Nevada State Board of Dental Examiners

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APPLICATION FOR SITE PERMIT

CONSCIOUS SEDATION

NAME: _____ LICENSE NO: _____

MAILING ADDRESS: _____

_____

_____

PHONE NUMBER: _____

Dental Practice Name: _____

SITE ADDRESS: _____

_____

DATE SITE AVAILABLE FOR INSPECTION:_____

(Now; After Date ____; Will Call With Date)

SITE TELEPHONE NUMBER: _____

SITE FACSIMILE NUMBER: _____

Do you currently hold a conscious sedation permit? YES _____ NO_____

SIGNATURE: _____ DATE: _____

Name of Person Administering: _____

NOTE: Please return this form and payment of $350.00 for the site inspection/evaluation fee**.**