



# STATE OF IOWA

## IOWA DENTAL BOARD

TERRY E. BRANSTAD, GOVERNOR  
KIM REYNOLDS, LT. GOVERNOR

MELANIE JOHNSON, J.D.  
EXECUTIVE DIRECTOR

### ANESTHESIA CREDENTIALS COMMITTEE

#### AGENDA

July 9, 2013

12:30 p.m.

**Location:** Iowa Dental Board, 400 SW 8<sup>th</sup> St., Suite D, Des Moines, Iowa  
(Committee Members May Participate in Person or by Telephone)

**Committee Members:** *Kaaren Vargas, D.D.S. Chair; Richard, Burton, D.D.S.; Steven Clark, D.D.S.; Douglas Horton, D.D.S.; Gary Roth, D.D.S.; Kurt Westlund, D.D.S., Lynn Curry, D.D.S.*

#### OPEN SESSION

- I. **CALL MEETING TO ORDER – ROLL CALL** *Kaaren Vargas, D.D.S.*
- II. **GENERAL ANESTHESIA PERMIT APPLICATIONS**
  - a. *Kyle M. Stein, D.D.S.*
- III. **MODERATE SEDATION PERMIT APPLICATIONS**
  - a. *Niels Oestervemb, D.D.S.*
- IV. **OPPORTUNITY FOR PUBLIC COMMENT**
- V. **ADJOURN**

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

Please Note: At the discretion of the Committee Chair, agenda items may be taken out of order to accommodate scheduling requests of Committee members, presenters or attendees or to facilitate meeting efficiency.

# REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE (ACC)

RECOMMENDATION

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<b>DATE OF MEETING:</b>	July 9, 2013
<b>RE:</b>	<b>General Anesthesia Permit Application</b>
<b>SUBMITTED BY:</b>	Christel Braness, Administrative Assistant
<b>ACTION REQUESTED:</b>	Recommendation regarding application

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## **Background**

The Anesthesia Credentials Committee is a peer review committee appointed by the Board to assist the Board. The administrative rules provide that one of the duties of the Committee is to:

- a.* Review all permit applications and make recommendations to the board regarding those applications.

The following practitioner has applied for a general anesthesia permit:

- **Dr. Kyle M. Stein, D.D.S.**

## **Committee Recommendation**

Should the applicant above be granted a general anesthesia permit?

Should the applicant be granted a provisional permit pending approval by the Board?

## **Facility Inspection/Peer Evaluation**

Dr. Stein will be providing sedation services at the University of Iowa College of Dentistry; therefore, a facility inspection does not need to be conducted. A peer evaluation has not been conducted so far as I am aware.

\*I will submit my residency program completion certificate as soon as it is available (late June).



**IOWA DENTAL BOARD**  
 400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa 50309-4687  
 Phone (515) 281-5157 Fax (515) 281-7969  
<http://www.dentalboard.iowa.gov>

**RECEIVED**

MAY 15 2013

IOWA DENTAL BOARD

**APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT**

**SECTION 1 - APPLICANT INFORMATION**

Instructions - Please read the accompanying instructions prior to completing this form. Answer each question. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle, Suffix)

Stein, Kyle Matthew

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

Kyle-stein@iowa.edu

Work E-mail:

Kyle-stein@iowa.edu

Home Address:

220 River St Apt 20

City:

Iowa City

State:

IA

Zip:

52246

Home Phone:

319-321-9854

License Number:

08648

Issue Date:

6/16/09

Expiration Date:

8/31/14

Type of Practice:

Oral & Maxillofacial Surgery

**SECTION 2 - LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED**

Principal Office Address:

UIHC - Hospital Dentistry 200 Hawkins Dr

City:

Iowa City

Zip:

52242

Phone:

319-356-7339

Office Hours/Days:

Tu/Th 8-5, F 1-5

Other Office Address:

UI College of Dentistry 201 Newton Rd

City:

Iowa City

Zip:

52242

Phone:

319-335-7457

Office Hours/Days:

M 12-5, F 8-12

Other Office Address:

Hawkeye Oral Surgery 2401 Coral Ct Suite 5

City:

Coralville

Zip:

52241

Phone:

319-338-6637

Office Hours/Days:

Wed 8-5

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

**SECTION 3 - BASIS FOR APPLICATION**

Check each box to indicate the type of training you have completed & attach proof.

Check all that apply.

DATE(S):

Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia - Oral & Maxillofacial Surgery

X

7/09 - 6/13

Formal training in airway management - UIHC anesthesiology rotation as part of residency

X

3/10 - 6/10

Minimum of one year of advanced training in anesthesiology in a training program approved by the board

**SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION**

Name of Course:

ACLS Provider

Location:

UIHC - EMSLRC 200 Hawkins Dr

Iowa City IA

Date of Course:

6/21/11

Date Certification Expires:

6/30/13 (renewal planned for 6/12/13)

Lic. #

Sent to ACC:

Peer Eval:

Fee \$02735160 - \$500

Permit #

Approved by ACC:

State Ver.:

ACLS

Issue Date:

Temp #

Inspection:

Res. Ver Form

Brd Approved:

T. Issue Date:

Inspection Fee:

Res. Cert

Office Use

Name of Applicant Kyle Stein

**SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE**

Name of Dental School: University of Iowa College of Dentistry From (Mo/Yr): 8/05 To (Mo/Yr): 6/09  
 City, State: Iowa City, Iowa Degree Received: DPS

**POST-GRADUATE TRAINING.** Attach a copy of your certificate of completion for each postgraduate program you have completed.

Name of Training Program: U of Iowa Oral + Maxillofacial Surgery Address: WHC - Hospital Dentistry City: Iowa City State: Iowa  
 Phone: 319-356-7339 Specialty: Oral + Maxillofacial surgery From (Mo/Yr): 7/09 To (Mo/Yr): 6/13

Type of Training:  Intern  Resident  Fellow  Other (Be Specific):

Name of Training Program: Address: City: State:  
 Phone: Specialty: From (Mo/Yr): To (Mo/Yr):

Type of Training:  Intern  Resident  Fellow  Other (Be Specific):

**CHRONOLOGY OF ACTIVITIES**

Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>Oral + Maxillofacial Surgery Residency</u> <u>University of Iowa</u>	<u>7/09</u>	<u>6/13</u>

**SECTION 6 - DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE**

- YES  NO A. Do you have a license, permit, or registration to perform sedation in any other state?  
If yes, specify state(s) and permit number(s): \_\_\_\_\_
- YES  NO B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?
- YES  NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of anti-anxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?
- YES  NO D. Do you plan to use deep sedation/general anesthesia in pediatric patients?
- YES  NO E. Do you plan to use deep sedation/general anesthesia in medically compromised patients?
- YES  NO F. Do you plan to engage in enteral moderate sedation?
- YES  NO G. Do you plan to engage in parenteral moderate sedation?

What major drugs and anesthetic techniques do you utilize or plan to utilize for sedation purposes? Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.  
IV - midazolam, diazepam, fentanyl, ketamine, propofol  
Inhalation - nitrous oxide  
PO - diazepam, midazolam  
IM - ketamine

100 Hawkins Dr Iowa City, IA 52242

Name of Applicant Kyle Stein

Facility Address UIHC - Hospital Dentistry - Oral + Maxillofacial Surgery

**SECTION 7 - AUXILIARY PERSONNEL**

A dentist administering sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	License/Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Elizabeth Bray, RN	066119	10/12	10/14
Marcia Widmer, RN	087136	10/12	10/14
Gloria Ruby	P09516	10/12	10/14
Joyce Bailey	Q09774	10/12	10/14
Melanie Macz	Q03712	10/12	10/14
Doris Jacobs	061106	10/12	10/14
Marilyn Wurth	056943	10/12	10/14
Linda Walls	069446	10/12	10/14

**SECTION 8 - FACILITIES & EQUIPMENT**

Each facility in which you perform sedation must be properly equipped. Copy this page and complete for each facility. You may apply for an exemption of any of these provisions. The Board may grant the exemption if it determines there is a reasonable basis for the exemption.

YES	NO	Is your dental office properly maintained and equipped with the following:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.		

801 Newton Rd Iowa City, IA 52242

Name of Applicant Kyle Stein

Facility Address UI College of Dentistry - Oral + Maxillofacial Surgery

**SECTION 7 - AUXILIARY PERSONNEL**

A dentist administering sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	License/Registration #:	BLS Certification Date:	Date BLS Certification Expires:
<u>Kathleen Kane, RN</u>	<u>064060</u>	<u>5/10/11</u>	<u>5/10/13</u>
<u>Melanie Kenney, RN</u>	<u>067348</u>	<u>5/10/11</u>	<u>5/10/13</u>
<u>Margaret Pardini, RN</u>	<u>078252</u>	<u>1/25/13</u>	<u>1/25/15</u>
<u>Cindy Smith</u>	<u>Q 00330</u>	<u>5/10/11</u>	<u>5/10/13</u>
<u>Teresa Hahn</u>	<u>Q 05014</u>	<u>5/10/11</u>	<u>5/10/13</u>
<u>Kiera Sovars</u>	<u>Q 05594</u>	<u>5/10/11</u>	<u>5/10/13</u>
<u>Ashley Ernst</u>	<u>Q 0032</u>	<u>6/28/12</u>	<u>6/28/14</u>
Name:	License/Registration #:	BLS Certification Date:	Date BLS Certification Expires:

**SECTION 8 - FACILITIES & EQUIPMENT**

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- YES NO Is your dental office properly maintained and equipped with the following:
- 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?
  - 2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
  - 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
  - 4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
  - 5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
  - 6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
  - 7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
  - 8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
  - 9. EKG monitor?
  - 10. Laryngoscope and blades?
  - 11. Endotracheal tubes?
  - 12. Magill forceps?
  - 13. Oral airways?
  - 14. Stethoscope?
  - 15. A blood pressure monitoring device?
  - 16. A pulse oximeter?
  - 17. Emergency drugs that are not expired?
  - 18. A defibrillator (an automated defibrillator is recommended)?
  - 19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
  - 20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

Name of Applicant

Kyle Stein

Facility Address

201 Coral Ct Suite 5  
Coralville, IA 52241  
Hawkeye Oral Surgery

SECTION 7 - AUXILIARY PERSONNEL

A dentist administering sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Shelley Schneider, RN	087121	3/18/13	3/15
Beth Gray	Q03323	3/18/13	3/15
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
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SECTION 8 - FACILITIES & EQUIPMENT

Each facility in which you perform sedation must be properly equipped. Copy this page and complete for each facility. You may apply for an exemption of any of these provisions. The Board may grant the exemption if it determines there is a reasonable basis for the exemption.

YES NO Is your dental office properly maintained and equipped with the following:

- 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?
- 2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
- 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
- 4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
- 5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
- 6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
- 7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
- 8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
- 9. EKG monitor?
- 10. Laryngoscope and blades?
- 11. Endotracheal tubes?
- 12. Magill forceps?
- 13. Oral airways?
- 14. Stethoscope?
- 15. A blood pressure monitoring device?
- 16. A pulse oximeter?
- 17. Emergency drugs that are not expired?
- 18. A defibrillator (an automated defibrillator is recommended)?
- 19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
- 20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

**SECTION 9 – If you answer Yes to any of the questions below, attach a full explanation. Read the instructions for important definitions.**

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	<input type="checkbox"/>	<input type="checkbox"/> N/A
5. Have you ever been requested to repeat a portion of any professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?	<input type="checkbox"/>	<input type="checkbox"/> N/A
8. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license or permit you held?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate or has your controlled substance registration ever been placed on probation, suspended, voluntarily surrendered or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**SECTION 10 – AFFIDAVIT OF APPLICANT**

STATE: Iowa COUNTY: Johnson

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide deep sedation/general anesthesia. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I understand that I have no legal authority to administer deep sedation/general anesthesia until a permit has been granted. I understand that my facility is subject to an on-site evaluation prior to the issuance of a permit and by submitting an application for a deep sedation/general anesthesia permit, I hereby consent to such an evaluation. In addition, I understand that I may be subject to a professional evaluation as part of the application process. The professional evaluation shall be conducted by the Anesthesia Credentials Committee and include, at a minimum, evaluation of my knowledge of case management and airway management.

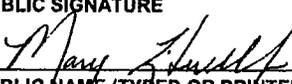
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and administering basic life support. I understand that a dentist performing a procedure for which deep sedation/general anesthesia is being employed shall not administer the general anesthetic and monitor the patient without the presence and assistance of at least two qualified auxiliary personnel.

I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation.

I hereby authorize the release of any and all information and records the Board shall deem pertinent to the evaluation of this application, and shall supply to the Board such records and information as requested for evaluation of my qualifications for a permit to administer sedation in the state of Iowa.

I understand that based on evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.

I further state that I have read the rules related to the use of sedation, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and deep sedation/general anesthesia in the state of Iowa.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</b>	SIGNATURE OF APPLICANT 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>30</u> DAY OF <u>April</u> , YEAR <u>2013</u>	
<b>NOTARY SEAL</b>	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Mary Litwiler</u>	MY COMMISSION EXPIRES: <u>June 27, 2015</u>

American Heart Association  
Learn and Live

Healthcare Provider

KYLE STEIN

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the BLS for Healthcare Providers (CPR & AED) Program.

6/2/11

6/13

Issue Date

Recommended Renewal Date

Training Center

Iowa Region

TC Address Contact Info

EMSLRC

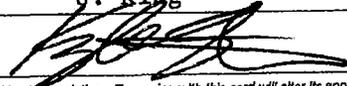
Course Location

UIHC

Instructor

J. King

Holder's Signature



© 2000 American Heart Association Tampering with this card will alter its appearance. 70-2915

ACLS Provider

American Heart Association

Kyle Stein

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.

6/21/2011

6/30/2013

Issue Date

Recommended Renewal Date

Training Center Name

UIHC-EMSLRC

TC ID #

TC Info City, State

TCCIA05137

TC

200 Hawkins Dr. Iowa City IA 52242

Course Location

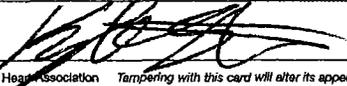
319-353-7495  
Mercy IC

Instructor Name

Valerie Mattison

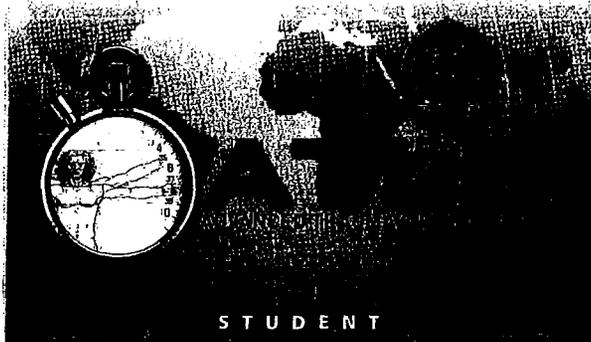
Inst. ID #

Holder's Signature



© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1805

COMMITTEE ON TRAUMA



STUDENT

Kyle Stein, DDS

is recognized as having successfully completed the ATLS® Course for Doctors according to the standards established by the ACS Committee on Trauma.

Issue Date: 09/17/2010

Expiration Date: 09/17/2014



Chairperson, ATLS Subcommittee



ACS Chairperson, State/Provincial Committee on Trauma

ATLS Course Director

\*ACLS renewal scheduled for 6/12/13



UNIVERSITY OF IOWA  
HOSPITALS & CLINICS

University of Iowa Health Care

*Hospital Dentistry Institute*

*Division of Oral & Maxillofacial Surgery  
200 Hawkins Drive  
Iowa City, IA 52242  
319-356-7339 Tel  
319-353-6923 Fax  
www.uihealthcare.org*

June 20, 2013

Iowa Dental Board  
400 SW 8<sup>th</sup> Street, Suite D  
Des Moines, IA 50309-4687

RE: Deep Sedation/General Anesthesia Permit

To Whom It May Concern,

Enclosed you will find a copy of my residency training certificate in oral and maxillofacial surgery as well as a copies of my ACLS and PALS certification. I previously mailed you the completed application form for the sedation permit indicating these documents would be mailed when available.

I begin practicing on July 1, 2013 and ask you to expedite this application. Please feel free to contact me with any questions at 319-321-9854. Thank you for your assistance with this matter.

Sincerely,

A handwritten signature in cursive script that reads "Kyle Stein".

Kyle M. Stein, DDS  
Hospital Dentistry Institute

The University of Iowa  
Hospitals and Clinics  
and  
Carver College of Medicine

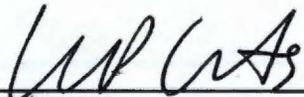
THIS IS TO CERTIFY THAT  
Kyle Matthew Stein, D.D.S.

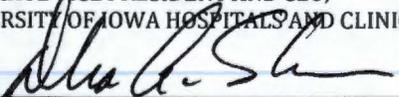
HAS SERVED AS A  
Resident

IN THE DEPARTMENT OF  
Hospital Dentistry  
Division of Oral and Maxillofacial Surgery

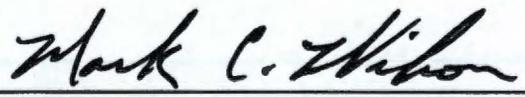
June 24, 2009 - June 30, 2013

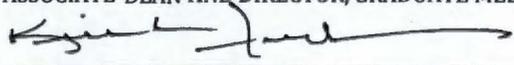
TO THE SATISFACTION OF THE  
OFFICERS AND STAFF OF THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS  
IN WITNESS WHEREOF, THIS CERTIFICATE IS AWARDED AT IOWA CITY IN THE STATE OF IOWA  
THIS FIRST DAY OF JULY, TWO THOUSAND AND THIRTEEN

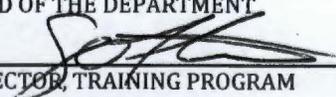
  
ASSOCIATE VICE PRESIDENT AND CEO,  
UNIVERSITY OF IOWA HOSPITALS AND CLINICS

  
DEAN, CARVER COLLEGE OF MEDICINE



  
ASSOCIATE DEAN AND DIRECTOR, GRADUATE MEDICAL EDUCATION

  
HEAD OF THE DEPARTMENT

  
DIRECTOR, TRAINING PROGRAM

PEDIATRIC ADVANCED LIFE SUPPORT



American Heart Association

American Academy of Pediatrics



PALS Provider

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Pediatric Advanced Life Support (PALS) Program.

Issue Date

Recommended Renewal Date

6/12/2015

6/30/2015

PEDIATRIC ADVANCED LIFE SUPPORT

Training Center Name UIHC-EMSLRC TC ID #

TC Info City, State ZIP Hawkins Dr, Iowa City IA 52242 Phone TCCIA05137 319-353-7495

Course Location EMSLRC

Instructor Name Doug York 05060084232 Inst. ID #

Holder's Signature

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ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider



American Heart Association

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.

Issue Date

Recommended Renewal Date

6/12/2015

6/30/2015

ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name UIHC-EMSLRC TC ID #

TC Info City, State ZIP Hawkins Dr, Iowa City IA 52242 Phone TCCIA05137 319-353-7495

Course Location EMSLRC

Instructor Name Doug York 05060084232 Inst. ID #

Holder's Signature

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# REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE (ACC)

RECOMMENDATION

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<b>DATE OF MEETING:</b>	July 9, 2013
<b>RE:</b>	<b>Moderate Sedation Application</b>
<b>SUBMITTED BY:</b>	Christel Braness, Administrative Assistant
<b>ACTION REQUESTED:</b>	Recommendation regarding application

---

## **Background**

The Anesthesia Credentials Committee is a peer review committee appointed by the Board to assist the Board. The administrative rules provide that one of the duties of the Committee is to:

- a.* Review all permit applications and make recommendations to the board regarding those applications.

The following practitioner has applied for a moderate sedation permit:

- **Dr. Niels Oestervemb, D.D.S.**

## **Committee Recommendation**

Should the applicant(s) above be granted a moderate sedation permit?

## **Added Qualifications: (Pediatric, medically-compromised patients (ASA-3-4))**

Dr. Oestervemb has indicated that he will not be providing sedation to pediatric or medically-compromised patients.

## **Facility Inspection/Peer Evaluation**

Dr. Stein will be providing sedation services at the University of Iowa College of Dentistry; therefore, a facility inspection does not need to be conducted. A peer evaluation has not been conducted so far as I am aware.

RECEIVED

JUN 7 2013



IOWA DENTAL BOARD  
 400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa 50309-4687  
 Phone (515) 281-5157 Fax (515) 281-7969  
<http://www.dentalboard.iowa.gov>

IOWA DENTAL BOARD

APPLICATION FOR MODERATE SEDATION PERMIT

SECTION 1 - APPLICANT INFORMATION

Instructions - Please read the accompanying instructions prior to completing this form. Answer each question. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle, Suffix)

Oestervemb, Niels

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

niels.oestervemb.dds@gmail.com

Work E-mail:

niels-oestervemb@iowa.edu

Home Address:

600 Grandview CT APT 622

City:

IOWA CITY

State:

IA

Zip:

52246

Home Phone:

319-936-9008

License Number:

08972

Issue Date:

09/28/2012

Expiration Date:

08/31/2014

Type of Practice:

General Dentistry

SECTION 2 - LOCATION(S) IN IOWA WHERE MODERATE SEDATION SERVICES ARE PROVIDED

Principal Office Address:

801 Newton Road

City:

IOWA CITY

Zip:

52242

Phone:

319-335-7499

Office Hours/Days:

M-F 18-5

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

SECTION 3 - BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.

Check if completed.

DATE(S):

Moderate Sedation Training Program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences

Completed

ADA-accredited Residency Program that includes moderate sedation training

Completed

6/30/11

You must have training in moderate sedation AND one of the following:

Formal training in airway management; OR

Completed

Moderate sedation experience at graduate level, approved by the Board

Completed

SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

ACLS Training

Location:

UIMC-EMSLRC

Date of Course:

07/11/2012

Date Certification Expires:

07/31/2014

Office Use	Lic. #	Sent to ACC:	Inspection	Fee #02741766 \$500
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

Name of Applicant Niels Oestervem

**SECTION 5 – MODERATE SEDATION TRAINING INFORMATION**

Type of Program:  
 Postgraduate Residency Program     Continuing Education Program     Other Board-approved program, specify:

Name of Training Program: <u>General Practice Residency with</u>	Address: <u>200 Hawkins Drive</u>	City: <u>IOWA City</u>	State: <u>IA</u>
Type of Experience: <u>6</u>			
Length of Training: <u>1 year</u>	Date(s) Completed: <u>07/1/10 - 06/30/11</u>		
Number of Patient Contact Hours:	Total Number of Supervised Sedation Cases:		

- YES  NO 1. Did you satisfactorily complete the above training program?
- YES  NO 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?
- YES  NO 3. Does the program include management of at least 20 clinical patients?  
As part of the curriculum, are the following concepts and procedures taught:
- YES  NO 4. Physical evaluation;
- YES  NO 5. IV sedation;
- YES  NO 6. Airway management;
- YES  NO 7. Monitoring; and
- YES  NO 8. Basic life support and emergency management.
- YES  NO 9. Does the program include clinical experience in managing compromised airways?
- YES  NO 10. Does the program provide training or experience in managing moderate sedation in pediatric patients?
- YES  NO 11. Does the program provide training or experience in managing moderate sedation in ASA category 3 or 4 patients?

Please attach the appropriate form to verify your moderate sedation training. Applicants who received their training in a postgraduate residency program must have their postgraduate program director complete Form A. In addition, attach a copy of your certificate of completion of the postgraduate program. Applicants who received their training in a formal moderate sedation continuing education program must have the program director complete Form B.

**SECTION 6 – MODERATE SEDATION EXPERIENCE**

- YES  NO A. Do you have a license, permit, or registration to perform moderate sedation in any other state?  
If yes, specify state(s) and permit number(s): \_\_\_\_\_
- YES  NO B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?
- YES  NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?
- YES  NO D. Do you plan to use moderate sedation in pediatric patients?
- YES  NO E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients?
- YES  NO F. Do you plan to engage in enteral moderate sedation?
- YES  NO G. Do you plan to engage in parenteral moderate sedation?

What major drugs and anesthetic techniques do you utilize or plan to utilize in your use of moderate sedation? Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.

<u>IV</u>	<u>Inhalation</u>	<u>Oral</u>
Diazepam	N <sub>2</sub> O - O <sub>2</sub>	Triazolam
Midazolam		Diazepam

Name of Applicant Niels Oesterveem

Facility Address 801 Newton Road, Iowa City, IA

**SECTION 7 - AUXILIARY PERSONNEL**

A dentist administering moderate sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
<u>Constance Herrick</u>	<u>Q02099</u>	<u>10/8/2012</u>	<u>10/31/2014</u>
<u>Judy Swails</u>	<u>Q02542</u>	<u>04/2/12</u>	<u>4/30/2014</u>
<u>Diane Wenman</u>	<u>Q00597</u>	<u>04/3/2013</u>	<u>4/30/2014</u>
<u>Stephanie Miller</u>	<u>Q04752</u>	<u>12/19/2011</u>	<u>12/31/2013</u>
<u>Jennifer Nay</u>	<u>Q06966</u>	<u>01/26/2012</u>	<u>01/31/2014</u>
<u>Susan Fegorasend</u>	<u>Q00549</u>	<u>05/20/2013</u>	<u>05/31/2015</u>
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

**SECTION 8 - FACILITIES & EQUIPMENT**

Each facility in which you perform moderate sedation must be properly equipped. Copy this page and complete for each facility. You may apply for a waiver of any of these provisions. The Board may grant the waiver if it determines there is a reasonable basis for the waiver.

YES NO Is your dental office properly maintained and equipped with the following:

- 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
- 2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
- 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
- 4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
- 5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
- 6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
- 7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
- 8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
- 9. EKG monitor?
- 10. Laryngoscope and blades?
- 11. Endotracheal tubes?
- 12. Magill forceps?
- 13. Oral airways?
- 14. Stethoscope?
- 15. A blood pressure monitoring device?
- 16. A pulse oximeter?
- 17. Emergency drugs that are not expired?
- 18. A defibrillator (an automated defibrillator is recommended)?
- 19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?

17

20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

**SECTION 9 – If you answer Yes to any of the questions below, attach a full explanation. Read the instructions for important definitions.**

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Have you ever been requested to repeat a portion of any professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license or permit you held?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate or has your controlled substance registration ever been placed on probation, suspended, voluntarily surrendered or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**SECTION 10 – AFFIDAVIT OF APPLICANT**

STATE: <i>IOWA</i>	COUNTY: <i>Johnson</i>
-----------------------	---------------------------

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide moderate sedation. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I understand that I have no legal authority to administer moderate sedation until a permit has been granted. I understand that my facility is subject to an on-site evaluation prior to the issuance of a permit and by submitting an application for a moderate sedation permit, I hereby consent to such an evaluation. In addition, I understand that I may be subject to a professional evaluation as part of the application process. The professional evaluation shall be conducted by the Anesthesia Credentials Committee and include, at a minimum, evaluation of my knowledge of case management and airway management.

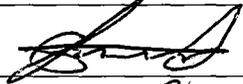
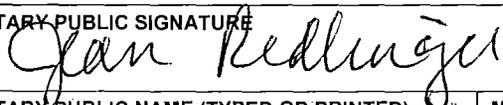
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and administering basic life support. I understand that a dentist performing a procedure for which moderate sedation is being employed shall not administer the pharmacologic agents and monitor the patient without the presence and assistance of at least one qualified auxiliary personnel.

I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation. I also understand that if moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

I hereby authorize the release of any and all information and records the Board shall deem pertinent to the evaluation of this application, and shall supply to the Board such records and information as requested for evaluation of my qualifications for a permit to administer moderate sedation in the state of Iowa.

I understand that based on evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.

I further state that I have read the rules related to the use of sedation and nitrous oxide inhalation analgesia, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and moderate sedation in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ▶	SIGNATURE OF APPLICANT 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <i>31</i> DAY OF <i>May</i> , YEAR <i>2013</i>	
	NOTARY PUBLIC SIGNATURE 	
NOTARY SEAL	NOTARY PUBLIC NAME (TYPED OR PRINTED) <i>Jean Redlinger</i>	MY COMMISSION EXPIRES: <i>10/12/13</i>



**IOWA DENTAL BOARD**  
 400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa 50309-4687  
 Phone (515) 281-5157 Fax (515) 281-7969  
<http://www.dentalboard.iowa.gov>

PLEASE TYPE OR PRINT LEGIBLY IN INK.

**FORM A: VERIFICATION OF MODERATE SEDATION TRAINING  
 IN A POSTGRADUATE RESIDENCY PROGRAM**

**SECTION 1 - APPLICANT INFORMATION**

Instructions - Use this form if you obtained your training in moderate sedation from an approved postgraduate residency program. Complete Section 1 and mail this form to the Postgraduate Program Director for verification of your having successfully completed this training.

NAME (First, Middle, Last, Suffix, Former/Maiden):

MAILING ADDRESS:

College of Dentistry 801 Newton Road, Admissions Clinic/Faculty General Practice

CITY: IOWA CITY

STATE: IA

ZIP CODE: 52242

PHONE: 319-335-7499

To obtain a permit to administer moderate sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:

DATE:

05/29/2013

**SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR**

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Ryan Hill

THIS POSTGRADUATE PROGRAM IS APPROVED OR ACCREDITED TO TEACH POSTGRADUATE DENTAL OR MEDICAL EDUCATION BY ONE OF THE FOLLOWING:

- American Dental Association;
- Accreditation Council for Graduate Medical Education of the American Medical Association (AMA); or
- Education Committee of the American Osteopathic Association (AOA).

NAME AND LOCATION OF POSTGRADUATE PROGRAM:

University of Iowa Hospitals and Clinics  
 200 Hawkins Dr.  
 Iowa City, IA 52242

PHONE:

(319) 353-8137

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR): 07-1-2010

TO (MO/YR): 06/30-2011

DATE PROGRAM COMPLETED: 06/30/2011

- YES  NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM?
- YES  NO 2. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?
- YES  NO 3. DOES THE PROGRAM COVER THE AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS?
- YES  NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE IN MANAGING COMPROMISED AIRWAYS?
- YES  NO 5. DOES THE PROGRAM INCLUDE MANAGEMENT OF AT LEAST 20 PATIENTS?

(If no to above, please provide a detailed explanation.)

- YES  NO 6. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR WAS THE APPLICANT PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES  NO 7. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES  NO 8. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR PEDIATRIC (AGE 12 OR YOUNGER) PATIENTS? If yes, please provide details.
- YES  NO 9. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR MEDICALLY COMPROMISED (ASA CLASS 3 OR 4) PATIENTS? If yes, please provide details.

I further certify that the above named applicant has demonstrated competency in airway management and moderate sedation.

PROGRAM DIRECTOR SIGNATURE:

DATE:

5/30/13

# ACLS Provider



American  
Heart  
Association

→  
PEEL  
HERE  
→

Niels Oestervemb

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.  
7/11/2012 7/31/2014

Issue Date

Recommended Renewal Date

Training Center Name UIHC-EMSLRC TC ID #

TC Info TCCIA05137  
200 Hawkins Dr, Iowa City IA 52242

Course Location 319-353-7495  
EMSLRC

Instructor Name Lance Heern 05060087756 Inst ID #

Holder's Signature

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Niels Oestervemb  
600 Grandview Ct. #622  
Iowa City Iowa 52246

Peel the wallet card off the sheet and fold it over.

This card contains unique security features to protect against forgery.  
This card can be inserted into either a number 10 window or regular envelope.  
If using a number 10 regular envelope, peel off the address label and apply it to the outside of the envelope.

The University of Iowa  
Hospitals and Clinics  
and  
Carver College of Medicine

THIS IS TO CERTIFY THAT  
Niels Oesterbemb, D.D.S.

HAS SERVED AS A

Resident

IN THE DEPARTMENT OF

Hospital Dentistry

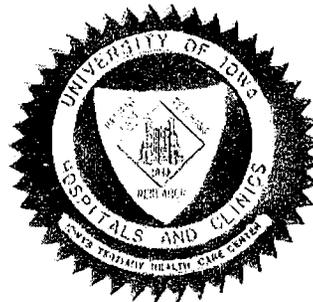
Division of General Dentistry

June 24, 2010 - June 30, 2011

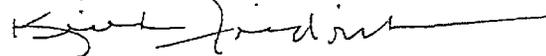
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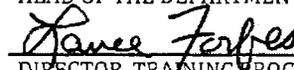
  
\_\_\_\_\_  
ASSOCIATE VICE PRESIDENT AND CEO,  
UNIVERSITY OF IOWA HOSPITALS AND CLINICS

  
\_\_\_\_\_  
DEAN, CARVER COLLEGE OF MEDICINE



  
\_\_\_\_\_  
DIRECTOR, GRADUATE MEDICAL EDUCATION

  
\_\_\_\_\_  
HEAD OF THE DEPARTMENT

  
\_\_\_\_\_  
DIRECTOR, TRAINING PROGRAM