MANITOBA DENTAL ASSOCIATION
202-1735 Corydon Ave. Winnipeg, MB R3N 0K4
T: 204.988.5300 F: 204.988.5310 www.manitobadentist.ca

APPLICATION FOR PHARMACOLOGICAL BEHAVIOUR MANAGEMENT ROSTER

APPLICANT NAME (please print): _____

☐ General Practitioner ☐ Dental Specialist | Specialty: _____

MDA REGISTRATION NUMBER: _____ **DATE OF REQUEST** (DD/MM/YYYY): _____

FULL MAILING ADDRESS: _____
Street City, Province Postal Code

NAME OF PRACTICE/FACILITY WHERE SERVICES WILL BE PROVIDED: _____

The requirements to be placed on a sedation roster are included in the *Pharmacological Behaviour Management Bylaw* found on the Manitoba Dental Association website at www.ManitobaDentist.ca.

Each modality will have specific requirements in regard to the documentation that must be submitted with your application. Please review these requirements carefully, as incomplete applications will be returned to the member.

MEMBER REGISTRATION APPLICATION FEE ☐ **$288.75**

PLACE A ✓ BESIDE THE TYPE OF MODALITY YOU ARE APPLYING FOR: (Indicate age range by marking all boxes that apply)

Single Modality

CONSCIOUS SEDATION: SINGLE ORAL SEDATIVE ☐ **$157.50** (Any combination in this category)
- ☐ Patients between 5-12 years (ASA I-II)
- ☐ Patients over 12 years (ASA I-II)
- ☐ Patients over 18 years (ASA – CLASS III)

CONSCIOUS SEDATION: NITROUS OXIDE (N_2O) INHALATION ☐ **$157.50** (Any combination in this category)
- ☐ Patients under 5 years (ASA I-II)
- ☐ Patients over 5 years (ASA I-II)
- ☐ Patients over 18 years (ASA – CLASS III)

CONSCIOUS SEDATION: PARENTERAL ☐ **$157.50** (Any combination in this category)
- ☐ Patients between 5-12 years (ASA I-II)
- ☐ Patients over 12 years (ASA I-II)
- ☐ Patients over 18 years (ASA – CLASS III)

Multiple Modalities

CONSCIOUS SEDATION: MULTIPLE MODALITIES ☐ **$157.50** (Any combination in this category)
- ☐ Patients between 5-12 years (ASA I-II), Combinations involving PARENTERAL
- ☐ Patients over 12 years (ASA I-II), Combination of N_2O + SINGLE ORAL AGENT
- ☐ Patients over 12 years (ASA I-II), Combination of: _____+_____ (list medications)
- ☐ Patients over 18 years (ASA III), Combination of: _____+_____ (list medications)

Deep Conscious Sedation/General Anesthesia ☐ **$157.50** (Any combination in this category)
- ☐ Patients between 5-16 years (ASA I-II)
- ☐ Patients over 16 years (ASA I-II)

Payment must be by CHEQUE or CASH (DO NOT MAIL CASH). NSF CHEQUES will be subject to an additional $30.00 fee.

Total Fee enclosed with your application is: $

Please note:
The submitted documents will be retained in your file and cannot be returned to you so providing the original certificate is not recommended. If it is more convenient, you may present at the MDA office with your original certificate. Once verified for authenticity it will be copied and returned to you. It would be best to call and schedule a time as only a few MDA office personnel can verify the certificate's authenticity.

On review of your documents, a determination on your application will be made. You will receive a letter confirming your name being placed on the roster and clarifying any conditions on your use of sedative agents. Until you receive this letter, you cannot provide sedation services in the Province.

A failure to comply with the documentation, continuing education or patient assessment requirements will lead to your name being suspended from the roster and the matter referred to the Peer Review Committee for investigation. You will also be expected to ensure the facility and office personnel where you provide these services also comply with the Bylaw.

SUPPORTING DOCUMENTS - EDUCATION

Supporting documents must be attached to this application form. Incomplete applications will be denied and returned to the member.

- ☐ An original or certified copy of your sedation certificate
- ☐ A letter from the programme's director confirming your attendance and successful completion. This letter must be sent directly from the programme director to the MDA. The letter should identify the dates, number of hours of training and number of supervised cases performed. If there were specific aspects of the course related to children (hours of didactic courses or supervised cases), they should be expressly indicated.
- ☐ A detailed synopsis of the course curriculum produced by the course. This should include information on the didactic courses and clinical aspects of the programme.
- ☐ Proof of valid resuscitation/life support training at a level specific to the type of sedation you are applying for.

SUPPORTING DOCUMENTS - PRACTICE HISTORY

Supporting documents must be attached to this application form. Incomplete applications will be denied and returned to the member.

- ☐ A letter from any jurisdiction you were or are allowed to provide sedation services. The letter should confirm the conditions of your use nitrous oxide inhalation sedation in that jurisdiction and standing with regards to the provision of these services. The letter must be sent directly from the dental regulatory authority of the jurisdiction.
- ☐ If you have never been authorized to provide nitrous oxide inhalation sedation in any other jurisdiction, please provide a signed written declaration stating that information.
- ☐ Identify the facility or facilities you plan to provide sedation services.

Completed applications and accompanying documentation may be mailed to:

Attention: Director of Regulatory Programs
Manitoba Dental Association
202-1735 Corydon Avenue
Winnipeg, Manitoba R3N 0K4

MEMBER DECLARATION

I solemnly declare that the contents of this application are true and complete to the best of my knowledge and belief.

I declare that I have read and shall comply with The Pharmacological Behaviour Management Bylaw and Code of Ethics.

I understand and accept responsibility to limit my usage of any sedation modality only to MDA facilities approved for that specific modality.

I understand and accept responsibility to ensure any facility that I provide sedation services complies with MDA bylaws.

I understand and accept responsibility to ensure that I comply with the required documentation and competency requirements for each modality that I am registered.

I understand and agree that if I make a false or misleading statement or representation in respect of my request to be added to a Pharmacological Behaviour Management Roster, I shall be deemed not to have satisfied the requirements for approval. I further understand and agree that if an approval should be issued to me based upon a false or misleading statement or representation that said approval is subject to immediate suspension, and the matter referred to the Peer Review Committee for investigation.

APPLICANT SIGNATURE: _____ **DATE:** _____

MDA OFFICE USE ONLY	
WAS ADDITIONAL INFORMATION NECESSARY FOR REVIEW? ☐ NO ☐ YES, SEE ATTACHED INFORMATION	
FACILITY HAS VALID PERMIT ☐ YES ☐ NO	LETTER SENT TO MEMBER ☐ YES ☐ NO
APPROVED BY REGISTRAR ☐ YES ☐ NO	DATE ADDED TO CRM: DD / MM / YYYY