



**MANITOBA DENTAL ASSOCIATION**

202-1735 Corydon Avenue, Winnipeg, MB, R3N 0K4  
T: 204.988.5300 F: 204.988.5310 www.manitobadentist.ca

**TO REQUEST A NEW FACILITY SEDATION PERMIT -  
PLEASE RETURN THIS COMPLETED FORM & SUBMIT  
PAYMENT OF APPLICABLE FEES.**

**APPLICANT WILL BE CONTACTED TO ARRANGE DATE  
AND TIME FOR FACILITY AUDIT BASED ON AUDITOR  
AVAILABILITY**

**FOR MORE INFORMATION GO TO:  
<https://www.manitobadentist.ca/professional-legislation-bylaws-dentist.cfm>**

**APPLICATION FOR NEW FACILITY SEDATION PERMIT**

- FACILITY PERMIT REGISTRATION FEE \$157.50
- FACILITY AUDIT - Inhalation Sedation \$840.00
- FACILITY AUDIT - Parenteral Sedation \$1050.00
- FACILITY AUDIT - General Anaesthesia \$1575.00

**NAME FACILITY DIRECTOR**

NAME: \_\_\_\_\_

**PRACTICE INFORMATION**

PRACTICE NAME:	
STREET ADDRESS	
CITY	
POSTAL CODE	
TELEPHONE:	
FAX:	
CELL PHONE:	
EMAIL ADDRESS:	

**SEDATION PROVIDERS**

NAME(S) OF PRACTITIONERS PROVIDING SEDATION:
1. _____
2. _____
3. _____
4. _____

**RAMSEY SEDATION SCALE**

In order to select appropriate personnel for the audit team, indicate the maximum level of sedation planned for your facility. Please use the Ramsey Sedation Scale (RSS) as defined in Bylaw to describe the sedation level.

RRS \_\_\_\_\_

**DECLARATIONS**

INITIALS HERE \_\_\_\_\_

I have read and shall comply with *The Pharmacological Behaviour Management Bylaw and Code of Ethics*. \_\_\_\_\_

As the Facility Director, I declare that I am aware of my responsibility to ensure provision of sedation services is limited to members on the MDA roster for the particular sedation service or individuals authorized under the provisions of their regulatory body. \_\_\_\_\_

Signature of Member \_\_\_\_\_

Date \_\_\_\_\_