTENDED**

3. **LAST PRELIMINARY SCHOOL LOCATION** (City and State)

4. **DATE OF GRADUATION**

   Month     Year

5. **COLLEGE OR UNIVERSITY** (Circle number of years completed)

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<tr>
<td>Graduated?</td>
<td>Yes</td>
<td>No</td>
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6. **COLLEGE OR UNIVERSITY NAME** (Undergraduate and Graduate)

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<tr>
<th>LOCATION (City and State or Country)</th>
<th>DATES OF ATTENDANCE FROM</th>
<th>TO</th>
<th>TYPE OF DEGREE EARNED</th>
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<td>Month/Year</td>
<td>Month/Year</td>
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7. **SPECIALIZED TRAINING** (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

<table>
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<tr>
<th>INSTITUTION NAME</th>
<th>LOCATION (City and State or Country)</th>
<th>DATES OF ATTENDANCE FROM</th>
<th>TO</th>
<th>Did You Complete Training?</th>
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<td>Month/Year</td>
<td>Month/Year</td>
<td>Yes</td>
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<td>Yes</td>
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PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROFESSION NAME</th>
<th>LICENSE NUMBER</th>
<th>DATE OF ISSUANCE</th>
<th>LICENSE STATUS (Active, Lapsed, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Original Licensure</td>
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<tr>
<td>State of Current Licensure where you most recently have been practicing,</td>
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<tr>
<td>Other States of Licensure</td>
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</table>

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

<table>
<thead>
<tr>
<th>NAME OF EXAMINATION</th>
<th>STATE</th>
<th>MONTH/YEAR</th>
<th>EXAM RESULTS (Passed, Failed, Absent)</th>
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(If additional space is needed, attach a separate sheet.)
**PART VI: Personal History Information** *(This part must be completed by all applicants)*

1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. **If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.**

2. Have you been convicted of a felony? **In general, a felony conviction by itself does not usually result in denial of licensure.**

3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? **If yes, attach a copy of the certificate.**

4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? **If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.**

5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? **If yes, attach a detailed explanation.**

6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? **If yes, attach a detailed explanation.**

**PART VII: Child Support and Tax Information** *(Every applicant is required by law to respond to the following questions)*

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant’s Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? **Yes** [ ]  **No** [ ]

   *(NOTE: If you are not subject to a child support order, answer "no.")*

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? **Yes** [ ]  **No** [ ]

**PART VIII: Certifying Statement**

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

________________________________________  __________________________
Signature of Applicant                          Date

**I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.** My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.
**APPLICANT:** Complete the applicant section of this form. Forward the form to the individual who will certify your training.

1. **NAME** LAST FIRST MIDDLE
2. **DATE OF BIRTH** __ __ / __ __ / __ __ __ __
   - Month
   - Day
   - Year
3. **SOCIAL SECURITY NUMBER** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
4. **ADDRESS** STREET, CITY, STATE, ZIP CODE
5. **REFER TO REFERENCE SHEET.** Record profession name and three digit profession code for which you are making Illinois application.
   - Profession Name
   - Profession Code

6. **MAIDEN OR GIVEN SURNAME**

7. **DATES OF TRAINING**
   - From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __
     - Month
     - Day
     - Year

8. **ISSUANCE DATE**
   - NUMBER (If Applicable)
   - ISSUANCE DATE (If Applicable)

9. **SPECIFIC NAME OF TRAINING RECEIVED**

10. **SUPERVISOR/INSTRUCTOR NAME**

**DIRECTOR/ADMINISTRATOR:** Complete the remainder of this form. Return the completed form to the applicant.

A. **SUPERVISOR/INSTRUCTOR NAME**
B. **INSTITUTION/BUSINESS NAME**

C. **SUPERVISOR/INSTRUCTOR JOB TITLE/PROFESSION NAME**
D. **INSTITUTION/BUSINESS STREET ADDRESS**

E. **SUPERVISOR/INSTRUCTOR LICENSE OR CERTIFICATE NO.**
F. **INSTITUTION/BUSINESS CITY, STATE, ZIP CODE**

G. **SUPERVISOR/INSTRUCTOR STATE OF LICENSURE OR CERTIFYING ASSOCIATION NAME**
H. **INSTITUTION/BUSINESS TELEPHONE NUMBER**
   - Area Code (___ ___ ___) __ __ __ __ - __ __ __ __ __ __

I. **RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT’S TRAINING.**
# I. DENTAL SPECIALTY TRAINING:
Certifying Official, i.e., Director of Program, or Dean of the dental school or the head of the Oral and Maxillofacial Surgery Department of the hospital or clinic: Complete the remainder of this form. Return the completed form to the applicant.

<table>
<thead>
<tr>
<th>A. APPLICANT’S TRAINING DATES</th>
<th>B. TRAINING CLOCK HOURS COMPLETED</th>
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<tr>
<td>From <strong>/</strong>/__ To <strong>/</strong>/__</td>
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<tr>
<th>C. SPECIALIZATION NAME IN WHICH APPLICANT TRAINED</th>
<th>D. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?</th>
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# II. ANESTHESIOLOGY TRAINING:
Director/Administrator: Verify only the anesthesiology training program inclusive of training hours in clinical and didactic. Return the completed form to the applicant.

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I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official and/or Director/Administrator of Training Programs

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of ____________, 20___.

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT
## AFFIDAVIT

### CHECK APPLICABLE PERMIT

- Permit A - Conscious Sedation
- Permit B - Deep Sedation and General Anesthesia (see reverse side)

### A. CONSCIOUS SEDATION - PERMIT A

**CERTIFICATION**

I certify that I will practice in a facility properly equipped in accordance with 68 Ill. Adm. Code Section 1220.510 h) for the administration of light conscious sedation and staffed with a supervised team which consists of a minimum of two individuals per patient, in addition to the dentist, capable of assisting with procedures, programs, and emergencies incident to the administration of such sedation (e.g., skilled in cardiopulmonary resuscitation).

I further certify that the facility is equipped with the following at a minimum:

1. sphygmomanometer and stethoscope;
2. an oxygen delivery system with full face masks and connectors that is capable of delivering oxygen to the patient under positive pressure, with a backup system;
3. emergency drugs and equipment appropriate to the medications administered;
4. adequate suction equipment;
5. an emergency back-up lighting system that will permit the completion of any operation underway; and
6. a pulse oximeter;
7. Latyngoscope complete with selection of blades and spare batteries and bulbs in sizes appropriate to the patient population being served:
8. Advanced airway devices that would isolate the trachea and facilitate positive pressure oxygen administration in sizes appropriate for the patient population being served (e.g., endotracheal tubes or laryngeal mask airway);
9. Tonsillar or pharyngeal suction tips adaptable to all office outlets;
10. Nasal and oral airways in sizes appropriate for the patient population being served;
11. Defibrillator (an automated external defibrillator is an acceptable defibrillator);
12. Equipment for the establishment of an intravenous infusion;

Continued on page 2
B. DEEP SEDATION AND GENERAL ANESTHESIA - PERMIT B

I certify that I will practice in a facility properly equipped in accordance with 68 Ill. Adm. Code Section 1220.510 h) & Section 1220.520 d) for the administration of deep sedation and general anesthesia and staffed with a supervised team that includes a minimum of two individuals per patient, in addition to the dentist, capable of assisting with procedures, problems and emergencies incident to the administration of such sedation (e.g., skilled in cardiopulmonary resuscitation).

I further certify that the facility is equipped in accordance with 68 Ill. Adm. Code 1220.510 h) as set forth in the Permit A Certification as well as the following:

1) laryngoscope complete with selection of blades and spare batteries and bulbs in sizes appropriate to the population being served;
2) endotracheal tubes and connectors and face masks in sizes appropriate for the population being served and a device capable of delivering positive pressure ventilation;
3) tonsillar or pharyngeal suction tips adaptable to all office outlets;
4) nasal and oral airways in sizes appropriate to the patient population being served;
5) device for monitoring temperature (e.g., temperature strips, thermometers);
6) electrocardioscope and defibrillator;
7) pulse oximeter;
8) equipment for the establishment of an intravenous infusion;
9) emergency drugs and equipment appropriate to the medications administered;
10) an operating table or an operating chair that permits appropriate access to the patient and provides a firm platform for the management of cardiopulmonary resuscitation;
11) a recovery area that has available oxygen, lighting, suction and electrical outlets. The patient should remain in the recovery area until the individual retains the ability to independently and consciously maintain an airway and respond appropriately to physical stimulation and verbal command. The recovery area may be the operating theatre; and
12) an emergency backup lighting system that will permit the completion of any operation underway;
13) syphygmanometer and stethoscope;
14) an oxygen delivery system with full face masks and connectors appropriate to the patient population being served that is capable of delivering oxygen to the patient under pressure, with an emergency backup system;
15) suction equipment, including an emergency backup suction system.

Signature: ________________________________
**APPLICANT:** Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

**1. NAME LAST FIRST MIDDLE**

**2. DATE OF BIRTH**

**3. SOCIAL SECURITY NUMBER**

**4. ADDRESS STREET, CITY, STATE, ZIP CODE**

**5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.**

**6. MAIDEN OR GIVEN SURNAME**

**7. APPLICANT TELEPHONE NUMBER (Daytime)**

**8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)**

**8b. LICENSE NUMBER (If applicable)**

**8c. ISSUANCE DATE OF LICENSE (If applicable)**

I hereby authorize _____________________________ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.

Signature _________________________________________ Date ____________________________

**RETURN COMPLETED FORM TO APPLICANT**

**LICENSING AGENCY:** The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

**PART I - CERTIFICATION OF EXAMINATION STATUS**

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

   **Name of Examination** ————

   **Date of Examination** ————

B. The applicant has or will have written the above-named examination _______ number of times.

**PART II - CERTIFICATION OF LICENSURE**

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE

B. LICENSE NUMBER

C. ISSUANCE DATE OF LICENSE

D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

☐ Examination (Administered in Your State)

☐ National (Name) ————

☐ State Constructed ————

☐ Other (Name) ————

☐ Endorsement of License (State) ————

☐ Acceptance of Examination Results ————

☐ Reciprocity with (State) ————

☐ Waiver/Grandfather ————

☐ Credentials ————

☐ Other (Describe) ————

F. CURRENT LICENSURE STATUS

☐ Active

☐ Inactive

☐ Lapsed

☐ Other (Explain) ————

G. IF LICENSED BY EXAMINATION, RECORD SCORES

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<thead>
<tr>
<th>Type of Examination</th>
<th>Score</th>
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<td>Practical</td>
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<td>Other (Describe)</td>
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Received no Grade Below

Examination Period ———— days ———— hours
PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

<table>
<thead>
<tr>
<th>Date of Examination</th>
<th>Scaled Score</th>
<th>Raw Score</th>
<th>Standard Deviation</th>
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<th>National Mean</th>
<th>Percent Score</th>
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A2.

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PART IV - FORMAL ACTIONS

A. Is there now or has there ever been any formal action commenced against the applicant? □ Yes □ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.) □ Yes □ No

PART V - RECIPROCAL REGISTRATION

This state □ does □ does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

Print Name
Title
Agency/Board Street Address
City, State, ZIP Code
Area Code (               ) Telephone Number

SEAL

Signature
Date

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.