

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 II -APPLICATION FOR APPROVAL OF A COURSE THAT
WILL MEET INITIAL REQUIREMENTS FOR PARENTERAL 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 parenteral 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.