MANITOBA DENTAL ASSOCIATION
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PHARMACOLOGICAL BEHAVIOUR MANAGEMENT (PBM) INITIAL APPLICATION FORM

MEMBER REGISTRATION APPLICATION FEE (ALL APPLICATIONS) ☐ **$157.50**

CHECK THE ROSTER CATEGORY(IES) YOU ARE APPLYING FOR:

CONSCIOUS SEDATION: SINGLE ORAL SEDATIVE [NOT ANXIOLYSIS]
- ☐ PATIENTS BETWEEN 5-12 YEARS (ASA I-II) ☐ $52.50
- ☐ PATIENTS OVER 12 YEARS (ASA I-II)
- ☐ PATIENTS OVER 18 YEARS (ASA III)

CONSCIOUS SEDATION: NITROUS OXIDE INHALATION ☐ **$52.50**
- ☐ PATIENTS UNDER 5 YEARS (ASA I-II)
- ☐ PATIENTS OVER 5 YEARS (ASA I-II)
- ☐ PATIENTS OVER 18 YEARS (ASA III)

CONSCIOUS SEDATION: PARENTERAL ☐ **$52.50**
- ☐ PATIENTS BETWEEN 5-12 YEARS (ASA I-II)
- ☐ PATIENTS OVER 12 YEARS (ASA I-II)
- ☐ PATIENTS OVER 18 YEARS (ASA III)

CONSCIOUS SEDATION: MULTIPLE MODALITIES ☐ **$52.50**
- ☐ 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), OTHER MODALITY COMBINATIONS (DESCRIBE)
- ☐ PATIENTS OVER 18 YEARS (ASA III) OTHER MODALITY COMBINATIONS (DESCRIBE)

DEEP CONSICIOUS SEDATION/GENERAL ANAESTHESIA ☐ **$52.50**
- ☐ PATIENTS OVER 16 YEARS (ASA I-II)
- ☐ PATIENTS BETWEEN 5-16 YEARS (ASA I-II)

INCLUDE REQUIRED SUPPORTING DOCUMENTS; CALCULATE FEE (REGISTRATION + NUMBER OF ROSTERS) AND SUBMIT FOR REVIEW
PAYMENT is by CHEQUE or CASH (Do not mail cash)

NAME

_____ _____
SURNAME GIVEN NAMES

PRACTICE NAME AND ADDRESS

IDENTIFY ALL PRACTICES AND THEIR ADDRESSES WHERE YOU PLAN TO PERFORM SEDATION SERVICES	
PRACTICE NAME	ADDRESS

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 roster application, I shall be suspended from all rosters and the matter referred for peer review. I further understand and agree that I may be subject to immediate suspension of my licence to practice dentistry for false or misleading representations to the MDA.

Signed in the city of _____ **this** _____ **day of** _____.

Signature of Member _____