



OHIO STATE DENTAL BOARD

77 South High Street, 17th Floor • Columbus, Ohio 43266-0306
614/466-2580 • Fax # 614/752-8995

APPLICATION FOR DENTAL HYGIENE MEDICAL EMERGENCY RECOGNITION COURSE IN OHIO

NAME OF PERMANENT SPONSOR PROVIDING COURSE		TELEPHONE NUMBER
ADDRESS		FAX NUMBER
CITY	STATE	ZIP CODE
NAME OF THE DESIGNATED CONTACT PERSON		

The designated contact person is responsible for the following:

- (a) Filing all information necessary for provider approval;
- (b) Ensuring that continuing education offerings comply with Chapter 4715. of the Revised Code, and all rules of the Dental Board;
- (c) Providing written certification that the course has been satisfactorily completed only to those attendees who have completed the course. This certification must include the sponsor's name, title of course, instructor, date of course, location, and number of hours of credit. Validation by the sponsor of a document furnished by the attendee will satisfy this requirement;
- (d) Notifying the board of any significant changes relative to the maintenance of standards as set forth in the laws and rules governing the sponsorship of continuing education.

Pursuant to 4715-9-05 (A)(2), the course shall be at least four (4) hours in duration and shall include, at a minimum, the following:

- (a) medical history;
- (b) recognition of common medical emergency situations;
- (c) office emergency protocols;
- (d) basic airway management;
- (e) prevention of emergency situations during dental appointments; and
- (f) recognition of symptoms, first aid treatment and possible outcomes for patients who exhibit bleeding injuries, cardiovascular disease, insulin reaction, diabetic coma, shock, syncope, epileptic seizures and allergic reactions..

Records must be maintained permanently.

All applications and materials must be received by the board executive office 10 days prior to the board meeting.

PLEASE LIST THE COURSE BEING OFFERED ALONG WITH THE NAMES OF INSTRUCTORS. (Please attach all instructor qualifications.)

Each sponsor must provide the licensee with documentaion of course attendance. Such documentation must include the following information:

1. The name of the sponsor.
2. The title of the course.
3. The number of contact hours: (a) clinical (b) didactic
4. The name(s) of course instructor(s).
5. The date and time of course offering.

Any additional courses must be registered with the Ohio State Dental Board. Please include ALL of the above required information for each additional course.

STATE OF _____)
 COUNTY OF _____) SS.

_____, being duly sworn, says that the foregoing statements are true in every respect.

I have carefully read the questions in the foregoing application and have answered them truthfully, fully and completely.

I fully understand that failure to make a full disclosure of any fact or information called for may result in the denial of the application.

Signature of the applicant _____

Sworn to and subscribed before me, this _____ day of _____, 19 _____

Signature of Notary Public _____

THIS SPACE TO BE COMPLETED BY THE OHIO STATE DENTAL BOARD	
<input type="checkbox"/>	Application approved _____
<input type="checkbox"/>	Application disapproved _____

Please forward completed application to:

OHIO STATE DENTAL BOARD
 77 South High Street, 17th Floor
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