

Kansas Dental Board
900 SW Jackson, Room 564-S
Topeka, KS 66612
Phone: 785-296-6400 Fax: 785-296-3116
Email: info@dental.state.ks.us Website: www.kansas.gov/kdb

**LEVEL I - APPLICATION FOR APPROVAL OF A COURSE THAT
WILL MEET INITIAL REQUIREMENTS FOR ENTERAL CONSCIOUS SEDATION OR
COMBINATION INHALATION-ENTERAL CONSCIOUS SEDATION FOR PATIENTS 12
YEARS OF AGE OR YOUNGER (K.A.R. 71-5-9)**

Title of Course: _____

Date(s): _____

Location(s): _____

Approximate Number of Participants: _____

Actual number of Clock Hours of the Course: _____

Clinicians/Instructors Names and Credentials (if additional sheets are attached, please note):

Sponsor: _____

Coordinator/Contact Person: _____

Address: _____

Phone Number: _____ Email address: _____ Website: _____

I certify that this course:

Provides comprehensive training in the administration and management of enteral conscious sedation or combination inhalation-enteral conscious sedation for patients 12 years of age or younger.

Signature of applicant

Date

Is this course already AGD PACE or ADA CERP approved?

_____ No _____ Yes Course # _____ Expiration date _____

PACE or CERP approval is not required, but information about prior approval may assist in the processing of this application)

-If this course is approved, the Kansas Dental Board may make information about the approval of, and contacts for this course available on the Board web site or in other communications.

-If the course content changes substantially in the future, you must send an agenda or course outline, with a copy of this original application or the approval letter you received from the Kansas Dental Board, with a summary of changes made.

-Notify the Kansas Dental Board when you discontinue this course.

Attach agenda or course outline and return this completed application to the Board.