



STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

CONTINUING EDUCATION ADVISORY COMMITTEE

AGENDA

July 24, 2013

12:00 p.m.

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

Committee Members: *Lori Elmitt, Board Member, Chair; George North, D.D.S.; Steven Fuller, D.D.S., Eileen Cacioppo, R.D.H.; Marijo Beasler, R.D.H.; Kristee Malmberg, R.D.A.; Jane Slach, R.D.A.*

I. CALL MEETING TO ORDER – ROLL CALL *Lori Elmitt*

II. REVIEW OF COMMITTEE RESPONSIBILITIES *Lori Elmitt*

III. COMMITTEE MINUTES

1. *May 1, 2013 – Teleconference*

IV. CONTINUING EDUCATION COURSE APPLICATIONS

1. **G.V. Black Study Club:** “Dental Sleep Medicine” (3 hours)
2. **G.V. Black Study Club:** “Temporomandibular Disorders(Diagnosis & Treatment), Radiology (Pathosis & Treatment)” (6 hours)
3. **G.V. Black Study Club:** “Medical Disorders/Current Treatment Protocols & Considerations of these in Dental Treatment” (6 hours)
4. **G.V. Black Study Club:** “Dental Materials, Caries Management, Composites, & Clinical Operative Techniques” (6 hours)
5. **Eastern Iowa Community College:** “Infection Control & Dental Radiography” (4 hours)
6. **Broadlawns Medical Center:** “The Refugee Experience” (2 hours)
7. **Institute for Natural Resources:** “Food, Mood & Cognition” (hours not specified)
8. **SE Iowa Dental Society:** “Considerations for Providing Dental Treatment to the Geriatric Patient” (3.5 hours)
9. **Nebraska Society of Periodontology:** “Restorative Driven Implant Failure – what every dentist, hygienist, assistant and lab technician needs to know!” (7 hours)

10. **Kirkwood Community College:** *“Mental Health First Aid”* (12 hours)
11. **Oral Surgery Associates of Iowa City:** *“State of the Art Topics & Techniques in Implant Prosthetics for Private Practice”* (6 hours)
12. **Gunderson Health Systems:** *“Radiation Safety and Quality Control for Dental Professionals”* (2 hours)
13. **Darcey Siemering:** *“Learn to Ease and Manage Cumulative Trauma Disorder – Therapeutic Workshop for Dental Assistants and Hygienists”* (2 hours)
14. **Institute for Natural Resources:** *“Understanding Dementia”* (hours not specified)

V. CONTINUING EDUCATION SPONSOR APPLICATIONS

1. Laboratory Consultation Services

VI. OTHER BUSINESS

1. Partial Residency Program & Continuing Education Hours – Review of new materials
2. Discussion re: Iowa Dental Association: *“Posture, Pain and Productivity in Dentistry”*

VII. OPPORTUNITY FOR PUBLIC COMMENT

VIII. 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 Board office 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.

Dr. Bradley provided some comments regarding the IDA May meeting course titled “Posture, Pain and Productivity in Dentistry.” Dr. Bradley indicated that the course was very clinical in its presentation. Dr. Bradley feels that the course should have been approved for credit.

RECEIVED

APR 23 2013

IOWA DENTAL BOARD

April 17, 2013

Dear Iowa Dental Board Members:

Enclosed are the forms for prior approval for the continuing education programs we have scheduled for the G.V. Black Dental Study Club for the 2013-14 year.

We are currently have "approved sponsor" status; however, I wanted to submit the schedule of our continuing education programs to you to verify that they qualify for the CEU's indicated.

Please let me know if you have any questions. Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sara Lukan".

Sara Lukan, D.D.S.

(225-6742)

**APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: GV Black Dental Study Club
C/O SARA LUKAN, DDS
Address: DENTAL ASSOCIATES, PC 3700 Westown Pkwy, West Des Moines,
IA 50266
Phone: (515) 225-6742 Fax: (515) 224-1560 E-mail: salukan@msn.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): Dental Study Club

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: DENTAL Sleep Medicine

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: Sept. 16, 2013 Hours of instruction: 3

7. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

DENTAL Prosthetic Services (from Cedar Rapids) → will be discussing ORAL
(DPS) appliance therapy

DPS will also bring a medical professional from one of the Sleep Clinics
to lecture on the physiology of sleep apnea, it's diagnosis, + treatment
(they have not yet determined who this speaker will be).

8. Please attach a program brochure, course description, or other explanatory material.

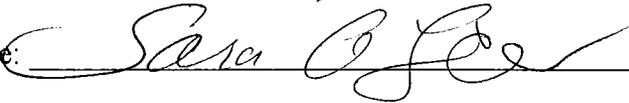
See above ↑

9. Name of person completing application: SARA LUKAN

Title: DDS / Pres. Elect of GV Black Club Phone Number: C: (515) 991-3103
W: (515) 225-6742

Fax Number: (515) 224-1560 E-mail: salukan@msn.com

Address: Dental Associates, PC 3700 Westown Pkwy West Des Moines, IA

Signature:  Date: 4/15/13 50246

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE** PER COURSE TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

**APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: GV BLACK Dental Study Club
C/o Sara Lukan, DDS
Address: DENTAL Associates, PC 3700 Westown Pkwy. West Des Moines, IA
50266
Phone: (515) 225-6742 Fax: (515) 224-1560 E-mail: salukan@msn.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): DENTAL Study Club

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: Temporomandibular Disorders (Diagnosis & Treatment)
Radiology (Pathosis & Treatment)

5. Course Subject:

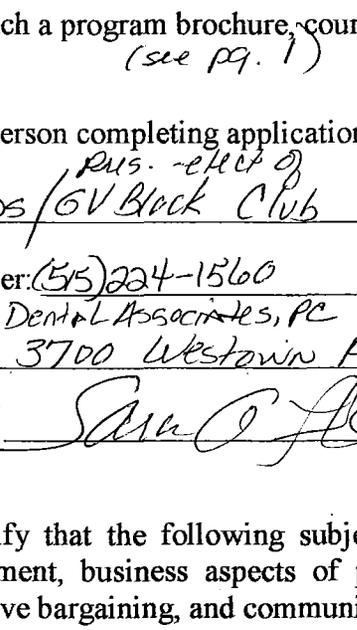
- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

- am session: TMD disorders, Radiology
- pm session: Physical therapy will lecture + demonstrate on methods of treatment used for TMD disorders

6. Course date: Nov. 11, 2013 Hours of instruction: 6

7. Provide the name(s) and briefly state the qualifications of the speaker(s):
DR. Ali POURIAN, DDS (University of Iowa College of Dentistry
Dept. of Oral Medicine & Radiology)
Rick Peterson, PT (Apex Physical Therapy in
West Des Moines, IA)

8. Please attach a program brochure, course description, or other explanatory material.
(see pg. 1)

9. Name of person completing application: SARA LUKAN
Title: DDS / ^{Pres. - elect of} GV Black Club Phone Number: (515) 991-3113 (C)
(515) 225-6742 (W)
Fax Number: (515) 224-1560 E-mail: salukan@msn.com
Dental Associates, PC
Address: 3700 Westown Pkwy West Des Moines, IA 50216
Signature:  Date: 4-15-13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

**APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: GV BLACK DENTAL STUDY CLUB
c/o Sara Lukan, DDS
Address: DENTAL ASSOCIATES, PC 3700 Westown Pkwy West Des Moines, IA
52266
Phone: (515) 225-6742 Fax: (515) 224-1560 E-mail: salukan@msn.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): DENTAL STUDY CLUB

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: MEDICAL DISORDERS / CURRENT TREATMENT PROTOCOLS
+ Considerations of these in Dental Treatment

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

(Basically an overall medical Review
of disorders / treatment
& how we as dentists may
need to modify treatment)

6. Course date: Jan. 30, 2014 Hours of instruction: 6

7. Provide the name(s) and briefly state the qualifications of the speaker(s):
Karen Baker, RPh, M.S. → University of Iowa
College of Dentistry +
College of Pharmacy

8. Please attach a program brochure, course description, or other explanatory material.
(see pg. 1)

9. Name of person completing application: Sara Lukan, DDS
President-elect
Title: DDS / of 6V Black Club Phone Number: *O: (515) 991-3103*
W: (515) 225-6742
Fax Number: (515) 224-1500 E-mail: salukan@msn.com
DENTAL ASSOCIATES, PC
Address: 3700 Westwin Pkwy West Des Moines, IA 50266
Signature: *Sara Lukan* Date: 4/15/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

**APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: GV Black Dental Study Club
c/o Sara Lukan, DDS
Address: Dental Associates, PC 3700 Westown Pkwy West Des Moines, IA
50266
Phone: (515) 225-6742 Fax: (515) 224-1560 E-mail: salukan@msn.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): Dental Study Club

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

- Alveolar Ridge Preservation / Implant Site Development
- Periodontal Regeneration / Grafting

4. Course Title: Implant Maintenance

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: Feb. 17, 2014 Hours of instruction: 6

7. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

- Dr. Gustavo Avila Ortiz, DDS, MS, PhD

- Dr. Satheesh Elangovan, B.D.S., DDS, DSc, DMSc

(both professors @ Univ. of Iowa College of Dentistry, Dept. of Perioodontics)

8. Please attach a program brochure, course description, or other explanatory material.

(see pg. 1)

9. Name of person completing application: SARA LUKAN, DDS

Title: DDS / 86V Black Club President-elect C: (515) 991-3103
Phone Number: W: (515) 225-6742
H: (515) 22

Fax Number: (515) 224-1560 E-mail: salukan@msn.com

Address: Dental Associates, PC 3700 Westown Pkwy, West Des Moines, IA 50266

Signature:  Date: 4/16/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE** PER COURSE TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

**APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM**

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: GV Black Dental Study Club
by Sara Lukon, DDS
Address: Dental Associates, PC 3700 Westown Pkwy West Des Moines, IA 50266
Phone: (515) 225-6742 Fax: (515) 224-1560 E-mail: salukan@msn.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify):

Dental Study Club

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: Dental Materials, Caries Management, Composites,
+ Clinical Operative Techniques

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: April 21, 2014 Hours of instruction: 6

7. Provide the name(s) and briefly state the qualifications of the speaker(s):

- Dr. Steve Armstrong } All professors in
 - Dr. Rodrigo Mai a } Dept. of Operative Dentistry,
 - Dr. Sundeia Guzman - Armstrong } The University of Iowa
 College of Dentistry

8. Please attach a program brochure, course description, or other explanatory material.
 (see pg. 1)

9. Name of person completing application: SARA LUKAN

Title: DPS / PUS. - elect of Phone Number: W: (515) 225-6742
GV Black Club C: (515) 991-3103

Fax Number: (515) 224-1560 E-mail: salukan@msn.com
Dental Associates, PC

Address: 3700 Westown Pkwy West Des Moines, IA 50266

Signature: [Signature] Date: 4/15/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE** PER COURSE TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

to
IDB
5/11/13

APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM

RECEIVED

MAY 21 2013

IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: EASTERN Iowa Community COLLEGES

Address: 306 WEST KIEWIT DRIVE Davenport, IA 52801

Phone: 563-336-3444 Fax: 563-336-3451 E-mail: DBRONES@EICC.EDU

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): Community COLLEGES; SLOH, custom -

muscular

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: INFECTION CONTROL + DENTAL RADIOGRAPHY

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: 6/29/13 Hours of instruction: INFECTION CONTROL 2
DENTAL RADIOGRAPHY 2

7. Provide a detailed breakdown of contact hours for the course or program:

SEE ATTACHED

8. Provide the name(s) and briefly state the qualifications of the speaker(s):

SEE ATTACHED

9. Please attach a program brochure, course description, or other explanatory material.

10. Name of person completing application: MARY BRIONES, RN, MS

Title: DIRECTOR HEALTH Phone Number: 563-336-3447

Fax Number: 563-336-3451 E-mail: MBRIONES@ECC.EDU
EASTERN IOWA COMMUNITY COLLEGE

Address: 306 WEST RIVER DR. DAVENPORT IA 52801

Signature: Mary Briones Date: 5/21/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov.

You will be contacted after the Continuing Education Advisory Committee has reviewed your request. Please allow a minimum of two to three weeks for a response.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED \$10 FEE PER COURSE TO:

Iowa Dental Board
Advisory Committee on Continuing Education
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

Kristee K. Malmberg CDA, EFDA, COMSA, RDA, BS

36 Williams Circle, Box 434, Hills, IA. 52235 * 319-679-2663 Kristee.Malmberg@kirkwood.edu

Objective: Dental Assisting Instructor -Full Time Faculty - Health Science Department

Education:

Bellevue University Bellevue, NE.	BS Health Care Management Completed November 2008
Kirkwood Community College Cedar Rapids, IA.	EFDA Program- Completed March 2005 Associate of Arts Degree-1999 Associate of Applied Science Degree-1987
Western Dental Education Center Los Angeles, CA.	Expanded Function Dental Auxiliary Training Program-Graduated- 1985
Kirkwood Community College Cedar Rapids, IA.	Dental Assisting Program-Graduated-1977
Iowa City West High School	Graduated-1976

Work History:

Full Time Faculty-Kirkwood Community College-Instructor Dental Assisting Program
Currently teaching Dental Assisting courses and Professionals in Health

Adjunct Faculty-Kirkwood Community College- Distance Learning 2000-2005

- Taught Professionals in Health, Health Skills I and II Lecture and Labs.
- Taught as an Adjunct Faculty for fall semester DA program-Endodontics and spring semester assisted with clinical and radiography at the College of Dentistry 1985-1986

Veterans Administration Hospital Dental Service Iowa City, IA. 1979-2006

- Assist with all aspects of dentistry in a hospital setting except Pediatric Dentistry. Including four-handed dentistry, radiography both intra oral and extra oral, record keeping, and assisting cases in the operating room.
- Dental Resident Coordinator includes resident rotation schedules, orientations and clinical supervising.
- Dental Assistant Supervisor, Clinical Supervisor to Dental Assisting from Kirkwood Community College and Scott Community College. Clinical Supervisor for Dental Lab Tech Students from Kirkwood Community College.
- In charge of ordering clinical supplies and inventory control, and in house Pharmacy medications for IV sedations and pre-medication.
- Serve on the Conscious Sedation Committee.
- Currently a certified CPR instructor- do recertification in our clinic and at the College of Dentistry.

Towncrest Dental Offices, PC Iowa City, IA. 1977-1979

- Assisted in all aspects of dentistry in a private practice setting including four-handed dentistry, record keeping, and clinical radiography both intra oral and extra oral.

Dr. Albert Soucek Iowa City, IA. 1975-1979

- Assisted in all aspects of dentistry in a private practice setting including four-hand dentistry, record keeping, and clinical radiography both intra oral and extra oral.

Professional Membership:

- American Dental Assistants Association 1977-Present
- Iowa Dental Assistants Association 1977-Present

Professional Credentials:

- Bachelor of Science Degree 2008
- Iowa Expanded Functions Dental Assistant-(EFDA) March 2005
- Registered Dental Assistant-(RDA) 2001-Present
- Certified Oral Maxillofacial Surgery Assistant-(COMSA) 2000-Present
- Dental Assisting National Board Infection Control-(ICE) 2000-Present
- Iowa Radiography Certificate 1985-Present

- Federal Expanded Functions Dental Assistant-(EFDA) 1985-Present
- Certified Dental Assistant-(CDA) 1977-Present

Honors and Awards:

- Dean's Scholar For Academic Achievement Award
Bellevue University 2008
- CPR Instructor Level 2007-2009
- 30 Year Pin-Dental Assisting National Board 2007
- Certificate of Recognition: Teaching Squares-Spring 2007
- Certificate of Recognition: Teaching Squares-Fall 2006
- Certificate of Recognition: Teaching Squares-Spring 2006
- Certificate of Retirement-Veterans Administration-26 years 2005
- Service Award Veterans Administration-25 years 2004
- Special Contribution Award Veterans Administration 2003
- 25 Year Pin-Dental Assisting National Board 2002
- Life American Dental Assistant Association Membership 2002
- Special Contribution Award Veterans Administration 2001
- Peggy Stevenson Loyal Assistant Award 2000
- Service Award Veterans Administration-20 years 1999
- American Dental Assistants Recognition of Contribution 1998
- Hands and Heart Award Veterans Administration 1994
- Service Award Veterans Administration-15 years 1992
- Special Contribution Award Veterans Administration 1992
- Service Award Veterans Administration-10 years 1989

Professional Offices Held:

- **University District:**
- Treasurer 2000-Present
- District Trustee 1982-1996
- President 1989-1990
- President Elect 1987-1988
- Secretary/Treasurer 1981-1982
- **Iowa Dental Assistants Association:**
- Secretary 2000-2009
- Immediate President 1998-2000
- President 1997-1998
- President Elect 1996-1997

Professional Committees held: Iowa Dental Assistants Association

- Bylaws, Education, and Nominating 2005-2009
- Student Involvement Co-Chair, Clinic, Exhibits and Awards, Membership 2000-2001
- Membership 1999-2000
- Strategic Planning, Manual of Procedures, Education, Clinic, Exhibits and Awards,
Budget and Finance, Past Presidents Council Chair 1998-2000
- Program 1999-2000
- IAGD Liaison, Nomination Chair, Program 1998-1999
- Program Chair 1996-1997
- Clinic, Exhibits and Awards Chair 1994-1997
- Public Relations, IDHA Liaison 1993-1994
- Membership 1991-1996
- Communicating Secretary 1987-1989

Other Committees held:

- Scholarship Committee
- Social Committee Member-Kirkwood Community College 2006-Present
- Iowa Board of Dental Examiners Education Committee-Appointed 2001-Present
- Kirkwood Community College Leadership Conference Panel member 1995
- St. Lukes Dental Health Center Board Member 1994-1997
- Veterans Administration Glove Review Committee 1993
- Veterans Administration Field Advisory for Dental Auxiliary 1993

- Veterans Administration Awards Committee 1993-1994
- Kirkwood Community College Dental Assisting Advisory Board-Chair 1991-2005
- Veterans Administration Committee for Dental Geriatrics 1991-1993
- Veterans Administration Recruitment and Retention Task Force for Dental Auxiliary 1998-1990
- Adjunct Faculty Appointment-Clinical-Kirkwood Community College 1986-2005
- Kirkwood Community College Dental Assisting Advisory Board-Member 1986-1990
- St. Joseph's Church:
 - Church Choir 2005-Present
 - Religion Instructor 2000-2002
 - Council President 1998-1999
 - Council President Elect 1997-1998
 - Eucharistic Minister 1997-Present
 - Council Secretary 1996-1997

Title of class: "Infection Control and Hazardous Materials- Getting Back to the Basics"

Kristee Malmberg CDA, EFDA, COMSA, RDA, BS

Purpose of educational offering: The purpose of the class is to provide dental professionals with a quality continuing education opportunity that will focus on Infection Control and Hazardous Materials. The course will discuss basic prevention of bloodborne pathogen transmission, health and safety standards from OSHA and CDC for the prevention of disease transmission in a dental setting. There will also be discussion on hazardous chemicals that are common to the dental office and the occupational environmental hazards they may cause.

Target Audience: Dental Assistants Dental Hygienists and Dentists

Course Outline:

Discuss prevention of bloodborne pathogens transmission and cross contamination, basic hand washing, types of infections, routes of transmission, Health and safety standards by OSHA and the CDC, different types of disinfections and sterilization methods and hazardous chemicals common to dentistry and the potential occupational hazards they present.

Type of instruction: Lecture

Instructor qualifications: Kristee Malmberg CDA, EFDA, COMSA, RDA, BS

See attached vita

Media and supportive materials required: Large screen to project presentation by computer/projector for computer for Power Point presentation.

Date: July 11, 2009

CEU's: Each attendee will receive 2 hours of continuing education credit for full attendance.

Attendance Requirement: 100% attendance is required to receive continuing education credit.

CURRICULUM VITAE

Jane H. Slach
2170 250th Street NW
Oxford, IA 52322

EDUCATION

- B.A. Governor State University, 2002, Business Administration
- A.A.S. Kirkwood Community College, 1976, Association of Applied Science,
Dental Assisting
- Diploma Kirkwood Community College, 1970, Dental Assisting
- C.D.A. Dental Assisting National Board, 1970 to present
- RDA Registered Dental Assisting, 2001 to present, Iowa State Board of Dental
Examiners
- Certificate Current Qualification in Dental Radiography, Iowa State Board of Dental
Examiners
- Certificate American Heart Association, Healthcare Provider, 1992 to present

PROFESSIONAL EMPLOYMENT EXPERIENCE

Kirkwood Community College
August 1992 to present

Professor

Instructor in dental assistant courses, maintain and assist with development of curriculum for accreditation status, prepare course syllabus, prepare lecture and laboratory for instruction, prepare course schedules, maintain facility equipment and advise students.

Department of Hospital Dentistry, University of Iowa
1980-1992

Dental Assistant III

Coordinate clinic for professional and support staff, assisted in dental procedures in the clinical site and operating room, record and tabulate daily procedures, billing and insurance, facilitate and assemble laboratory cases, hired and supervised dental assistants and dental hygienist, maintained inventory control,

maintained vendors, member of Quality Assurance and Total Quality Management Committee.

Towncrest Dental Office
1973-1980

Clinic Coordinator/Supervisor

Coordinate clinic for professional and support staff, assisted in dental procedures in the clinical site, record and tabulate daily procedures, facilitate and assemble laboratory cases, supervised dental assistants, maintained inventory control, maintained vendors.

PROFESSIONAL ASSOCIATION MEMBERSHIP AND ACTIVITIES

American Dental Assistants Association	Member 1992 to present
Iowa Dental Assistants Association	Member 1992 to present
Iowa Dental Assistant Educators Council	Member 1992 to present
Iowa City/Cedar Rapids Dental Assistant Association	Member 1992 to present
Iowa Dental Board Continue Education Committee	Member 2001 to present
Kirkwood Faculty Association	Member 2000 to present

Dental
Radiography
Update
Presented By:
Jane Slach CDA RDA BA
EFDA

OBJECTIVES

- Review the anatomical structures of the human skull
- Identify radiolucent or radiopaque of the anatomical structures
- Identify anatomical landmarks as seen on a dental radiograph

OSTEOLOGY OF THE SKULL

- Bones of the skull
 - 22 bones (not including the three bones of the ears)
 - Single or paired bones
- Two categories
 - One surrounds the brain (neurocranium)
 - One forms the face (viscerocranium)
- Type of Bone
 - Cortical bone
 - Cancellous bone

Neurocranium Bones

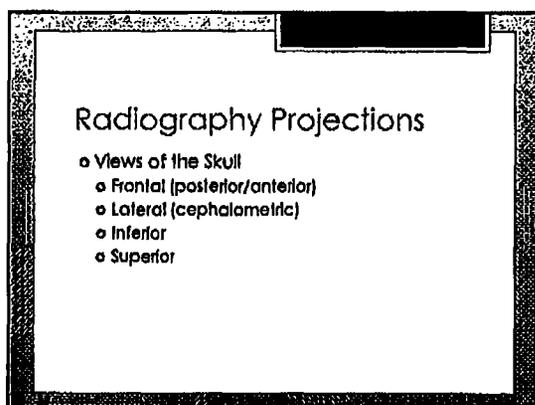
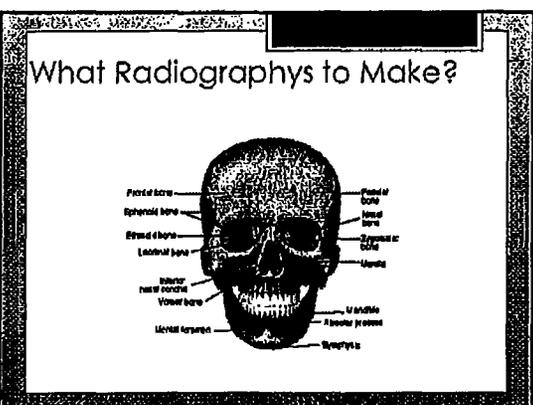
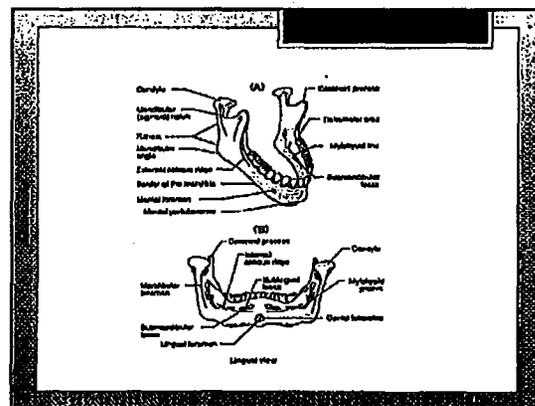
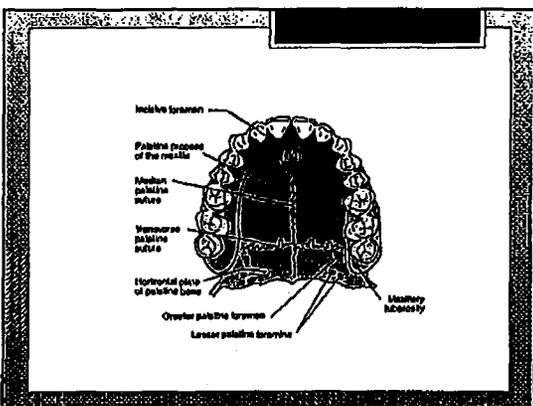
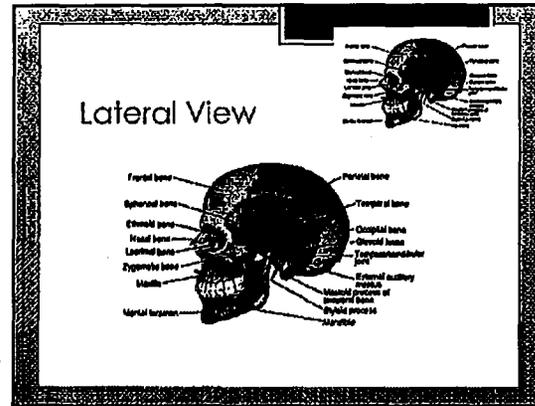
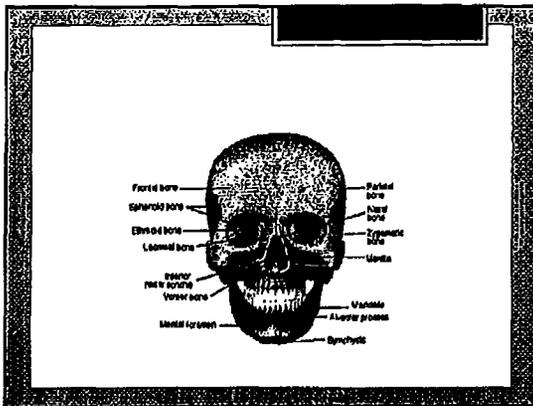
- Frontal bone - single
- Sphenoid bone - single
- Ethmoid bone - single
- Occipital bone - single
- Temporal bone - paired
- Parietal bone - paired

Prominences of Bone

- Composed of dense cortical bone appears radiopaque
- Process-coronoid process
- Ridge-internal oblique ridge
- Spine-anterior nasal spine
- Tubercle-mental tubercles
- Tuberosity-maxillary tuberosity

Spaces or depressions in bone

- Canal-tube-like passageway
 - Mandibular canal
- Foramen-opening or hole
 - mental foramen
- Fossa-broad shallow depressed area
 - submandibular fossa
- Sinus-hollow space
 - maxillary sinus



Radiography Projections

- o Intra-oral radiographs
 - o Two dimensional view
 - o Mesial
 - o Distal
 - o Anatomical crown (clinical)
 - o Apical
 - o Three dimensional - additional views
 - o Panoramic
 - o Posterior/anterior
 - o Cephalometric
 - o Occlusal

Panoramic Film



What do you see?
What additional radiography would you make?

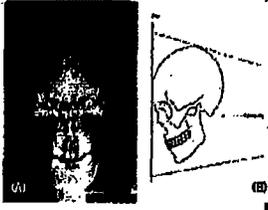
Lateral Skull/Cephalometric

- o Lateral View of entire head
- o Show anterior to posterior
- o Show superior to inferior borders of skull
- o Shows relationship of anatomical structures to one another



Posterior Anterior

- o Used
 - o detect fractures and gross pathology
 - o determine superior-inferior positions of objects or lesions



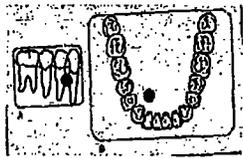
Occlusal Radiographs

- o Uses
 - o impacted teeth
 - o identify location buccally or lingual or normal ridge



Localization technique

- o Right Angle technique
 - o obtain a three dimensional relationship
 - o locate the position of a tooth or object in the jaw
 - o foreign bodies
 - o impacted teeth
 - o retained roots
 - o jaw fractures
 - o unerupted teeth
 - o Buccal to lingual relationship of tooth or object



Number	RO/RL	
o	_____	_____ Nasal Fossa
o	_____	_____ Incisive Foramen
o	_____	_____ Nasal Septum
o	_____	_____ Median Palatine Suture
o	_____	_____ Anterior Nasal Spine
o	_____	_____ Outline of the Nose

Incisive Foramen

- o midline of palate behind central incisors
- o round pea-shaped image
- o radiolucent



Nasal Spine

- o v-shaped projection at midline
- o radiopaque



Nasal Fossa

- o hollow area of nose (nostril)
- o radiolucent



Nasal Septum

- o dense cartilage structure
- o separates nasal fossa
- o radiopaque



Median Palatine Suture

- o junction of palatine process
- o vertical line between maxillary centrals
- o radiolucent



Number	RO/RL	
o _____	_____	Lateral Fossa
o _____	_____	Nasal Fossa
o _____	_____	Inverted "Y" (border of nasal fossa and maxillary sinus)
o _____	_____	Maxillary Sinus

Lateral Fossa

- o Contour between the lateral and canine
- o radiolucent



Inverted "Y"

- o located in canine-premolar area
- o junction of nasal fossa and anterior median wall of maxillary sinus
- o radiopaque



Number	RO/RL	
o _____	_____	Floor of Maxillary Sinus
o _____	_____	Maxillary Sinus
o _____	_____	Septum In Maxillary Sinus
o _____	_____	Malar Bone (Zygomatic Process)

Septum in Maxillary Sinus

- o divides sinus into two compartments
- o located in the first molar area
- o radiopaque



Floor of Maxillary Sinus

Maxillary Sinus

- o radiopaque
- o radiolucent



Zygomatic Process (malar bone)

- broad u-shaped band
- seen in first & second molar area
- radiopaque



Number	RO/RL
◦ _____	_____ Floor of Maxillary Sinus
◦ _____	_____ Maxillary Sinus
◦ _____	_____ Malar Process (Zygomatic Process)
◦ _____	_____ Hamulus
◦ _____	_____ Maxillary Tuberosity
◦ _____	_____ Coronoid Process (Mandible)

Maxillary Tuberosity

- extension of alveolar bone
- located behind the molars
- radiopaque



Hamulus

- downward projection of median pterygoid plate
- radiopaque



Coronoid Process of Mandible

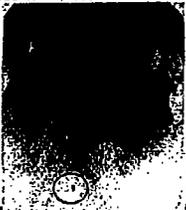
- seen overlapping maxillary tuberosity
- radiopaque



Number	RO/RL
◦ _____	_____ Mental Ridge
◦ _____	_____ Nutrient Canal
◦ _____	_____ Genial Tubercles
◦ _____	_____ Lingual Foramen
◦ _____	_____ Inferior Border of Mandible

Genial Tubercles

- o bony crest on lingual surface
- o located at midline below apices of central incisors
- o round doughnut like shape
- o serves as muscle attachment
- o radiopaque



Lingual Foramen

- o small circular area
- o surrounded by genial tubercles
- o radiolucent



Nutrient Canals

- o contains blood vessels and nerves
- o supplies to teeth, bone & gingiva
- o visible mainly in anterior of mandible
- o radiolucent



Mental Ridge

- o extend from premolar to symphysis
- o bilateral
- o radiopaque



Inferior Border of the Mandible

- o heavy layer of cortical bone
- o radiopaque



o Number	RO/RI	
o _____	_____	Torus Mandibular
o _____	_____	External Oblique Ridge
o _____	_____	Internal Oblique Ridge (mylohyoid ridge)
o _____	_____	Submandibular fossa
o _____	_____	Mandibular Canal
o _____	_____	Mental Foramen

Mental Foramen

- opening on the buccal aspect of mandible
- located in the premolar area
- radiolucent



Mandibular Canal

- extends from mandibular foramen to mental foramen
- carries nerves and blood vessels
- parallel lines outlined by cortical bone
- radiolucent



External Oblique Ridge

- diagonal ridge of bone (buccal)
- appears at the cervical portion of the molar and premolar roots
- radiopaque



Internal Oblique Ridge

- mylohyoid ridge
- diagonal ridge of bone (lingual)
- appears near the apices of the molar roots
- radiopaque



Submandibular Fossa

- depression in the lingual of the mandible
- appears at the roots of the molar and can extend to premolar region
- radiolucent



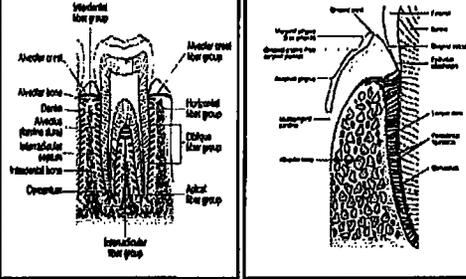
Torus Maxilla and Mandible

- radiopaque



Torus Mandibular

- o outgrowth of bone
- o radiopaque

Number	RO/RL	
o	—	Enamel
p	—	Pulp Canal
o	—	Cancellous (trabeculae) Bone
o	—	Dentin
e	—	Lamina Dura
o	—	Alveolar Crest
o	—	Periodontal Membrane
o	—	Pulp Chamber
a	—	Cementum

Tooth Anatomy

- o enamel
 - o white, compact
 - o very hard substance
 - o covers the dentin
 - o Radiopaque
- o dentin
 - o substance that surrounds the tooth pulp
 - o covered by enamel & cementum
 - o Radiopaque
- o enamel/dentin junction



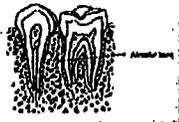
Tooth Anatomy

- o cementum
 - o bony tissue that covers the root of the teeth
 - o radiopaque
- o pulp
 - o noncalcified tooth structure
 - o radiolucent



Alveolar Process

- o surrounds & supports the roots of the teeth
- o radiopaque



trabecular bone (cancellous bone)
softer spongy bone
inside portion of bone (bulk)
cells vary in size and density
radiopaque

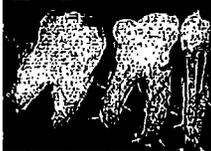
Lamina Dura

- Thin layer of cortical bone
- Lines the alveolus
- Radiopaque line that surrounds the root



Periodontal Ligament

- dense fibrous tissue that binds cementum to lamina dura
- radiolucent



Dental Pathology

- Dental caries - radiolucent
 - Interproximal
 - occlusal
 - recurrent
 - advanced (pulpal involvement)
 - deciduous decay



To Whom it May Concern,

I participated in the Advanced General Residency Program (AGPR) at Cherokee Nation W.W. Hastings Indian Hospital in Tahlequah, OK from 10 SEP 2012 through 08 APR 2013. The program is an ADA Accredited 2 year full time hospital based program that consists of both full time clinical, as well as, an included didactic component. The program is an equivalent to the 2 year AGPR provided through the United States Navy at the National Navy Medical Center in Bethesda, MD. The program included a pediatrics(clinical, lecture and OR training), OMFS(clinical, lecture and OR), Periodontics(clinical and lecture), endodontics(clinical and lecture), and prosthodontics(primarily clinical). The curriculum also included a 6 week Anesthesia/ Sedation rotation in the 1st year, as well as, a 6 week Internal Medicine rotation in the second year. Lastly, the program included after hours ER call which consisted of management of primarily facial swellings, trauma(suturing of complex facial laceration, avulsions and alveolar fractures).

I have requested and am awaiting receipt of a verification letter from the Residency Director for enrollment dates.

I would like consideration for Continuing Education hours for my time of enrollment as requested in my previous letter.

V/R

LCDR Scott B. Williams, DDS

Braness, Christel [IDB]

From: Williams, Scott (IHS/OKC/CLA) <scott.williams@ihs.gov>
Sent: Monday, May 13, 2013 12:20 PM
To: Iowa Dental Board [IDB]
Subject: RE: Continuing ed hours for residency
Attachments: IOWA Dental Board.docx

Here is a summary letter describing the program. I am awaiting a verification letter from the AGPR director. I will send it to you as soon as I receive it. Thanks

From: Iowa Dental Board [IDB] [mailto:IDB@iowa.gov]
Sent: Monday, May 13, 2013 11:17 AM
To: Williams, Scott (IHS/OKC/CLA)
Subject: RE: Continuing ed hours for residency
Importance: High

The Continuing Education Advisory Committee has reviewed your request. They asked that you forward some additional information about the residency program in which you participated. They had some difficulty in arriving at the number of continuing education hours, which should be awarded.

Specifically, they would like information about what you completed during your time in residency. Did you attend lectures/classroom training? Did you spend time practicing in a clinic? The more information that you can provide, the better it will help the committee arrive at a final recommendation.

Let me know if you have any other questions.

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

CONFIDENTIAL NOTICE: This email and the documents accompanying this electronic transmission may contain confidential information belonging to the sender, which is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reference to the contents of this electronic information is strictly prohibited. If you have received this email in error, please notify the sender and delete all copies of the email and all attachments. Thank you.

From: Williams, Scott (IHS/OKC/CLA) [mailto:scott.williams@ihs.gov]
Sent: Monday, May 13, 2013 9:10 AM
To: Iowa Dental Board [IDB]
Subject: Continuing ed hours for residency

Christel Braness,

Were you able to determine the number of continuing ed hours I will receive for the 7 months I was in the AGPR Residency ending in APR 2013? I know the continuing ed committee was going to look into it, and I had not heard anything in response. Thanks

License number IA08585

LCDR Scott B. Williams, DDS

APPLICATION FOR PRIOR APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Broadlawn Medical Center

Address: 1801 Hickman Road

Phone: 282-2278 Fax: E-mail: kford@broadlawn.org

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
Dental School
Dental Hygiene School
Dental Assisting School
Military

Other (please specify): Medical Center with Dental Clinic

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
Home study (e.g. self assessment, reading, educational TV)
Participation
Discussion
Demonstration

4. Course Title: The Refugee Experience

5. Course Subject:

- Related to clinical practice
Patient record keeping
Risk Management
Communication
OSHA regulations/Infection Control
Other:

6. Course date: June 5 2013 Hours of instruction: 2

CK# 0023344B

7. Provide the name(s) and briefly state the qualifications of the speaker(s): Resume highlighted and attached

8. Please attach a program brochure, course description, or other explanatory material. Attached

9. Name of person completing application: Kari Ford

Title: Clinical Educator Phone Number: 282-2278

Fax Number: 282-7458 E-mail: kford@broadlawns.org

Address: 1801 Hickman Road DSM, Ia 50314

Signature: [Signature] Date: 5-23-13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

**Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**



THE REFUGEE EXPERIENCE

WHEN:

Wednesday, June 5, 2013
8:30 – 11:30 a.m.

WHERE:

MOB Conference Room
Broadlawns Medical Center
1801 Hickman Road, Des Moines, Iowa 50314

AUDIENCE:

This course is intended for all health professions and students.

COURSE FACULTY:

Laura Wonderlin, B.A.
R.P. Case Manager & Community Outreach Specialist
U.S. Committee for Refugees and Immigrants

CONTACT HOURS:

3.6 contact hours will be awarded for successful completion of the course. Contact hours will not be awarded for partial attendance.

REGISTRATION FEES:

Free - BMC Employees
\$30 - Non-BMC Employees

CONTACT:

Kelsey Wolfe, Central Iowa AHEC
515-282-4891
kwolfe@broadlawns.org

Approved by BMC Academy & brought to you by:

Central Iowa AHEC & Broadlawns Medical Center
Iowa Board of Nursing – Provider #38

LEARNING OBJECTIVES

1. Identify refugee communities, challenges in the United States and specifically with health care.
2. Demonstrate a basic understanding of cultural competency.
3. Describe techniques they can use to increase communication.

REGISTRATION

Name: _____
License #: _____
Company: _____
Phone: _____
Email: _____

*Please return this registration form along with a check by mail (made payable to Broadlawns Medical Center) to Kelsey Wolfe, Broadlawns Medical Center, 1801 Hickman Rd, Des Moines, IA 50314, or via email to kwolfe@broadlawns.org. BMC employees can now register for this course on Healthstream. Registration must be received by May 31st. **Cancellations received by this date will be eligible for a full refund.***

broadlawns
MEDICAL CENTER

Central
iOWA
Area Health Education Center

1801 Hickman Road
Des Moines, Iowa 50314
www.centraliowaahec.org

LAURA L. WONDERLIN

9527 University Ave #23 Clive, IA 50325

(515) 867-6334

Laura.Wonderlin@gmail.com

EXPERIENCE

Reception and Placement Coordinator, US Committee for Refugees and Immigrants, Des Moines, Iowa

November 2011-present

- Serves as central contact point for newly arrived refugees in the Reception and Placement program
- Networks and maintains relationships with employers to assist with job placement
- Manages individual cases with tasks including apartment control, budgeting, employment applications, donation tracking, school enrollments and home visits
- Coordinates all volunteer activities, ESL and community orientation classes
- Pays rent for clients in timely manner
- Maintains case files of Reception and Placement program to comply with all governmental regulations

Freelance writer

January 2010-present

- Published articles include "Life Abroad," *University of Iowa Honors newsletter*, January 2011; "Women in Jordan," *PinkPangea.com*, October 2010; "Practicing Hospitality," *The Lutheran Witness*, April 2010; "Becoming Vegan: 14 Days of No Dairy, Meat or Eggs," *Iowa Source magazine*, March 2010

Intern, Iowa Health Care Association, West Des Moines, Iowa

May-September 2010

- Wrote and designed quarterly newsletters for Certified Nursing Assistants
- Coordinated scholarship competition and recipient notification

Intern, Stanley Foundation, Muscatine, Iowa

October 2009-January 2010

- Researched articles related to nuclear non-proliferation
- Helped plan and write articles on current events for monthly online newsletter

Receptionist, Duncan, Green, Brown and Langeness, Des Moines, Iowa

May-August, December 2008

- Handled bank deposits
- Delivered certified documents to the Iowa Supreme Court and Polk County Courthouse

Cashier, Dairy Queen, Windsor Heights, Iowa

April 2005-August 2008, May-August 2009, 2010

EDUCATION

University of Iowa, Iowa City, Iowa

2008-2011

Degree B.A.
Majors Journalism and Mass Communications
 International Studies with emphasis on Middle Eastern and Muslim World Studies
Recipient University of Iowa Old Gold Scholarship, Study Abroad Merit Scholarship

University of Jordan, Amman, Jordan

2010

Focuses Arabic, International Studies

Theodore Roosevelt High School and Central Academy, Des Moines, Iowa

2004-2008

Class Rank: 1
Honors National AP Scholar
 National Honor Society
 Four-time Academic Letter Winner
 Global Youth Institute participant, Taipei, Taiwan, and Edmonton, Canada

RECEIVED

MAY 31 2013

IOWA DENTAL BOARD

APPLICATION FOR PRIOR APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Institute for Natural Resources (INR)
Address: P.O. Box 5757, Concord, California 94524-0757
Phone: (925) 609-2820 ext. 238 Fax: (925) 363-7798 E-mail: dcheung@biocorp.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
Dental School
Dental Hygiene School
Dental Assisting School
Military
Other (please specify): Non-profit organization offering CE courses

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
Home study (e.g. self assessment, reading, educational TV)
Participation
Discussion
Demonstration

4. Course Title: Food, Mood, & Cognition

5. Course Subject:

- Related to clinical practice
Patient record keeping
Risk Management
Communication
OSHA regulations/Infection Control
Other:

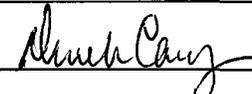
6. Course date: Please see Appendix A Hours of instruction: Six

Handwritten notes: CK # 7882 \$10

7. Provide a detailed breakdown of contact hours for the course or program:
Please see appendix B. Thank You.

8. Provide the name(s) and briefly state the qualifications of the speaker(s):
Dr. Laura Pawlak, Ph.D., please see appendix C. Thank You.

9. Please attach a program brochure, course description, or other explanatory material.

10. Name of person completing application: Deborah Cheung
Title: Accreditation Manager Phone Number: (925) 609-2820, ext. 238
Fax Number: (925) 363-7798 E-mail: dcheung@biocorp.com
Address: P.O. Box 5757, Concord, California 94524-0757
Signature:  Date: May 28, 2013

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov.

You will be contacted after the Continuing Education Advisory Committee has reviewed your request. Please allow a minimum of two to three weeks for a response.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

**Iowa Dental Board
Advisory Committee on Continuing Education
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**

Institute for Natural Resources

P.O. Box 5757 ♦ Concord, CA 94524-0757 ♦ (925) 609-2820 ♦ FAX (925) 363-7798

May 28, 2013

Iowa Board of Dental Examiners
Advisory Committee on Continuing Education
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Dear Board Representative:

Under its current organizational approval with the Iowa Board of Dental Examiners, the Institute for Natural Resources would like to submit an application for **prior approval** of its continuing education course entitled, "Food, Mood, & Cognition." This course is designed to meet the needs of licensed dentists seeking continuing education credit.

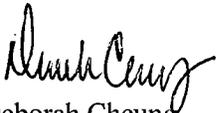
In addition to the completed application, please find appendices A through D enclosed. These materials include a check for \$10 and the following appendices.

- ✓ Dates, Times, & Locations—**Appendix A**
- ✓ Time Agenda/Course Outline—**Appendix B**
- ✓ Instructor's Resume—**Appendix C**
- ✓ Course Description & Brochure—**Appendix D**

The Institute is a non-profit, scientific, and educational organization founded and maintained by professional scientists and educators. The Institute is free of any ties to commercial, political, or religious organizations. The purpose of the Institute is to provide high-quality, professional continuing education programs that enable healthcare professionals to provide quality services. The education courses offer up-to-date, in-depth information about the latest scientific and clinical research.

Please contact me at 925-609-2820 ext. 238 if you have any questions or require further information.

Sincerely,



Deborah Cheung,
Accreditation Manager
Accreditation Department

Enclosures

**INSTITUTE FOR NATURAL RESOURCES
COURSE: "FOOD, MOOD, & COGNITION"**

Appendix A
Dates, Times, & Locations

Davenport, Iowa

Wednesday, August 14, 2013
8:30am to 3:30pm

Instructor: Dr. Laura Pawlak, Ph.D.

Waterloo, Iowa

Thursday, August 15, 2013
8:30am to 3:30pm

Instructor: Dr. Laura Pawlak, Ph.D.

Des Moines, Iowa

Friday, August 16, 2013
8:30am to 3:30pm

Instructor: Dr. Laura Pawlak, Ph.D.

Kearney, Nebraska

Thursday, August 29, 2013
8:30am to 3:30pm

Instructor: Dr. Laura Pawlak, Ph.D.

Omaha, Nebraska

Friday, August 30, 2013
8:30am to 3:30pm

Instructor: Dr. Laura Pawlak, Ph.D.

Appendix B

Food, Mood & Cognition (Updated Outline)

7:45-8:30 Registration

8:30-10:00 AM

- **Key Factors for Building and Preserving a Healthy Brain**
- **Brain Food.** How Food and Nutrients Affect Brain Cells
- **The Brain Under Assault:** Neuro-inflammation /" Inflammaging," Brain Insulin Resistance ("Type 3 Diabetes"), and Oxidative Stress

10:00 AM-11:30 AM

- **Western Diet and Cognitive Impairment.** The Insidious Effect of Saturated Fats. Does Sugar Make Us Dumb?
- **The Hungry Brain. Overeating and Brain Deterioration.** Energy Balance, Brain Health and Cognition.
- **Food and Mood. The Link Between Junk Food and Depression/Anxiety.** The Rise of Mental Health Disorders in Our Youth. Inflammation as the Common Denominator?
- **Obesity and Poor Mental Health. Is it What We Eat, or What's Eating Us?** Interactions Between Stress, Sadness and Food Intake.
- **Poor quality diet: promoting food addiction?**
- **Dental Health Implications.** Impact of Diet, Obesity, Stress and Depression on Oral Health.

11:30 AM-12:20 PM Lunch

12:20 PM – 2:00 PM

- **The Gut as Our 2nd Brain:** Your Gut Has a Mind of its Own. Could the Gut be the Center of Many of Our Physical and Psychiatric Ailments? Gut Signals That Impact Overeating, Mood and Cognition. Gut Dysfunction, Inflammation and Brain Health.
- **Our Inner Ecosystem.** How **Gut Bacteria** Shape Our Minds and Bodies. To What Extent Can We Blame Our "Bugs" for Obesity and Depression?
- **The Gastrointestinal (GI) Barrier:** Our Defense Against the External Environment. Leaky Gut Syndrome.
- **Chronic Stress:** How it Impairs Our Intestinal Barrier and Alters Gut Bacteria.
- **Do All Diseases Begin in the Gut?** The Link Between Altered GI Function and Allergy, Inflammatory Diseases, Autoimmune Diseases, Diabetes, Arthritis, Autism, ADD/ADHD, Obesity, Eating Disorders, Depression, and Other Chronic Disease States.
- **America's Chemical Cuisine:** Food Additives, Preservatives, Pesticides, Genetically Modified Foods. What Impact is it Having Our Gut and Brain Health? Dangerous Grains: Who Could Benefit From a Gluten Free Diet?
- **Medications** That Cause Digestive Problems (eg., Antibiotics, NSAIDs, etc.).
- **Prebiotics and Probiotics:** Superfoods or Super Swindle? Probiotics to Treat Depression? What to Recommend to Our Patients?

2:00 PM – 3:20 PM

- **Can We Eat our Way to Happiness?** Diet as a Depression Cure. Nutrition for Addiction Recovery.
- **The WAY to Eat** to Improve Brain Health, Appetite and Weight Control, Energy, Mood, Cognition, Dental Health and Gut Health. What's the Secret?
- **Shaping a Better Brain.** Food for Thought. Feeding the Brain to Optimize Academic Success.
- **Dietary Supplements and Cognition** (Omega 3, Gingko, Coconut oil, etc.): What *Really* Works?

3:20 PM – 3:30 PM Evaluation, Questions and Answers

INSTITUTE FOR NATURAL RESOURCES
COURSE: "FOOD, MOOD, & COGNITION"

Appendix C
Instructor Resume

Dr. Laura Pawlak, Ph.D.

Please see the attached resume. Thank You.

LAURA LOUISE PAWLAK, R.D., M.S., Ph. D.
HC1 Box 8 Elgin AZ 85611
PHONE: 520.455.5760
FAX: 520.455.5117
CELL: 520.483.1337

BIRTH DATE: 11-18-43

EDUCATION:

Mundelein College, Chicago, Illinois, B.S., 1965
University of Illinois, Urbana, Illinois, M.S. Nutrition, 1966
Hines V. A. Hospital, Maywood, Illinois, Dietetic Internship, 1967
University of Illinois, Medical Center, Chicago, Illinois, 1973
Ph.D., Biochemistry, specialty Immunology, Genetics, Neurochemistry
University of California, San Francisco Medical Center,
Postdoctorate, 1976, Immunology
Teaching Credentials, California, College level, 1981
Certification - Aerobic Instructor, CPR Trained, AFAA Assoc., 1984
Certification - Fitness Instructor, A.C.S. M., 1985.
Certification - Health Rhythm Drummng Facilitator, 2006
(proven stress management protocol to elevate NK cells)

PROFESSIONAL ASSOCIATIONS:

American Dietetic Association
Aerobics and Fitness Association of America
Am. Dietetic Association Practice Group
Sports & Cardiovascular Nutritionists
American College of Sports Medicine

HONORS:

Honor Society, Mundelein College, Chicago, Illinois, 1961 through 1965
Magna Cum Laude Graduate, Mundelein College, Chicago, Illinois, 1965
Full Fellowship, University of Illinois, Urbana, Illinois, 1965-66
Full Fellowship, University of Illinois, Chicago, Illinois, 1969-73
Postdoctoral Fellowship, U. California, San Francisco, 1973-76
Award, Best Performance, Dietetic Internship, Hines VA Hospital, 1967
Award, Best Graduate Lecturer, University of Illinois, Chicago, 1973.

CURRENT POSITION: INTERNATIONAL SPEAKER, 80 seminars/ year
Institute for Natural Resources/Biomed Corporations, Berkeley, CA
1991 to present

6 hour continuing education seminars for health professionals

The Aging Brain

Mood, Mind, and Appetite

Hormones, Diet and Behavior

Diseases of Aging

The Genetics Revolution

The Power of Estrogen

Women's Health: PMS, Menopause & Beyond

Women's Health: Obesity, menopause, fatigue

Skin Health

Beyond Cholesterol

Beyond Overeating

Beyond Prozac

Beyond Ritalin

Beyond Estrogen

The Craving Brain

Sexuality and Health

Allergies, Asthma, and Hives

Alternative Medicine

Herbs, Nutraceuticals, and Vitamins

Hormone Replacement Therapy

Bipolar Disorder and Depression

Brain Circuits

Cerebral Dominance

The Female Brain

Fighting Fat After Thirty

Obesity and Diabetes

Weight Matters

Sleep, Anxiety and Drugs

Hyperactivity, Dyslexia, and Autism

Cerebral Mysteries

The Low Carb Frenzy

Inflammation and the Fat Cell

Stress, Depression, and Pain

Depression and Bipolar disorder

Brain Injury

Dementia, Parkinson's and Alzheimer's Diseases

Memory, Aging, and Sleep

Stress, Emotions, and Disease

Aging Body, Aging Mind

TELEVISION INTERVIEW:

KVCR Cable TV, Public Broadcasting in Southern California,
LIFE WITHOUT DIETS, February 15, 1991

PAST CORPORATE EXPERIENCE:

SENIOR VICE-PRESIDENT, Technology & Product Development,
HEALTHVU, La Jolla, California, 1992

NATIONAL LECTURES, NUTRITION & FITNESS

THE R.D.: LEADER OF THE FITNESS BOOM,
lecture tour 1986 to 1990

A product of LAURA PAWLAK SEMINARS,
Laura Pawlak, owner and speaker.
Presented in 40 major cities within the U.S. each year.

INTERFACING WITH THE PUBLIC...SUCCESSFULLY
lecture tour 1990

A product of LAURA PAWLAK SEMINARS,
Laura Pawlak, owner and speaker.
Presented in 40 major cities within the U.S. in 1990.
Promoted by Rockport Shoes and Healthy Choice Frozen Meals

SPORTS NUTRITION SEMINAR

Seminar for Dietetic interns in Chicago Area, presented annually
Hines VA Hospital, Maywood, Illinois 1988-1994

CONFERENCE FOR WOMEN

El Camino Hospital, Mountain View, California,
May 30, 1992

ALL ABOUT FAT

A lecture for the public, Mercer Medical Center, Trenton, New
Jersey, April 7, 1992

CHILDREN AND HEART DISEASE

A lecture for the public, Mercer Medical Center, Trenton, New
Jersey, May 9, 1992

LIGHTEN THE LOAD ON YOUR HEART

A lecture for the public, Eden Hospital Medical Center, Castro
Valley, California, February 29, 1992

CHALLENGES AND CHOICES...WOMEN IN MIDLIFE

A lecture for the public, Eden Hospital Medical Center, Castro Valley, California, June 1, 1991

DO YOU FILL A NEED OR CREATE ONE?

New York Dietetic Association
Keynote Speaker, Albany, New York, May 5, 1991

SPORTS NUTRITION

Arkansas Dietetic Association
Little Rock, Arkansas, March 10, 1991

NUTRITION FOR THE ACTIVE PERSON

Monterey Dietetic Association
Monterey, California, March 2, 1991

WEIGHT MANAGEMENT: EXERCISE\METABOLIC FACTORS

Greater Cincinnati Dietetic Association, Cincinnati, Ohio,
November 3, 1990

NUTRIENT UTILIZATION: BENEFIT OF EXERCISE

University of Cincinnati Medical Center, Cincinnati, Ohio,
August 30, 1990

STOP FEEDING YOUR FAT CELLS.

Caldwell Bankers' Spouse Program, Stouffer Resort, Indian Wells, California, January 17, 1990

MUSCLES IN MOTION & EXERCISE PRESCRIPTION

Washington State Dietetic Association, Seattle, Washington, May 22, 1990

Missouri State Dietetic Association, St. Louis, Missouri, April 23, 1990

Michigan State Dietetic Association, Lansing, Michigan, April 20, 1990

Oklahoma State Dietetic Association, Oklahoma City, Oklahoma, April 19, 1990

New Jersey Dietetic Association, Newark, New Jersey, September 22, 1989

LIFE WITHOUT DIETS in Hawaii

Wailuku Community Center, lecture for public, Oahu, Hawaii, May 20, 1989

Maui Memorial Hospital, lecture for professionals, May 19, 1989

FITNESS IN TODAY'S LIFESTYLE

Maui Fitness Day, Keynote Speech, Maui, Hawaii May 20, 1989

LIFE WITHOUT DIETS

New Mexico Dietetic Association
Las Cruces, New Mexico, June 14, 1989

LIFE WITHOUT DIETS

California Dietetic Association Meeting,
May 14, 1989, San Jose, California

MARKETING FAT LOSS AND FITNESS

Continuing Education Seminar for Registered Dietitians and
Physicians,
Annual Winter Meeting, Park City, Utah, March 11, 1989

EXERCISE FOR FAT LOSS AND FITNESS

New York Dietetic Association, Albany, New York,
March 10, 1989

IS THERE "LIFE WITHOUT DIETS"?

Maine Nutrition Association, Portland, Maine,
March 9, 1989

THE R.D.: LEADER IN THE WELLNESS ERA

Oregon Dietetic Association, Portland, Oregon, February 1, 1989
Continuing Education Seminar for Registered Dietitians

LIFE WITHOUT DIETS

Fresno Dietetic Association, Fresno, California, February 9, 1989
Continuing Education Seminar for Registered Dietitians

SUPERMARKET SMART

Palm Valley Health Spa, Palm Desert, California, January 7, 1989
Seminar for public

THE WELLNESS-FITNESS PRESCRIPTION

Continuing Education Seminar for all health professionals,
sponsored by Ross Laboratories and Mead Johnson, Nashville,
Tennessee, December 1 & 2, 1988.

LIFE WITHOUT DIETS

Kansas Dietetic Association, Wichita, Kansas, November 3, 1988
Continuing Education Seminar For Registered Dietitians

PACKAGING YOURSELF FOR SUCCESS

Women in business, Nashville, Tennessee, September 23, 1988

THE DIABETIC AND EXERCISE

Continuing Education Program for Physicians and Dietitians
Nashville, Tennessee, September 22, 1988

LIFE WITHOUT DIETS

Continuing Education Program for Registered Dietitians
sponsored by AHEC & Veteran's Administration Hospital, Boise,
Idaho, September 20, 1988

LIFE WITHOUT DIETS

Continuing Education Program for Registered Dietitians
sponsored by AHEC, Lewiston, Idaho, September 19, 1988

SELLING THE PUBLIC THE PRODUCT...YOU

Arizona Dietetic Association, Phoenix, Arizona, June 3, 1988
Seminar for Registered Dietitians

LIFE WITHOUT DIETS

Arizona Dietetic Association, Phoenix, Arizona, June 3, 1988
Continuing Education Seminar for Registered Dietitians

LIFE WITHOUT DIETS

Long Beach Chapter American Heart Association, Long Beach,
California, November 4, 1987
Continuing Education Program for Registered Dietitians

LIFE WITHOUT DIETS

Program for Physicians
Pasadena, California, October 28, 1987
Culver City, California, November 7, 1987
Torrance, California, November 20, 1987

THE REGISTERED NURSE: FACING THE WELLNESS ERA

San Bernardino, California, November 16 and November 18,
1987
Continuing Education Program for Registered Nurses

LIGHTEN YOUR LOAD - CORPORATE PROGRAM

E. F. Hutton Corporation
Palm Springs, California, February 12, 1987.

THE UNTAPPED OPPORTUNITIES IN FITNESS EVALUATION
AND NUTRITIONAL ANALYSIS

International Racquet and Sports Association, Los Angeles,
California, September 22, 1986
lecture for owners/managers of Health Spas

MEETING THE CHALLENGE OF THE WELLNESS ERA

San Gabriel Chapter of the California Dietetic Association
Pasadena, California, September 10, 1986
Continuing education for Registered Dietitians

THE R.D. LEADS THE FITNESS BOOM

Stanford University, Annual Clinical Dietetics Meeting
Palo Alto, California, September 1986
lecture for Registered Dietitians

PREVENTIVE HEALTH - NUTRITION AND EXERCISE

Presented through Medical Seminars, Sacramento, California
Continuing education for Physicians, Registered Nurses,
Pharmacists, Dentists
Cancun, Mexico, March 10-17, 1986, January 15-22, 1987,
June 5-12, 1987
Palm Springs, California, February 2-3, 1987

LIGHTEN YOUR LOAD

Palm Valley Health Spa, Palm Desert, California
A heart disease prevention program for the general public
February 4, 1986, November 20, 1986, March 1, 1987,
January 26, 1988

YOU AND YOUR DIET, WHY WEIGHT? EAT LOTS, WEIGH LESS!
THE PREVENTABLE BONE ROBBERY. THE VITAMIN CONTROVERSY
LIFE WITHOUT DIETS

Palm Valley Health Spa, Palm Desert, California
lectures for the public, 1985/86/87

REFUTING THE SETPOINT THEORY FOR PERMANENT
WEIGHT CONTROL

Medical Education Program Planners, Millbrae, California
Continuing education for Registered Nurses:
Sunnyvale, California, February, 1985, January, 1986,
April, 1986
Sacramento, California, November, 1985
Minneapolis, Minnesota, April, 1985, November, 1986

OSTEOPOROSIS: THE ROLE OF DIET AND EXERCISE
Medical Ed Program Planners, Millbrae, California
Continuing education for Registered Nurses
Palo Alto, California, August, 1984
Minneapolis, Minnesota, Oct. 1984
Minneapolis, Minnesota, May, 1985
Sunnyvale, California, June, 1984
Minneapolis, Minnesota, May, 1986
Minneapolis, Minnesota, November, 1986
Minneapolis, Minnesota, May, 1986
Minneapolis, Minnesota, April, 1987

UNDERSTANDING EXERCISE
Medical Ed Program Planners, Millbrae, California
Continuing education for Registered Nurses
Minneapolis, Minnesota, April, 1987

TODAY HYPOGLYCEMIA, TOMORROW DIABETES?
Medical Ed Program Planners, Millbrae, California
Continuing education for Registered Nurses
Sunnyvale, Ca., Nov. 1985
Minneapolis, Minnesota, May, 1986
Sacramento, Ca., Jan. 1986
Oakland, California, April, 1986

DIABETES, CONTROL BY DIET AND EXERCISE
Medical Educational Program Planners, Millbrae, California
Continuing education for Registered Nurses
Sunnyvale, California, November, 1984

TOOLS OF PREVENTIVE HEALTH:
NUTRITION AND EXERCISE
Medical Educational Program Planners, Millbrae, California,
Continuing education for Registered Nurses
Santa Rosa, California, February, 1984

SPORTS NUTRITION AND WEIGHT CONTROL
Aerobic and Fitness Association of America
Certification lecture for Aerobic Instructor
Anaheim, California, March, 1985
Palm Springs, California, July, 1985
Los Angeles, California, July, 1985 and January, 1996

OSTEOPOROSIS: INEVITABLE OR PREVENTABLE?

Aerobic and Fitness Association of America, Anaheim, California,
April, 1985 Annual Meeting Seminar Series

FOR TENNIS NUTS ONLY: AEROBICS

Sponsored by Aerobic and Fitness Association of America,
Anaheim, California, April, 1985 Annual Meeting Seminar Series

EXERCISING IN HOT WEATHER:
NUTRITIONAL CONSIDERATIONS

Palm Valley Health Spa, Palm Desert, California,
one hour lecture for the general public June, 1984

THE MARRIAGE THAT LASTS: FOOD AND FITNESS

The Tennis Club, Palm Springs, California, February, 12, 1984

FITNESS, NOT APPLES FOR HEALTH

Lakeside Hospital, Lakeport, California, January, 1984
Continuing education for Registered Nurses

GET FIT, LOSE WEIGHT

Common Health Care Heart Risk Study,
Lakeport, California, February, 1984
lecture series for the general public

POSITIONS HELD: NUTRITION AND FITNESS

CONSULTANT DIETITIAN, PRIVATE PRACTICE

Part time private consultation, 1978-1994
Areas of consultation: exercise prescription for the active
person, sports nutrition, weight management

BOARD OF ADVISORS AND CONSULTANT DIETITIAN

Palm Valley Health Spa, Palm Desert, California, 1978 - 1994

VIDEO - EFFECTIVE WEIGHT LOSS

Palm Valley Health Spa Educational program
for employees at Palm Desert, California, June, 1986

AEROBIC INSTRUCTOR

Woodhaven Country Club,
January, 1985, through June, 1985

VOCATIONAL EXPERIENCE: TEACHING

Nutrition Instructor, Mendocino College, Lakeport, California, 1981

Assistant Instructor, University of Illinois, Medical Center,
Chicago, Illinois, Biochemistry, 1972-73

Nutrition Instructor, Wesley Memorial Hospital, Chicago, Illinois,
Nursing School, 1968, 1969

VOCATIONAL EXPERIENCES: CONSULTANT DIETITIAN

Sebastopol Convalescent Hospital, Sebastopol, California, 1984

Gravenstein Convalescent Hospital, Sebastopol, California, 1984

Fircrest Convalescent Hospital, Sebastopol, California, 1984

Ukiah Convalescent Hospital, Ukiah, California, 1984

Healdsburg Convalescent Hospital, Healdsburg, California, 1984

Santa Rosa Convalescent Hospital, Santa Rosa, California, 1984

Valley View Convalescent Hospital, Ukiah, California, 1984

Creekside Convalescent Hospital, Santa Rosa, California, 1984

Crestview Convalescent Hospital, Petaluma, California, 1984

Lakeport Convalescent Hospital, Lakeport, California, 1984

Public Health, Lake County, Lakeport, California, 1983-84

Multipurpose Senior Service Project, Ukiah, California, 1982-84

Northcoast Area Health Education Center, Ukiah, California, 1982

Obesity Clinic, Lakeside Hospital, Lakeport, California, 1981

Hacienda Convalescent Hospitals, Los Angeles, California, 1977-1984

Private Practice with Dr. Kurz, MD., Lakeport, California, 1980-81

Fair Oaks Nursing Homes, Chicago, Illinois, 1978-81

Kentfield Medical Hospital, Kentfield, California, 1977

Hines V.A. Hospital, Maywood, Il., Rehabilitation Center, Maywood,
Illinois 1968

PUBLICATIONS

Pawlak, L.L.

BEYOND STRESS (working title)

(book, @ 400 pages)

in progress, completion 2007

Study of hormones from fetal life through retirement and the
effects of cortisol on all hormone cycles

- Pawlak, L.L.
STOP GAINING WEIGHT, 2001, 2nd Edition, 2005
(book, 400 pages)
Natural remedies against stressors, rage, depression, addictions,
and food cravings
- Pawlak, L.L.
FOOD SMART, 2000
(book, 200 pages)
A food encyclopedia
- Pawlak, L.L.
A PERFECT 10, 1997
(book, 350 pages)
Understanding phytochemistry against common cancers and
aging diseases
- Pawlak, L.L.
ESTROGEN DILEMMAS, 1996
(book, 212 pages)
Making decisions about estrogen throughout a woman's life
- Pawlak, L.L.
ANTIOXIDANTS, 1995
(2 audiotapes and book, 32 pages),
How antioxidants work, how to set up a nutrient-protective
program
- Pawlak, L.L.
APPETITE: THE BRAIN-BODY CONNECTION, 1994
(book, 208 pages)
Managing appetite and mood for better health
- Pawlak, L.L.
TOMORROW'S WOMAN: ESTROGEN AND HEALTH, 1992
(book, 208 pages)
A unique look at estrogen's power over a woman's life and
health.
- Pawlak, L.L.
FROM THE INSIDE OUT: A UNIQUE LOOK AT THE NUTRITIONAL
NEEDS OF ACTIVE PERSONS, 1989
A Home Study Course for Registered Dietitians

Pawlak, L.L.

LIFE WITHOUT DIETS, 1989

(book, 200 pages)

A beginner's nutrition and exercise book for the public

Pawlak, L.L. and Neid, D.

LIFE WITHOUT DIETS WEIGHT MANAGEMENT PROGRAM

A 2-6 month weight management program for the public presented by hospitals, physicians' offices, dietitians, health clubs, sports medicine centers, and chiropractors throughout the nation.

Pawlak, L.L.

LIGHTEN YOUR LOAD, 1990

(Booklet, 60 pages)

Pawlak, L.L.

LIFE WITHOUT DIETS, PROFESSIONAL GUIDE, 1987

(Workbook for Dietitians, 62 pages)

Pawlak, L.L.

LIFE WITHOUT DIETS, CLIENT PAMPHLET, 1987

(Booklet for the public, 12 pages)

Pawlak, L.L.

OBESITY, 1986

Home Study Course for Registered Nurses

Pawlak, L.L.

OSTEOPOROSIS, 1986

Home Study Course for Registered Nurses

Pawlak, L.L.

GENERAL NUTRITION

Chapter in "Aerobics: Theory and Practice", 1985

Published by Aerobics and Fitness Association of America, Sherman Oaks, California

Pawlak, L.L.

NUTRITION FOR ENDURANCE

Chapter in "Aerobics: Theory and Practice", 1985

Published by Aerobics and Fitness Association of America, Sherman Oaks, California

- Pawlak, L.L.
OSTEOPOROSIS, INEVITABLE OR PREVENTIBLE? 1985
Journal of Aerobic and Fitness Association of America
- Pawlak, L.L.
SPORTS NUTRITION FOR THE YOUNG ATHLETE, 1984
Lake County Public Health Publication for Health Professionals
- Pawlak, L.L., D. A. Hart, and A. Nisonoff.
REQUIREMENTS OF PROLONGED SUPPRESSION OF AN
IDIOTYPIC SPECIFICITY IN ADULT MICE.
J. Exp. Med. 137:1442, 1973
- Pawlak, L.L., E. Mushinski, A. Nisonoff and M. Potter
EVIDENCE FOR THE LINKAGE OF THE IgG LOCUS TO A GENE
CONTROLLING THE IDIOTYPIC SPECIFICITY OF ANTI-P-
AZOPHENYLARSONATE ANTIBODIES IN STRAIN A MICE.
J. Exp. Med. 137:22, 1973
- Stites, D., and L.L. Pawlak
ONTOGENY OF BETA-2-MICROGLOBULIN SYNTHESIS IN THE
HUMAN FETUS.
Develop. Comp. Immunol. 2:185, 1978
- Pawlak, L.L.
IDIOTYPIC SPECIFICITIES AS A GENETIC MARKER FOR THE
V-REGIONS OF IMMUNOGLOBULINS POLYPEPTIDE CHAINS.
Ph.D. Thesis, 1973
- Pawlak, L. L., and A. Nisonoff
DISTRIBUTION OF A CROSS-REACTIVE IDIOTYPIC SPECIFICITY
IN INBRED STRAINS OF MICE.
J. Exp. Med. 137:855, 1973
- Pawlak, L.L., A. L. Wang, and A. Nisonoff.
CONCENTRATION OF CROSS REACTIVE IDIOTYPIC
SPECIFICITIES IN UNRELATED MOUSE IMMUNOGLOBULINS.
J. Immunol. 110:579, 1973
- Pawlak, L.L., D. A. Hart, A. Nisonoff, E. Mushinski, and M. Potter.
IDIOTYPIC SPECIFICITY AND THE BIOSYNTHESIS OF ANTIBODY
Third International Convocation of Immunology, January, 1973

Pawlak, L.L., D. A. Hart and A. Nisonoff.

SUPPRESSION OF IMMUNOLOGICAL MEMORY FOR A CROSS-
REACTIVE IDIOTYPE IN ADULT MICE.

Eur. J. Immunol. 4:10, 1974

Hart, D. A., A. L. Wang, L.L. Pawlak, and A. Nisonoff.

SUPPRESSION OF IDIOTYPIC SPECIFICITIES IN ADULT MICE BY
ADMINISTRATION OF ANTI-IDIOTYPIC ANTIBODY.

J. Exp. Med., 135:1293, 1972

Hart, D.A., L.L. Pawlak, and A. Nisonoff.

NATURE OF ANTIHAPTEN ANTIBODIES ARISING AFTER IMMUNE
SUPPRESSION OF A SET OF CROSS-REACTING IDIOTYPIC
SPECIFICITIES.

Eur. J. Immunol., 3:44, 1972

ABSTRACTS:

Pawlak, L.L. and A. Nisonoff.

PRODUCTION OF A CROSS-REACTIVE IDIOTYPE IN INBRED
MICE.

Fed. Proc. 32:4334, 1973

Hart, D.A., Pawlak, L.L., and A. Nisonoff.

PROLONGED SUPPRESSION OF IDIOTYPE IN A/J MICE.

Fed. Proc. 32:1570, 1973.

EDITOR:

THE ANTIOXIDANT COOKBOOK, 1996

Freedman, et. al.

Biomed General, Berkeley, CA

INSTITUTE FOR NATURAL RESOURCES
COURSE: "FOOD, MOOD, & COGNITION"

Appendix D
Course Description & Brochure
(Please see attached brochure)

Maintaining and improving the health of our brains it is essential so as to ensure that it can carry out its vital roles. The course "*Food, Mood and Cognition*" will examine three of these roles. First, it will address the brain's role in maintaining homeostasis or a constant internal environment. One aspect of this is the brain's role in regulating body weight or body fat. Given the fact that ~70% of American adults and at least 30% of American children are overweight, it is clear that, for many of us, this regulatory mechanism is not working efficiently.

A second critical role of the brain is to ensure proper cognitive function. Cognition is the ability to use simple-to-complex information to meet the challenges of daily living. Cognitive health includes elements such as language, thought, memory, executive functions, perception, judgment, attention, remembered skills, and the ability to live a purposeful life. Preserving these functions can literally make the difference between leading an independent or a dependent life. Unfortunately, the risk for cognitive decline increases with age. This is a concern considering that, while today, ~13% of the U.S. population is aged 65 years or older, but by 2020 it will rise to 16%, and by 2050, it will rise to 20% (US Census Bureau). Moreover, while today, ~13% of people age 65 and older has Alzheimer's disease, this number is projected to double by 2050 (Alzheimers Association). The good news is that research is identifying many *modifiable* factors that influence cognitive health. However, it is clear that the best time to incorporate these factors in *earlier* in life. The Alzheimer's Association has a campaign: "Think about your future. Maintain your brain today." The course "*Food, Mood and Cognition*" will provide an overview of valid, evidence-based messages about preserving cognitive health so we can counsel clients and integrate cognitive health issues into *all* healthcare encounters.

A third critical role of the brain is to regulate mood and emotions, so as to ensure emotional and mental health. Unfortunately, many of us do not enjoy this state of well-being. An estimated 1 in 4 people will suffer from mental illness at some stage in their lifetime, causing enormous suffering, a great personal, social and financial burden, as well as associated physical illness (WHO, 2004; Sinn, 2010). Moreover, according to an American Psychological Association survey, the majority of Americans are living with at least moderate to high levels of anxiety and stress. Oftentimes, stress impacts our gut health. According to the National Institutes of Health, ~60-70 million people in the US are affected by digestive disturbances. This is important since we are gaining a much greater appreciation of the strong connections between disturbances of the gut and disturbances of the brain.

The course "*Food, Mood and Cognition*" will provide an overview of the seven key elements for optimal brain health. These include: (1) developmental building blocks or early life influences, (2) proper neurotransmission/brain communication, (3) sufficient oxygen and glucose, (4) nutrients, (5) free of disease or metabolic perturbations, (6) an effective blood brain barrier, and (7) plasticity or the ability to change or adapt.

Unfortunately, we know that our brains are under constant assault. A major cause of brain assault is chronic inflammation. The course "*Food, Mood and Cognition*" will explore factors that promote chronic inflammation in the body, and describe how this ultimately promotes inflammation in the brain or neuroinflammation. It will explain how neuroinflammation adversely impacts the brain's critical roles of maintaining homeostasis (thus influencing energy balance, as well as other functions such as cardiovascular homeostasis), ensuring cognition (thus increasing the risk for cognitive decline), and regulating mood/emotions (thus increasing the risk for depression and negative mood states). This course will also explore two other important sources of brain assault: insulin resistance and oxidative stress, examining their sources and consequences.

The course "*Food, Mood and Cognition*" will provide an overview of factors that contribute to decreased brain health. Much of the focus will be on obesity/excess calories and poor quality diet. Research has identified key dietary components/dietary patterns that can either promote or protect against cognitive decline and poor mental health. This course will describe the role of stress and depression in terms of impacting food choice, influencing inflammation and compromising brain health. It will also outline the fascinating connection between gut health and brain health, exploring the "gut-brain-emotions" link and the many consequences of a disrupted brain-gut axis or alterations in our microbiomes, such as its impact on brain development, mood and behavior, immune function and inflammation, and obesity and metabolic dysfunction.

Finally, the course "*Food, Mood and Cognition*" will provide an overview of a key dietary factors to improve mental health as well as to ensure cognitive health. This will include a discussion of the importance of energy balance, an exploration of the benefit of calorie restriction, the role of omega 3 fatty acids and the Mediterranean diet pattern, the potential benefit of antioxidants and some dietary supplements, and the collaborative effects of diet and exercise. Finally, it will address ways to improve gut health so as to improve brain health.

Participants who complete this course will gain a much fuller understanding of the factors that impact brain health, as well as a range of techniques to help themselves and their patients/clients improve homeostatic function, preserve cognitive function and ensure positive emotional and mental health.

FOOD, MOOD, & COGNITION

Instructor: Laura Pawlak, Ph.D., M.S.

Seminar registration is from 7:45 AM to 8:15 AM. The seminar will begin at 8:30 AM. A lunch break (on your own) will take place from approximately 11:30 AM to 12:20 PM. The course will adjourn at 3:30 PM, at which time course completion certificates are distributed.

PROGRAM / LECTURE

Registration: 7:45 AM – 8:30 AM

Morning Lecture: 8:30 AM – 10:00 AM

- Brain Food, How Food and Nutrients Affect Brain Cells.
- Dietary Supplements and Cognition (Omega 3, Gingko, Coconut oil, etc.): What Really Works?
- Shaping a Better Brain. Food for Thought. Feeding the Brain to Optimize Academic Success.
- Western Diet and Cognitive Impairment – Causing Hippocampal Dysfunction. The Insidious Effect of Saturated Fats. Does Sugar Make Us Dumb?
- The Hungry Brain. Overeating and Brain Deterioration. Energy Balance, Brain Health and Cognition.
- Obesity and Poor Mental Health. Is It What We Eat, or What's Eating Us? Interactions Between Stress, Sadness and Food Intake. Obesity-Associated Brain Inflammation – Promoting Addictive Behaviors?

Mid-Morning Lecture: 10:00 AM – 11:30 AM

- Food and Mood. The Link Between Junk Food and Depression/Anxiety. The Rise of Mental Health Disorders in Our Youth. Inflammation as the Common Denominator?
- The Gut as Our 2nd Brain: Your Gut Has a Mind of its Own. Could the Gut be the Center of Many of Our Physical and Psychiatric Ailments? Gut Signals That Impact Overeating, Mood and Cognition. Gut Dysfunction, Inflammation and Brain Health.
- Our Inner Ecosystem. How Gut Bacteria Shape Our Minds and Bodies. To What Extent Can We Blame Our "Bugs" for Obesity and Depression?
- The Gastrointestinal (GI) Barrier: Our Defense Against the External Environment. Leaky Gut Syndrome.

Lunch: 11:30 AM – 12:20 PM

Afternoon Lecture: 12:20 PM – 2:00 PM

- Chronic Stress: How it Impairs Our Intestinal Barrier and Alters Gut Bacteria. Evidence That Gut Bacteria Actually Influence How Well We Respond to Stress.
- Do All Diseases Begin In the Gut? The Link Between Altered GI Function and Allergy, Inflammatory Diseases, Autoimmune Diseases, Diabetes, Arthritis, Autism, ADD/ADHD, Obesity, Eating Disorders, Depression, and Other Chronic Disease States.
- The Curse of the Inflammatory Western Diet: Promoting Gut Dysfunction and Toxic Intestinal Bacteria That's Taking a Toll on Our Health.
- America's Chemical Cuisine: Food Additives, Preservatives, Pesticides, Genetically Modified Foods. What Impact is it Having Our Gut and Brain Health? Dangerous Grains: Who Could Benefit From a Gluten Free Diet?
- Medications That Cause Digestive Problems (eg., Antibiotics, NSAIDs, etc.).

Mid-Afternoon Lecture: 2:00 PM – 3:20 PM

- Dental Health Implications. Impact of Diet, Obesity and Depression on Oral Health.
- The WAY to Eat to Improve Gut health, Brain Health, Appetite and Weight Control, Dental Health, Energy, Mood and Cognition. What's the Secret?
- Can We Eat our Way to Happiness? Diet as a Depression Cure. Nutrition for Addiction Recovery.
- Food Allergies: How Common Are They Really?
- New-Fangled Fibers: Will the Real Fiber Please Stand Up?
- Probiotics and Prebiotics: Superfoods or Super Swindle? Probiotics to Treat Depression? The GAPS (Gut and Psychology Syndrome) Diet. What to Recommend to Our Patients?

Evaluation, Questions, and Answers: 3:20 PM – 3:30 PM

6 CONTACT HOURS / www.INRseminars.com

MEETING TIMES & LOCATIONS

DAVENPORT, IA	WATERLOO, IA	DES MOINES, IA	KEARNEY, NE	OMAHA, NE
Wed., Aug. 14, 2013	Thu., Aug. 15, 2013	Fri., Aug. 16, 2013	Thu., Aug. 29, 2013	Fri., Aug. 30, 2013
8:30 AM to 3:30 PM	8:30 AM to 3:30 PM	8:30 AM to 3:30 PM	8:30 AM to 3:30 PM	8:30 AM to 3:30 PM
Best Western Plus Inn	Ramada Hotel & Conv. Ctr.	Holiday Inn	Ramada Kearney	Sheraton Omaha
100 West 76th St.	205 West 4th St.	4800 Merle Hay Rd.	301 2nd Ave.	655 North 108th Ave.
Davenport, IA	Waterloo, IA	Des Moines, IA	Kearney, NE	Omaha, NE

TUITION: \$81.00 per person with pre-registration (\$96.00 at the door if space remains). Tuition includes a syllabus. (Group pre-registration rate: \$76.00 per person. To qualify, 3 or more registrations must be submitted together. Please list names of all registrants.)

TO REGISTER: There are **four** ways to register:
 1) **Online:** www.INRseminars.com
 2) **By mail:** Complete and return the Registration Form below.
 3) **By phone:** Register toll-free with Visa, MasterCard, American Express®, or Discover® by calling **1-800-937-6878**. (This number is for registrations only.)
 4) **By fax:** Fax the completed registration form—including Visa, MasterCard, American Express®, or Discover® Number—to (925) 687-0860.
 For all inquiries, please contact **customer service at 1-877-246-6336 or (925) 609-2820**.

Please register early and arrive before the scheduled start time. Space is limited. Attendees requiring special accommodation must advise INR in writing at least 50 days in advance and provide proof of disability. Registrations are subject to cancellation after the scheduled start time. A transfer can be made from one seminar location to another if space is available. Registrants cancelling up to 72 hours before a seminar will receive a tuition refund less a \$25.00 administrative fee or, if requested, a full-value voucher, good for one year, for a future seminar. Cancellation or voucher requests must be made in writing. If a seminar cannot be held for reasons beyond the control of the sponsor (e.g., acts of God), the registrant will receive free admission to a rescheduled seminar or a full-value voucher, good for one year, for a future seminar. A \$25.00 service charge applies to each returned check. Nonpayment of full tuition may, at the sponsor's option, result in cancellation of CE credits issued. The syllabus is not available for separate purchase. A \$15.00 fee will be charged for the issuance of a duplicate certificate. Fees subject to change without notice.

Please check course date:

____ Wed., Aug. 14, 2013 (Davenport, IA)
 ____ Thu., Aug. 15, 2013 (Waterloo, IA)
 ____ Fri., Aug. 16, 2013 (Des Moines, IA)

REGISTRATION FORM

(This registration form may be copied.)

____ Thu., Aug. 29, 2013 (Kearney, NE)
 ____ Fri., Aug. 30, 2013 (Omaha, NE)

Please return form to:

INR
 P.O. Box 5757
 Concord, CA 94524-0757
TOLL-FREE: 1-877-246-6336
 TEL: (925) 609-2820
 FAX: (925) 687-0860

Please print:

Name: _____ Profession: _____
 Home Address: _____ Professional License #: _____
 City: _____ State: _____ Zip: _____ Lic. Exp. Date: _____
 Home Phone: (____) _____ Work Phone: (____) _____ Employer: _____

Please enclose full payment with registration form. Check method of payment. E-Mail: _____ (needed for confirmation & receipt)

____ Check for \$ _____ (Make payable to INR)
 ____ Charge the amount of \$ _____ to my _____ Visa _____ MasterCard _____ American Express® _____ Discover®
 Card Number: _____ Exp. Date: _____
 (enter all raised numbers)

Signature: _____

Please provide an e-mail address above to receive a confirmation and directions to the meeting site.

INR

P.O. Box 5757
Concord, CA 94524-0757
1-877-246-6336
(925) 609-2820
www.INRseminars.com

Celebrating 28 Years

FOOD, MOOD, & COGNITION



6 CONTACT HOURS; \$81 Tuition
Register with Visa, MC, American Express®, or Discover® at: 1-800-937-6878

Presented by Institute for Natural Resources
1-877-246-6336 • (925) 609-2820

DISCOUNTED TUITION

Tuition \$81

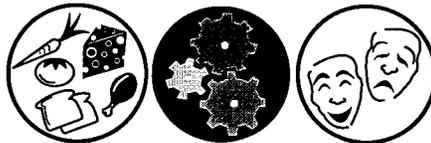
A course for:

Dentists
Dental Hygienists
Members of the Academy
of General Dentistry (AGD)

www.INRseminars.com

6 CONTACT HOURS*

(*See Approval Information for Iowa)



DENTAL EDUCATION 1945

FOOD, MOOD, & COGNITION

Non-Profit Org.
U.S. Postage
PAID
Emporia, KS
Permit No. 16



ACCREDITATION

To obtain the 6 contact hours (0.6 CEU) associated with this course, the dental professional will need to sign in, attend the course, and complete program evaluation forms. At the end of the program, the dental professional successfully completing the course will receive a statement of credit. This is an intermediate-level course.

DENTISTS & DENTAL HYGIENISTS

INR (Institute for Natural Resources) has been approved by the national office of the Academy of General Dentistry (AGD) as a program provider of continuing dental education (see below). Many state boards of dentistry will accept, for credit toward license renewal, courses presented by an AGD-approved organization. INR's approval from AGD covers both live and home-study courses.

Dental professionals in over 40 states have received continuing education credit by completing INR courses. INR or its courses have been approved for continuing education by dental boards in Indiana and California.

Iowa

Application for approval of this course has been made to the Iowa State Board of Dental Examiners for 6 hours of continuing education credit.

Nebraska

Application for approval of this course has been made to the Nebraska Board of Dental Examiners for 6 hours of continuing education credit.

Illinois

Under Sponsor #174-00128, the Illinois Dept. of Prof. Regulation has approved INR as a sponsor of continuing dental work education.

Kansas & Missouri

The Kansas and Missouri Dental Boards will accept continuing education courses sponsored by an organization approved by the Academy of General Dentistry (AGD).

MEMBERS OF THE ACADEMY OF GENERAL DENTISTRY

INR is designated as an Approved PACE Program Provider by the Academy of General Dentistry. The formal continuing dental education programs of this program provider are accepted by AGD for Fellowship/Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from 06/01/12 to 05/31/16.



COURSE RELEVANCE

This course reviews three critical roles of the brain: (1) maintaining homeostasis, with emphasis on the regulation of food intake and body weight, (2) ensuring proper cognitive function, and (3) regulating mood and emotions. It then outlines key elements for optimal brain health, major sources of brain "assault" (chronic inflammation, insulin resistance and oxidative stress), and important factors that contribute to decreased brain health, including poor quality diet and stress. This course examines the effect of stress, not only in terms of how it impacts food choice, but also in terms of its influence on oral health. The behavioral and biological mechanisms whereby stress and depression can increase the risk and severity of dental health problems, as well as impair the healing response to therapy are covered. Finally, this course outlines key lifestyle factors that will improve mental health, as well as to preserve cognitive health. After completing this course dental professionals will be able to give their patients sound advice for improving oral health care, nutritional status and brain health, and to be better able to communicate with physicians, nurses, pharmacists, and other health professionals involved in their patient's care.

Health professionals in fields other than dentistry have been invited to attend this seminar.

INSTRUCTOR

Dr. Laura Pawlak (Ph.D., M.S.) is a full-time biochemist-lecturer for INR. Dr. Pawlak undertook her graduate studies in biochemistry at the University of Illinois, where she received her masters and doctoral degrees. Author of 22 scientific publications and many academic books, she conducted her postdoctoral research in biochemistry at the University of California San Francisco Medical Center.

On such subjects as brain biochemistry, geriatric care, pharmacology, women's health issues, and nutrition, Dr. Pawlak frequently speaks to audiences of health professionals.

INR reserves the right to change instructors without prior notice. Every instructor is either a compensated employee or independent contractor of INR.

SPONSOR

INR (Institute for Natural Resources) is a non-profit scientific organization dedicated to research and education in the fields of science and medicine. INR is the nation's largest provider of live continuing education programs, offering over 600 live seminars yearly.

INR has no ties to any commercial organizations and sells no products of any kind, except educational materials. Neither INR nor any instructor has a material or other financial relationship with any health care-related business that may be mentioned in an educational program. If INR were ever to use an instructor who had a material or other financial relationship with an entity mentioned in an educational program, that relationship would be disclosed at the beginning of the program. INR does not solicit or receive gifts or grants from any source, has no connection with any religious or political entities, and is totally supported by its course tuition.

INR's address and other contact information follows:

P.O. Box 5757, Concord, CA 94524-0757

Customer service: 1-877-246-6336 or (925) 609-2820

Fax: (925) 687-0860

E-Mail: info@inrseminars.com; website, www.INRseminars.com

Tax Identification Number 94-2848967.

Education expenses (including enrollment fees, books, tapes, travel costs) may be deductible if they improve or maintain professional skills. Treas. Reg. Sec. 1.162-5. Recording of the seminar, or any portion, by any means is strictly prohibited. INR's liability to any registrant for any reason shall not exceed the amount of tuition paid by such registrant.

For American Disability Act (ADA) accommodations or for addressing a grievance, please fax the request to INR at (925) 687-0860. Or, please send the request by email to: info@inrseminars.com

LEARNING OBJECTIVES

Participants completing this course will be able to:

- 1) describe how nutrition can be used to enhance cognitive function.
- 2) characterize the relationship between diet, obesity and poor mental health.
- 3) describe how gut health can affect brain health, and vice versa.
- 4) explain how stress and inflammation impact the gut and the brain, and therefore influence our physical and mental health.
- 5) list interventions to improve appetite control and mood.
- 6) outline the relationship between food, mood and dental health.
- 7) describe, for this course, the implications for dentistry, mental health, and other health professions.

STATE OF IOWA
DEPARTMENT OF REVENUE
IOWA DENTAL BOARD

RECEIVED

MAY 28 2013

APPLICATION FOR POST APPROVAL OF IOWA DENTAL BOARD
CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
www.dentalboard.iowa.gov

NOTE: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Course Title: "Considerations for Providing Dental Treatment to the Geriatric Patient"

2. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

3. Course date: 4/5/13 Hours of instruction: 3.5 hours

4. Provide a detailed breakdown of contact hours for the course or program:

Registration started 8:00A, course started @ 8:30A.

10 min break from 10:00-10:10A.

Course finished @ 12:15p

5. Name of course sponsor: SE IA Dental Society

Address: _____

6. Which of the following educational methods were used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

CK# 1082
\$10

7. Provide the name(s) and briefly state the qualifications of the speaker(s): Lindsey Cosper, DDS
Visiting Assistant Professor @ UofI, College of Dentistry in the Geriatric &
Special Needs Clinic. Completed 1 yr Fellowship in Geriatrics & Special Needs
Current clinical instructor to 4th yr dental students & Geriatric & Special Needs
Fellows, didactic instruction & seminars to 3rd & 4th yr dental students

8. Please attach a program brochure, course description, or other explanatory material.

9. Name of person completing application: Lucas Lemburg, DDS
Title: SEIA Dental Society President Elect Phone Number: 319-728-7400
Fax Number: 319-728-7404 E-mail: llemburg@chcseia.com
Address: 2409 Spring St. Columbus City, IA 52737
Signature:  Date: 5/9/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(6), within 90 days after the receipt of application, the Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

GUEST SPEAKER

DR. LINDSEY COSPER

Dr. Lindsey Cosper is currently a Visiting Assistant Professor at the University of Iowa, College of Dentistry in the Geriatric and Special Needs Clinic. After growing up in Hinsdale, IL, she moved to Iowa and completed both her undergraduate and graduate studies at the University of Iowa, receiving her D.D.S. in 2011. After graduation, she completed a one-year fellowship in the Geriatric and Special Needs Clinic at the University of Iowa College of Dentistry.

Through the fellowship she provided care in various nursing homes for the medically compromised elderly. She worked with an interdisciplinary team including physicians, nurses, pharmacists, and social workers at local nursing homes, the Iowa City VA hospital, and the UIHC Psychiatric Unit.

Her current duties include clinical instruction to the fourth year dental students and Geriatric and Special Needs Fellows, as well as didactic instruction and seminars to third and fourth year dental students.

HALF DAY CONTINUING EDUCATION

8:00 AM – 8:30 AM

▶ Registration

8:30 AM – 12:30 PM

▶ Considerations for Providing Dental Treatment to the Geriatric Patient

12:30 PM – 1:30 PM

▶ Working Lunch

CEU = 3.5 HOURS

CEU Credits will be handed out at the end of the course.

REGISTRATION FEES

Assistants/Hygienists

▶ \$50 – Course & Lunch

Dentists

▶ \$65 – ADA Member

▶ \$150 – NonADA Member

(Fee includes lunch)

Make checks payable to:

SE Iowa District Dental Society

Please return pre-registration form and fees by Friday, March 29, 2013, to

▶ Dr. Marty Gleason
51 West Adams Avenue
Fairfield, Iowa 52556

Name	DAHS	Fee
Total Fees		\$

RECEIVED

JUN 17 2013

APPLICATION FOR PRIOR APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval NEBRASKA SOCIETY OF PERIODONTOLOGY

Address: 5211 UNDERWOOD AVE, OMAHA, NE 68132

Phone: 402-493-9429 Fax: 402-493-4746 E-mail: gumsrus3@cox.net

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
Dental School
Dental Hygiene School
Dental Assisting School
Military
Other (please specify)

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
Home study (e.g. self assessment, reading, educational TV)
Participation
Discussion
Demonstration

4. Course Title: RESTORATIVELY DRIVEN IMPLANT FAILURE - WHAT

5. Course Subject: EVERY DENTIST, HYGIENIST, ASSISTANT AND LAB MECHANICIAN NEEDS TO KNOW!

- Related to clinical practice
Patient record keeping
Risk Management
Communication
OSHA regulations/Infection Control
Other:

6. Course date: 6 SEPT 2013 Hours of instruction: 7.0

1058
10.00

7. Provide the name(s) and briefly state the qualifications of the speaker(s): SEE
ENCLOSED BROCHURE,

8. Please attach a program brochure, course description, or other explanatory material

9. Name of person completing application: DR DENNIS M. ANDERSON
Title: DDS Phone Number: 402-493-9429
Fax Number: 402-493-4746 E-mail: gumsrus3@cox.net
Address: 5211 UNDERWOOD AVE OMAHA, NE 68132
Signature: [Signature] Date: 12 June 13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25 3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED \$10 FEE PER COURSE TO:

Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687

FRIDAY, September 6th, 2013

Continental Breakfast and Registrations 7:15-8:00am

There will be a fifteen minute break in the morning and the afternoon, with lunch from noon-12:30pm. The program will conclude at 5:00 pm.

**Restoratively Driven Implant Failure—
what every dentist, hygienist, assistant and
lab technician needs to know!**

7 Hours CE



ABOUT THE SPEAKER...

Chadnur Wadhvani, DDS, MSD received his specialty certificate in prosthodontics with a masters degree from the University of Washington School of Dentistry. He is currently in private practice in Bellevue, WA and is past president of the Washington State Society of Prosthodontics. He also teaches at the University of Washington in graduate prosthodontics. Dr. Wadhvani is heavily involved in prosthodontic and implant research and has authored multiple peer-reviewed scientific articles on cement and implant restorations.

ABOUT THE COURSE...

- Simple techniques to avoid putting implants for cement-induced peri-implantitis.
- Which cements you should avoid
- Which cements are actually bacteriostatic
- Cementation techniques that minimize excess cement at the restorative margin
- Consequences of excess cement
- Consequences of using the wrong cement
- Simple modifications you can request your lab to make to decrease retained cement
- How to create more esthetic screw-retained restorations
- Hygiene of dental implants
- Results of applicable current research

Midlands Periodontal Symposium - September 6th, 2013

Only registered attendees will be admitted!

Please use a separate sheet if needed to list all attendees by name. All fees are based on registrations received by August 23rd, 2013.

Please add \$25.00 per person for registrations postmarked after this date.

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OFFICE PHONE: _____ HOME PHONE: _____

EMAIL ADDRESS: _____

REGISTRATION FEES

Dentist # _____ @190.00 Lab Tech # _____ @\$120
Hygienist # _____ @130.00 Student # _____ @\$100

Make checks payable to: Send to:
Nebraska Society of Dr. Dennis Anderson
Periodontology 3635 N. 129th St.
Omaha, NE 68164

RECEIVED
JUN 21 2013

RECEIVED

JUN 21 2013

APPLICATION FOR POST APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
www.dentalboard.iowa.gov

NOTE: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Course Title: Mental Health First Aid

2. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

3. Course date: 5/30, 6/6, 6/13 Hours of instruction: 12 (3 4hr classes)

4. Provide a detailed breakdown of contact hours for the course or program:

see attachments

5. Name of course sponsor: Kirkwood Community College

Address: 6301 Kirkwood Blvd SW
Cedar Rapids, IA 52406

6. Which of the following educational methods were used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

#4809
\$10

Mental Health First Aid Course – Learning Services

Three Four-Hour Sessions

Day 1: May 30

Introduction/Overview

- Introduce MHFA
- Give overview of prevalence and impact of mental health problems in the US
- Introduce MHFA Action Plan and how it fits within all mental health interventions

Break

Depressive Disorders

- Overview of possible risk factors and warning signs of **Major Depressive Disorder and Suicidal Behavior**
- Demonstrate the MHFA Action Plan for someone who is experiencing depressive symptoms and may be in crisis
- Review of possible risk factors and warning signs of **Major Depressive Disorder and Suicidal Behavior** and MHFA Action Plan

Day 2: June 6

Anxiety Disorders

- Welcome back and review Depression Scenarios from homework
- Overview of possible risk factors and warning signs of **Nonsuicidal Self-Injury and Anxiety disorders**
- Demonstrate the MHFA Action Plan for people who are experiencing nonsuicidal self-injury or a panic attack and may be in crisis
- Demonstrate the MHFA Action Plan for people who are experiencing a traumatic event and may be in crisis
- Demonstrate the MHFA Action Plan for someone who is experiencing symptoms of depression or anxiety disorders, but not in a crisis.

Break

Psychotic Disorders

- Overview of risk factors and warning signs of **Psychotic Disorders**
- Demonstrate the MHFA Action Plan for people with symptoms of psychotic disorder or a related crisis

Learning Objectives for Mental Health First Aid (12 Hour Course)

Mental Health First Aid is a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Just as CPR training helps a layperson without medical training assist an individual following a heart attack, Mental Health First Aid training helps a layperson assist someone experiencing a mental health crisis.

The evidence behind Mental Health First Aid demonstrates that it makes people feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness. Specifically, studies found that those who trained in Mental Health First Aid have greater confidence in providing help to others, greater likelihood of advising people to seek professional help, improved concordance with health professionals about treatments, and decreased stigmatizing attitudes.

Mental Health First Aid Course Objectives

Participants learn:

- Knowledge of the potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis and psychotic disorders, eating disorders, substance use disorders, and self-injury
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities
- Working knowledge of the appropriate professional, peer, social, and self-help resources available to help someone with a mental health problem treat and manage the problem and achieve recovery.

Mental Health First Aiders, like regular First Aiders, **aim to ultimately connect a person to appropriate professional care**; however, unlike regular First Aiders, MHFA does not include any core physical intervention (such as chest compressions, which may lead to direct physical injury).

Mental Health
First Aid USA



MENTAL
HEALTH
FIRST AID

Certificate

Ronda Thompson

has completed the 12-hour course and is now certified in

Mental Health First Aid USA

And has been trained to provide initial help to people experiencing mental health problems such as depression, anxiety disorders, psychosis and substance use disorders.

This certification became effective on: **June 13, 2013**
Date

This certification expires on: **June 13, 2016**
Date

Angie Freeman Westler
Instructor

Mary Wesing
Instructor



 **NATIONAL COUNCIL**
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Mental Health First Aid USA is coordinated by the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.



RECEIVED

JUN 24 2013

APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 *per course* is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Oral Surgery Associates of Iowa City
Address: 2814 Northgate Drive Suite 2 Iowa City Iowa 52245
Phone: 319-338-5484 Fax: 319-338-9413 E-mail: racann@iowacityoralsurgery.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): Private Practice

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: State of the Art Topics + Techniques in Implant Prosthetics
for private practice.

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: 11-15-13

Hours of instruction: 6

23315
\$10

7. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

See Attached Dr. Robert Vogel

8. Please attach a program brochure, course description, or other explanatory material. Attached.

9. Name of person completing application: RAE ANN HOSIER

Title: Dental Implant Coordinator Phone Number: 319-338-5484 107

Fax Number: 319-338-9413 E-mail: racann@iowacityoral surgery.com

Address: 2814 Northgate Drive Suite 2 Iowa City, IA 52245

Signature: [Handwritten Signature] Date: 6-20-13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

**Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**

Robert C. Vogel, DDS

Precision, Productivity and Profitability of Implant Prosthetics in Private Practice

State of the Art Topics and Techniques in Implant Prosthetics For Private Practice

Comprehensive Implant Prosthetics and Ideal Anterior Esthetics

Advanced Topics and Techniques in Implant Prosthetics

This scientifically based fast moving presentation designed for private practice will cover state of the art Topics, Tips, Tricks and step-by-step Techniques in Implant Prosthetics. A systematic approach to ideal Esthetic treatment of the single tooth through fully edentulous patient will be presented emphasizing long-term stability, predictability and profitability in private practice.

This program is designed for the entire implant team stressing ideal interaction for simplification of even the most advanced Implant cases with reduced chairtime and increased predictability.

Topics in Fixed and Removable Implant Prosthetics will be addressed focusing on: Predictable Treatment Planning, Provisionalization and Soft Tissue Esthetics, Occlusal schemes and Simplified Overdentures and Implant Retained Partial Dentures start to finish including foolproof Fee Determination and Patient Presentation Techniques. Also included will be a complete overview of the newest technology to gain comfort and confidence in incorporating the benefits of CAD CAM and zirconium restorative materials.

Objectives

- *Confidence and Predictability with State of the Art Implant Techniques.
- *Update knowledge of current concepts and materials in Implant Dentistry.
- *Integrate Advanced Techniques into Private Practice with Simplification.
- *Allow more patients to benefit from implant-based treatment through ideal fee determination and presentation techniques

Dr. Robert Vogel graduated from the Columbia University School of Dental and Oral Surgery in New York City, New York; upon graduation, he completed a combined residency program in Miami, Florida at Jackson Memorial Hospital, Mount Sinai Medical Center, and Miami Children's Hospital. He maintains a full-time private practice in implant prosthetics and reconstructive dentistry, located in Palm Beach Gardens, FL. He works closely as a team member with several specialists providing implant-based comprehensive treatment, as well as conducting clinical trials and providing clinical advice to the dental attachment and implant fields. Dr. Vogel has developed and collaborated on the development of several prosthetic components and techniques currently in use in implant dentistry. He lectures internationally on implant dentistry, focusing on simplification, confidence, and predictability of implant prosthetics through ideal treatment planning and team interaction. Dr. Vogel continues to publish scientific articles on implant dentistry, and is a Fellow of the International Team for Implantology (ITI).

RECEIVED

JUN 24 2013

IOWA DENTAL BOARD

APPLICATION FOR PRIOR APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Alan Daus and Mary Ellen Jafari, M.S., D.A.B.R.
Medical Physicist
Address: Gunderson Health Systems, 1900 S. Ave., mail stop: C02-002, LACROSSE, WI 54601
Phone: 608-775-4879 Fax: 608-775-7355 E-mail: amdaus@gundersonhealth.org

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
Dental School
Dental Hygiene School
Dental Assisting School
Military
Other (please specify): Medical Center with oral surgery services

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
Home study (e.g. self assessment, reading, educational TV)
Participation
Discussion
Demonstration

4. Course Title: Radiation Safety and Quality Control for Dental Professionals

5. Course Subject:

- Related to clinical practice
Patient record keeping
Risk Management
Communication
OSHA regulations/Infection Control
Other:

6. Course date: Sometime in July if course gets approved. Hours of instruction: 2.0 hours

#645361
\$10

RECEIVED

JUN 26 2013

APPLICATION FOR POST APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157
www.dentalboard.iowa.gov

NOTE: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Course Title: TMD Workshop : Team Approach to TMD

2. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

3. Course date: 6/13/13 & 6/14/13 Hours of instruction: 8:00am-5:00pm, 8:00am-4:00pm

4. Provide a detailed breakdown of contact hours for the course or program:

Please See Attachment

5. Name of course sponsor: Omni Dental

Address: 1026 Woodbury Ave Council Bluffs
IA 51503

6. Which of the following educational methods were used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

3000
\$10

7. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

Herb Blumenthal, DDS - Instructor at Parkey Institute
Kathy Johnson, PT - Physical Therapist + Instructor at Parkey Institute
Mary Osborne, RDH - Dental Hygienist + Consultant, Instructor at Parkey Institute

8. Please attach a program brochure, course description, or other explanatory material.

9. Name of person completing application: David L Jones

Title: DDS Phone Number: 712-328-8573

Fax Number: 712-328-0233 E-mail: office@omnidentalcentre.com

Address: 1026 Woodbury Ave, Council Bluffs, IA 51503

Signature:  DDS Date: 6/19/13

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

You will be contacted after the Continuing Education Advisory Committee has reviewed your request. Please allow a minimum of two to three weeks for a response.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

**Iowa Dental Board
Advisory Committee on Continuing Education
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**

A TEAM APPROACH TO TMD

Thursday Morning

- 8:00-9:00 Mary Osborne: "Influencing with Integrity . . . How to Help People Make Healthy Choices"
- 9:00 Break
- 9:15-10:15 Herb Blumenthal: "The Stomatognathic System, Part One"
- 10:15 Break
- 10:30-12:00 Kathy Johnson: "The Role of Physical Therapy in TMD"

12:00 -1:15 Lunch Break and Herb, Pam and Kathy meet with patient

Thursday Afternoon

- 1:15-2:45 Herb, Kathy and Pam with patient
- 2:45 Break
- 3:00 Mary: Discussion of Exam Process
- 3:30-5:00 Herb: "The Stomatognathic System, Part Two" Participant Exams
- 5:00 End

Friday Morning

- 8:00- 9:30 Mary: "The Power of the Question"
- 9:30 Break and Herb, Kathy and Pam meet with patient
- 10:00 – 11:30 Herb , Kathy and Pam with patient
- 11:30 -12:00 Debrief

12:00 Lunch

Friday Afternoon

- 1:00-2:00 Pam Welden: "Systems and Strategies"
- 2:00 Break
- 2:15-3:45 Herb, Kathy, Mary and Pam: Exam on Participant
- 4:00 End



pankeydentist.org

The Pankey Institute

a subsidiary of the
L.D. Pankey Dental Foundation Inc.

One Crandon Blvd.
Key Biscayne, FL 33149

[Home](#)

[Before & After](#)

[Testimonials](#)

[About Pankey](#)

[For Dentists](#)

[Find A Dentist In Your Area](#)

[Return to Search Results](#)

Dr. Herbert E. Blumenthal

280 German Oak Drive
Cordova, TN 38018 United States

Phone: 901.755.1080
Email: hbwb2@aol.com

Vcard: [Download](#)
Locate on map: [Click here](#)

Designation: Visiting Faculty
This dentist has participated in **500+** Pankey Credit Hours.



Biographical Information:

In active practice for more than 40 years, Dr. Blumenthal has always sought out new knowledge that would help him better serve his patients. That quest has led him to study medicine, occlusion, chiropractic medicine, kinesiology, restorative dentistry, biofeedback, neurophysiology, muscle physiology, nutrition, sleep disorders the list goes on and on with subjects in and outside of dentistry. He has applied this multi-disciplinary education to the diagnosis and treatment of TMD patients for more than 35 years. He has partnered with a wide range of professionals and developed a unique perspective of the interrelationship of TMD treatment as a multidisciplinary therapy involving many professionals who work in concert to best treat these very special patients.

He has directly and positively impacted the lives of countless patients with his ability to listen, observe, and understand. That number has been exponentially increased by his sharing of what he has learned over the years with other dentists as a teacher, mentor, and advisor.

The quest to be the best he could be led him to the Pankey Institute 34 years ago and started a relationship that continues today. He began to give back as a member of the visiting faculty 23 years ago and is one of the Lead Faculty for the Bite Splint and Temporomandibular Evaluation course.

Postural Restoration Certified (PRC)

Kathy Johnson, PT, PRC

Johnson Physical Therapy
1727 W Main St.
Albert Lea, Minnesota 56007
www.johnsonphysicaltherapy.com
Phone: 507-473-2200

Kathy graduated with a degree in Physical Therapy from the University of North Dakota in 1981. Throughout her career, she has been involved in many aspects of PT, including rehabilitation following stroke and head injury, treatment of movement disorders as a result of MS and Parkinson's, and evaluation and treatment of orthopedic conditions. Her work in Postural Restoration led to the accomplishment of Certification in 2009. Currently Kathy specializes in treatment of chronic pain conditions as a result of injury and disease. She works in a multi-disciplinary team approach with local dentists who specialize in splint treatment for TMJ and facial pain to provide relief of jaw, head, neck and shoulder pain.

Blog Entries

- [New Opportunities for Interdisciplinary Integration](#)

[Back...](#)



- [Postural Restoration Certified \(PRC\)](#)
- [PRC Therapists](#)
- [PRC Centers](#)
- [Application](#)
- [Testimonials](#)
- [FAQ](#)
- [Members Only](#)

- [Home](#)
- [Site Map](#)

RECEIVED

JUL 3 2013

APPLICATION FOR PRIOR APPROVAL OF
CONTINUING EDUCATION COURSE OR PROGRAM IOWA DENTAL BOARD

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 per course is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Darcey Siemering, RDH
Address: 1398 Randall Dr. NW Swisher, IA 52338
Phone: 319-981-6763 Fax: _____ E-mail: darcsiem@gmail.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): self

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: Learn to ease and Manage "Cumulative Trauma Disorder" -
Therapeutic Workshop for Dental Assistants and Hygienists.

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: Occupational discomfort + trauma

6. Course date: 7-20-2013

Hours of instruction: 2

1003
10

7. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

Darcey Siemering - 14 years dental assistant, 17 years dental hygienist, studied + practiced yoga for 10 years - 9 years (over 200 hrs.) of yoga teacher training.

8. Please attach a program brochure, course description, or other explanatory material.

9. Name of person completing application: Darcey Siemering

Title: RDH / RYT (Registered Yoga Teacher) Phone Number: 319-981-6763

Fax Number: _____ E-mail: darcsiem@gmail.com

Address: 1398 Randall Dr. NW Swisher, IA 52338

Signature: Darcey Siemering Date: 6-30-2013

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov. Continuing education guidelines and rules are also available on the Board's website. A course is generally acceptable and does not need to go through this formal approval process if it is directly related to clinical practice/oral health care.

Pursuant to Iowa Administrative Code 650—25.3(5), please submit the application for approval 90 days in advance of the commencement of the activity. The Board shall issue a final decision as to whether the activity is approved for credit and the number of hours allowed. The Board may be unable to issue a final decision in less than 90 days. Please keep this in mind as you submit courses for prior approval.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE** PER COURSE TO:

**Iowa Dental Board
Continuing Education Advisory Committee
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**

DENTAL ASSISTANTS & HYGIENISTS

**“Learn to ease and manage cumulative trauma disorder.”
With Darcey Siemering, RDH, RYT-200**



Therapeutic Workshop with Yoga

Saturday, July 20

1:00 – 3:00

@ OHM Studio in Marion

Your Investment is only \$25.00

This workshop focuses on occupational discomforts as a Dental Assistant or Hygienist such as:

- dental instrumentation
- repetitive motion
- neck & back pain

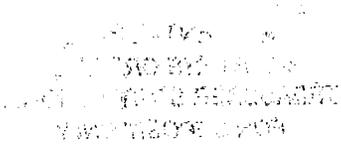
Darcey will introduce you to uplifting yoga poses focusing on hands, wrists, neck and back. You will also receive “tips and guidelines” that will help you in your current career and throughout your life!

Darcey has 31 years of experience as a Dental Assistant/Hygienist. She fully understands the joy and satisfaction of caring for patients and has experienced many of the occupational discomforts associated in her dental profession. Over the past 10 years Darcey has been practicing yoga and is a Registered Yoga Teacher. She is currently teaching yoga and conducts workshops at Open Hearts and Minds (OHM) Studio in Marion.

For further information or to register for this 2-hour workshop, go online to www.ohmstudiomarion.com, click on “Workshops” or email Darcey at darcsiem@gmail.com. Please make your check payable to Darcey Siemering and mail it to 1398 Randall Dr. NW, Swisher, IA, 52338 and include your email address for confirmation purposes.

Space is limited so sign up soon to reserve your place! If you do not have a yoga mat, one will be provided along with other yoga props.

(OHM Studio is located at 1060 7th Avenue in Marion, inside The Cotton Gallery on 7th.)



RECEIVED

JUL 11 2013

IOWA DENTAL BOARD

APPLICATION FOR PRIOR APPROVAL OF CONTINUING EDUCATION COURSE OR PROGRAM

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D
Des Moines, IA 50309-4687
515-281-5157
www.dentalboard.iowa.gov

Note: A fee of \$10 *per course* is required to process your request. PLEASE TYPE OR PRINT.

1. Name of organization or person requesting approval: Institute for Natural Resources (INR)
Address: P.O. Box 5757, Concord, California 94524-0757
Phone: (925) 609-2820 ext. 238 Fax: (925) 363-7798 E-mail: kfinley@biocorp.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Military
- Other (please specify): Non-profit organization offering CE courses

3. Which of the following educational methods will be used in the program? Please check all applicable.

- Lectures
- Home study (e.g. self assessment, reading, educational TV)
- Participation
- Discussion
- Demonstration

4. Course Title: Understanding Dementia

5. Course Subject:

- Related to clinical practice
- Patient record keeping
- Risk Management
- Communication
- OSHA regulations/Infection Control
- Other: _____

6. Course date: See Appendix A Hours of instruction: 7:45am to 3:30pm

8366
\$10

7. Provide a detailed breakdown of contact hours for the course or program:

Please see appendix B. Thank You.

8. Provide the name(s) and briefly state the qualifications of the speaker(s): _____

Dr. James Coggin, M.D., please see appendix C. Thank You.

9. Please attach a program brochure, course description, or other explanatory material.

10. Name of person completing application: Deborah Cheung

Title: Accreditation Manager Phone Number: (925) 609-2820, ext. 238

Fax Number: (925) 363-7798 E-mail: dcheung@biocorp.com

Address: P.O. Box 5757, Concord, California 94524-0757

Signature: _____ Date: July 11, 2013

Board rules specify that the following subjects are NOT acceptable for continuing education credit: personal development, business aspects of practice, personnel management, government regulations, insurance, collective bargaining, and community service presentations.

If the course was offered by a Board approved sponsor, you should contact the sponsor directly for approval information, rather than submitting this form. A list of approved sponsors and contact information is available on the Board website at www.dentalboard.iowa.gov.

You will be contacted after the Continuing Education Advisory Committee has reviewed your request. Please allow a minimum of two to three weeks for a response.

MAIL COMPLETED APPLICATION ALONG WITH THE REQUIRED **\$10 FEE PER COURSE** TO:

**Iowa Dental Board
Advisory Committee on Continuing Education
400 S.W. 8th Street, Suite D
Des Moines, Iowa 50309-4687**

**INSTITUTE FOR NATURAL RESOURCES
COURSE: "UNDERSTANDING DEMENTIA"**

**Appendix A
Dates, Times, & Locations**

Davenport, Iowa

Wednesday, October 2, 2013
8:30am to 3:30pm

Instructor: Dr. James Coggin, M.D.

Cedar Rapids, Iowa

Thursday, October 3, 2013
8:30am to 3:30pm

Instructor: Dr. James Coggin, M.D.

Des Moines, Iowa

Friday, October 4, 2013
8:30am to 3:30pm

Instructor: Dr. James Coggin, M.D.

Kearney, Nebraska

Thursday, October 17, 2013
8:30am to 3:30pm

Instructor: Dr. James Coggin, M.D.

Omaha, Nebraska

Friday, October 18, 2013
8:30am to 3:30pm

Instructor: Dr. James Coggin, M.D.

INSTITUTE FOR NATURAL RESOURCES
COURSE: "UNDERSTANDING DEMENTIA"

Appendix B
Time Agenda

Registration: 7:45 AM – 8:30 AM

Morning Lecture: 8:30 AM – 10:00 AM

- **Our "Three Brains."** How They Are Affected by Dementia.
- **The Brain And Memory:** How We Remember And Forget.
- **The Four Stages of Memory:** Sensory, Short-Term, Long-Term, and Retrieval.
- **The Two Separate Memory Systems:** Declarative Memory and Procedural Memory.
- **The Accuracy Of Our Memories:** Reconstructing Memories. Do We All Confabulate?
- **Myths And Realities Of The Aging Brain:** Do We Lose Thousands of Neurons a Day?

Mid-Morning Lecture: 10:00 AM – 11:30 AM

- **Brain Push-Ups:** Can Mental Exercises Slow or Stop Brain Aging and Memory Loss? Does Doing Crossword Puzzles Protect The Brain From Aging And Dementia?
- **The Exercise Question:** Physical Exercise vs. Mental Exercise.
- **Brain Aging And Memory:** Do All Types of Memory Deteriorate As We Age?
- **Super-Agers:** Amazing People Who Maintain Excellent Memory in Advanced Age.
- **Increased Forgetting:** Is It Normal With Aging? Age-Associated Memory Impairment and Mild Cognitive Impairment.
- **Reversible Dementias:** Secondary Dementias Such As Depression, Normal Pressure Hydrocephalus, Metabolic Disorders, and Cognitive Dysfunction.

Lunch: 11:30 AM – 12:20 PM

Afternoon Lecture: 12:20 PM – 2:00 PM

- **Huntington's Disease:** How One Bad Gene Can Cause An Irreversible Dementia.
- **The Surprising Cause Of Many Dementias:** Misfolded and Unfolded Proteins.
- **Sex, Gender, And Dementia:** Are There Sex Differences In Many Dementias? Do More Women Develop Alzheimer's Disease? Some Surprising Facts.
- **Teeth, Gums, and Dementia.** Does Gum Disease Raise the Risk of Dementia? How to Evaluate and Treat Dental Patients with Dementia.
- **The Road to Parkinson's Disease:** Alpha Synuclein Protein Unfolding To Lewy Bodies To Substantia Nigra Deterioration To Basal Ganglia Malfunction.
- **Football, Boxing, and Dementia:** Multiple Concussions. Traumatic Brain Injury and Alzheimer's Disease. Military Implications.
- **The Great Mystery:** What Triggers Alzheimer's Disease? Amyloid Hypothesis. Tau Hypothesis. Acetylcholine Depletion. Inflammation. Vascular Changes. Oxidative Stress. Excitotoxicity. Myelin Sheath Deterioration. Blood-Brain Barrier Dysfunction.

Mid-Afternoon Lecture: 2:00 PM – 3:20 PM

- **Veins and Brains:** The Cardiovascular-Alzheimer's Connection.
- **Can Alzheimer's Disease Be Prevented?** Reducing the Risk of Alzheimer's.
- **Early Warning Signs of Alzheimer's Disease:** What To Look For.
- **Can Alzheimer's Disease Be Accurately Diagnosed Years Before Symptoms Appear?**
- **Treatments For Alzheimer's Disease:** What Are They? Do They Work?
- **New Experimental Treatments for Alzheimer's.** Do They Work? Can We Be Vaccinated? The Future of Alzheimer's Research.
- **Ten Signs of Caregiver Stress: Coping with Exhaustion and Heartache.**

Evaluation, Questions, and Answers: 3:20 PM – 3:30 PM

INSTITUTE FOR NATURAL RESOURCES
COURSE: "UNDERSTANDING DEMENTIA"

Appendix C
Instructor Resume

Dr. James Coggin, M.D.

Please see the attached resume. Thank You.

Curriculum Vitae

NAME: James Michael Coggin, M.D.

PRESENT TITLE: Physician Educator

EDUCATION:

Undergraduate BS from Davidson College, Davidson, NC, 1974

Graduate and Professional MD from University of North Carolina, Chapel Hill School of Medicine, Chapel Hill NC, 1991

POST DOCTORAL or ADDITIONAL TRAINING:

New Hanover Regional Med. Ctr. Internship/Residency GP/OB/Gyn

Bowman Gray School of Medicine Extern-ship Certification Epidural Anesthesia

North Carolina State University Honors Cell Biology

EMPLOYMENT/WORK EXPERIENCE:

Myomed Treatment Center (M.T.C.) Solo Practice, Sanford, N. C. 1996-Present

MyoDerm Aesthetics Clinic, (Subsidiary of Myomed Treatment Center) 2005

Family Medical Center, Sanford, North Carolina 1995

New Hanover Regional Medical Center-Internship and Residency 1991

Coggin Heating and Air Conditioning, Inc. 1976

President and Chairman of the Board of Directors 1960

Vice President 1978

Sales Manager-Solar Energy and Energy Management Divisions 1977

Service Department Manager 1960

Sanford Plating Company, Laboratory Technician 1976

Sanford Central High School, Sanford, North Carolina

Physical Science and Biology Teacher, Grades 9-10 1974

English Teacher, Summer School Grades 11-12 1975

Director, Intramural Athletics 1975

High I.Q. Bowl Team - Faculty Advisor 1974

Huntersville Hospital, Orderly Service, Geriatric Floor 1973

Lee Drug Store. Sanford, North Carolina - Pharmacist Assistant 1967

ACADEMIC APPOINTMENTS:

Teaching Adult Education for INR since 2005

LICENSURE: Actively licensed in North Carolina

CERTIFICATION: GP/OB/Gyn

PRESENTATIONS GIVEN: At least Past five years, topic, location

Presentations given throughout the United States:

WOMEN'S HEALTH: OBESITY, MENOPAUSE; CHRONIC PAIN; BRAIN FITNESS AFTER 30;
WEIGHT LOSS; WHAT WORKS WHAT DOESN'T; ALZHEIMER'S, MEMORY & DEMENTIA;
WEIGHT LOSS; ADVANCES IN WOMEN'S HEALTH: HORMONES; AGING BODY, AGING MIND;
SWINE FLU; SWINE FLU / WINTER FLU; INSOMNIA, DEPRESSION & ANXIETY; THE AGING
BRAIN - NEWLY UPDATED; IMMUNE POWER: ALLERGIES, FATIGUE; SWINE FLU /
SEASONAL FLU; BRAIN INJURY: STROKE, ALZHEIMER'S; SUCCESSFUL AGING IN MEN &
WOMEN; WOMEN'S HEALTH UPDATE: BREAST HEALTH; ARTHRITIS; BACK ACHE & BONE
DISEASE; CONQUERING PAIN; TRANQUIL BRAIN; BETTER SLEEP, BETTER MEMORY;
STRESS, ANXIETY & DEPRESSION

CONTINUING EDUCATION/CONTINUING COMPETENCE:

Initial Antidepressant Treatment: Balancing Effectiveness and Tolerability	12/23/2012
Implementing Strategies For Implementing Strategies for Safe Use of Pain Medication	10/24/2012
Restless Leg Syndrome and Heart Disease in Women	10/20/2012
Who Should Be Screened for Ovarian Cancer	10/11/2012
Can AREs Protect Against Alzheimer's Disease	10/11/2012
Safe Prescribing For Pain	10/5/2012
Clinical Perspective on Insomnia: Pathophysiologic Targets and Implications on Therapies	10/5/2012
Link Between Early Menopause and Rheumatoid Arthritis	9/24/2012
FDA Approvals: Enzalutemide for Treatment of Advanced Prostate Cancer	9/24/2012
Struggling With Shift Work Disorder	9/16/2012
Does a Healthy Diet Prevent Chronic Disease?	9/16/2012
Epidural Anesthesia Does Not Increase Maternal Temperature During Labor	8/26/2012
Vulvodynia Can Be an Indicator of Other Chronic Pain	8/21/2012
Negative Emotions Increase Feelings of Pain and Itching	8/21/2012
Doctor This Pain Is Unbearable	8/21/2012
Vitamin D May Slow the Progression of Lung Disease in Smokers	8/17/2012
Insomnia Treatment: Highlights From Sleep 2012	8/17/2012
FDA Approvals: Pregabalin for Neuropathic Pain	8/4/2012
Mental Health Disorders Linked with Long-Term Opioid Use in Adolescents	8/4/2012
Protection Against Urinary Tract Infection Seen With Cranberry Products	8/3/2012
High Vitamin D Supplementation Yields Decreased Risk for Hip, Non vertebral Fractures	7/18/2012
Delirium After Heart Surgery Linked with Prolonged Decline in Cognitive Function	7/18/2012
Vitamin D with Calcium Decreases Mortality Risk in Older People	7/10/2012
Can Caffeine Prevent Progression To Dementia?	7/3/2012
Viscosupplementation in Knee OA May Not Be Worth the Risk	6/30/2012
The Predictive Value of Biomarkers in Heart	6/30/2012
Treatment Advances for Systemic Lupus Erythematosus	6/30/2012
Hormonal Contraception Linked with Acceptable Risks for Stroke and MI	6/28/2012
FDA Approvals: Gabapentin Enacarbil for Post Therapeutic Neuralgia	6/26/2012
Scenarios in Women's Health: Recognizing and Managing Menopausal Symptoms	6/26/2012
Two-Week Steroid Regimen Okay For Severe Eosinophilic Pneumonia	6/24/2012
Concurrent Use of Speed, Ecstasy in Teens Ups Depression Risk	6/24/2012
Juvenile Idiopathic Arthritis Associated with Increased Risk for Infection	6/24/2012
New Guidelines for Aneurysmal Subarachnoid Hemorrhage Issued	6/24/2012
Three Independent Risk Factors Increases Diabetes Risk	6/23/2012
What Do We Know about Reducing Cardiovascular Events In Type 2 Diabetes	6/23/2012
A 62-Year Old Man with Type 2 Diabetes and Leg Fatigue	6/23/2012
Update on Advances in the Management of RA from the Berlin 2012 Meeting	6/21/2012
Panel Revises Guidelines on Assessment of AD	6/20/2012
ACMG Issues New Guidelines for Genetic Testing in Alzheimer's Disease	6/20/2012

Distinguishing Alzheimer's Disease from Other forms of Dementia	6/20/2012
Beta-Amyloid Ratios May Predict Dementia, Alzheimer's Disease	6/20/2012
The Role of Imaging for Early Identification and Diagnosis of Alzheimer's Disease	6/20/2012
PCT Test Helps Pinpoint Cause of Fever in Patients with Autoimmune Disease	6/17/2012
Improving the Management of Systemic Lupus Erythematosus	6/17/2012
High BMI Yields Less Treatment Response to Ankylosing Spondylitis	6/17/2012
Cognitive Behavior Therapy Relieves Tinnitus Symptoms	6/17/2012
Aspirin Decreases Recurrence Rate of Venous Thromboembolism	6/16/2012
Benefits of Mammography May Trump Risks in Certain Women	6/16/2012
Fish Oil Offers Some Benefits in Dialysis Graft Patency	6/16/2012
Trends in Invasive Infection with Methicillin-Resistant Staphylococcus Aureus	6/16/2012
Advances in the Management of Gout: Issues and Answers	6/16/2012
Oral Zinc May Lessen Cold Symptom Duration In Adults	6/16/2012
IUDs, Implants, Pills, Rings, or Patches, What works?	6/11/2012
Long-Term NSAID Use Reduces Risk for Certain Skin Cancers	6/11/2012
Community CME: When Should Clinicians Change Antipsychotics?	6/11/2012
Making Sense of Sunscreen Controversies	6/11/2012
The Role of Imaging for Early Identification and Diagnosis of Alzheimer's Disease	6/10/2012
A 41-Year Old Man with Sudden On-Set Headache and Diplopia	6/7/2012
CMS and Primary Care: A New World	5/17/2012
Targeted Therapy for the Treatment of Basal Cell Carcinoma and Melanoma: Implications for Patients and Health Care Practitioners	5/12/2012
Hypnotherapy Effective Way to Improve IBS Symptoms	4/26/2012
Rates of Depression Similar After Stroke or Transient Ischemic Attack	4/24/2012
New Evidence-Based Treatment Recommendations for Inflammatory Arthritis	4/24/2012
Chronic Pain: Translating Population-Based Clinical Studies into Patient Specific Treatment Strategies	3/3/2012
Intense Grief May Cause Acute MI	1/23/2012
Memory Complaints Useful in Cognitive Assessment of Older Patients Enduring Material	12/27/2011
Fundamentals of Major Depressive Disorder Treatment in Adults, Volume 1	12/27/2011
New Insights into Pain Mechanisms and Rationale for Treatment	12/27/2011
Immunization Update for the 2011-2012 Influenza Season	12/27/2011
Repeated Use of Acetaminophen Can Be Fatal	12/19/2011
Hip Fracture Increases 1-Year Mortality Rate in Elderly Women	10/17/2011
Chocolate Intake Benefits the Heart and Brain	9/25/2011
Hip Fracture Risk Climbs When Older Women Go Off Hormone Therapy	9/18/2011
In My Practice: Combination Therapy With Neurotoxin & Filters	9/18/2011
Updated Recommendations for Influenza Vaccine Released	9/18/2011
Cognitive Problems Common in Oldest Older Women	8/30/2011
New Diagnostic Criteria for Alzheimer's Published	7/17/2011
Aesthetic Use of Neurotoxin: Avoiding Managing Complications	7/17/2011
Stress Causes Slow Steady Increase In Panic Symptoms	7/17/2011
Obstructive Sleep Apnea May Be Improved With Low Energy Diet	7/11/2011
Fibromyalgia Multidisciplinary Expert Column Series Multicomponent Therapy Setting and Current Recommendations for Pharmacologic and Non Pharmacologic Treatment Options	5/28/2011
Oral Contraceptive Combo May Reduce Heavy Menstrual Bleeding	5/8/2011
Bipolar Disorder Often Mistaken for Depression in Primary Care	5/8/2011
Risk of Estrogen Therapy May Change with Longer Follow-Up	4/30/2011
ACP Issues Guidelines for Diagnostic Imaging for Low Back Pain	4/30/2011
Omega-3 Fatty Acids Linked to Lower Risk for AMD in Women	4/4/2011
Shift Work and Sleep: Optimizing Health, Safety, and Performance	3/13/2011
Case Study: Osteoporosis Management in Postmenopausal Women and Patients Receiving Glucocorticoids	3/4/2011
US Task Force Releases Updated Osteoporosis Screening Recommendations	2/1/2011
Updated Guidelines to Prevent Falls in Elderly	2/1/2011
Loud Snoring, Insomnia Symptoms Linked to Risk for Metabolic Syndrome	1/30/2011

New Guidelines on Primary Stroke Prevention From AHA/ASA
All Non Steroidal Anti-inflammatory Drugs Have Cardiovascular Risk

1/29/2011
1/23/2011

OTHER SCHOLARSHIP/RESEARCH PUBLICATIONS:

Development and Patent Pending of Topical Muscle analgesic and anti-spasmodic.

Post-Marketing Surveillance Study in coordination with Glaxo SmithKline for
the use of Imitrex Injection In Select Patients with Migraine Headache.

University of North Carolina School of Medicine at Chapel Hill, Department
of Obstetrics and Gynaecology, Watson Bowes, M.D. Faculty Sponsor.
Research on "Surgical Incision Closure: Materials, Methods, and Techniques"
for fulfillment of the requirements for the Degree of
Doctor of Medicine with Honors.

Woods Hole Marine Biological Laboratory, Woods Hole, Massachusetts, in
association with the Davidson Honors College and the Department of Biology. Faculty Preceptor:
David Grant, Ph.D., Professor of Biology, Davidson College I designed and executed this research
project on the Investigation of Benthic
Marine Life Population Diversity in the Zostera marina community.

HONORS AND AWARDS:

International Who's Who of Entrepreneurs

Who's Who of Professionals

Strathmore's Who's Who of Professionals

Specialist Certification as a Preferred Provider: Fibromyalgia & Chronic Fatigue Syndromes

Book Dedication: Mary E. O'Brien, M.D. (author) Anadem Publishing
Chronic Fatigue Syndrome - Charting Your Course to Recovery
"This book is dedicated to Dr. Jim Coggin, whose gentle understanding and compassion
have been a healing force in my life and in the lives of his patients."

Awarded the Degree of Doctor of Medicine with Honors
University of North Carolina School of Medicine (Top 10 of his class) 1991

Clinical Honors - Third & Fourth years - U.N.C. Medical School 1989-1991

Sanford Junior Chamber of Commerce "Outstanding Young
Educator of the Year" Sanford-Lee County School System 1975

President's Award for "Most Valuable Senior"
Sigma Phi Epsilon Fraternity, Davidson College 1974

Alpha Epsilon Delta Pre-Medical Fraternity 1970-1974

Philanthropic Literary Society, Davidson College
Oldest extant Davidson Student Organization, 1970-1974
Membership by invitation, Office of First Critic 1973-1974

Davidson College Honors College 1970-1974
One of only two Freshmen selected for special academic pursuits

Dr. John E. Dotterer "Mathematics Achievement Award"
Sanford Central High School, Sanford, North Carolina 1970

God and Country Award, Boy Scouts of America and
The First Baptist Church of Sanford, North Carolina 1968

Eagle Scout, Boy Scouts of America 1966

MEMBERSHIPS, OFFICES AND COMMITTEE ASSIGNMENTS IN PROFESSIONAL SOCIETIES:

HEADACHE NETWORK for Physicians (National). Selected to participate in Research and Seminars. Certified to treat Patients with Primary Headache conditions.

CERTIFIED BY THE FIBROMYALGIA NETWORK for providing Healthcare to Fibromyalgia and Chronic Fatigue Patients. (Listed on the N.C. Referral List)

Certified Disability Examiner for the State of North Carolina
American Medical Association, National, and State
Southern Medical Association
American College of Obstetricians and Gynaecologists, Junior Fellow
American Medical Student Association
N.C. State Board of Medical Examiners - State License and State License
Registration Certificate
Board Certified in General Practice / Prior Board Eligibility in Gynaecology

Drug Enforcement Agency - DEA Registration Class II-V
North Carolina Medicare and Medicaid Provider
Uniform Provider Identification Number (F74977)

N.C. State Board of Refrigeration Examiners-State License
State of North Carolina Board of Examiners of Electrical
Contractors. State License-SP-PH Class I

State Board of Examiners of Plumbing, Heating and
Fire Sprinkler Contractors License Number
Class I Licenses: H-1 (Hydronic Heating)
H-2 (Commercial Air Conditioning)
H-3 (Residential Heating and Air Conditioning)

SERVICE ON INSTITUTIONAL/SCHOOL, COMMITTEES AND TO THE COMMUNITY:

CEMC Annual Health Fair Participant 1996-05

Fibromyalgia/Chronic Fatigue Support Group, Local Region (Founder) 1995

Student Health Action Committee Clinic, Carrboro, N. C., 1988-89 Position: Laboratory Technician.
Faculty precepted and Student administered Health Clinic for the indigent

North Carolina Triangle J Council of Governments Private Industry Council Representative of Private
Business Sector for a 5 county area 1984-86

Rotary Club of Sanford: 1977-87 Chairman of Rotary Youth Committee
Chairman of the Committee for the Muscular Dystrophy Telethon

Lee County United Way-Board of Directors 1977-86

TEACHING RESPONSIBILITIES:

- Lecture/Presentation: "Secrets of Successful Aging"
North Carolina Dental Society Annual Meeting 2005
- Lecture/Presentation: "Women's Health Update"
North Carolina Dental Society Annual Meeting 2003
- Radio Talk Show: "Key Issues in Menopause"
WCBS National Radio, New York City 1997
- National Television appearance: The Joe Franklin Show,
A Nationally Syndicated Television talk show, Newark, New Jersey. 1997
- Chronic Pain, Migraine Headaches, Fibromyalgia and Myofascial
Pain Syndromes - Monthly Lectures, Family Medical Center 1995
- "Focus on Migraines" (Televised Symposium) - Sanford Civic Center 1994
- "Osteoporosis and Menopause" (Public Forum) - Sanford, N. C. 1994
- "Neonatal Herpes Simplex Virus Infection" - New Hanover
Regional Medical Center, Departments of OB/GYN, Pediatrics
and Neonatology, Wilmington, N. C. 1992
- "Polycystic Ovarian Syndrome" - New Hanover Regional Medical
Center, Department of OB/GYN, Wilmington, N. C. 1992
- "Pregnancy Induced Hypertension" - New Hanover Regional Medical
Center, Department of OB/GYN, Wilmington, N. C. 1992
- "Surgical Incision Closure: Materials, Methods, and Techniques"
UNC School of Medicine - Doctor of Medicine with Honors 1990-91
- "The Evolution of Man-A Review of Anthropology"
Philanthropic Literary Society, Davidson, N. C. 1974
- "Benthic Population Diversity in a *Zostera marina* Community"
Woods Hole Marine Biological Laboratory, Woods Hole Mass.
Davidson Honors College Marine Science Program 1972

**INSTITUTE FOR NATURAL RESOURCES
COURSE: "UNDERSTANDING DEMENTIA"**

Appendix D
Course Description & Brochure
(Please see attached brochure)

This course reviews the symptoms and treatment strategies for disorders relevant to the aging population. These disorders include chronic pain, temporo-mandibular disorders, hypertension, depression, bipolar disorder, and dementia. This course covers the clinical and scientific bases of these disorders. In addition, it provides updates on the pharmacology and interactions of drugs used in treating these disorders. Dental professionals will acquire the knowledge necessary to accommodate the special needs of aging dental patients and will be better able to communicate confidently in consults with physicians, pharmacists, and other health professionals regarding these patients. After completing this course, dental professionals will be able to give these patients sound advice for proper oral health care.

UNDERSTANDING DEMENTIA

Instructor: James M. Coggin, M.D.

Seminar registration is from 7:45 AM to 8:15 AM. The seminar will begin at 8:30 AM. A lunch break (on your own) will take place from approximately 11:30 AM to 12:20 PM. The course will adjourn at 3:30 PM, at which time course completion certificates are distributed.

PROGRAM / LECTURE

Registration: 7:45 AM – 8:30 AM

Morning Lecture: 8:30 AM – 10:00 AM

- Our "Three Brains." How They Are Affected by Dementia.
- The Brain And Memory: How We Remember And Forget.
- The Four Stages of Memory: Sensory, Short-Term, Long-Term, and Retrieval.
- The Two Separate Memory Systems: Declarative Memory and Procedural Memory.
- The Accuracy Of Our Memories: Reconstructing Memories. Do We All Confabulate?
- Myths And Realities Of The Aging Brain: Do We Lose Thousands of Neurons a Day?

Mid-Morning Lecture: 10:00 AM – 11:30 AM

- Brain Push-Ups: Can Mental Exercises Slow or Stop Brain Aging and Memory Loss? Does Doing Crossword Puzzles Protect The Brain From Aging And Dementia?
- The Exercise Question: Physical Exercise vs. Mental Exercise.
- Brain Aging And Memory: Do All Types of Memory Deteriorate As We Age?
- Super-Agers: Amazing People Who Maintain Excellent Memory In Advanced Age.
- Increased Forgetting: Is It Normal With Aging? Age-Associated Memory Impairment and Mild Cognitive Impairment.
- Reversible Dementias: Secondary Dementias Such As Depression, Normal Pressure Hydrocephalus, Metabolic Disorders, and Cognitive Dysfunction.

Lunch: 11:30 AM – 12:20 PM

Afternoon Lecture: 12:20 PM – 2:00 PM

- Huntington's Disease: How One Bad Gene Can Cause An Irreversible Dementia.
- The Surprising Cause Of Many Dementias: Misfolded and Unfolded Proteins.
- Sex, Gender, And Dementia: Are There Sex Differences In Many Dementias? Do More Women Develop Alzheimer's Disease? Some Surprising Facts.
- Teeth, Gums, and Dementia. Does Gum Disease Raise the Risk of Dementia? How to Evaluate and Treat Dental Patients with Dementia.
- The Road to Parkinson's Disease: Alpha Synuclein Protein Unfolding To Lewy Bodies To Substantia Nigra Deterioration To Basal Ganglia Malfunction.
- Football, Boxing, and Dementia: Multiple Concussions. Traumatic Brain Injury and Alzheimer's Disease. Military Implications.
- The Great Mystery: What Triggers Alzheimer's Disease? Amyloid Hypothesis. Tau Hypothesis. Acetylcholine Depletion. Inflammation. Vascular Changes. Oxidative Stress. Excitotoxicity. Myelin Sheath Deterioration. Blood-Brain Barrier Dysfunction.

Mid-Afternoon Lecture: 2:00 PM – 3:20 PM

- Veins and Brains: The Cardiovascular-Alzheimer's Connection.
- Can Alzheimer's Disease Be Prevented? Reducing the Risk of Alzheimer's.
- Early Warning Signs of Alzheimer's Disease: What To Look For.
- Can Alzheimer's Disease Be Accurately Diagnosed Years Before Symptoms Appear?
- Treatments For Alzheimer's Disease: What Are They? Do They Work?
- New Experimental Treatments for Alzheimer's. Do They Work? Can We Be Vaccinated? The Future of Alzheimer's Research.
- Ten Signs of Caregiver Stress: Coping with Exhaustion and Heartache.

Evaluation, Questions, and Answers: 3:20 PM – 3:30 PM

6 CONTACT HOURS / www.INRseminars.com

MEETING TIMES & LOCATIONS

DAVENPORT, IA	CEDAR RAPIDS, IA	DES MOINES, IA	KEARNEY, NE	OMAHA, NE
Wed., Oct. 2, 2013	Thu., Oct. 3, 2013	Fri., Oct. 4, 2013	Wed., Oct. 16, 2013	Thu., Oct. 17, 2013
8:30 AM to 3:30 PM	8:30 AM to 3:30 PM			
Best Western	Clairion Hotel	Holiday Inn	Ramada Kearney	Ramada Plaza Hotel
100 West 76th St.	525 33rd Ave. SW	6111 Fleur Dr.	301 2nd Ave.	3321 South 72nd St.
Davenport, IA	Cedar Rapids, IA	Des Moines, IA	Kearney, NE	Omaha, NE

TUITION: \$81.00 per person with pre-registration (\$96.00 at the door if space remains). Tuition includes a syllabus. (Group pre-registration rate: \$76.00 per person. To qualify, 3 or more registrations must be submitted together. Please list names of all registrants.)

TO REGISTER: There are **four** ways to register:

- 1) **Online:** www.INRseminars.com
- 2) **By mail:** Complete and return the Registration Form below.
- 3) **By phone:** Register toll-free with Visa, MasterCard, American Express®, or Discover® by calling **1-800-937-6878**. (This number is for registrations only.)
- 4) **By fax:** Fax the completed registration form—including Visa, MasterCard, American Express®, or Discover® Number—to (925) 687-0860.

For all inquiries, please contact customer service at **1-877-246-6336** or **(925) 609-2820**.

Please register early and arrive before the scheduled start time. Space is limited. Attendees requiring special accommodation must advise INR in writing at least 90 days in advance and provide proof of disability. Registrations are subject to cancellation after the scheduled start time. A transfer can be made from one seminar location to another if space is available. Registrants cancelling up to 72 hours before a seminar will receive a tuition refund less a \$25.00 administrative fee or, if requested, a full-value voucher, good for one year, for a future seminar. Cancellation or voucher requests must be made in writing. If a seminar cannot be held for reasons beyond the control of the sponsor (e.g., acts of God), the registrant will receive free admission to a rescheduled seminar or a full-value voucher, good for one year, for a future seminar. A \$25.00 service charge applies to each returned check. Nonpayment of full tuition may, at the sponsor's option, result in cancellation of CE credits issued. The syllabus is not available for separate purchase. A \$15.00 fee will be charged for the issuance of a duplicate certificate. Fees subject to change without notice.

Please check course date:

REGISTRATION FORM

(This registration form may be copied.)

Please return form to:

INR
P.O. Box 5757
Concord, CA 94524-0757
TOLL-FREE: 1-877-246-6336
TEL: (925) 609-2820
FAX: (925) 687-0860

____ Wed., Oct. 2, 2013 (Davenport, IA)
____ Thu., Oct. 3, 2013 (Cedar Rapids, IA)
____ Fri., Oct. 4, 2013 (Des Moines, IA)

____ Wed., Oct. 16, 2013 (Kearney, NE)
____ Thu., Oct. 17, 2013 (Omaha, NE)

Please print:

Name: _____ Profession: _____

Home Address: _____ Professional License #: _____

City: _____ State: _____ Zip: _____ Lic. Exp. Date: _____

Home Phone: (____) _____ Work Phone: (____) _____ Employer: _____

Please enclose full payment with registration form. Check method of payment. E-Mail: _____ (needed for confirmation & receipt)

____ Check for \$ _____ (Make payable to INR)

____ Charge the amount of \$ _____ to my _____ Visa _____ MasterCard _____ American Express® _____ Discover®

Card Number: _____ Exp. Date: _____
(enter all raised numbers)

Signature: _____

Please provide an e-mail address above to receive a confirmation and directions to the meeting site.

CODE: UD-WZ965

Non-Profit Org.
U.S. Postage
PAID
Emporia, KS
Permit No. 16



To learn more, scan QR (quick response) code with your smartphone or reader.

INR
P.O. Box 5757
Concord, CA 94524-0757
1-877-246-6336
(925) 609-2820
www.INRseminars.com

Celebrating 29 Years

UNDERSTANDING DEMENTIA



6 CONTACT HOURS; \$81 Tuition
Register with Visa, MC, American Express®, or Discover® at: 1-800-937-6878

DENTAL EDUCATION 1975

UNDERSTANDING DEMENTIA



www.INRseminars.com

6 CONTACT HOURS*

(*See Approval Information for Iowa)

A course for:

Dentists
Dental Hygienists
Members of the Academy
of General Dentistry (AGD)



Tuition \$81

Presented by Institute for Natural Resources
1-877-246-6336 • (925) 609-2820

ACCREDITATION

To obtain the 6 contact hours (0.6 CEU) associated with this course, the dental professional will need to sign in, attend the course, and complete program evaluation forms. At the end of the program, the dental professional successfully completing the course will receive a statement of credit. This is an intermediate-level course.

DENTISTS & DENTAL HYGIENISTS

INR (Institute for Natural Resources) has been approved by the national office of the Academy of General Dentistry (AGD) as a program provider of continuing dental education (see below). Many state boards of dentistry will accept, for credit toward license renewal, courses presented by an AGD-approved organization. INR's approval from AGD covers both live and home-study courses.

Dental professionals in over 40 states have received continuing education credit by completing INR courses. INR or its courses have been approved for continuing education by dental boards in Indiana and California.

Iowa

Application for approval of this course has been made to the Iowa State Board of Dental Examiners for 6 hours of continuing education credit.

Nebraska

Application for approval of this course has been made to the Nebraska Board of Dental Examiners for 6 hours of continuing education credit.

Illinois

Under Sponsor #174-000128, the Illinois Dept. of Prof. Regulation has approved INR as a sponsor of continuing dental work education.

Kansas & Missouri

The Kansas and Missouri Dental Boards will accept continuing education courses sponsored by an organization approved by the Academy of General Dentistry (AGD).

MEMBERS OF THE ACADEMY OF GENERAL DENTISTRY

INR is designated as an Approved PACE Program Provider by the Academy of General Dentistry. The formal continuing dental education programs of this program provider are accepted by AGD for Fellowship/Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from 06/01/12 to 05/31/16.

COURSE RELEVANCE

This course reviews the symptoms and treatment strategies for Alzheimer's disease, dementia, head trauma, depression, stress, and premature brain aging. It covers the clinical and scientific bases of these disorders. It provides updates on the pharmacology and interactions of drugs used in treating these conditions and in preventing premature aging. In addition, the course emphasizes modifiable lifestyle factors relevant to brain health. Dental professionals will acquire the knowledge necessary to accommodate the special needs of dental patients with these disorders, and will enhance their understanding of preventive approaches to the covered disorders. After completing this course, dental professionals will be able to give their patients sound advice for proper oral health care.

Health professionals in fields other than dentistry have been invited to attend this seminar.

INSTRUCTOR

Dr. James M. Cogglin (M.D.) is a full-time physician-lecturer for INR. Dr. Cogglin graduated with honors from the University of North Carolina School of Medicine. After residency training in obstetrics and gynecology, he entered private practice.

Dr. Cogglin maintains a solo private practice and an active speaking career.

Dr. Cogglin's clinical work focuses on a wide range of topics, including women's health, fibromyalgia, chronic fatigue, weight control, migraine headaches, and medical aesthetics.

INR reserves the right to change instructors without prior notice. Every instructor is either a compensated employee or independent contractor of INR.

SPONSOR

INR (Institute for Natural Resources) is a non-profit scientific organization dedicated to research and education in the fields of science and medicine. INR is the nation's largest provider of live continuing education programs, offering over 600 live seminars yearly.

INR has no ties to any commercial organizations and sells no products of any kind, except educational materials. Neither INR nor any instructor has a material or other financial relationship with any health care-related business that may be mentioned in an educational program. If INR were ever to use an instructor who had a material or other financial relationship with an entity mentioned in an educational program, that relationship would be disclosed at the beginning of the program. INR does not solicit or receive gifts or grants from any source, has no connection with any religious or political entities, and is totally supported by its course tuition.

INR's address and other contact information follows:

P.O. Box 5757, Concord, CA 94524-0757

Customer service: 1-877-246-6336 or (925) 609-2820

Fax: (925) 687-0860

E-Mail: info@inrseminars.com; website, www.INRseminars.com

Tax Identification Number 94-2948967.

Education expenses (including enrollment fees, books, tapes, travel costs) may be deductible if they improve or maintain professional skills. Treas. Reg. Sec. 1.162-5. Recording of the seminar, or any portion, by any means is strictly prohibited. INR's liability to any registrant for any reason shall not exceed the amount of tuition paid by such registrant.

For American Disability Act (ADA) accommodations or for addressing a grievance, please fax the request to INR at (925) 687-0860. Or, please send the request by email to: info@inrseminars.com

LEARNING OBJECTIVES

Participants completing this program will be able to:

- 1) discuss the components and stages of memory, including those relating to sensory, short-term, long-term, and retrieval.
- 2) define key aspects of normal forgetting, age-associated memory impairment, mild cognitive impairment, and dementia.
- 3) outline the risk factors, symptoms, and treatments for reversible and irreversible dementias.
- 4) identify the connection among cardiovascular disease, vascular dementia, and Alzheimer's disease.
- 5) describe the different characteristics, progression factor, and treatments for a mild concussion, severe traumatic brain injury, and chronic traumatic encephalopathy.
- 6) describe, for this course, the implications for dentistry, mental health, and other health professions.

© Institute for Natural Resources, 2013. CODE: UD-W2965

Institute for Natural Resources

P.O. Box 5757 ♦ Concord, CA 94524-0757 ♦ (925) 609-2820 ♦ FAX (925) 363-7798

July 09, 2013

Iowa Dental Board
Advisory Committee on Continuing Education
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

RECEIVED

JUL 11 2013

IOWA DENTAL BOARD

Dear Board Representative:

Under its current organizational approval with the Iowa Board of Dental Examiners, the Institute for Natural Resources would like to submit an application for **prior approval** of its continuing education course entitled, "Understanding Dementia." This course is designed to meet the needs of licensed dentists seeking continuing education credit.

In addition to the completed application and the \$10 fee, please find appendices A through D enclosed. These materials include:

- ✓ Dates, Times, & Locations—**Appendix A**
- ✓ Time Agenda/Course Outline—**Appendix B**
- ✓ Instructor's Resume—**Appendix C**
- ✓ Course Description & Brochure—**Appendix D**

The Institute is a non-profit, scientific, and educational organization founded and maintained by professional scientists and educators. The Institute is free of any ties to commercial, political, or religious organizations. The purpose of the Institute is to provide high-quality, professional continuing education programs that enable healthcare professionals to provide quality services. The education courses offer up-to-date, in-depth information about the latest scientific and clinical research.

Please contact me at 925-609-2820 ext. 238 if you have any questions or require further information.

Sincerely,



Deborah Cheung,
Accreditation Manager
Accreditation Department

Enclosures

CONTINUING EDUCATION SPONSOR APPLICATION RECEIVED

IOWA DENTAL BOARD

400 S.W. 8th St, Suite D • Des Moines, IA 50309-4687
Phone (515) 281-5157 • www.dentalboard.iowa.gov

MAY 24 2013

IOWA DENTAL BOARD

Groups or organizations wanting to obtain status as a board-approved sponsor of continuing education must complete this application and enclose the sponsor fee of \$100.

1. Official Name of Sponsor Group: Laboratory Consultation Services, Inc.

Contact Person: Gershon Dubin Phone: 646-812-0441 Fax: _____

Address: 908 Avenue M Brooklyn NY 11230 E-mail: gdubin@laboratoryconsultationservices.com

2. Type of organization (attach bylaws if applicable):

- Constituent or component society
- Dental School
- Dental Hygiene School
- Dental Assisting School
- Other (please specify): Consulting group

3. If applicable, approximate number of active members _____

Name of Current Officers	TITLE	ADDRESS	PHONE
<u>Gershon Dubin</u>	<u>President</u>	<u>908 Avenue M 11230</u>	<u>646-812-0441</u>
<u>Saul Z. WASSERMAN</u>	<u>D.P. Inc.</u>	<u>1291 DICKERSON RD TEANECK 07666</u>	<u>201-575-0783</u>

5. Please provide contact information below. The name you provide will be posted as the contact person for your organization on the Board's website.

Name: Gershon Dubin Phone: 646-812-0441 Fax: _____

Full Address: 908 Avenue M Brooklyn NY 11230

Internet Address: www.laboratoryconsultationservices.com E-mail: gdubin@laboratoryconsultationservices.com

6. Approximately how many courses, meetings or programs does your group or organization sponsor each year? 5 online courses

7. Average number of attendees at each course or meeting: N/A

8. How many courses, meetings or programs do you anticipate sponsoring this year? we anticipate adding 2-3 courses

9. Which of the following educational methods does your organization use? Please check all applicable.

- Home study (e.g. self assessment, reading, educational TV, internet courses)
- Lectures
- Participation
- Discussion
- Demonstration

\$1802 \$100

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Introduction

This training is designed to comply with the requirement for a two-hour certification course to be conducted for teachers, teaching assistants, pupil personnel service professionals, and administrators in New York State as part of the Safe Schools Against Violence in Education Act (SAVE). It can also be used to fulfill the professional development plan requirement to provide a two-hour course for all currently certified staff, covering the items as specified in regulation.

The following items are included in the two-hour course:

- Statutes, regulations, and policies relating to a safe, non-violent school climate
- Effective classroom management techniques and other academic supports that promote a non-violent school climate and enhance learning
- Integration of social and problem-solving skill development for students within the regular curriculum
- Intervention techniques designed to address a school violence situation
- Study of the warning signs within a developmental and social context that relate to violence and other troubling behaviors in children
- How to participate in an effective school/community referral process for students exhibiting violent behavior

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Background

During the 1990s, our nation witnessed several highly publicized school based acts of violence. The continual reoccurrence of such incidents serves to reinforce the notion that formerly unheard-of events are now becoming commonplace. It is to our discredit that we accept these episodes as ordinary. We must cultivate a sense of outrage and delve further into their causes and actual incident rates. By reviewing the data and findings up close, we will discover some encouraging trends and remarkable successes in the effort to stem youth violence.

In our not-too-distant past, school was depicted as a place for active learning, where childhood curiosity was served, as mutual respect existed between pupil and teacher. Corporal discipline was meted out in a measured fashion, and students accordingly accepted their punishment, when deserved. Such an idyllic version of the "good ol' days" did not represent emerging societal trends unique to the United States. The aforementioned school model existed up until the early nineteenth century in the United States, where the majority of citizens lived in rural areas and students divided their days between farm chores and local school education. Our school calendar still accommodates the agricultural work cycle by providing a summer break for students during peak planting and harvesting seasons on farms.

In the mid-to-late nineteenth century, massive waves of immigrants from Europe created new educational and societal challenges. The need for uniform educational standards and professional teacher training fostered curriculum development and the refinement of teaching methodologies. As we approached the twentieth century, compulsory educational laws were written and enforced, and secondary school was no longer a secular luxury of the well-to-do who were college bound. Now, all students were mandated to complete a standardized curriculum.

Educators and psychologists established and further defined the concepts of childhood learning-Piaget's theoretical paradigm that human development occurred in stages of progressively learned tasks became the blueprint for formulating curricula at the various grade levels. Child labor laws codified the concept that children required supervision and special protection by society, with clear stipulations for parental responsibilities, as well as rights afforded to children.

The mid-twentieth century witnessed explosive technological change reflected in educational settings. Society moved into the information age; teachers faced the task of organizing the continual stream of information resulting from this revolution. The model for the typical American family was nuclear, living isolated in suburban settings and accessing the community only through the use of the automobile. Teenagers were also courted as a consumer market in their own right-a group prosperous enough to support its own separate

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

demand for clothing, music, and entertainment. By the mid-twentieth century, the identity of American adolescents was defined as rebellious youth, whose music, dress, and speech departed markedly from their parents' own adolescent expression.

Further development of youth marketing channels, such as MTV, created explicit video images depicting drug use and unbridled sexual activity without negative consequences. With the advent of sophisticated technology, extreme violence was now easily depicted in popular movies, television, and video games and touted as the inevitable outcome of any conflict. Several factors now influenced youth behavior:

- The growing infusion of drugs into mainstream America
- The easy accessibility of guns
- The pervasive youth culture with harmful messages supported by the popular media
- The decline of the family structure

Societal safety nets vanished as the number of homeless, foster, and abused/ neglected children increased exponentially. The onset of the AIDS epidemic and the reduction in health care spending boded ill for children who, all too frequently, made early decisions to engage in drug use and sexual activity. Finally, constant exposure to violent images in both real life and through videos taught youth a false message: that violence is an appropriate choice of action. These influences on youth's attitudes have created the misperception that youth violence is an inevitable rite of passage for many, and that both educational and community settings are unprepared to cope with these inevitable episodes.

A Closer Look at Risk Factors

According to a recent report by the Office of the Surgeon General (2001), serious violence, including aggravated assault, robbery, rape, and homicide, is most likely to occur during the second decade of life. In addition, a disturbing statistical trend showed the number of violent acts committed by high school seniors increased nearly 50 percent in the past twenty years.

Misperceptions concerning the causality beyond youth violence abound, including:

- Conduct-disordered children are predetermined to commit violence in adolescence.
- African American and Hispanic youths are more likely to be involved in violence. (Arrest rates differ, but not self-reported incidents.)
- Violent youths will be arrested for a violent crime. (Most will never be arrested for a violent crime.)
- Incarcerating youth in adult facilities will "cure them." (Introducing youth into adult facilities indoctrinates them with the core value system of adult criminals.)

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Rigorous evaluation of these misperceptions revealed a flaw in our approach and led us to discern that youth's personal characteristics interact in various ways with environmental risk factors. In short, we re-examined our own approach to solving this problem and found that cause and effect do not necessarily form a linear relationship.

Research supporting this report also reveals that there are several identifiable factors that predispose youth toward both violent and non-violent behavioral choices. Identification of such factors is deemed critical in developing targeted interventions. The research points to the early onset of violent behavior (before puberty), which contributes to a longer personal history of violent crimes than those who begin perpetrating violent crimes after puberty. The co-occurrence of drug use, early sexual activity, and violent actions make up a risky lifestyle, which, as a whole, has been implicated as a significant factor contributing to a continuation of a violent lifestyle. In fact, the involvement in criminal behavior (not only violent behavior) has been shown to predispose children toward violent actions. The presence of individualized personal characteristics and strong environmental supports has been shown to counter the probability of a youth's choice to engage in violent behavior.

Societal Trends

The school typically has been viewed as the setting where societal trends are reflected. To some, it may come as a surprise that students are more likely to be injured away from school than at the school environment itself (Task Force on School Violence 1999). According to the report from the New York State Lieutenant Governor's Task Force, trends show that student violence against other students has declined and that younger students (9th grade vs. 12th grade) were more likely to carry weapons and become involved in violent confrontations at school. In New York State, less than 10 percent of students have been threatened or carried a weapon to school or missed school due to safety concerns. Yet this number represents a significant number of students who live with the threat of violence on a daily basis.

The percentage of teachers reported as victims of serious violent crime is much smaller than student victims: 4 teachers per 1,000, versus 10 students per 1,000 (in 1996). An encouraging trend shows the decline in the use of weapons at school, a finding also reflected in the U.S. Surgeon General's report. The statistic that shows fewer students bringing firearms to school (in 1999) is a reversal of a ten-year trend of youth violence that peaked in 1993. Overall, students in New York State are safer from the threat of firearms than students in other states.

This is not to state that comprehensive school safety planning is unwarranted or unnecessary. There are still disturbing trends showing that youth arrests for violent actions, such as aggravated assault, remain nearly 70 percent higher than pre-epidemic levels (Office of the Surgeon General 2001). Careful analysis of community and individual risk factors and

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

development of a comprehensive school-planning model can create an effective antidote against the incidence of youth-based violence.

New York State

Safe Schools Against Violence in Education (SAVE)

At the close of the 2000 legislative session, a bill was introduced and passed in New York State. That bill is known as SAVE, Safe Schools Against Violence in Education. SAVE addresses many important issues that affect education. For most components of SAVE, the full compliance date is July 1, 2001.

Included in the SAVE legislation are

1. District-wide School Safety Plans

The board of education of every school district must appoint a team to develop a comprehensive safety plan to include:

Policies and procedures for:

- Responding to threats
- Responding to acts of violence
- Appropriate prevention/intervention strategies, such as:
 - Training for security personnel (for example: de-escalate potentially violent situation)
 - Conflict resolution
 - Peer mediation youth courts extended day programs
 - Contacting law enforcement
 - Contacting parents and/or guardians
 - School building security
 - Dissemination of informative materials regarding early detection of
 - Potentially violent behaviors
 - Annual school safety training for staff and students
 - Protocol for responding to bomb threats, hostage takings, intrusions, and kidnappings
 - Developing strategies to improve communication among students and between students and staff
- Description of duties of hall monitors and other school safety personnel

This team must include a representative of the board of education, students, teachers, administrators, parent organizations, and other school and school safety personnel. Representatives must be appointed by the board of education.

2. Building Level Emergency Response Plans

This team is appointed by the principal under guidelines established by the board of education. Typically, the core team includes the building administrator, general and special

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

education teachers, parent(s), and a pupil support services representative (a school psychologist, social worker, or counselor), school resource officer, and a safe and drug-free schools program coordinator. If no school psychologist or mental health professional is available to the staff, involve someone from an outside mental health agency. Other individuals may be added to the team depending on the task. For example, when undertaking school wide prevention planning, the team might be expanded to include students, representatives of community agencies and organizations, the school nurse, school board members, and support staff (secretaries, bus drivers, and custodians). Similarly, crisis response planning can be enhanced with the presence of a central office administrator, security officer, and youth officer or community police team member.

The core team also should coordinate with any school advisory boards already in place. For example, most effective schools have developed an advisory board of parents and community leaders that meets regularly with school administrators. While these advisory groups generally offer advice and support, that role can be expanded to bringing resources related to violence prevention and intervention into the school.

Consider involving a variety of community leaders and parents when building the violence prevention and response team:

- Parent group leaders, such as PTA officers.
- Law enforcement personnel.
- Attorneys, judges, and probation officers.
- Clergy and other representatives of the faith community.
- Media representatives.
- Violence prevention group representatives.
- Mental health and child welfare personnel.
- Physicians and nurses.
- Family agency and family resource center staff.
- Business leaders.
- Recreation, cultural, and arts organizations staff.
- Youth workers and volunteers.
- Local officials, including school board members and representatives from special commissions.
- Interest group representatives and grass roots community organization members.
- College or university faculty.
- Members of local advisory boards.
- Other influential community members.

The school board should authorize and support the formation of and the tasks undertaken by the violence prevention and response team.

While we cannot prevent all violence from occurring, we can do much to reduce the likelihood of its occurrence. Through thoughtful planning and the establishment of a school violence prevention and response team, we can avert many crises and be prepared when they do happen.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

The plan must include:

- Policies and procedures for safe evacuation, to include evacuation routes, shelter sites, procedures for addressing medical needs, transportation, and emergency notification to parents
- Designation of an emergency response team
- Access to floor plans, blueprints, schematics of school interior, grounds, and road maps of surrounding area
- Internal and external communication system
- Implementation of incident command system (ICS)
- Coordination with Statewide Disaster Mental Health Plan (New York State Office of Mental Health 1997)
- Procedures to review and conduct drills and exercises to test components of plan
- Policies and procedures for securing and restricting access to crime scene

3. Codes of Conduct

Requires schools to adopt codes of conduct for the maintenance of order on school grounds and to file such codes with the New York State Education Department. Applies to teachers, students, personnel, and visitors.

Minimum elements include:

- Appropriate dress and language
- Security issues
- Removal from classroom
- Disciplinary procedures for violators
- Policies and procedures for detention, suspension, and removal of disruptive pupil
- Procedures for reporting code violations and imposing penalties
- Provisions to insure compliance with state and federal laws in relationship to students with disabilities
- Provisions for notifying law enforcement of violations (e.g., violent crimes)
- Procedures for parental notification
- Committee to review actions relating to the code
- Procedures regarding PINS petitions and juvenile delinquency provisions
- Procedures for referral to human services agencies
- Minimum suspension periods for students who are repeatedly and substantially disruptive
- Minimum suspension periods for acts that qualify a student as violent

District-wide School Safety Plans, Building Level Emergency Response Plans, and Codes of Conduct, are subject to a public hearing, reviewed and updated annually, and filed with the commissioner of education no later than 30 days after adoption.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

4. Teacher Authority/Principal Authority

Allow teachers to remove disruptive or violent pupils from the classroom, consistent with district codes of conduct, with appropriate procedural safeguards for affected students.

Adds principals to those empowered to suspend pupils from school entirely, without specific board delegation of that authority.

Requires districts to include, in their codes of conduct, minimum periods of suspension for violent or repeatedly disruptive pupils.

Disruptive pupil is defined as one who:

- Is substantially disruptive of the educational process or interferes with the teacher's authority over the classroom

Violent pupil is defined as one who:

- Commits an act of violence on a teacher, other school district employee, or fellow student
- Possesses, displays, or threatens to use a gun, knife, or other dangerous weapon
- Knowingly and intentionally damages or destroys the personal property of a teacher or other school district employee
- Knowingly and intentionally damages or destroys school district property

Removal Procedures:

- Teachers report and refer violent pupil to administration for minimum suspension period.
- Administration has authority to suspend for up to five days without delegation from board of education.
- District shall implement policies and procedures to provide for continued educational programming for removed pupil.
- Student must be informed of reason for removal by teacher.
- Principal must be informed of reason for student removal by teacher.
- Sets time lines for negotiations of removal to student and parent.
- Requires notification of charges and an explanation for suspension with timelines as required by legislation.

5. Uniform Violent Incident Reporting

- Established by the New York State Education Department and the New York State Department of Criminal Justice Services
- Schools shall report annually to the commissioner of education:
 - Number and types of violent incidents
 - Number of suspensions and other forms of discipline
 - Location where the incident occurred
 - Whether the incident involved a weapon

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- Actions taken by the school
- Ages and grades of disciplined pupils
- The nature of the victim and victim's age when appropriate

This includes an annual report to the governor and the legislature regarding the prevalence of violent incidents on school grounds and at school-sponsored functions and inclusion of such information on school report cards.

6. Instruction in Civility, Citizenship, and Character Education

Requires districts to include a civility, citizenship, and character education component in the K-12 course of instruction concerning the principles of honesty, tolerance, personal responsibility, respect for others, observance of laws and rules, courtesy, dignity, and other positive traits.

7. Health Curriculum

Requires the Board of Regents to review the current health curriculum requirements to ensure that students have sufficient time and instruction to develop skills to address issues of violence prevention and mental health.

8. Interpersonal Violence Prevention Education

Commissioner shall develop and distribute an interpersonal violence prevention package to schools for use in health and related areas.

9. School Violence Prevention Training

- Must be included in Superintendent's Conference Days annually
- All individuals seeking certification as of February 2001 must have completed a two-hour course in violence prevention.
- Must address violence prevention training for current staff in the yearly professional development plan.

10. Whistle Blower Protection

Protection for those employees who report violent incidents, whereby an employee may not be disciplined or fired for reporting these incidents and is protected from any civil liability.

11. Fingerprinting

- Requires prospective school district employees and applicants for certification to be fingerprinted for a criminal history background check in order to be cleared for employment

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- Does not apply to volunteers.

- Does not apply to current employees of a school district. However, if a current employee terminates employment and seeks employment in a different school district, the individual must undergo the fingerprinting process. This law will also apply if a currently certified individual applies for additional certification, such as a teacher applying for an administrator's certificate.

The New York State Education Department will collect fingerprints and a \$74 processing fee from each applicant and submit to the New York State Department of Criminal Justice Services. Provisions exist for a waiver of the fee for applicants for employment who demonstrate to the district that payment of the fee would create a financial hardship. Criminal history records, if any, will be sent by the New York State Department of Criminal Justice Services and FBI to the New York State Education Department for review and consideration of whether any convictions or outstanding arrests justify denial of clearance for employment or certification. Applicants who are denied clearance will be afforded an opportunity to challenge the determination by the New York State Education Department and to review and challenge content of criminal history records through the New York State Department of Criminal Justice Services process.

12. Assaults on Teachers

Increases assaults to a Class D felony from Class A misdemeanor.

13. Child Abuse Reporting

- Defines child abuse in an educational setting.
- Requires the immediate reporting of allegations of child abuse in an educational setting to school authorities, parents, and law enforcement
- Defines mandatory reporters
- Requires a written report of allegations transmitted to school administrator
- Administrator determines whether there is reasonable suspicion, notifies parents if determination is made, and forwards report to law enforcement
- District attorney required to notify superintendent of the filing of an indictment, conviction, suspension, or determination of a criminal investigation
- District attorney notifies the commissioner of conviction of a certified individual.

14. Prohibiting Silent Resignations

- Ends practice of allowing person to resign rather than disclose allegations of child abuse
- Class E felony, punishable by up to four years in prison, civil penalty not to exceed \$20,000.00 for those superintendents who allow employee to resign under these circumstances
- Individuals who in good faith comply with the reporting requirements will be entitled to immunity from any civil or criminal liability that might otherwise result from such actions.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

15. Teacher Discipline

Provides for a range of discipline measures. In addition to revocation of a teaching certificate, discipline will now include suspension, continuing education, limitation on certificates and monetary fines.

16. Court Notification

Requires family and criminal courts to notify schools about juvenile delinquency adjudications.

- Increases coordination between the juvenile justice system and schools
- Requires school to appoint a Designated Educational Official (DEO) to receive records and coordinate student's participation in programs
- Cannot be part of permanent record
- Information can only be used in the execution of student's educational plan

The Role of Data Collection in Planning for Safer Schools

Why Collect Data?

Why should schools collect data? Data is collected when we want to uncover or define a problem or issue. In seeking an answer to the specific question, "What makes a school unsafe?" we must look for those particular factors that contribute to an unsafe school environment. Here, the data collection process can provide us with the answers to our question.

Our method of data collection must be systematic and unbiased, allowing us to readily examine a variety of details, ranging from school-level incidents to individual student behaviors. Such a breadth of view will give us the opportunity to identify specific cause and-effect relationships that compromise school safety. The collection of data, then, is a critical first step in the school safety planning process.

For example, a report that an entire grade in your school is a "problem," does not define the specific justification for such a label. Using a systematic method of getting to the cause of this problem, you start by looking at your school's discipline referrals, and note that this grade has received 86 percent of these referrals. As you look at the incident reports, you delve further and find that the majority of the referrals are for insubordination, specifically for males. In fact, you discover that five male students in this class are responsible for all of the referrals. A review of the referral forms reveals that these boys do not receive referrals from every teacher, but from just one particular class. Can it be a matter of teaching style, you may ask. Does the time of day affect student behavior? Or is it the subject matter? An examination of the documentation has revealed the cause for the entire seventh grade class's unjustified reputation.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

This particular example demonstrates the importance of thorough data collection. Had we not proceeded with our investigation of the particular cause for the grade's label of "problem," we would have unfairly stigmatized students who never misbehaved. Data collection, in this case, can contribute to a positive school climate by helping us identify (and correct) the misbehavior. Well-behaved students from this class who may have been unfairly stigmatized can be reconnected to the school, thus improving the school environment. Lastly, the process of collecting these student referrals and other data becomes systematized and part of the overall collection process that can be used to formulate safer school environments.

Data collection has been recognized by the U.S. Department of Education as one of the primary Principles of Effectiveness. It has become so essential to school practices that the SAVE legislation requires all New York State school districts to establish district-wide safety teams to assist in the planning process, which includes data collection. Improved data collection and tracking methods can assist school districts in their efforts to focus on problem solving before the problem develops. (See Appendix A for Principles of Effectiveness)

Collecting Data to Construct Safety Programs

The ability of schools to obtain and utilize relevant safety information is critical for the ultimate development of successful safety programs and strategies. "A school's ability to ensure a safe and disciplined learning environment is determined by the availability of quality school safety information and the skills to use that information effectively".

Not only is it essential to collect data, but schools must also be judicious in determining the type of data to be collected. Routine data collection is useful, also, because it provides the basis for consistent reporting methods. Finally, data collection should include reporting of incident resolution outcomes. Review of such data will allow the school safety team to make comparisons between their problems and those of other schools and can provide the basis for solving potential problems before they develop.

Prevention, Intervention, and Post Event Strategies

Characteristics of a School That Is Safe and Responsive to All Children

Well functioning schools foster learning, safety, and socially appropriate behaviors. They have a strong academic focus and support students in achieving high standards, foster positive relationships between school staff and students, and promote meaningful parental and community involvement. Most prevention programs in effective schools address multiple factors and recognize that safety and order are related to children's social, emotional, and academic development.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Effective prevention, intervention, and crisis response strategies operate best in school communities that:

- **Focus on academic achievement**

Effective schools convey the attitude that all children can achieve academically and behave appropriately, while at the same time appreciating individual differences. Adequate resources and programs help ensure that expectations are met.

Expectations are communicated clearly, with the understanding that meeting such expectations is a responsibility of the student, the school, and the home. Students who do not receive the support they need are less likely to behave in socially desirable ways.

- **Involve families in meaningful ways**

Students whose families are involved in their growth in and outside of school are more likely to experience school success and less likely to become involved in antisocial activities. School communities must make parents feel welcome in school, address barriers to their participation, and keep families positively engaged in their children's education.

Effective schools also support families in expressing concerns about their children-and they support families in getting the help they need to address behaviors that cause concern.

- **Develop links to the community**

Everyone must be committed to improving schools. Schools that have close ties to families, support services, community police, the faith-based community, and the community at large can benefit from many valuable resources. When these links are weak, the risk of school violence is heightened and the opportunity to serve children who are at risk for violence or who may be affected by it is decreased.

- **Emphasize positive relationships among students and staff**

Research shows that a positive relationship with an adult who is available to provide support when needed is one of the most critical factors in preventing student violence. Students often look to adults in the school community for guidance, support, and direction. Some children need help overcoming feelings of isolation and support in developing connections to others.

Effective schools make sure that opportunities exist for adults to spend quality, personal time with children. Effective schools also foster positive student interpersonal relations--they encourage students to help each other and to feel comfortable assisting others in getting help when needed.

- **Discuss safety issues openly**

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Children come to school with many different perceptions--and misconceptions--about death, violence, and the use of weapons. Schools can reduce the risk of violence by teaching children about the dangers of firearms, as well as appropriate strategies for dealing with feelings, expressing anger in appropriate ways, and resolving conflicts. Schools also should teach children that they are responsible for their actions and that the choices they make have consequences for which they will be held accountable.

- **Treat students with equal respect**

A major source of conflict in many schools is the perceived or real problem of bias and unfair treatment of students because of ethnicity, gender, race, social class, religion, disability, nationality, sexual orientation, physical appearance, or some other factor--both by staff and by peers. Students who have been treated unfairly may become scapegoats and/or targets of violence. In some cases, victims may react in aggressive ways.

Effective schools communicate to students and the greater community that all children are valued and respected [Fine, 1986]. There is a deliberate and systematic effort--for example, displaying children's artwork, posting academic work prominently throughout the building, respecting students' diversity--to establish a climate that demonstrates care and a sense of community.

- **Create ways for students to share their concerns**

It has been found that peers often are the most likely group to know in advance about potential school violence. Schools must create ways for students to safely report such troubling behaviors that may lead to dangerous situations. Students who report potential school violence must be protected. It is important for schools to support and foster positive relationships between students and adults so students will feel safe providing information about a potentially dangerous situation.

- **Help children feel safe expressing their feelings**

It is very important that children feel safe when expressing their needs, fears, and anxieties to school staff. When they do not have access to caring adults, feelings of isolation, rejection, and disappointment are more likely to occur, increasing the probability of acting-out behaviors.

- **Have in place a system for referring children who are suspected of being abused or neglected**

The referral system must be appropriate and reflect federal and state guidelines.

- **Offer extended day programs for children**

School-based before- and after-school programs can be effective in reducing violence. Effective programs are well supervised and provide children with support and a range of options, such as counseling, tutoring, mentoring, cultural arts, community service, clubs, access to computers, and help with homework.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- **Promote good citizenship and character**

In addition to their academic mission, schools must help students become good citizens. First, schools stand for the civic values set forth in our Constitution and Bill of Rights (patriotism; freedom of religion, speech, and press; equal protection/nondiscrimination; and due process/fairness). Schools also reinforce and promote the shared values of their local communities, such as honesty, kindness, responsibility, and respect for others. Schools should acknowledge that parents are the primary moral educators of their children and work in partnership with them.

- **Identify problems and assess progress toward solutions**

Schools must openly and objectively examine circumstances that are potentially dangerous for students and staff and situations where members of the school community feel threatened or intimidated. Safe schools continually assess progress by identifying problems and collecting information regarding progress toward solutions. Moreover, effective schools share this information with students, families, and the community at large.

- **Support students in making the transition to adult life and the workplace**

Youth need assistance in planning their future and in developing skills that will result in success. For example, schools can provide students with community service opportunities, work-study programs, and apprenticeships that help connect them to caring adults in the community. These relationships, when established early, foster in youth a sense of hope and security for the future.

Research has demonstrated repeatedly that school communities can do a great deal to prevent violence. Having in place a safe and responsive foundation helps all children—and it enables school communities to provide more efficient and effective services to students who need more support. The next step is to learn the early warning signs of a child who is troubled, so that effective interventions can be provided.

Research on Risk Factors for School Violence

Research in the area of violence prevention is relatively new; much of what we know has been borrowed from the substance abuse prevention field. This is because researchers have found that a correlation (statistically significant relationship) exists in many areas between individuals who engage in violent behavior and those who abuse alcohol and other drugs. A recent report released by the Office of the Surgeon General shows that the prevalence of drug use occurs more frequently among youth who engage in violent behavior.

Current research identifies three critical areas that form the core of violence prevention efforts:

- Education
- Legal/regulatory
- Environmental

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Education covers the areas of information dissemination and teaching skills. Legal/regulatory includes codes of conduct, rules, policies and procedures, laws and disciplinary codes. The environmental domain encompasses the physical and social environment. The physical environment includes such things as lighting, landscaping, widening of hallways-modifications to the actual physical plant. The social environment includes activities such as after-school programs and day care.

Under the SAVE legislation in New York State, all of these domains will be addressed in every school's comprehensive safety plan in a variety of ways. Through SAVE, the education domain will be addressed through training of school personnel in violence prevention and student training in character education and development of non-violent communication skills.

The legal and regulatory domain is extensive; some of these provisions under SAVE include:

- Required codes of conduct
- Detailed procedures for pupil removal and suspension
- Coordination of efforts between the juvenile justice system and the school

The physical and environmental domains are addressed under the SAVE law by examining the school environment and physical plant for safety and security and continual refinement of the school's safety plans.

New York State's health education mandates are based on a skills-based approach in six critical areas:

- Communication
- Decision making
- Planning and goal setting
- Self-management
- Stress management
- Advocacy

Students must demonstrate competency in each of these areas, and effective interpersonal violence prevention curriculum includes all of these skill areas. (See Appendix B for a brief description of health education skills.)

There is much discussion of what works in prevention and what constitutes an effective program. As we mentioned earlier, the much-needed longitudinal studies in violence prevention are in their infancy, but a review of the existing literature reveals promising educational strategies. These strategies require skills such as those developed through the New York State health mandates. One way students can apply and develop fluency in these skills is through the direct application of these strategies in a school-based environment. The strategies are

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- Mentoring (requires competency in communication, self-management and advocacy skills)
- Social skills (communication, advocacy)
- Conflict resolution (communication, decision making, planning, self management, and advocacy)
- Peer mediation (communication, decision making, planning, self-management, and advocacy)
- Parent involvement (communication, planning, and goal setting)

Some of the ways these strategies are used are through curricula that teach anger management, empathy and perspective taking, social problem solving, communication, and peace building.

Violence studies are relatively new, but research has shown a high degree of correlation between violent behavior and other factors: poverty, substance abuse, low levels of aggression (such as bullying and taunting). Such factors, referred to as risk factors, can negatively affect efforts to reduce violence in the school. Research has shown that risk factors can occur at the individual, school, peer, family, and community levels; some of these factors were mentioned earlier, such as poverty and substance abuse.

Other notable risk factors are gang membership and delinquent peers, low bonding to school, parental criminality, and poor parental involvement. (See Appendix C: Predictors of Youth Violence for additional risk factors.)

Prevention: Early Warning Signs

Why didn't we see it coming? In the wake of violence, we ask this question not so much to place blame, but to understand better what we can do to prevent such an occurrence from ever happening again. We review over and over in our minds the days leading up to the incident--did the child say or do anything that would have cued us in to the impending crisis? Did we miss an opportunity to help?

There are early warning signs in most cases of violence to self and others--certain behavioral and emotional signs that, when viewed in context, can signal a troubled child. But early warning signs are just that--indicators that a student may need help. Such signs may or may not indicate a serious problem--they do not necessarily mean that a child is prone to violence toward self or others. Rather, early warning signs provide us with the impetus to check out our concerns and address the child's needs. Early warning signs allow us to act responsibly by getting help for the child before problems escalate.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Early warning signs can help frame concern for a child. However, it is important to avoid inappropriately labeling or stigmatizing individual students because they appear to fit a specific profile or set of early warning indicators. It's okay to be worried about a child, but it's not okay to overreact and jump to conclusions.

Teachers and administrators--and other school support staff--are not professionally trained to analyze children's feelings and motives. But they are on the front line when it comes to observing troublesome behavior and making referrals to appropriate professionals, such as school psychologists, social workers, counselors, and nurses. They also play a significant role in responding to diagnostic information provided by specialists. Thus, it is no surprise that effective schools take special care in training the entire school community to understand and identify early warning signs.

When staff members seek help for a troubled child, when friends report worries about a peer or friend, when parents raise concerns about their child's thoughts or habits, children can get the help they need. By actively sharing information, a school community can provide quick, effective responses.

Principles for Identifying the Early Warning Signs of School Violence

Educators and families can increase their ability to recognize early warning signs by establishing close, caring, and supportive relationships with children and youth--getting to know them well enough to be aware of their needs, feelings, attitudes, and behavior patterns. Educators and parents together can review school records for patterns of behavior or sudden changes in behavior.

Unfortunately, there is a real danger that early warning signs will be misinterpreted. Educators and parents--and in some cases, students--can ensure that the early warning signs are not misinterpreted by using several significant principles to better understand them. These principles include:

- **Do no harm**

There are certain risks associated with using early warning signs to identify children who are troubled. First and foremost, the intent should be to get help for a child early. The early warning signs should not to be used as rationale to exclude, isolate, or punish a child. Nor should they be used as a checklist for formally identifying, mislabeling, or stereotyping children.

Formal disability identification under federal law requires individualized evaluation by qualified professionals. In addition, all referrals to outside agencies based on the early warning signs must be kept confidential and must be done with parental consent (except referrals for suspected child abuse or neglect).

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- **Understand violence and aggression within a context**

Violence is contextual. Violent and aggressive behavior as an expression of emotion may have many antecedent factors--factors that exist within the school, the home, and the larger social environment. In fact, for those children who are at risk for aggression and violence, certain environments or situations can set it off. Some children may act out if stress becomes too great, if they lack positive coping skills, and if they have learned to react with aggression.

- **Avoid stereotypes**

Stereotypes can interfere with--and even harm--the school community's ability to identify and help children. It is important to be aware of false cues--including race, socio-economic status, cognitive or academic ability, or physical appearance. In fact, such stereotypes can unfairly harm children, especially when the school community acts upon them.

- **View warning signs within a developmental context**

Children and youth at different levels of development have varying social and emotional capabilities. They may express their needs differently in elementary, middle, and high school. The point is to know what is developmentally typical behavior, so that behaviors are not misinterpreted.

- **Understand that children typically exhibit multiple warning signs**

It is common for children who are troubled to exhibit multiple signs. Research confirms that most children who are troubled and at risk for aggression exhibit more than one warning sign, repeatedly, and with increasing intensity over time. Thus, it is important not to overreact to single signs, words, or actions.

Early Warning Signs

It is not always possible to predict behavior that will lead to violence. However, educators and parents--and sometimes students--can recognize certain early warning signs. In some situations and for some youth, different combinations of events, behaviors, and emotions may lead to aggressive rage or violent behavior toward self or others. A good rule of thumb is to assume that these warning signs, especially when they are presented in combination, indicate a need for further analysis to determine an appropriate intervention.

We know from research that most children who become violent toward self or others feel rejected and psychologically victimized. In most cases, children exhibit aggressive behavior early in life and, if not provided support, will continue a progressive

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

developmental pattern toward severe aggression or violence. However, research also shows that when children have a positive, meaningful connection to an adult--whether it be at home, in school, or in the community--the potential for violence is reduced significantly.

None of these signs alone is sufficient for predicting aggression and violence. Moreover, it is inappropriate--and potentially harmful--to use the early warning signs as a checklist against which to match individual children. Rather, the early warning signs are offered only as an aid in identifying and referring children who may need help. School communities must ensure that staff and students only use the early warning signs for identification and referral purposes--only trained professionals should make diagnoses in consultation with the child's parents or guardian.

The following early warning signs are presented with the following qualifications: They are not equally significant and they are not presented in order of seriousness. The early warning signs include:

- Social withdrawal. In some situations, gradual and eventually complete withdrawal from social contacts can be an important indicator of a troubled child. The withdrawal often stems from feelings of depression, rejection, persecution, unworthiness, and lack of confidence.
- Excessive feelings of isolation and being alone. Research has shown that the majority of children who are isolated and appear to be friendless are not violent. In fact, these feelings are sometimes characteristic of children and youth who may be troubled, withdrawn, or have internal issues that hinder development of social affiliations. However, research also has shown that in some cases feelings of isolation and not having friends are associated with children who behave aggressively and violently.
- Excessive feelings of rejection. In the process of growing up, and in the course of adolescent development, many young people experience emotionally painful rejection. Children who are troubled often are isolated from their mentally healthy peers. Their responses to rejection will depend on many background factors. Without support, they may be at risk of expressing their emotional distress in negative ways--including violence. Some aggressive children who are rejected by non-aggressive peers seek out aggressive friends who, in turn, reinforce their violent tendencies.
- Being a victim of violence. Children who are victims of violence--including physical or sexual abuse--in the community, at school, or at home are sometimes at risk themselves of becoming violent toward themselves or others.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- Feelings of being picked on and persecuted. The youth who feels constantly picked on, teased, bullied, singled out for ridicule, and humiliated at home or at school may initially withdraw socially. If not given adequate support in addressing these feelings, some children may vent them in inappropriate ways—including possible aggression or violence.
- Low school interest and poor academic performance. Poor school achievement can be the result of many factors. It is important to consider whether there is a drastic change in performance and/or poor performance becomes a chronic condition that limits the child's capacity to learn. In some situations--such as when the low achiever feels frustrated, unworthy, chastised, and denigrated--acting out and aggressive behaviors may occur. It is important to assess the emotional and cognitive reasons for the academic performance change to determine the true nature of the problem.
- Expression of violence in writings and drawings. Children and youth often express their thoughts, feelings, desires, and intentions in their drawings and in stories, poetry, and other written expressive forms. Many children produce work about violent themes that for the most part is harmless when taken in context. However, an overrepresentation of violence in writings and drawings that is directed at specific individuals (family members, peers, other adults) consistently over time, may signal emotional problems and the potential for violence. Because there is a real danger in misdiagnosing such a sign, it is important to seek the guidance of a qualified professional--such as a school psychologist, counselor, or other mental health specialist--to determine its meaning.
- Uncontrolled anger. Everyone gets angry; anger is a natural emotion. However, anger that is expressed frequently and intensely in response to minor irritants may signal potential violent behavior toward self or others.
- Patterns of impulsive and chronic hitting, intimidating, and bullying behaviors. Children often engage in acts of shoving and mild aggression. However, some mildly aggressive behaviors such as constant hitting and bullying of others that occur early in children's lives, if left unattended, might later escalate into more serious behaviors.
- History of discipline problems. Chronic behavior and disciplinary problems both in school and at home may suggest that underlying emotional needs are not being met. These unmet needs may be manifested in acting out and aggressive behaviors. These problems may set the stage for the child to violate norms and rules, defy authority, disengage from school, and engage in aggressive behaviors with other children and adults.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

- Past history of violent and aggressive behavior. Unless provided with support and counseling, a youth who has a history of aggressive or violent behavior is likely to repeat those behaviors. Aggressive and violent acts may be directed toward other individuals, be expressed in cruelty to animals, or include fire setting. Youth who show an early pattern of antisocial behavior frequently and across multiple settings are particularly at risk for future aggressive and antisocial behavior. Similarly, youth who engage in overt behaviors such as bullying, generalized aggression and defiance, and covert behaviors such as stealing, vandalism, lying, cheating, and fire setting also are at risk for more serious aggressive behavior. Research suggests that age of onset may be a key factor in interpreting early warning signs. For example, children who engage in aggression and drug abuse at an early age (before age 12) are more likely to show violence later on than are children who begin such behavior at an older age. In the presence of such signs it is important to review the child's history with behavioral experts and seek parents' observations and insights.
- Intolerance for differences and prejudicial attitudes. All children have likes and dislikes. However, an intense prejudice toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability, and physical appearance--when coupled with other factors--may lead to violent assaults against those who are perceived to be different. Membership in hate groups or the willingness to victimize individuals with disabilities or health problems also should be treated as early warning signs.
- Drug use and alcohol use. Apart from being unhealthy behaviors, drug use and alcohol use reduces self-control and exposes children and youth to violence, either as perpetrators, as victims, or both.
- Affiliation with gangs. Gangs that support anti-social values and behaviors--including extortion, intimidation, and acts of violence toward other students--cause fear and stress among other students. Youth who are influenced by these groups--those who emulate and copy their behavior, as well as those who become affiliated with them--may adopt these values and act in violent or aggressive ways in certain situations. Gang-related violence and turf battles are common occurrences tied to the use of drugs that often result in injury and/or death.
- Inappropriate access to, possession of, and use of firearms. Children and youth who inappropriately possess or have access to firearms can have an increased risk for violence. Research shows that such youngsters also have a higher probability of becoming victims. Families can reduce inappropriate access and use by restricting, monitoring, and supervising children's access to firearms and other

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

weapons. Children who have a history of aggression, impulsiveness, or other emotional problems should not have access to firearms and other weapons.

- Serious threats of violence. Idle threats are a common response to frustration. Alternatively, one of the most reliable indicators that a youth is likely to commit a dangerous act toward self or others is a detailed and specific threat to use violence. Recent incidents across the country clearly indicate that threats to commit violence against oneself or others should be taken very seriously. Steps must be taken to understand the nature of these threats and to prevent them from being carried out.

Identifying and Responding to Imminent Warning Signs

Unlike early warning signs, imminent warning signs indicate that a student is very close to behaving in a way that is potentially dangerous to self and/or to others. Imminent warning signs require an immediate response.

No single warning sign can predict that a dangerous act will occur. Rather, imminent warning signs usually are presented as a sequence of overt, serious, hostile behaviors or threats directed at peers, staff, or other individuals. Usually, imminent warning signs are evident to more than one staff member--as well as to the child's family.

Imminent warning signs may include:

Serious physical fighting with peers or family members (Green & Donnerstein, 1983; Lemerise & Dodge, 1993; Lochman, Dunn, & Wagner, 1997).

Severe destruction of property (Harris, Rice, & Quinsey, 1993; Serin & Amos, in press).

Severe rage for seemingly minor reasons (Keltikangas-Jaervinen, 1978).

Detailed threats of lethal violence (Lattimore, Visher, & Linster, 1995; Tolan, Guerra, & Kendall, 1995).

Possession and/or use of firearms and other weapons (Lin, Bussiere, Matthews, & Wilber, 1994).

Other self-injurious behaviors or threats of suicide (Garber et al., 1991; Hillbrand, 1995).

When warning signs indicate that danger is imminent, safety must always be the first and foremost consideration. Action must be taken immediately. Immediate intervention by school authorities and possibly law enforcement officers is needed when a child:

Has presented a detailed plan (time, place, method) to harm or kill others--particularly if the child has a history of aggression or has attempted to carry out threats in the past.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Is carrying a weapon, particularly a firearm, and has threatened to use it.

In situations where students present other threatening behaviors, parents should be informed of the concerns immediately. School communities also have the responsibility to seek assistance from appropriate agencies, such as child and family services and community mental health. These responses should reflect school board policies and be consistent with the violence prevention and response plan (for more information see Section 5).

Using the Early Warning Signs To Shape Intervention Practices

An early warning sign is not a predictor that a child or youth will commit a violent act toward self or others. Effective schools recognize the potential in every child to overcome difficult experiences and to control negative emotions. Adults in these school communities use their knowledge of early warning signs to address problems before they escalate into violence.

Effective school communities support staff, students, and families in understanding the early warning signs. Support strategies include having:

School board policies in place that support training and ongoing consultation. The entire school community knows how to identify early warning signs, and understands the principles that support them (Dwyer, 1996).

School leaders who encourage others to raise concerns about observed early warning signs and to report all observations of imminent warning signs immediately (Dwyer, 1996). This is in addition to school district policies that sanction and promote the identification of early warning signs (Day & Golench, 1997).

Easy access to a team of specialists trained in evaluating and addressing serious behavioral and academic concerns (Comer & Woodruff, in press; Wager, 1992-1993).

Each school community should develop a procedure that students and staff can follow when reporting their concerns about a child who exhibits early warning signs (Walker & Severson, 1992). For example, in many schools the principal is the first point of contact. In cases that do not pose imminent danger, the principal contacts a school psychologist or other qualified professional, who takes responsibility for addressing the concern immediately. If the concern is determined to be serious--but not to pose a threat of imminent danger--the child's family should be contacted. The family should be consulted before implementing any interventions with the child. In cases where school-based contextual factors are determined to be causing or exacerbating the child's troubling behavior, the school should act quickly to modify them.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

It is often difficult to acknowledge that a child is troubled. Everyone--including administrators, families, teachers, school staff, students, and community members--may find it too troubling sometimes to admit that a child close to them needs help. When faced with resistance or denial, school communities must persist to ensure that children get the help they need.

Understanding early and imminent warning signs is an essential step in ensuring a safe school. The next step involves supporting the emotional and behavioral adjustment of children.

Use the Signs Responsibly

It is important to avoid inappropriately labeling or stigmatizing individual students because they appear to fit a specific profile or set of early warning indicators. It's okay to be worried about a child, but it's not okay to overreact and jump to conclusions.

"When doing consultation with school staff and families, we advise them to think of the early warning signs within a context. We encourage them to look for combinations of warning signs that might tell us the student's behavior is changing and becoming more problematic." Deborah Crockett, School Psychologist, Atlanta, GA

Use the Signs Responsibly

None of these signs alone is sufficient for predicting aggression and violence. Moreover, it is inappropriate--and potentially harmful--to use the early warning signs as a checklist against which to match individual children.

Know the Law

The Gun Free Schools Act requires that each state receiving federal funds under the Elementary and Secondary Education Act (ESEA) must have put in effect, by October 1995, a state law requiring local educational agencies to expel from school for a period of not less than one year a student who is determined to have brought a firearm to school.

Each state's law also must allow the chief administering officer of the local educational agency to modify the expulsion requirement on a case-by-case basis. All local educational agencies receiving ESEA funds must have a policy that requires the referral of any student who brings a firearm to school to the criminal justice or juvenile justice system.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

"Being proactive and having the ability to consult and meet with my school psychologist on an ongoing basis has helped create a positive school environment in terms of resolving student issues prior to their reaching a crisis level." J. Randy Alton, Teacher, Bethesda, MD
J. Randy Alton, Teacher, Bethesda, MD

Section 4: What To Do

Intervention: Getting Help for Troubled Children

Prevention approaches have proved effective in enabling school communities to decrease the frequency and intensity of behavior problems (Hunter & Elias, 1998). However, prevention programs alone cannot eliminate the problems of all students. Some 5 to 10 percent of students will need more intensive interventions to decrease their high-risk behaviors, although the percentage can vary among schools and communities (Sugai & Horner, in press).

What happens when we recognize early warning signs in a child?

The message is clear: It's okay to be concerned when you notice warning signs in a child--and it's even more appropriate to do something about those concerns. School communities that encourage staff, families, and students to raise concerns about observed warning signs--and that have in place a process for getting help to troubled children once they are identified--are more likely to have effective schools with reduced disruption, bullying, fighting, and other forms of aggression.

Principles Underlying Intervention

Violence prevention and response plans should consider both prevention and intervention. Plans also should provide all staff with easy access to a team of specialists trained in evaluating serious behavioral and academic concerns. Eligible students should have access to special education services, and classroom teachers should be able to consult school psychologists, other mental health specialists, counselors, reading specialists, and special educators.

Effective practices for improving the behavior of troubled children are well documented in the research literature. Research has shown that effective interventions are culturally appropriate, family-supported, individualized, coordinated, and monitored (Fradd, Weissmantel, Corria, & Algozzine, 1990). Further, interventions are more effective when they are designed and implemented consistently over time with input from the child, the family, and appropriate professionals (Goldstein & Conoley, 1997; Martin & Waltman

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

[Greenwood, 1995] [Vickers & Minke, 1997]. Schools also can draw upon the resources of their community to strengthen and enhance intervention planning.

When drafting a violence prevention and response plan, it is helpful to consider certain principles that research or expert-based experience show have a significant impact on success. The principles include:

Share responsibility by establishing a partnership with the child, school, home, and community. Coordinated service systems should be available for children who are at risk for violent behavior. Effective schools reach out to include families and the entire community in the education of children [APA, 1993] [Drug Strategies, 1998]. In addition, effective schools coordinate and collaborate with child and family service agencies, law enforcement and juvenile justice systems, mental health agencies, businesses, faith and ethnic leaders, and other community agencies [Skiba, Polsgrove, & Nasstrom, 1995] [Webster-Stratton, 1993].

Inform parents and listen to them when early warning signs are observed. Parents should be involved as soon as possible. Effective and safe schools make persistent efforts to involve parents by: informing them routinely about school discipline policies, procedures, and rules, and about their children's behavior (both good and bad); involving them in making decisions concerning schoolwide disciplinary policies and procedures; and encouraging them to participate in prevention programs, intervention programs, and crisis planning [Cantor, Kivel, & Creighton, 1997]. Parents need to know what school-based interventions are being used with their children and how they can support their success.

Maintain confidentiality and parents' rights to privacy. Parental involvement and consent is required before personally identifiable information is shared with other agencies, except in the case of emergencies or suspicion of abuse. The Family Educational Rights and Privacy Act (FERPA), a federal law that addresses the privacy of education records, must be observed in all referrals to or sharing of information with other community agencies. Furthermore, parent-approved interagency communication must be kept confidential. FERPA does not prevent disclosure of personally identifiable information to appropriate parties--such as law enforcement officials, trained medical personnel, and other emergency personnel--when responsible personnel determine there is an acute emergency (imminent danger).

Develop the capacity of staff, students, and families to intervene. Many school staff members are afraid of saying or doing the wrong thing when faced with a potentially violent student. Effective schools provide the entire school community--teachers, students, parents, support staff--with training and support in responding to imminent warning signs, preventing violence, and intervening safely and effectively. Interventions must be monitored by professionals who are competent in the approach. According to

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

researchers, programs do not succeed without the ongoing support of administrators, parents, and community leaders [Gottfredson, 1997] [Quinn et al., 1998].

Support students in being responsible for their actions. Effective school communities encourage students to see themselves as responsible for their actions, and actively engage them in planning, implementing, and evaluating violence prevention initiatives [Felner & Adan, 1988] [Gottfredson, 1987].

Simplify staff requests for urgent assistance. Many school systems and community agencies have complex legalistic referral systems with timelines and waiting lists. Children who are at risk of endangering themselves or others cannot be placed on waiting lists.

Make interventions available as early as possible. Too frequently, interventions are not made available until the student becomes violent or is adjudicated as a youthful offender. Interventions for children who have reached this stage are both costly, restrictive, and relatively inefficient [Short & Shapiro, 1993]. Effective schools build mechanisms into their intervention processes to ensure that referrals are addressed promptly, and that feedback is provided to the referring individual.

Use sustained, multiple, coordinated interventions. It is rare that children are violent or disruptive only in school [Horne & Sayger, 1990]. Thus, interventions that are most successful are comprehensive, sustained, and properly implemented. They help families and staff work together to help the child [Elliot, Huizinga, & Azeton, 1985] [Hawkins & Weiss, 1985]. Coordinated efforts draw resources from community agencies that are respectful of and responsive to the needs of families. Isolated, inconsistent, short-term, and fragmented interventions will not be successful-and may actually do harm [Epstein, Kutash, & Duchnowski, 1998].

Analyze the contexts in which violent behavior occurs. School communities can enhance their effectiveness by conducting a functional analysis of the factors that set off violence and problem behaviors [Skiba, Waldron, Bahamonde, & Michalek, 1998, May]. In determining an appropriate course of action, consider the child's age, cultural background, and family experiences and values. Decisions about interventions should be measured against a standard of reasonableness to ensure the likelihood that they will be implemented effectively [Elliott, Witt, & Kratochwill, 1996].

Build upon and coordinate internal school resources. In developing and implementing violence prevention and response plans, effective schools draw upon the resources of various school-based programs and staff--such as special education, safe and drug free school programs, pupil services, and Title I [Quinn et al., 1998].

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Violent behavior is a problem for everyone. It is a normal response to become angry or even frightened in the presence of a violent child. But, it is essential that these emotional reactions be controlled. The goal must always be to ensure safety and seek help for the child.

Intervening Early with Students Who Are at Risk for Behavioral Problems

The incidence of violent acts against students or staff is low. However, pre-violent behaviors-such as threats, bullying, and classroom disruptions-are common. Thus, early responses to warning signs are most effective in preventing problems from escalating

(Walker et al., 1995).

Intervention programs that reduce behavior problems and related school violence typically are multifaceted, long-term, and broad reaching (Kazdin, 1991). They also are rigorously implemented. Effective early intervention efforts include working with small groups or individual students to provide direct support, as well as linking children and their families to necessary community services and/or providing these services in the school (Kazdin,

1993; Reid, 1993).

Examples of early intervention components that work include:

Providing training and support to staff, students, and families in understanding factors that can set off and/or exacerbate aggressive outbursts (Walker et al., 1995).

Teaching the child alternative, socially appropriate replacement responses-such as problem solving and anger control skills (Hollinger, 1987; Zangoza, Vaughn, & McIntosh, 1991).

Providing skill training, therapeutic assistance, and other support to the family through community-based services (Epstein et al., 1998; Webster-Stratton, 1996).

Encouraging the family to make sure that firearms are out of the child's immediate reach. Law enforcement officers can provide families with information about safe firearm storage as well as guidelines for addressing children's access to and possession of firearms (Berkowitz & Lepage, 1967; Heide, 1997).

In some cases, more comprehensive early interventions are called for to address the needs of troubled children. Focused, coordinated, proven interventions reduce violent behavior. Following are several comprehensive approaches that effective schools are using to provide early intervention to students who are at risk of becoming violent toward themselves or others.

Intervention Tactic: Teaching Positive Interaction Skills

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Although most schools do teach positive social interaction skills indirectly, some have adopted social skills programs specifically designed to prevent or reduce antisocial behavior in troubled children. In fact, the direct teaching of social problem solving and social decision making is now a standard feature of most effective drug and violence prevention programs (Gresham et al., 1998) (Knoff & Batsche, 1995) (Lochman, Dunn, & Klimes-Dougan, 1993). Children who are at risk of becoming violent toward themselves or others need additional support. They often need to learn interpersonal, problem solving, and conflict resolution skills at home and in school. They also may need more intensive assistance in learning how to stop and think before they react, and to listen effectively (Gresham et al., 1998) (Knoff & Batsche, 1995).

Intervention Tactic: Providing Comprehensive Services

In some cases, the early intervention may involve getting services to families. The violence prevention and response team together with the child and family designs a comprehensive intervention plan that focuses on reducing aggressive behaviors and supporting responsible behaviors at school, in the home, and in the community. When multiple services are required there also must be psychological counseling and ongoing consultation with classroom teachers, school staff, and the family to ensure intended results occur (Guerra, Tolan, & Hammond, 1994) (Osher & Osher, 1996). All services-including community services-must be coordinated and progress must be monitored and evaluated carefully (Poland, 1994).

Intervention Tactic: Referring the Child for Special Education Evaluation

If there is evidence of persistent problem behavior or poor academic achievement, it may be appropriate to conduct a formal assessment to determine if the child is disabled and eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA). If a multidisciplinary team determines that the child is eligible for services under the IDEA, an individualized educational program (IEP) should be developed by a team that includes a parent, a regular educator, a special educator, an evaluator, a representative of the local school district, the child (if appropriate), and others as appropriate. This team will identify the support necessary to enable the child to learn-including the strategies and support systems necessary to address any behavior that may impede the child's learning or the learning of his or her peers.

Providing Intensive, Individualized Interventions for Students with Severe Behavioral Problems

Children who show dangerous patterns and a potential for more serious violence usually require more intensive interventions that involve multiple agencies, community-based service providers, and intense family support. By working with families and community services, schools can comprehensively and effectively intervene.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Effective individualized interventions provide a range of services for students. Multiple, intensive, focused approaches used over time can reduce the chances for continued offenses and the potential for violence [Scattergood, Dash, Epstein, & Adler, 1998; Taylor-Greene et al., 1997]. The child, his or her family, and appropriate school staff should be involved in developing and monitoring the interventions.

Nontraditional schooling in an alternative school or therapeutic facility may be required in severe cases where the safety of students and staff remains a concern, or when the complexity of the intervention plan warrants it. Research has shown that effective alternative programs can have long-term positive results by reducing expulsions and court referrals [Garrison, 1989]. Effective alternative programs support students in meeting high academic and behavioral standards [Morley, 1991; Oklahoma Technical Assistance Center; Quinn et al., 1998; Raywid, 1994]. They provide anger and impulse control training, psychological counseling, effective academic and remedial instruction, and vocational training as appropriate. Such programs also make provisions for active family involvement. Moreover, they offer guidance and staff support when the child returns to his or her regular school [Garrison, 1989].

Providing a Foundation To Prevent and Reduce Violent Behavior

Schoolwide strategies create a foundation that is more responsive to children in general--one that makes interventions for individual children more effective and efficient.

Effective and safe schools are places where there is strong leadership, caring faculty, parent and community involvement--including law enforcement officials--and student participation in the design of programs and policies [Centers for Disease Control & Prevention, 1993; Cornell, 1998]. Effective and safe schools also are places where prevention and intervention programs are based upon careful assessment of student problems, where community members help set measurable goals and objectives, where research-based prevention and intervention approaches are used, and where evaluations are conducted regularly to ensure that the programs are meeting stated goals [Gottfredson, 1997; National Association of School Psychologists, 1998]. Effective and safe schools are also places where teachers and staff have access to qualified consultants who can help them address behavioral and academic barriers to learning [Dwyer & Bernstein, 1998].

Effective schools ensure that the physical environment of the school is safe, and that schoolwide policies are in place to support responsible behaviors.

Characteristics of a Safe Physical Environment

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Prevention starts by making sure the school campus is a safe and caring place. Effective and safe schools communicate a strong sense of security. Experts suggest that school officials can enhance physical safety by:

Supervising access to the building and grounds (Stephens, 1994).

Reducing class size and school size (Haller, 1992).

Adjusting scheduling to minimize time in the hallways or in potentially dangerous locations. Traffic flow patterns can be modified to limit potential for conflicts or altercations (Nelson, 1996).

Conducting a building safety audit in consultation with school security personnel and/or law enforcement experts (Cornell, 1998) (Crowe, 1990). Effective schools adhere to federal, state, and local nondiscrimination and public safety laws, and use guidelines set by the state department of education (Knapp, 1996).

Closing school campuses during lunch periods (Knapp, 1996).

Adopting a school policy on uniforms (Murray, 1997) (Stanley, 1996).

Arranging supervision at critical times (for example, in hallways between classes) and having a plan to deploy supervisory staff to areas where incidents are likely to occur (Astor, 1996) (Nelson, 1996).

Prohibiting students from congregating in areas where they are likely to engage in rule-breaking or intimidating and aggressive behaviors (Nelson, 1996).

Having adults visibly present throughout the school building. This includes encouraging parents to visit the school (Nelson, 1996).

Staggering dismissal times and lunch periods (Steward & Knapp, 1997).

Monitoring the surrounding school grounds-including landscaping, parking lots, and bus stops (Cornell, 1998) (Steward & Knapp, 1997).

Coordinating with local police to ensure that there are safe routes to and from school (Centers for Disease Control, National Center for Injury Prevention & Control, 1993).

In addition to targeting areas for increased safety measures, schools also should identify safe areas where staff and children should go in the event of a crisis.

The physical condition of the school building also has an impact on student attitude, behavior, and motivation to achieve. Typically, there tend to be more incidents of fighting

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

and violence in school buildings that are dirty, too cold or too hot, filled with graffiti, in need of repair, or unsanitary.

Post-vention Strategies

In the aftermath of a critical incident, schools must recognize the emotional effects upon students and staff, which may have long-term consequences for the individuals, depending upon the severity of the incident. The Guide for School Safety & Security (The University of New York, Office of Intercultural Relations 1996) lists important responses and follow-up methods for school personnel to undertake. First, it is important to re-create emotional security for children who may have witnessed and/or heard about a violent incident. Staff, too, may be affected. A specific psychological disorder, called "post-traumatic stress disorder," can frequently appear as a response to witnessing such events. Signs of this disorder may include reliving the event, distress upon recollection of the event, feelings of detachment or estrangement, and an exaggerated startle response, as well as other responses. Counseling and mental health services should be offered to students and staff who may need assistance coping with the aftermath of such an incident.

School personnel, especially emergency response team members, should evaluate their emergency response plan in light of any such incidents. Gaps in safety measures and coordination of response should be examined. Schools must report such events to the commissioner under the Uniform Violent Incident Reporting clause of the SAVE legislation.

Setting the Stage for Safer Schools

0 0

v m U >°.

0 0 N



Characteristics of Effective Violence Intervention Programs



OBJECTIVES

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

After this learning experience, participants will be able to:

1. name two primary characteristics of effective violence intervention programs
2. describe other key criteria of promising intervention approaches
3. understand and recognize events that can serve as a warning sign of a violent outcome
4. develop appropriate responses for potentially dangerous situations

CONTENT

The American Psychological Association (APA) states that effective violence intervention programs share two primary characteristics:

1. They draw on the understanding of developmental and sociocultural risk factors leading to antisocial behavior.

York State Center for School Safety

2. They use theory-based intervention strategies with known efficacy in changing behavior, tested program designs, and validated, objective measurement techniques to assess outcomes.

Other key criteria that describe the most promising intervention approaches include the following.

- They begin as early as possible to interrupt the "trajectory toward violence." Evidence indicates that intervention early in childhood can reduce aggressive and antisocial behavior and can also affect certain risk factors associated with antisocial behavior, such as low educational achievement and inconsistent parenting practices. A few studies have included ten- to twenty-year follow-up data that suggest these positive effects may endure. Some of the most promising programs are interventions designed to assist and educate families who are at risk even before a child is born.

0 0 N O

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

A Two-Hour Violence Prevention Training for Persons Seeking Certification in New York State



They address aggression as part of a constellation of antisocial behaviors in the child or youth. Aggression usually is just one of a number of problem behaviors found in the aggressive child. Often the cluster includes academic difficulties, poor interpersonal relations, cognitive deficits, and attributional biases.

They include multiple components that reinforce each other across the child's everyday social contexts: family, school, peer groups, media, and community. Aggressive behavior tends to be consistent across social domains. For this reason, multimodal interventions that use techniques known to affect behavior and that can be implemented in complementary ways across social domains are needed to produce enduring effects.

They take advantage of developmental "windows of opportunity," points at which interventions are especially needed or especially likely to make a difference. Such windows of opportunity include transitions in children's lives: birth, entry into preschool, the beginning of elementary school, and adolescence. The developmental challenges of adolescence are a particular window of opportunity because the limits-testing and other age-appropriate behaviors of adolescents tend to challenge even a functional family's well-developed patterns of interaction. Also, antisocial behaviors tend to peak during adolescence, and many adolescents engage in sporadic aggression or antisocial behavior. Programs that prepare children to navigate the developmental crises of adolescence may help prevent violence by and toward the adolescent.

In addition to the risk factors that are present when violent behavior occurs, there are also signs of an imminent crisis—an emotional or behavioral event that can result in a violent outcome. Some of these warning signs include (Dwyer, Osher, and Warger 1998):

- verbalizing threats of lethal violence
- presenting a detailed plan (time, place, and method) to harm self or others • displaying self-injurious behaviors
- displaying severe rage for seemingly minor reasons
- engaging in serious physical fighting with peers or family members • severe destruction of property

Setting the Stage for Safer Schools

0 0 U

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

U m >°.

0 0 N

Understanding the Individual



OBJECTIVES

After this learning experience, participants will be able to:

1. identify early warning signs of potentially violent individuals' behavior
2. describe their role in the referral process
3. identify ways to assist troubled students

CONTENT

In response to the violence that was plaguing some of our nation's schools, the U.S. Department of Education Office of Special Education and Rehabilitation Services supported the development of the Early Warning, Timely Response: A Guide to Safe Schools* document. This handbook was not developed as a checklist or as an excuse to exclude, but as a tool-a resource to help us identify and assist children who are in need.

Early Warning, Timely Response encourages participants to adhere to these principles:

- Do no harm.
- Avoid stereotypes.

Understand violence and aggression within a context.

View warning signs within a developmental context.

Understand that children typically display multiple warning signs.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

York State Center for School Safety

*This document and the implementation guide, SafeGuarding Our Children; An Action Guide, can be downloaded from the following Websites:

<http://www.ed.gov/offices/OSERS/OSEP/ActionGuide/>

<http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html>

0 0 N O

A Two-Hour Violence Prevention Training for Persons Seeking Certification in New York State



APPENDIX A

Principles of Effectiveness



Needs Assessment

(PRINCIPLE I)

"A grant recipient shall base its program on a thorough assessment of objective data about the drug and violence problems in their schools and communities served" (USDOE SDFS 1998).

Subjective data may also be included to enhance the school's assessment. Subjective data may come from focus groups, parent input, student feedback, and community meetings.

School safety teams use both subjective and objective sources of data to identify potential areas of risk and intervention strategies for their buildings.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

Data can be organized and analyzed around five domains:

- social-political environment • community
- school system
- families in the school community
- individual students and peer groups

Action Planning-Measurable Goals and Objectives

(PRINCIPLE II) Nam, -

"Recipients of federal funds shall, with the assistance of a local or regional advisory council, which includes community representatives, establish a set of measurable goals and objectives, and design its activities to meet those goals and objectives" (USDOE SDFS 1998).

School safety teams can be critical planners in the process of change. School safety teams can develop their goals and objectives from the analysis of the data found in the five domains. An essential component of the planning process is ongoing technical assistance provided by staff with expertise in school safety.

© 2001 New York State Center for School Safety

Setting the Stage for Safer Schools



Research Approaches to Violence Prevention

(PRINCIPLE III)

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

"A grant recipient shall design and implement its activities based on research or evaluation that provides evidence that the strategies used prevent or reduce drug use, violence, or destructive behavior" (USDOE SDFS 1998).

Millions of prevention dollars have been expended on programs for which there is no evidence of effectiveness. School safety teams can be trained to critically review research-based approaches. Teams can begin to evaluate these questions:

Which programs are more effective, commercially produced or researchbased?

What does a comprehensive prevention program look like?

Which strategies are effective?

What are the best strategies/programs for our school? (Consider population, target group, data-based problem.)

Evaluation

(PRINCIPLE IV)

"Grant recipient shall evaluate its program periodically to assess its progress toward achieving its goals and objectives and use its evaluation results to refine, improve, and strengthen its program and to refine its goals and objectives as appropriate" (USDOE SDFS 1998).

0 0

A planned, systematic, and well-designed evaluation yields information to guide program modifications and document effectiveness of efforts. There are three general categories of evaluation:

U

1. process evaluation-describes the program's features
2. impact evaluation-provides an immediate measure for a program

v

3. outcome evaluation-measures the effects of a program

>°.

s

School safety teams are trained to understand and employ these categ

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

evaluation.

0

0

N

ries of

A Two-Hour Violence Prevention Training for Persons Seeking Certification in New York State



0 0 v

© 2001 New York State Center for S

Health Education Skills

(From the Health Education Scope and Sequence)

Communication: Demonstrates the ability to apply communication strategies and skills to enhance personal, family, and community health

Decision-Making: Demonstrates the ability to apply decision-making strategies and skills to enhance personal, family, and community health

Planning and Goal-Setting: Demonstrates the ability to apply planning and goal-setting strategies and skills to enhance personal, family, and community health.

Self-Management: Demonstrates the ability to apply personal health-enhancing behaviors, and reduce health risks

Advocacy: Demonstrates the ability to apply advocacy strategies and skills to enhance personal, family, and community health.

School Violence Prevention Course

© 2005 Laboratory Consultation Services, Inc.

New York State SVP Provider 0112

<http://www.laboratoryconsultationservices.com/>

A Two-Hour Violence Prevention Training for Persons Seeking Certification in New York State



- [Home](#)
- [Online Courses](#)
- [Complete Course](#)
- [FAQ](#)
- [Services](#)
- [Contact Us](#)

Home

Child Abuse Prevention Course



Article Index

- Child Abuse Prevention Course
- Part 1
- Part 2
- Part 3
- Part 4
- All Pages

Child Abuse Prevention

This course consists of the required syllabus for the New York State course for mandated reporters and satisfies the training requirement for all professions.

The entire course is on line and may be studied at your own pace. When you have completed the course, take the short quiz at the end to assess your level of understanding of the material.

The fee for the course is \$30 and may be paid for with Visa, Master Card or Paypal.

Then, you will have the opportunity to review your demographic information and to view and print out your certificate.

Child Abuse Prevention Course Part I

Introduction

This syllabus meets the training requirements of Chapter 544 of the Laws of 1988. That law, as amended, established a new requirement for all physicians, chiropractors, dentists, registered nurses, podiatrists, optometrists, psychologists, and dental hygienists. When applying on or after January 1, 1991, initially, or for the renewal of, a license, registration, or limited permit, affected individuals must provide documentation of having completed two hours of coursework or training regarding the identification and reporting of child abuse and maltreatment.

Chapter 544 of the Laws of 1988 also includes this training among the requirements for certification or licensure of classroom teachers, school service personnel, and administrators and supervisors. All persons applying on or after January 1, 1991, for a provisional or permanent certificate or license valid for administrative or supervisory service, classroom teaching service, or school service must have completed the two hours of coursework or training. The only individuals exempt from the required study are those who possess--with an effective date no later than September 1, 1990--a permanent New York State certificate or full credentialing from the cities of Buffalo or New York, and who do not subsequently apply for any additional classroom training service, administrative-supervisory service, or school service credential.

The above requirements are found on the website of the New York State Education Department, Office of the Professions; the link is here.

The law specifies that the coursework or training must include information regarding the physical and behavioral indicators of child abuse and maltreatment. This training must also include the statutory reporting requirements set out in the New York Social Services Law, such as when and how a report must be made, what other actions the reporter is mandated or authorized to take, the legal protections afforded reporters, and the consequences for failing to report. The law further states that the coursework or training must be obtained from a provider approved for that purpose by The State Education Department.

In November of 1989, the Board of Regents adopted Part 57 of the Regulations of the Commissioner of Education. These regulations define the types of entities that are eligible to serve as providers of the training and establish the responsibilities of approved providers. The regulations require providers to use, at a minimum, the material contained in this syllabus.

This course has been reviewed and revised in accordance with the revised Child Abuse Prevention curriculum developed at the request of, and funded by, the New York State Office of Children and Family Services (NYSOCFS) Bureau of Training and published by the Center for Development of Human Services Research Foundation of the State University of New York Buffalo State College in February 2005. We gratefully acknowledge their permission in using portions of the syllabus as well as PowerPoint slides in this revised online course. All materials developed by them and incorporated into this course are © 2006 Center for Development of Human Services/Research Foundation of SUNY/ Buffalo State College.

Further updates have been made based on the updated curriculum developed by NYSOCFS in conjunction with the New York State Education Department (NYSED) in August 2011. Slides from the updated curriculum are @2011 New York State Office of Children and Family Services.

This syllabus is not intended to be an exhaustive or complete overview of the serious and complex issue of child abuse and maltreatment. However, it includes the legally required aspects of this important topic in a format that can be presented in the minimum period of time specified by the law. A bibliography and appendices are included at the end of this syllabus to aid in locating additional information on identification, reporting and prevention of child abuse, maltreatment and neglect.

The New York State Office of Child Protective Services has a FAQ (frequently asked questions) section that can serve as an introduction and quick review of this course. It can be found here.

Learning Objectives

At the conclusion of this section, learners will be able to:

1. Define what constitutes abuse, maltreatment, and neglect according to the New York State Family Court Act and Social Services Law
2. Distinguish among various behavioral and environmental characteristics of abusive parents or caretakers
3. Identify physical and behavioral indicators of physical abuse
4. Identify physical and behavioral indicators of maltreatment and neglect
5. Contrast the physical and behavioral indicators of sexual abuse.

Child Abuse Prevention Course Part II

Definitions Of What To Report

Abuse

Pursuant to the Social Services Law, Section 412, an abused child means a child less than eighteen years of age who is defined as abused by the Family Court Act. Section 1012(e) of the Family Court Act further defines an abused child as a child less than eighteen years of age whose parent or other person legally responsible for his/her care:

Inflicts or allows to be inflicted upon such child physical injury by other than accidental means
Creates or allows to be created a substantial risk of physical injury to such a child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ

Commits, or allows to be committed, a sex offense against such child, as defined in the penal law

Allows, permits or encourages such child to engage in any act described in sections 230.25, 230.30 and 230.32 of the penal law [i.e., prostitution]

Commits any of the acts described in section 255.25 of the penal law [i.e., incest]

Allows such child to engage in acts or conduct described in article 263 of the penal law [e.g., obscene sexual performance, sexual conduct]

When identifying suspected child abuse or maltreatment, consider:

What happened to the child

How parents or other legally responsible persons may be responsible for this condition

In addition, pursuant to Section 412.8 of the Social Services Law, an abused child can include a child residing in a group residential care facility under the jurisdiction of the State Department of Social Services, Division for Youth, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, or State Education Department. The definition of an abused child in these settings is virtually identical to the above definition of abuse occurring in a familial setting .

Pursuant to Section 412.11, an abused child can include a child with a handicapping condition, who is *eighteen years of age or older*, who is defined as an abused child in residential care, and who is in residential care provided in one of the following:

The New York State School for the Blind (Batavia, NY) or the New York State School for the Deaf (Rome, NY)

A private residential school which has been approved by the Commissioner of Education for special education services or programs

A special act school district; or state-supported institutions for the instruction of the deaf and blind which have a residential component.

Consider the Child

- **Must be less than 18 years of age**
- **What has happened?**
- **Who is responsible?**

Abuse

- **Inflicts or allows to be inflicted injury**
- **Creates or allows to be created substantial risk of physical injury**
- **Commits or allows to be committed a sex offense**

Maltreatment And Neglect

The New York State Social Services Law, Sec. 412, states that a *maltreated child* includes a child less than eighteen years of age, defined as a neglected child by the Family Court Act; or who has had serious physical injury inflicted upon him/her by other than accidental means

Section 1012(f) of the Family Court Act defines a *neglected child* as a child less than eighteen years of age

Whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parent or other person legally responsible for his/her care to exercise a minimum degree of care in

Supplying the child with adequate food, clothing, shelter or education in accordance with provisions of part one of article sixty-five of the education law, or medical, dental, optometric or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or

Providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he or she loses self-control of his/her actions; or by any other acts of similarly serious nature requiring the aid of the court

Who has been abandoned by his/her parents or other person legally responsible for the child's care

The circumstances which constitute impairment of mental or emotional condition, more commonly referred to as *emotional neglect*, are also defined as follows:

"Impairment of emotional health" and "impairment of mental or emotional condition" includes a state of substantially diminished psychological or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggression or self-destructive impulses, ability to think and reason, or acting out and misbehavior, including incorrigibility, ungovernability or habitual truancy; provided, however, that such impairment must be clearly attributable to the unwillingness or inability of the respondent [i.e., parent or other person legally responsible for the child] to exercise a minimum degree of care toward the child. (Family Court Act, Sec. 1012(h)).

Pursuant to Section 412.9 of the Social Services Law, there is a separate definition of a neglected child in residential care. Such definition pertains to children residing in group residential facilities under the jurisdiction of the State Department of Social Services, Division for Youth, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, or State Education Department. Section 412.6 defines a "custodian" as a director, operator, employee or volunteer of a residential care facility or program. A neglected child in residential care means a child whose custodian impairs, or places in imminent danger of becoming impaired, the child's physical, mental or emotional condition by

Intentionally administering to the child any prescription drug other than in accordance with a physician's or physician's assistant's prescription

In accordance with the regulations of the state agency operating, certifying, or supervising such facility or program, which shall be consistent with the child's age, condition, service and treatment needs, by

Failing to adhere to standards for the provision of food, clothing, shelter, education, medical, dental, optometric or surgical care, or for the use of isolation or restraint; or
Failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm, or a substantial risk thereof; or
Failing to conform to applicable state regulations for appropriate custodial conduct.

Pursuant to Section 412.2 I, a maltreated child can include a child with a handicapping condition, who is eighteen years of age or older, who is defined as a neglected child in residential care, and who is in residential care provided in one of the following:

The New York State School for the Blind (Batavia, NY) or the New York State School for the Deaf (Rome, NY);

A private residential school which has been approved by the Commissioner of Education for special education services or programs;

A special act school district; or state-supported institutions for the instruction of the deaf and the blind that have a residential component.

Child Abuse Prevention Course Part III

Possible Behavioral And Environmental Characteristics Of Abusive Parents Or Caretakers

Introduction

It is important to emphasize that abuse or maltreatment can result from the acts of the parent or person legally responsible for a child's care, and suspected incidents should be reported accordingly.

In accordance with Section 1012(g) of the Family Court Act, "person legally responsible" includes the child's custodian, guardian, or any other person responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such persons causes or contributes to the abuse or neglect of the child.

It should be noted that these indicators are clues but not conclusive proof. These indicators may exist in situations where no abuse or mal-treatment of the child is suspected. However, they are useful to remember when dealing with the parent/ caretaker or child.

Clues rarely appear as single entities. Typically, several clues will appear regarding the child and his/her family. Except for the obvious, single clues should be treated as "flags" which indicate that the professional needs to look further, and look more closely, carefully, and methodically.

Abuse

- **Inflicts or allows to be inflicted injury**
- **Creates or allows to be created substantial risk of physical injury**
- **Commits or allows to be committed a sex offense**

Maltreatment/Neglect

- **A child whose physical, mental, or emotional condition has been impaired or is at imminent danger of becoming impaired**
- **A parent's or custodian's failure to provide a minimum degree of care**

Maltreatment/Neglect

- **A child whose physical, mental, or emotional condition has been impaired or is at imminent danger of becoming impaired**
- **A parent's or custodian's failure to provide a minimum degree of care**

Abuse

Parent / Caretaker History

The following historical indicators may be clues to abuse or neglect:

Parent abused or neglected as a child
Lack of friendships or emotional support
Isolated from supports such as friends, relatives, neighbors, community groups
Lack of self-esteem; feelings of worthlessness
Marital problems of parents (and grandparents) including spouse abuse
Physical or mental health problems; irrational behavior
Alcohol/substance abuse (also includes grandparents)
Adolescent parents

Parent-Child History

Some clues in the history of the relationship between parent and child that may indicate the need to look carefully at the possibility of abuse/neglect:

Parent's unrealistic expectations of child's physical and emotional needs (mentally/ developmentally disabled children are particularly vulnerable)
Parent's unrealistic expectations of child to meet parent's emotional needs (role reversal) (children viewed as miniature adults)
Absence of nurturing child-rearing skills

Violence/corporal punishment is accepted as unquestioned child-rearing practice within the parent's culture

Violence is accepted as a normal means of personal interaction

Delay or failure in seeking health care for child's injury, illness, routine checkups, immunizations, etc.

Parent views child as bad, evil, different, etc.

Environmental

Some clues in the environment of the suspected abused/neglected child, whether home or institutional environment, are:

Lack of social support--inability to ask for and receive the kind of help and support parents need for themselves and their children

Social contact is avoided; no one is trusted

Homelessness

Physical and behavioral indicators of abuse

Physical Abuse

Physical Indicators

Some of the physical indicators of physical abuse to be watchful for are:

Bruises, welts, and bite marks
On face, lips, mouth, neck, wrists, and ankle
On torso, back, buttocks, and thigh

Injuries to both eyes or cheeks (always of suspicious origin because only one side of face is usually injured as the result of an accident)

Clustered or forming regular patterns reflecting shape of article used to inflict (electric cord, belt buckle

"Grab-marks" on arms or shoulders or on several different surface areas

Evidence of human bite (A human bite compresses the flesh while an animal bite tears flesh and has narrower teeth imprint in various stages of healing) regularly appear after absence, weekend, or vacation

Lacerations or abrasions to mouth, lips, gums, eyes

To external genitalia

On backs or arms, legs or torso

Burns

Cigar or cigarette burns, especially on soles, palms, back, or buttocks

Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped burns on buttocks or genitalia – "dunking syndrome")

Patterned like electric burner, iron, etc.

Rope burns on arms, legs, neck, or torso

Fractures

To skull, nose, facial structure

Skeletal trauma accompanied by other injuries, such as dislocations

Multiple or spiral fractures in various stages of healing

Fractures "accidentally" discovered in course of an exam

Head injuries

Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling

Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)

Retinal hemorrhage or detachment, due to shaking/whiplash (shaken infant syndrome)

Eye injury

Jaw or nasal fractures

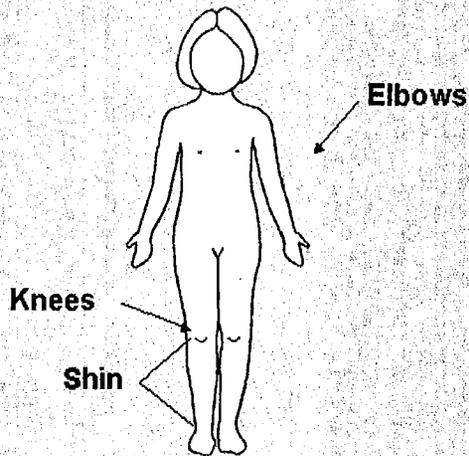
Tooth or frenulum injury

Symptoms suggestive of parentally-induced or fabricated illnesses, sometimes known as Munchausen Syndrome by Proxy (MSP). An example might be repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization.

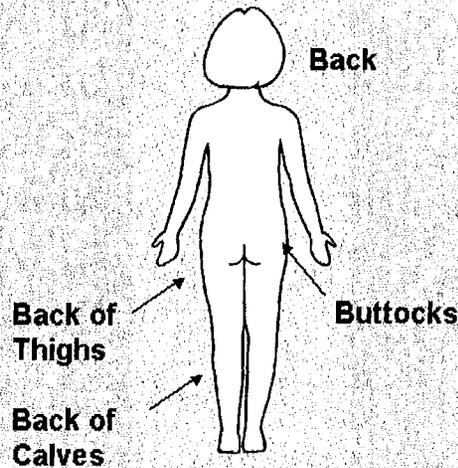
Special attention should be paid to injuries that are unexplained or are inconsistent with the parent (s) /caretaker's explanation and/or the developmental stage of the child.

Bruising Areas

Normal Bruising Areas



Suspicious Bruising Areas



Common Indicators

- **Child's Physical Indicators**
- **Child's Behavioral Indicators**
- **Parent's Behavioral Indicators**

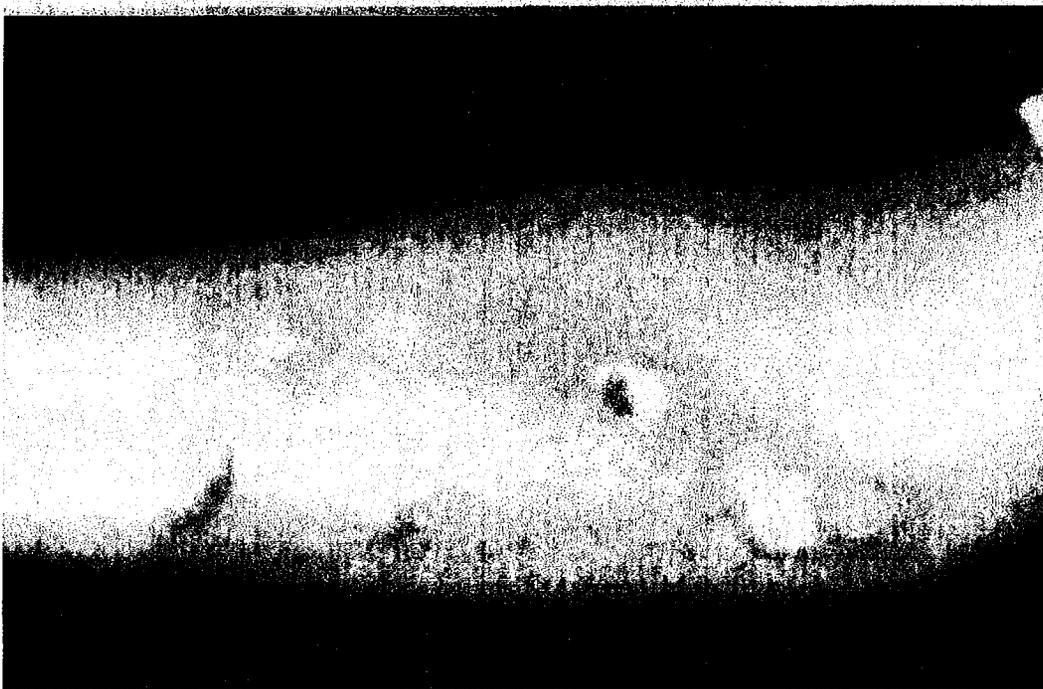
Handprint Injury



Looped Cord Injury



Steam Iron Injury



Behavioral Indicators

Some of the behavioral indicators of physical abuse to be watchful for are if the child is:

- Wary of contacts with parents or other adults
- Apprehensive when other children cry

Shows behavioral extremes: aggressiveness, withdrawal, or extreme mood changes
Afraid to go home; repeated incidents of running away

Also, if the child

Reports injury by parents; sometimes blames self, e.g., "I was bad and I was punished."
Exhibits habit disorder or self-injurious behaviors such as psychoneurotic reactions (obsessions, phobias, compulsions, hypochondria)
Wears long sleeves or other concealing clothing inappropriate for season to hide physical indicators of abuse
Manifests signs of low self-esteem
Attempts suicide

Maltreatment And Neglect

Physical Indicators

Some of the physical indicators of possible maltreatment or neglect include:

Failure to thrive (physically or emotionally)
Positive indicator of toxicology, especially in newborns (drug withdrawal symptoms, tremors, etc.)
Lags in physical development
Consistent hunger, poor hygiene (skin, teeth, ears, etc.), inappropriate dress for the season
Speech disorders
Consistent lack of supervision, especially in dangerous activities or for long periods
Unattended physical problems or medical needs
Chronic truancy
Abandonment

Behavioral Indicators

Some of the behavioral indicators of maltreatment or neglect to be watchful for are if the child:

Begs or steals food
Is in school for extended stays (early arrival or late departure)
Shows constant fatigue, listlessness or falling asleep in class
Has signs or symptoms of alcohol or drug abuse
Exhibits delinquent behavior (e.g., thefts)
States there is no caretaker
Shows runaway behavior
Manifests severe habit disorders (sucking, biting, rocking, etc.) or conduct disorders (antisocial, destructive, etc.)
Displays neurotic traits (sleep disorders, inhibition of play) or psychoneurotic reactions (hysteria, obsession, compulsion, phobias, hypochondria)
Demonstrates behavior extremes: compliant-passive/aggressive-demanding
Exhibits overly adaptive ""> either inappropriately adult or inappropriately infantile
Shows lags in mental and/or emotional development
Attempts suicide

Sexual Abuse

Most sexual abuse cases do not present apparent physical evidence or indicators. Therefore, identification and recognition are often very difficult. To compound the problem of detection and identification, the many legitimate fears which child victims of a sexual abuse experience make it extremely difficult for them to report the abuse, even to a very trusted adult or friend.

The fact that the vast majority of child molesters are family members or friends of the child or his/her family makes disclosure of the abuse very difficult for the child. Victims of child sexual abuse experience the fear of betraying a loved one (e.g., the perpetrator or non-abusing parent) and possibly losing their affections forever if they disclose the abuse. Child victims fear the overwhelming anticipated shame and guilt that such disclosure will cause and they fear that family members and other significant people in their lives will blame them for the abuse. They also fear the common threats of being hurt or even killed if they disclose the abuse. Even after disclosing sexual abuse, a child may retract the disclosure as the family system begins to place pressure. For these and other reasons, sexually abused children often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

It is very important to keep in mind that the overwhelming majority of child sexual abuse occurs within the child's immediate or extended family. Most perpetrators of child sexual abuse are known to the child before the abuse. They are usually trusted family members who have easy physical access to their child victims, not necessarily the stereotypical strangers in raincoats who wait for children on street corners with lures of candy or money.

Child sexual abuse is not a problem uniquely found in only certain geographic areas or among people of certain economic conditions, races, or occupations. There is absolutely no profile of a child molester or of the typical victim. Do not assume that, because an alleged offender has an unparalleled reputation for good work in the community or holds a certain job, he or she could not also be a child molester.

Physical Indicators

Some physical indicators of possible sexual abuse are:

- Difficulty in walking or sitting
 - Torn, stained, or bloody underclothing
 - Pain or itching in genital area
 - Bruises or bleeding in external genitalia, vaginal, or anal areas
 - Bruises to the hard or soft palate
 - Sexually transmitted diseases, especially in preteens (including venereal oral infections)
 - Pregnancy, especially in the early adolescent years
 - Painful discharge of urine and/or repeated urinary infection
 - Foreign bodies in vagina or rectum
-

Behavioral Indicators

Some behavioral indicators of possible sexual abuse are that the child

- Is unwilling to change for gym or participate in physical education class
- Shows withdrawal, fantasy, or infantile behavior
- Exhibits bizarre, sophisticated, or unusual sexual behavior or knowledge or seductive or promiscuous behavior
- Has poor peer relationships
- Is delinquent or runaway
- Reports sexual assault by caretaker
- Engages in prostitution or forces sexual acts on other children
- Has an extreme fear of being touched; is unwilling to submit to physical examination
- Is truant
- Engages in self-injurious behaviors, up to and including suicide attempts
- Has manifestations of low self-esteem, general fearfulness

Child Abuse Prevention Course Part IV

Reporting Child Abuse, Maltreatment And Neglect

At the conclusion of this section learners will be able to:

Describe situations in which mandated reporters must report suspected cases of child abuse or maltreatment

Describe what constitutes "reasonable cause to suspect" that a child has been abused or maltreated

Outline the proper procedure for making a report of suspected child abuse

List what actions certain mandated reporters may take to protect a child in addition to filing a child abuse report

Describe the legal protections afforded reporters and the consequences for failing to report.

Required Instances For Reporting

Persons Mandated To Report

According to Section 413 of the Social Services Law, the following persons are mandated child abuse reporters in New York State:

Physician
Surgeon
Intern
Resident
Medical Examiner
Coroner
Osteopath
Chiropractor
Psychiatrist
Psychologist
Mental Health Professional
Dentist
Dental Hygienist
Optometrist
Podiatrist
Christian Science Practitioner
Registered Nurse
Social Service Worker

Also:

Peace Officer
Police Officer
School Official
Day Care Center Worker
Hospital personnel engaged in the admission, examination, care or treatment of persons
Employee or volunteer in a Residential Care Facility defined by §412(7).
Provider of family or group family day care
Any other Child Care or Foster Care Worker

District Attorney or Assistant District Attorney
Investigator Employed in the office of the D.A. or other Law Enforcement Official

Notes:

1. *The definition of a school official "includes but is not limited to school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator, or other school personnel required to hold a teaching or administrative license or certificate."*
2. *Social service workers must make a report when a person comes before them with allegations of abuse. Any person, not necessarily the parent, child, or other legally responsible person.*

Situations In Which Reports Are Required

When a mandated reporter has reasonable cause to suspect that a child whom the reporter sees in his/her professional or official capacity is abused or maltreated; or

When a mandated reporter has reasonable cause to suspect that a child is abused or maltreated

Where the parent or person legally responsible for such child comes before them in his/her professional or official capacity and states from personal knowledge, facts, conditions, or circumstances which, if correct, would render the child abused or maltreated

Whenever a mandated reporter suspects child abuse or maltreatment while acting in his/her professional capacity as a staff member of a medical or other public or private institution, school, facility, or agency, he or she shall make the report as required.

He or she should also immediately notify the person in charge of that school, facility, institution or his/her designated agent, who will then (also) become responsible for all subsequent administration necessitated by the report. It should be noted that Section 413.1 of the Social Services Law does not require more than one report from the institution, school, facility, or agency on any one incident of suspected abuse or maltreatment.

The report should include the name, title and contact information for every staff person of the institution who is believed to have direct knowledge of the allegations in the report.

A situation could occur in which the staff member is mistaken about the standard of abuse or maltreatment, or about whom a subject of a report may be; the person in charge, or his/her designated agent, could determine that a report need not be made in this situation. Nevertheless, the person in charge-- or his/her designated agent -- may not prevent the staff member from making a report. No employer can establish any conditions, prior approval or prior notification for the reporting.

Reasonable Cause To Suspect

Reasonable Cause

A person can have "reasonable cause" to suspect that a child is abused or maltreated if, considering what physical evidence s/he observes or is told about, and from his/her own training and experience, it is possible that the injury or condition was caused by neglect or by non-accidental means. The reporter need not be absolutely certain that the injury or condition was caused by neglect or by non-accidental means; the reporter should only *be able to entertain the possibility that it could have been neglect or non-accidental* in order to possess the necessary "reasonable cause."

Suspicion

Certainty is not required

To be suspicious, it is enough for the mandated reporter to distrust or doubt what he or she personally observes or is told. In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also be helpful in forming a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

Legal Protections

There are three components to the legal status of a mandated reporter:

1. Mandated reporters are immune from any criminal or civil liability if the report was made in good faith. Good faith is presumed, so if a mandated reporter is accused of acting in bad faith, the burden of proof of gross negligence or willful misconduct is on the accuser.
2. Mandated reporters are provided confidentiality. Local and State authorities are not permitted to release the name of the reporter unless the reporter has given written permission to do so.
3. A mandated reporter who fails to report can be found guilty of a Class A misdemeanor and subject to a fine of up to \$1,000 and/or imprisonment of up to one year.

Role of Mandated Reporter

To report suspected incidents of child abuse or maltreatment/neglect while acting in their professional capacity.

Reasonable Cause to Suspect

- **Do not have to prove it**
- **Distrust or doubt is enough**
- **Based on observation or disclosure**
- **Child is harmed or in imminent danger of harm**

Reporting Procedures

When

- Immediately, by telephone, at any time of day, seven days a week
- Additionally, a written report must be filed within 48 hours of oral report

Where

LOADING...

Oral telephone reports should be made to the New York State Central Register of Child Abuse and Maltreatment (SCR) by calling the statewide, toll free telephone number: 1-800-635-1522 (Mandated Reporters)

A written report, signed by the reporter, must be filed with the local child protective services (CPS) within 48 hours of the oral report. You may obtain the address of the local CPS when making the report to the Central Register. (A written report involving a child cared for away from his or her home [e.g., foster care, residential care] should be submitted to the New York State Child Abuse and Maltreatment Register, 40 North Pearl Street, Albany, NY 12243.)

Talking with Children

Do:

- **Find a private place**
- **Remain calm**
- **Be honest, open, up-front, supportive**
- **Be an advocate**
- **Listen to the child**
- **Report the situation immediately**

Talking with Children

Don't:

- **Overreact**
- **Make judgments/promises**
- **Interrogate or investigate**

Reporters may wish to maintain careful notes for their own personal records, noting such things as dates, times, places, names of individuals involved in any reporting incident, etc.

For purposes of reporting suspected cases of child abuse and maltreatment to the State Central Register and Child Protective Services, it is important to understand the definition of who can be the subject of the report as defined by Section 412.4 of the Social Services Law.

Subject of the report means any parent, guardian, custodian, or other person 18 or older who is legally responsible (as defined in Section 1012(g) of the Family Court Act for a child reported to the Central Register of Child Abuse and Maltreatment and who is allegedly responsible for causing--or allowing the infliction of--injury, abuse, or maltreatment to such child.

Subject of the report also means an operator of, or employee or volunteer in a home operated or supervised by an authorized agency, the Division for Youth, or an office of the Department of Mental Hygiene, or a family day-care home, day-care center, group family day-care home, or a day services program, who is allegedly responsible for causing --or allowing the infliction of -- injury, abuse or maltreatment to a child who is reported to the Central Register.

Of course, abuse and maltreatment may be caused by individuals other than a parent or person legally responsible for the child's care, such as neighbors or strangers. Such individuals might not fit the legal definition of the subject of the report. In such instances, law enforcement authorities should be contacted.

Note: When the alleged perpetrator of child abuse or maltreatment cannot be the subject of a report (as defined in Section 412.4 of the Social Services Law), law enforcement authorities should be contacted directly. If a call is received by the State Central Register, and the person allegedly responsible for the abuse or maltreatment cannot be the subject of a report, and the SCR believes that the alleged acts or circumstances described by the caller may constitute a crime or an immediate threat to the child's health or safety, the SCR is required by law to transmit the information contained in the call to the appropriate law enforcement agency, district attorney, or other public official empowered to provide necessary aid or assistance (Social Services Law, Sec. 422.2(c)).

Who can be Reported?

- Day Care Provider
- Parent
- Guardian
- Residential Child Care Staff

What To Include

1. Telephone Report:

Names and addresses of the child and his/her parents or other person responsible for his/her care
Child's age, sex, and race
Nature and extent of the child's injuries, abuse or maltreatment, including any evidence of prior injuries, abuse, or maltreatment to the child or his/her sibling
Name of the person or persons responsible for causing the injury, abuse, or maltreatment
Family composition
Source of the report

Person making the report and where s/he can be reached
Actions taken by the reporting source, including the taking of photographs or X-rays, removal or keeping of the child, or notifying the medical examiner or coroner; and
Any additional information, which may be helpful

Note: The lack of complete information does not prohibit (and should not prevent) a person from reporting.

2. Written Report - DSS-2221-A (Report of Suspected Child Abuse or Maltreatment)

Form (obtainable from local CPS); copy here [Form 2221A](#)

Identical information as in telephone report (see above)

All information should be written as clearly and objectively as possible

Written reports are admissible as evidence in any judicial proceedings; accurate completion is vital.

HIPAA restrictions should not inhibit provision of any necessary information on the report. Any information relevant to the subsequent investigation by CPS must be included.

If the report is registered by the CPS specialist, request the call identification number associated with your report, as well as the full name of the CPS specialist you are speaking with.

In the event of a disagreement between CPS and the mandated reporter on the degree of disclosure required, CPS may obtain a court order to compel disclosure.

The CPS may not register a report. If this is the case, the reason for that decision should be clearly explained to you, and you should be offered the opportunity to speak to a supervisor.

Some situations are more appropriate for intervention at the local level than for CPS intervention. Contact the local CPS office for assistance.

If the report will not be registered, but the circumstances of the call constitute a crime or immediate threat to the child's health or safety, the SCR will send the information to the New York State Police Information Network or to the New York City Police Department. No SCR identification number is assigned to these "Law Enforcement Referrals" (LER) and you do not need to complete Form LDSS-2221A.

Make the call

Mandated Reporter Express Line

1-800-635-1522

**New York State Child Abuse and
Maltreatment Register**

Prepare for the Call

- **Demographics**
- **Has the child been harmed, or is at risk of harm, and how?**
- **Role of parent or person legally responsible?**
- **Ongoing pattern?**

Prepare for the Call

- **Where is the child?**
- **Special needs or medications?**
- **Concerns for local CPS (weapons)?**
- **Any other information?**

After The Phone Call

Sections 422.2(a) and 422.11 of the Social Services Law establish the procedures to be followed by the Department of Social Services after the phone call is received.

After you complete the call, immediately notify the person in charge of the institution, school, facility or agency, or the designated agent of that person. Provide the information given to SCR, including the names of other persons identified as having direct knowledge of the alleged abuse or maltreatment, and other mandated reporters identified as having reasonable cause to suspect.

That person now becomes responsible for all subsequent administrative actions concerning the report, including preparation and submission of Form LDSS-2221A.

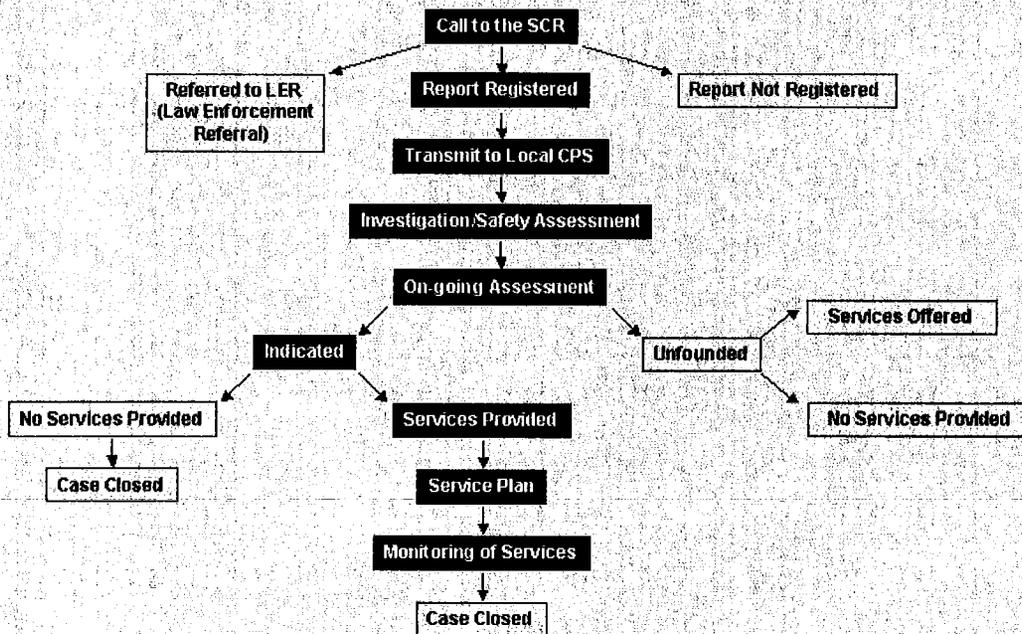
Written reports using the LDSS-2221A should be sent to the local CPS office within 48 hours of making the oral report. Send them one original and one duplicate, and keep a copy for yourself.

When any allegations contained in the phone call could reasonably constitute a report of child abuse or maltreatment, including reports involving children who reside in residential facilities or programs, such allegations must be immediately transmitted by the Department of Social Services to the appropriate agency or local child protective service for investigation. If the Department records indicate a previous report concerning a subject of the report, other persons named in the report, or other pertinent information, the appropriate agency or local child protective service must be immediately notified of this fact.

Follow up the Call

- Complete Form 2221A within 48 hours
- Send to local CPS

New York State Child Protective Services System



Local District Response

- **Begin investigation within 24 hours**
 - Verification of report
 - Develop plan

- **Determination of report within 60 days**
 - Indicated
 - Unfounded and sealed

Inquiring About The Report

Section 422.4 of the Social Services Law provides that a mandated reporter can receive, upon request, the findings of an investigation made pursuant to his/her report. This request can be made to the SCR at the time of making the report or to the appropriate local CPS at any time thereafter. However, no information can be released unless the reporter's identity is confirmed.

If the request for information is made prior to the completion of an investigation of a report, the released information shall be limited to whether the report is "indicated" (i.e., substantiated), "unfounded," or "under investigation," whichever the case may be.

If the request for information is made after the completion of an investigation of a report, the released information shall be limited to whether a report is "indicated" or, if the report has been expunged, that there is "no record of such report," whichever the case may be. (Note: Reports are expunged for lack of credible evidence of alleged abuse or maltreatment after an investigation, or 10, years after the 18th birthday of the youngest child named in the report.)

National Incidence Study

Found professionals report only half the incidents they knew about.

The reasons for this are:

- **Confusion or misunderstanding about reporting laws and procedures**
- **Lack of knowledge or awareness of warning signs/clues**

University of Rochester Study

Mandated Reporters disclosed they were:

- **Not clear about abuse/neglect as defined in State Law**
- **Often influenced by their professional beliefs, values, and experiences**

Other Mandated Or Authorized Actions

Photographs And X-Rays

Any mandated reporter may take, or cause to be taken, at public expense, color photographs of the area of trauma visible on a child (a reporter may ask the local CPS to take photographs when appropriate; suggested guidelines for the photography of trauma are available in Appendix E)

If medically indicated, cause X-Rays to be taken.

Photos or X-rays must accompany the DSS-2221-A, or be sent as soon as possible after its submission; they should be appropriately identified with child's name, date, and name of person taking the photos or X-rays.

Protective Custody

A child may be taken into protective custody (i.e., without court order or parental consent):

If the child is in such circumstances or condition that continuing to stay in his/her residence or in the care and custody of the parent or person legally responsible for the child's care, presents an imminent danger to the child's life or health; and if there is not enough time to apply for an order of temporary removal from the Family Court. Protective custody should not be confused with status of child admitted voluntarily to hospital by parent(s)

Persons legally authorized to place child into physical protective custody:

- Peace officer (acting pursuant to his/her special duties)
- Police officer
- Law enforcement official
- Agent of a duly incorporated society for the prevention of cruelty to children
- Designated employee of a city or county department of social services, or
- Person in charge of a hospital or similar institution.

Imminent Danger

- **Distance between child and harm by actions or failure to act**
- **Could occur immediately or very soon**
- **How direct the threat is to the child**

When protective custody occurs, the authorized person must take the following actions:

S/he must bring the child immediately to a place designated by the rules of the Family Court for this purpose, unless the person is a physician treating the child and the child is or will be presently admitted to a hospital

S/he must make every reasonable effort to inform the parent or other person legally responsible for the child's care of the facility to which the child has been brought.

S/he must provide the parent or the person legally responsible with written notice, coincident with removal (Family Court Act 1024(b)(iii)).

S/he must inform the court and make a report of suspected child abuse or maltreatment pursuant to Title 6 of the Social Services Law, as soon as possible (FCA, Sec. 1024(b)).

S/he must immediately notify the appropriate local child protective service, which shall commence a child protective proceeding in the Family Court at the next regular weekday session of the appropriate Family Court or recommend that the child be returned to his/her parents or guardian.

In neglect cases, pursuant to Section 1026 of the Family Court Act, the authorized person or entity (usually CPS) may return a child prior to a child protective proceeding if it concludes there is no imminent risk to the child's health.

Note: For a discussion of what happens after a report is made, please see Appendix A.

Legal Protections For Reporters

Immunity

To encourage prompt and complete reporting of suspected child abuse and maltreatment, the Social Services Law, Section 419, affords the reporter certain legal protections from liability.

Any persons, officials, or institutions who in good faith make a report, take photographs and/or take protective custody, have immunity from any liability, civil or criminal, that might be a result of such actions.

All persons, officials, or institutions who are required to report suspected child abuse or maltreatment are presumed to have done so in good faith as long as they were acting in the discharge of their official duties and within the scope of their employment and so long as their actions did not result from willful misconduct or gross negligence.

Confidentiality

The Commissioner of Social Services and the local department of social services are not permitted to release, to the subject of a report, data which identify the person who made the report, unless such person has given written permission for the central register to do so.

The person who made the report may also grant the local child protective services permission to release his/her identity to the subject of the report. (If a reporter needs reassurance, he or she should feel free to stress the need for confidentiality if the situation warrants.)

Consequences For Failing To Report

Legal Repercussions

Any person, official, or institution required by the law to report a case of suspected child abuse or maltreatment who willfully fails to do so:

- May be guilty of a Class A misdemeanor

- May be civilly liable for the damages caused by such failure

Societal Repercussions

Child Protective Services cannot act until child abuse is identified and reported, i.e., services cannot be offered to the family nor can the child be protected from further suffering.

All material on this site is Copyright © 2005 - 2012 Laboratory Consultation Services, Inc. except as noted.

Sample Course Material

You can review the course material without logging in, but in order to complete the course you will need to register and login to this site. Go to the **Online Course** Section.

Frequently Asked Questions

Need Help? Check out our **FAQ** section to get you started.

Copyright © 2005 - 2012 Laboratory Consultation Services, Inc.. Designed by HitekPros.com.

Home

Infection Control Course



Article Index

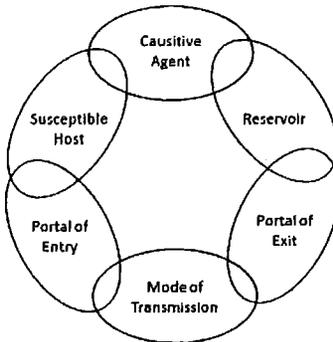
- Infection Control Course
- Introduction
- Element I
- Element II
- Element III
- Element IV
- Element V
- Element VI
- Element VII
- All Pages

This course consists of the seven elements of the New York State required course and satisfies the infection control training requirement for all professions.

The entire course is on line and may be studied at your own pace. When you have completed the course, take the short quiz at the end to assess your level of understanding of the material.

The fee for the course is \$30 and may be paid for with Visa, Master Card or Paypal.

Then, you will have the opportunity to review your demographic information and to view and print out your certificate.



This is an illustration of the chain of infection, which is a description of how infection is propagated. Breaking the chain of infection is the purpose of infection control and barrier precautions.

All dentists, dental hygienists, licensed practical nurses, optometrists, podiatrists, and registered nurses must complete course work or training appropriate to their practice regarding infection control and barrier precautions, including engineering and work controls to prevent the transmission of human immunodeficiency virus (HIV) and the hepatitis b virus (HBV) in the course of professional practice, every four years according to Section 6505-b of the Education Law. You must attest to having completed this requirement to the State Education Department on your first licensure/registration application and at every subsequent registration.

All physicians, physician assistants, and specialist assistants must complete course work or training in accordance with Chapter 786 of the Laws of 1992 at the time of their initial licensure/registration and every four years thereafter. You must attest compliance to the State Education Department at the time of each registration.

Health Professionals Required to Receive Training in Infection Control:

Dentists	Registered Professional Nurses
Dental hygienists	Licensed Practical Nurses
Physicians	Optometrists
Physician assistants	Podiatrists
Specialist assistants	

The goals of infection control training are to:

- Assure that health professionals understand how bloodborne and other pathogens can be transmitted in the work environment: patient to health care worker, healthcare worker to patient, and patient-to-patient
- Apply current scientifically accepted infection control principles as appropriate for the specific work environment.
- Minimize opportunity for transmission of pathogens to patients and healthcare workers.
- Familiarize professionals with the law requiring this training and the professional misconduct charges that may result from

Courses are still only \$30 each

Account Login

Hi Gershon Dubin,

Excel Reports

- Training Results
- All Sales
- Sales Report

Your Details

Administration

Administrator

Certification History

Course	Date
NYIC	18-July-2008
NYCA	30-July-2008
NYSV	07-August-2008
CAIC	11-November-2008
CADX	11-November-2008
CADA	28-February-2011
NYSV	15-November-2011
NYSV	24-September-2007
NYIC	28-December-2011
CAIC	31-July-2012
CADA	31-July-2012
CADX	31-July-2012

New Courses!

We recently added California Courses to our site.

Certificates are in PDF format. If you don't have a PDF reader you can download it free.



failure to comply with the law.

The New York State Syllabus for this course consists of seven elements, as follows:

ELEMENT I

PROFESSIONAL RESPONSIBILITY FOR INFECTION CONTROL

All health-care professionals share responsibility to adhere to scientifically accepted principles and practices of infection control, and to monitor the performance of those for whom they are responsible.

Standards of care in infection control

A. Standard Precautions are used to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources in hospitals; this is the first level of precautions for all patients.

B. Transmission based precautions, the second level of precautions used for caring for patients with or suspected to have certain communicable diseases. Possible modes of transmission include:

Airborne
Contact
Droplet

C. Hand washing and aseptic technique, practices to prevent contact spread of most bacterial infections including staphylococcal and streptococcal infections) and some viruses (herpes, cold viruses, CMV) in health-care settings;

D. Appropriate cleaning, disinfection, and sterilization processes of medical devices and equipment to prevent transmission of infection.

E. Occupational health practices used for the prevention and control of communicable diseases in health-care workers.

Standards of professional conduct in infection control

(Statutory authority: Public Health Law, section 230-a)

Part 92 of Subchapter N of Chapter II of Title 10 (Health)

of the Official Compilation of Codes, Rules and Regulations of the State of New York

Section 92.2 For physicians, registered physicians assistants, and specialist assistants, the definition of unprofessional conduct shall include the failure to use scientifically accepted infection control practices to prevent transmission of disease pathogens from patient to patient, physician to patient, registered physician (assistant) or specialist assistant to patient, employee to patient, and patient to employee, as appropriate to physicians, registered physician assistants and specialist assistants. Such practices include:

(a) adherence to scientifically accepted standards for: handwashing; aseptic technique; use of gloves and other barriers for preventing bidirectional contact with blood and body fluids; thorough cleaning following sterilization or disinfection of medical devices; disposal of non-reusable materials and equipment; and cleaning between patients of objects that are visibly contaminated or subject to touch contamination with blood or body fluids;

(b) use of scientifically accepted injury prevention techniques or engineering controls to reduce the opportunity for patient and employee exposure; and

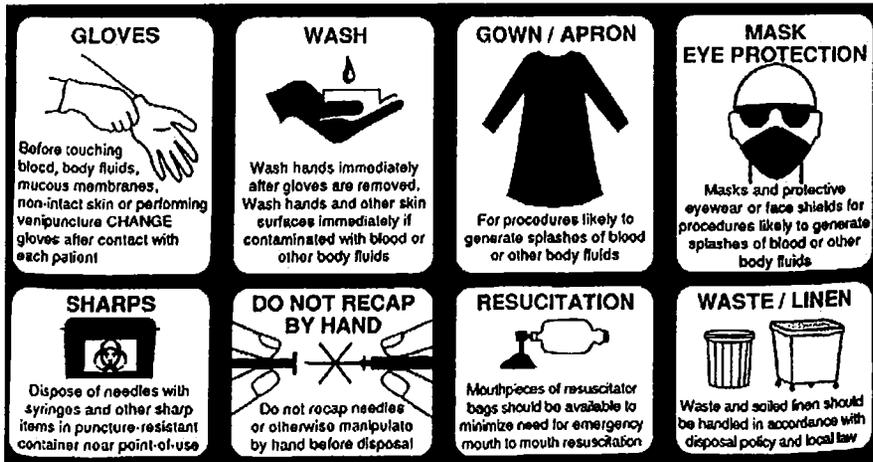
(c) performance monitoring of all personnel, licensed or unlicensed, for whom the licensee is responsible regarding infection control techniques.

The infection control practices include but are not limited to the following:

1. Wearing of appropriate protective gloves at all times when touching blood, saliva, other body fluids or secretions, mucous membranes, non-intact skin, blood-soiled items or bodily fluid-soiled items, contaminated surfaces, and sterile body areas, and during instrument cleaning and decontamination procedures;
2. Discarding gloves used following treatment of a patient and changing to new gloves if torn or damaged during treatment of a patient; washing hands and donning new gloves prior to performing services for another patient; and washing hands and other skin surfaces immediately if contaminated with blood or other body fluids;
3. Wearing of appropriate masks, gowns or aprons, and protective eyewear or chin length plastic face shields whenever splashing or spattering of blood or other body fluids is likely to occur;
4. Sterilizing equipment and devices that enter the patient's vascular system or other normally sterile areas of the body;
5. Sterilizing equipment and devices that touch intact mucous membranes but do not penetrate the patient's body or using high-level disinfection for equipment and devices that cannot be sterilized prior to use for a patient;
6. Using appropriate agents including but not limited to detergents for cleaning all equipment and devices prior to sterilization or disinfection;
7. Cleaning, by use of appropriate agents including but not limited to detergents, equipment and devices that do not touch the patient or that only touch the intact skin of the patient;
8. Maintaining equipment and devices used for sterilization according to the manufacturer's instructions;
9. Adequately monitoring the performance of all personnel, licensed or unlicensed, for whom the licensee is responsible regarding infection control techniques;

10. Placing disposable used syringes, needles, scalpel blades, and other sharp instruments in appropriate puncture-resistant containers for disposal; and placing reusable needles, scalpel blades, and other sharp instruments in appropriate puncture resistant containers until appropriately cleaned and sterilized;
11. Maintaining appropriate ventilation devices to minimize the need for emergency mouth-to-mouth resuscitation;
12. Refraining from all direct patient care and handling of patient care equipment when the health care professional has exudative lesions or weeping dermatitis and the condition has not been medically evaluated and determined to be safe or capable of being safely protected against in providing direct patient care or in handling patient care equipment;
13. Placing all specimens of blood and body fluids in well-constructed containers with secure lids to prevent leaking; and cleaning any spill of blood or other body fluid with an appropriate detergent and appropriate chemical germicide.

The following chart summarizes many of these techniques:



The responsibility for monitoring infection control procedures of both licensed and non-licensed personnel falls on the licensed supervisor. Any breach of scientifically accepted infection control procedures can result in charges of professional misconduct against any licensed professional who was directly involved, was aware of the violation or who was responsible for ensuring staff training. (see Part 92, Subchapter N of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York).

The mandated training for which this course is designed is intended to assist medical and dental professionals in maintaining these professional standards.

Infection Control and OSHA

In 1991 the OSHA (Occupational Safety and Health Administration, an agency of the United States Department of Labor) Blood borne Pathogens Standard took effect, requiring enforcement of Universal/Standard Precautions and training of all employees with potential blood or body fluid exposure in infection control techniques.

The Standard also mandates the availability of appropriate protective equipment and barriers, and requires procedures for follow-up after an exposure.

While there is significant overlap between the New York State Mandated Infection Control Training Course and the training required under the Bloodborne Pathogen Standard (Section 1910.1030 of the Code of Federal Regulations), it is important to note that the OSHA regulation applies to employees, while the New York State law applies to professional personnel.

ELEMENT II

TRANSMISSION AND CONTROL OF INFECTION IN HEALTH CARE SETTINGS

Modes and mechanisms of transmission of pathogenic organisms in the Health-care setting and strategies for prevention and control.

I. Definitions:

ANTIBIOTIC - medications that weaken or kill bacteria, and are used to treat infections caused by bacteria. Antibiotics have no effect on infections caused by viruses.

ANTIBIOTIC RESISTANCE - when bacteria can no longer be killed by a particular antibiotic. MRSA and VRE are examples of bacteria that have developed resistance to many commonly used antibiotics. If a bacterium is resistant to many antibiotics, treating the infections it causes can be very difficult or even impossible. Widespread inappropriate use of antibiotics contributes to the development of antibiotic resistance.

COLONIZATION - when bacteria are present in a person's nose, mouth, gut or other site, but do not cause illness. A person may be colonized with bacteria and feel fine. He or she may not know that these bacteria are present in their body.

CARRIER - A person or animal without apparent disease who harbors a specific infectious agent and is capable of transmitting the agent to others. The carrier state may occur in an individual with an infection that is unapparent throughout its course (known as asymptomatic carrier), or during the incubation period, convalescence, and post convalescence of an individual with a clinically recognizable disease. The carrier state may be of short or long duration (transient carrier or chronic carrier).

DIRECT TRANSMISSION. The immediate transfer of an agent from a reservoir to a susceptible host by direct contact or droplet spread.

INDIRECT TRANSMISSION. The transmission of an agent carried from a reservoir to a susceptible host by suspended air particles or by animate (vector) or inanimate (vehicle) intermediaries.

HOST. A person or other living organism that can be infected by an infectious agent under natural conditions.

IMMUNITY

Active: Resistance developed in response to stimulus by an antigen (infecting agent or vaccine) and usually characterized by the presence of antibody produced by the host.

Herd: The resistance of a group to invasion and spread of an infectious agent, based on the resistance to infection of a high proportion of individual members of the group. The resistance is a product of the number susceptible and the probability that those who are susceptible will come into contact with an infected person

Passive: Immunity conferred by an antibody produced in another host and acquired naturally by an infant from its mother or artificially by administration of an antibody-containing preparation (antiserum or immune globulin).

INCUBATION PERIOD. The time from the moment of exposure to an infectious agent until signs and symptoms of the disease appear. For example, the incubation period of chicken pox is 14-16 days.

INFECTION - When a bacterium or other germ (like a virus) causes illness in a person. Some signs and symptoms of infection include fever, pus from a wound, coughing, or diarrhea.

RESERVOIR - The habitat in which an infectious agent normally lives, grows and multiplies; reservoirs include human reservoirs, animals reservoirs, and environmental reservoirs.

People
Symptomatic - Smallpox
Asymptomatic - HIV

Animals
Lyme Disease

Environmental
Histoplasmosis
Anthrax

RISK FACTOR - An aspect of personal behavior or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased occurrence of disease or other health-related event or condition.

TRANSMISSION OF INFECTION. Any mode or mechanism by which an infectious agent is spread through the environment or to another person.

Direct Contact
Cutaneous Anthrax
Droplet - Smallpox

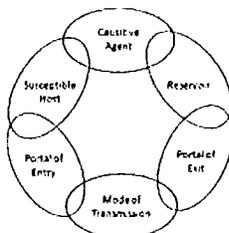
Indirect
Airborne - Histoplasmosis, Inhalation Anthrax
Vehicle borne - Salmonella
Vector borne
Mechanical - Tularemia by fly bites
Biological - Lyme disease

UNIVERSAL PRECAUTIONS - Recommendations issued by CDC to minimize the risk of transmission of bloodborne pathogens, particularly HIV and HBV, by health care and public safety workers. Barrier precautions are to be used to prevent exposure to blood and certain body fluids of all patients.

VECTOR - An animate intermediary in the indirect transmission of an agent that carries the agent from a reservoir to a susceptible host.

II. The Chain of infection

The spread of infection may be summarized using the "chain of infection"; a pattern of spread of infection from one host to another susceptible host, or from the environment to a susceptible host. This chain requires a pathogen, a source or reservoir, a portal of exit, a mode of transmission, a portal of entry, and a susceptible host.



Infection control measures are designed to break the links and thereby prevent the infection from spreading.

The causative agents of infection can be bacteria, viruses, fungi and/or parasites.

The reservoir, as defined above, can be animate, inanimate or environmental.

The portal of exit is how the infection leaves the reservoir. This can be the respiratory tract, gastrointestinal tract, genitourinary tract, skin, mucous membrane, blood or other exudates.

The modes of transmission of infection are the mechanisms for transfer of the infection from the reservoir to a susceptible host. This can be affected by direct contact, indirect contact, droplet, common vehicle, airborne or vector borne means. In the healthcare setting healthcare professionals are a major source for the transmission of infection.

Indeed, infection transmission is not limited to healthcare professional transmitting to patient, but transmission can be from patient to patient, patient to healthcare professional and to others.

The portal of entry is the path by which the infection is able to enter the susceptible host. The portals of entry are much the same as the portals of exit. Entry of the infection can be made into the respiratory tract, GI tract, GU tract, compromised skin, mucus membrane or parenterally. Percutaneous (through the skin) transmission of infection continues to be a major source of infection. Care should be taken to ensure proper handling and disposal of sharp instruments. The advent of safety needles have been helpful in reducing needle sticks and the healthcare worker must adhere procedures to minimize exposure to sharps.

The susceptible host is the person whose resistance to the causative agent is lacking. Many people are more susceptible to infection than others. For example, persons whose immune system is deficient due to HIV, AIDS, chemotherapy, organ transplants or age should be treated with care to minimize their exposure to infection. Any healthcare worker that presents with symptoms of infection (e.g. Influenza) should not expose themselves to patients who are at risk. Other factors that make a person more susceptible include: sex, ethnicity, lifestyle, occupation, nutritional status, immunization status, family medical history, medication, pregnancy, injury or post surgery.

III Breaking the Chain of Infection

It is the responsibility of all healthcare workers to break the chain of infection. The earlier the chain is broken the less chance the causative agent of the infection has a chance to spread, hence good infection control.

Preventing the spread of infections includes:

- Recognizing, diagnosing, and treating persons with diseases
- Early identification of the infectious agent
- Prompt and appropriate isolation of the patient
- Disinfecting inanimate reservoirs of pathogenic organisms
- Good handwashing technique

Standard Precautions must be observed (universally) on all patients whether they are suspected of being infectious or not. This will reduce the risk of transmission even before a definitive diagnosis can be made. Patients suspected of having a condition requiring Airborne, Droplet, or Contact Precautions require the use of enhanced precautions while diagnosis continues.

ELEMENT III

USE OF ENGINEERING AND WORK PRACTICE CONTROLS TO REDUCE THE OPPORTUNITY FOR PATIENT AND HEALTH-CARE WORKER EXPOSURE TO POTENTIALLY INFECTIOUS MATERIAL

I. Definitions:

Engineering Controls: Use of equipment, devices or instruments that remove, isolate or minimize exposure to a hazard.

Work Practice Controls: Controls that reduce or eliminate the likelihood of exposure by altering the manner in which a task is performed.

Anyone who has direct patient contact that may be exposed to blood or other potentially infectious materials (OPIM) or contact with items contaminated with blood or OPIM must identify where engineering or work practice controls can be utilized to prevent exposure. These include:

- Physicians
- Dentists
- Podiatrists
- Nurses: RN, LPN
- Dental Hygienists
- Physician Assistants
- Nursing Assistants
- Lab Technicians
- Phlebotomy technicians
- Physical therapists
- Housekeeping and laundry staff

II. High risk practices and procedures

Percutaneous exposure: exposures that occur through penetration of skin

Injury through handling, disassembly, disposal or reprocessing of needles and other sharps. Examples:

- Manipulating needles and sharps by hand
- Recapping needles using both hands
- Removing scalpel blades with bare hand
- Handling broken glass or exposed ends of dental wire
- Transplantation of contaminated organs or tissue

Procedures in which there is opportunity for injury, particularly where there is poor visualization which can expose the patient as well as the health care worker.

Examples:

- Blind suturing
- Non-dominant hand opposing or next to a sharp
- Manipulating bone spicules or metal fragments.

Mucous membrane or non-intact skin exposures (eyes, mouth, nose, broken skin) occur via

Direct contact with blood or body fluid
Contaminated hand in contact with eyes, nose or mouth
Open skin lesions on hands/dermatitis
Handling contaminated instruments or linens
Disinfecting surfaces

Sprays or splashes of blood or body fluid
Irrigation or suctioning
During a surgical or dental procedure
During childbirth

Parenteral exposures (exposure via the blood stream), may occur by:

Injection with infectious material
Infusion of contaminated blood products

III. Evaluation and Surveillance of Exposure Incidents

Identification of those at risk for exposure (anyone who has direct patient exposure to blood or body fluids or contact with anything contaminated with blood or body fluids)

Identification of the devices causing the injury
Devices with a higher risk of disease transmission - hollow bore needle
Devices with higher injury rate – butterfly recoil action

Identification areas or settings where exposures are occurring

Identification of circumstances by which exposures are occurring

Passing instruments in the OR
Suturing
Any function using syringes
Laboratory processing including phlebotomy
Cleaning / sterilizing medical and dental instruments

IV. Engineering controls which eliminate or minimize the hazard

Use safer medical devices where possible to prevent sharps injuries and consider the elimination of conventional sharps

Evaluation and selection of safer devices with input from employees responsible for direct care

Identification of the type and brand of device involved in an exposure, the department or work area where the incident occurred and an explanation of how the incident occurred
Passive devices are preferable to active devices
Mechanisms that provide continuous protection are preferable, such as shielded or recessed needles
Integrated safety equipment is preferable to accessory devices

Proper education and training on use of safety devices.

Puncture resistant, leak proof containers for disposal and transport of needles and other sharps (scalpel blades, lancets, slides, surgical staples, orthodontic wires, etc.)
Employers must provide sharps disposal containers that are accessible to employees and as close as feasible to the area of sharps use
Containers must be red in color or labeled with biohazard sign
Containers must be removed for disposal before becoming overfilled
Containers must not be accessible to the public
Containers must be secured and sealed appropriately before removal for disposal/transport
Splatter shields on medical equipment, e.g. locking centrifuge lids, or a biosafety cabinet for laboratory procedures.

V. Work practice controls

General Practices

Handwashing

Spills: Promptly clean blood and body fluid spills with appropriate disinfectant while wearing appropriate PPE

Disposal: Proper handling and disposal of blood and OPIM including contaminated patient care items in the appropriate biohazard waste container (or laundry container for contaminated laundry)

PPCE: Use of personal protective clothing and equipment

For prevention of percutaneous (needlestick) exposures

Avoid unnecessary use of needles and other sharps

Use special care in handling and disposal of sharps

Do not recap needles or, if absolutely necessary, use a one-handed recapping technique:

place one hand behind your back

place needle-cap on a flat surface

take hand away from cap and away from needle

holding only the syringe, guide needle into cap and scoop up the cap

lift up syringe so cap is sitting on needle hub

secure needle-cap into place.

In surgery, dentistry, or emergencies, pass sharps using an area or basin or tray designated as a "safe zone" (not hand-to-hand)

Only disassemble sharp equipment using forceps or other devices

Always dispose of sharps you have used: NEVER leave sharps behind on trays, counters, or beds for someone else to pick up

Watch out for overfilled sharps containers when disposing of sharps

Appropriate use of safety devices whenever available

Learn how safety device operates and practice with it

Always activate the safety mechanism

Do not bypass the safety mechanism

Modify procedures to avoid injury:

Use forceps, suture holders or other instruments for suturing

Do not use fingers to hold tissue when suturing

Never leave sharps in a surgical field

Do not reach into trash to retrieve items

Do not reach into a sink or basin of water to retrieve contaminated instruments

Seek help prior to any procedure when dealing with confused or combative patients.

Controls applied to airborne pathogens

Circumstances that increase opportunities for exposure include:

Inadequate ventilation

Lack of source control: failure to institute airborne isolation precautions for known or suspected cases of TB or other airborne diseases; failure to triage immediately for febrile rash or known exposure to communicable disease

Unrecognized cases: failure to consider the diagnosis of TB or other airborne disease, resulting in delayed recognition, isolation, and treatment of cases. Transmission to health care workers and other patients may follow.

Engineering controls for prevention of airborne transmission

Isolation rooms with appropriate air exchanges (negative pressure or direct exhaust) Doors to these rooms must be kept closed

Appropriate air exchange -A minimum of 12 air exchanges per hour are required in rooms housing patients with known or suspected TB or other airborne diseases

Air from these rooms must be exhausted to the outside, or appropriately filtered (HEPA filtration) before recirculation

HEPA filtration

HEPA filters: high-efficiency-particulate-air filters remove infectious particles from the air. Isolation booths, tents, and portable HEPA filtration units can be used to minimize airborne transmission in isolation rooms or during procedures such as sputum induction or aerosolized pentamidine treatments.

Ultraviolet irradiation

Ultraviolet (UV) lights are a supplemental measure for control of airborne pathogens.

Source control

Instruct infectious patient to cover mouth when coughing or sneezing, and to appropriately discard tissues

Potentially infectious patients should be triaged early and isolated from others at risk, e.g., in an emergency department, clinic, or office. In an office setting, potentially infectious patients can be scheduled for the end of the day, or taken directly to a treatment room without exposing waiting patients.

Personal Protective Equipment (masks, particulate respirators): see Element IV.

Special considerations

Operating Suites have positive pressure to prevent wound contamination

Airborne precautions would be necessary for an operative procedure for extra pulmonary tuberculosis because of the risk of aerosolization

When transporting a patient with a disease spread through the air, place a surgical mask or non-rebreather oxygen mask on the patient.

ELEMENT IV

SELECTION AND USE OF BARRIERS AND PERSONAL PROTECTIVE EQUIPMENT (PPE)

Definitions:

Personal Protective Equipment (PPE): specialized clothing or equipment (e.g., gloves, gowns, masks, goggles) worn by a health-care worker (HCW) for protection against a hazard.

Barrier: an material object that separates a person from a hazard.

Types of PPE and barriers and criteria for selection

Gloves:

Gloves must be worn for all anticipated hand contact with blood, potentially infectious body fluids, mucous membranes, non-intact skin, or wounds, and when handling items contaminated with blood or body fluids. Gloves must be worn during all invasive procedures and all vascular access procedures, including all phlebotomies and insertion of IV's or other vascular catheters.

Gloves are not to be washed, disinfected, or sterilized for reuse (except utility gloves). Gloves must be changed between patients, and hands must be washed after glove removal. Gloves MUST be changes between patients.

Sterile and non-sterile gloves:

Sterile gloves are required to prevent transmission of infection from health care worker to patient in surgery and in other procedures associated with a high risk of infection due to interruption of normal host defenses. (Examples: insertion of central venous catheters and urinary catheterization)

Non-sterile gloves are used to reduce transmission of infection in situations where sterility is not required (examples: oral or vaginal examination, cleaning a spill, emptying suction containers, urine drainage bags, or bedpans) or where sterile technique does not necessitate sterile gloves (Examples: phlebotomy, peripheral IV catheter insertion).

Glove Material:

Latex, nitrile or vinyl (examination) gloves are used for most medical, dental, and laboratory procedures. Disposable single use gloves must be replaced as soon as practical if contaminated, punctured or damaged during use. Double gloving or puncture-resistant liners can be used to decrease the risk of percutaneous injury and exposure to blood/body fluids.

Latex gloves - More pliable with a tighter fit, but contain proteins that can cause allergic reactions in the health care worker or patient. Often they are powdered which can contribute to dermatitis.

Hypo-allergenic gloves, glove liners, or powder less gloves are available

Vinyl gloves- Usually white in color, less irritating, not associated with allergy reactions, but are less pliable & do not fit as tightly.

Utility gloves are used for heavy-duty housekeeping chores. They may be decontaminated and reused unless they are cracked, peeling, torn, or punctured.

Protective Clothing

Protective clothing helps prevent contamination of skin, mucous membranes, work clothes, and undergarments. (Regular work clothes,

uniforms, surgical scrubs are not considered protective attire.)

Gowns (with sleeves) are used when splashing, spraying, or spattering of blood/body fluids or when blood/body fluid contamination of arms is anticipated.

Aprons (no sleeves) may be worn for lesser degrees of exposure

Laboratory coats are worn in laboratory setting.

Protective clothing should be impervious to fluids or fluid resistant (i.e., resists penetration of fluids under most but not all circumstances).

The choice of gown or apron depends on the level of blood or body fluid exposure anticipated. Fluid resistant gowns are suitable for most situations; extra fluid resistant sleeves can be worn over a gown, and/or an impervious apron can be worn under a gown, to improve protection against soak-through during prolonged or high- blood-loss surgical procedures. Impervious gowns may be preferable for procedures with the highest risk of blood exposure. Impervious gowns may be less comfortable since the material is also impervious to perspiration.

Masks

Types of masks:

The purpose of a surgical mask is to protect the patient by preventing discharge of contaminated nasal and oral secretions from the wearer during a procedure, and thereby reduce risk of wound infection.

A surgical or procedure mask with face shield's purpose is to protect the wearer's eyes, nose and mouth from exposure to splattered or splashed blood or body fluids.

Particulate respirator is used to filter out, and protect the wearer from, inhalation of airborne infectious particles of specific sizes. An OSHA class, N- 95 respirator is an acceptable respirator for protection from small droplet inhalation such as with tuberculosis. Positive Air Purifying Respirators (PAPRs) may be worn by those unable to be fitted with an N-95 type respirator.

Characteristics of masks:

Filtration characteristics

Surgical masks may effectively block discharge of large droplets into the air, but the material is not an effective filter to prevent inhalation of very small, aerosolized particles characteristic of TB and airborne viral diseases. Particulate respirators provide an increased level of filtration. A wet mask is generally less effective

Face seal

A tight seal around the edges of a particulate respirator is essential to its effectiveness. If loose fitting, contaminated air will be drawn in around the edges of the mask, instead of the air being drawn through the filter. If face seal is not achieved or not possible, a PAPR can be used as an alternative.

Face shields

Face shields protect eyes, nose, and mouth from exposure to blood or body fluids via splash, splatter, or spray. Protection against airborne pathogens requires the addition of an appropriate mask.

Eye protection

Eye protection (goggles, safety glasses, or face shield) should be worn during all major surgical procedures and whenever splashes/sprays of blood or body fluid may be generated. Ordinary glasses are not acceptable unless a solid side shield is added.

Shoe covers, leg covers, boots, and head covers

These are appropriate attire whenever heavy exposure to blood/ body fluids is anticipated, e.g. surgery. Usually caps or hoods are already required for sterility. Shoe/leg and head covers should be removed or discarded before leaving the OR suite

Other barriers such as wound dressings reduce risk of exposure to blood/body fluids.

Proper and effective use of PPE and barriers:

Proper fit

Gloves: too small may tear; too large are clumsy

Mask: must fit snugly around mouth and nose, with metal band molded across bridge of nose, and straps or ties in place

Gowns: should cover skin and clothes

Integrity of barrier

Inspect gloves for tears or holes before use. Replace gloves as soon as practical if damaged during use. Masks should be replaced if damaged or wet.

Disposable vs. reusable barriers and PPE:

Disposable items should not be reused

Reusable items must be properly cleaned and reprocessed before reuse

Surgical masks are replaced after each use, and between patients. Particulate respirators are often used for longer periods of time, but should be replaced if damaged, soiled, or wet

All PPE, whether disposable or reusable, must be removed before leaving the work area, and hands must be washed.

Potential for cross-contamination if PPE is not changed between patients

Gloves, gowns, aprons, and surgical masks must be changed between patient contacts. Never wear the same gloves or other PPE from patient-to-patient

Hands must be washed before putting gloves on and after gloves are removed. Gloves do not completely prevent penetration of bacteria and viruses, and the moist environment inside a glove can promote growth of bacteria on the skin.

Under- and over-utilization of barriers and PPE

Under-utilization places health care workers and patients at unnecessary risk

Over-utilization of barriers wastes resources, may intimidate patients, and may interfere with patient care.

A chart with suggested PPE may be found here.

ELEMENT V

PRINCIPLES AND PRACTICES FOR CLEANING, DISINFECTION, AND STERILIZATION

I. Definitions:

Cleaning: The removal of all foreign material (e.g., soil, organic debris) from objects.

Contamination: The presence of microorganisms on inanimate objects (e.g. clothing, surgical instruments) or in substances (e.g. water, food, milk).

Decontamination: The process of removing disease-producing microorganisms and rendering the object safe for handling.

Disinfection: A process that results in the elimination of many or all pathogenic microorganisms on inanimate objects, with the exception of bacterial endospores.

High-level disinfection - kills bacteria, Mycobacteria (TB), fungi, viruses and some bacterial spores.

Intermediate-level disinfection - kills bacteria, Mycobacteria (TB), most fungi, and most viruses. Does not kill bacterial spores.

Low-level disinfection - kills most bacteria, some fungi, and some viruses. Will not kill bacterial spores and is less active against some gram-negative rods (e.g. Pseudomonas) and Mycobacteria.

Sterilization - A process that completely eliminates all forms of microbial life

II. Potential for Contamination

A. The composition/material of the device or equipment may be a factor in the level of contamination (i.e. upholstery).

External contamination occurs when devices such as BP cuffs, oximeters, and electronic thermometers are used from patient to patient

Internal contamination occurs when the inner lumen of a device has exposure to blood and body fluids. Examples: Vascular access devices (IV cannulas, etc.), contamination of devices at time of insertion, or subsequent contamination, may result in blood infection, site of entry infection, or remote infection.

Genito-urinary tract devices: contaminated urinary drainage systems or cystoscopes can cause nosocomial urinary tract infection and subsequent blood stream infection.

Respiratory tract devices: contaminated fluid nebulizers, ventilators, in-line temperature probes or bronchoscopes may cause nosocomial pneumonia and tuberculosis.

B. Identification of surfaces or equipment that require between patient cleaning is essential.

All items having contact with mucous membranes must be cleaned and disinfected between patient uses. Example: reusable thermometers

Items having contact with intact skin, such as blood pressure cuffs and stethoscopes, need periodic cleaning and decontamination

Any environmental surface, equipment, or device contaminated with blood or body fluids should be cleaned and disinfected immediately

Dedicated patient equipment such as infusion pumps is to be cleaned and disinfected between patients

Clean and dirty work areas should be separated to reduce cross-contamination of supplies.

Environmental cleaning must be performed on a regular basis to reduce microbial load on surfaces (e.g. commodes contaminated with feces may be a vehicle for spread of *C. difficile* between patients.)

Gloves must be removed and hands washed after touching contaminated surfaces or equipment (e.g. urinary collection devices, bedpans, dressings)

III. Factors contributing to contamination:

1. Inadequate cleaning

Examples: inadequately cleaned commodes contributing to transmission of *Clostridium difficile* colitis; inadequate clean-up of blood spills contributing to transmission of hepatitis B

2. Inadequate disinfection/sterilization processes

Example: inadequately sterilized instruments increasing post-operative wound infection rates

3. Contamination of disinfectant or rinse solution

Example: *Pseudomonas* contaminated disinfectant causing contamination of bronchoscopes; *C. difficile* or Hepatitis C contaminated endoscopes.

4. Reuse of disposable equipment. Example: reuse of disposable platforms on glucometers linked with transmission of Hepatitis B

5. Failure to reprocess or dispose of equipment between patients

Example: transmission of *S. aureus*, hepatitis B, vancomycin resistant enterococci and numerous other pathogens

IV. General Principles of Cleaning:

1. Soil protects microorganisms from contact with lethal agents (disinfectants, sterilants) and may directly inactivate these agents.
2. Physical cleaning eliminates large numbers of organisms associated with gross soil.
3. Sound cleaning practices, in addition to their aesthetic benefits, reduce the microbial load on environmental surfaces.
4. Manufacturer's recommendations for operation of cleaning equipment and use of cleaning supplies must be followed carefully.

V. Different Types of Disinfectants:

1. Alcohol (ethyl or isopropyl): Intermediate level disinfectant
2. Glutaraldehyde (2% and 4% solutions): high level disinfectant
3. Hypochlorites (e.g. chlorine bleach) at 1: 10 to 1: 100 dilutions: intermediate level disinfectant
4. Iodophors: Intermediate disinfectant. Note this is not the antiseptic formulation.
5. Phenolics; Intermediate disinfectant
6. Quaternary Ammonium Compound: low level disinfectant

VI. General Principles Regarding Use of any Chemical Disinfectant:

1. Read the label for activity and use instructions
2. All items must be thoroughly cleaned before disinfecting
3. Only surface in direct contact with the solution will be disinfected (instruments must be opened, disassembled and completely submerged for the required period of time)
4. Items should be dry before submerging to avoid diluting the solution to inactive levels

5. Disinfectants are designed for inanimate objects and are damaging to the skin. Gloves should always be worn to protect the hands. Protective eyewear maybe advisable to protect eyes from splashes. Generally, the more effective against microorganisms, the more toxic to humans.
6. Disinfectants should be used in well ventilated rooms
7. Keep records on employee training procedure manual and record/log books to document process.

VII. Disinfection/sterilization methods and agents

1. Choice of reprocessing method should be based on the:

Intended use of the equipment or device
Manufacturer's recommendations for reprocessing
Desired level of antimicrobial activity (high, intermediate low)

2. Health professionals who practice in settings where the responsibility for handling, cleaning and reprocessing equipment or devices is performed elsewhere (Central Sterile Processing) still need to be knowledgeable regarding basic concepts and principles of cleaning, disinfection, and sterilization described above.

Sterilization

Destroys: All forms of microbial life including high numbers of bacterial spores

Methods: Steam under pressure (autoclave), gas (ethylene oxide), dry heat, or immersion in EPA-approved chemical sterilant, for prolonged period of time. e.g., 6-10 hours or according to manufacturer's instructions

Note: liquid chemical sterilants should be used only on those instruments that are impossible to sterilize or disinfect with heat.

Use: For those instruments or devices that penetrate skin or contact normally sterile areas of the body, e.g. scalpels, needles, etc. Disposable invasive equipment eliminates the need to reprocess these types of items. When indicated, however, arrangements should be made with a health care facility for reprocessing of reusable invasive instruments.

High Level Disinfection:

Destroys: All forms of microbial life except high numbers of bacterial spores

Methods: Hot water pasteurization (80-100°C. 30 minutes) or exposure to an EPA-registered sterilant chemical as above, except for a short exposure time (10-15 minutes or as directed by the manufacturer).

Use: For reusable instruments or devices that come into contact with mucous membranes (e.g., laryngoscope blades, endotracheal tubes, etc.)

Intermediate Level Disinfection:

Destroys: Mycobacterium tuberculosis, vegetative bacteria, most viruses, and most fungi, but does not kill bacterial spores

Methods: EPA-registered "hospital disinfectant" chemical germicides that have a label claim for tuberculocidal activity; commercially available hard surface germicides or solutions containing at least 500 ppm (parts per million) free available chlorine (a 1:100 dilution of common household bleach - approximately 1/4 cup bleach per gallon of tap water)

Use: For those surfaces that come into contact only with intact skin, e.g., stethoscopes, blood pressure cuffs, splints, etc., and have been visibly contaminated with blood or blood body fluids. Surfaces must be precleaned of visible material before the germicidal chemical is applied for disinfection.

Low Level Disinfection:

Destroys: Most bacteria, some viruses, some fungi, but not mycobacterium tuberculosis or bacterial spores

Methods: EPA-registered "hospital disinfectants" (no label claim for tuberculocidal activity)

Use: These agents are excellent cleaners and can be used for routine housekeeping or removal of soiling in the absence of visible blood contamination.

Environmental Disinfection:

Environmental surfaces which have become soiled should be cleaned and disinfected using any cleaner or disinfectant agent which is intended for environmental use. Such surfaces include floors, woodwork, ambulance seats, counter tops, etc.

Important: To assure the effectiveness of any sterilization or disinfection process, equipment and instruments must first be thoroughly cleaned of all visible soil.

ELEMENT VI

PREVENTION AND CONTROL OF INFECTIOUS AND COMMUNICABLE DISEASES IN HEALTHCARE WORKERS

I. Goals of occupational health strategies for infection control

1. Prevent disease transmission from health care workers to patients and staff.

2. Protect susceptible health care workers from infectious or communicable diseases.

II. Strategies to assess health care workers for disease risks:

1. Pre-employment and periodic (annual) health assessments: review of overall health and immunization status, TB testing, administration of necessary vaccinations and assessments based on employee report of illness or exposure to communicable disease.
2. Immunization/screening programs are targeted at several diseases:

Tuberculosis (TB): at least annual tuberculin skin testing (PPD) is required; more often for high risk positions; annual symptom evaluation of known skin test positive individuals.

Hepatitis B (HBV): HBV vaccination is highly recommended; must be offered at no charge to all health care workers whose work involves risk of exposure to blood/body fluids

Rubeola (measles): documentation of immunity (2 doses of vaccine, positive antibody titer or history of illness documented by a physician) required of all health care workers born in 1957 or later

Rubella (German measles) documentation of immunity (1 dose of vaccine or positive antibody titer) required of all health care workers born in 1957 or later

Varicella (chickenpox): Vaccine is indicated for health care worker's who do not have either a reliable history of varicella or serologic evidence of immunity, particularly indicated for health care worker who have contact with persons at high risk for serious complications

Influenza: annual influenza vaccination highly recommended

3. Evaluation of acute or incubating illnesses in health care workers:

Health care workers exhibiting any of these symptoms should be promptly evaluated for fitness to work (i.e., risk of transmitting to patients, staff, visitors):

Fever, chills

Cough, sputum production

Exanthems (rash), vesicles

Skin lesions, weeping dermatitis

Draining wounds, sores

Diarrhea or vomiting

Post-exposure evaluation: susceptible health care workers who have been exposed to the following diseases should also be evaluated:

Tuberculosis

Varicella (chickenpox or herpes zoster, shingles)

Rubeola

Rubella

Pertussis (whooping cough)

Mumps

Example: If a health care worker is exposed to a personal family member or patient with active TB, the health care worker must be evaluated for symptoms of active TB and tested for TB infection (PPD skin test). If infection is present, a chest x-ray is performed and preventive treatment is begun.

Management of ill or exposed health care workers with acute or incubating communicable disease. Goal is to prevent potential transmission to susceptible patients and staff.

Limit contact with susceptibles, possibly through temporary job re-assignment

Furlough from work until health care worker is no longer infectious or risk of contracting infection (post-exposure) has passed

Treatment as needed.

NY State Department of Health requires that cases of certain communicable diseases be reported to county and state health departments so that screening and/or treatment can be provided to contacts, and for epidemiologic analysis. Physicians, infection control practitioners, laboratories, hospitals, nursing homes, school nurses, and day care directors are responsible for reporting these diseases. Call your county health department or Infection Control if you have questions.

III. Prevention and control of blood borne pathogen transmission

A. Risk of blood borne pathogens to health care workers:

Occupational exposure is defined as work-related contact to blood and other potentially infectious material via percutaneous exposure, mucous membrane exposure, or non-intact skin exposure. Potentially infectious material includes blood, semen, vaginal secretions, spinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, all fluids contaminated with blood, and any unknown fluid.

B. Risks of specific pathogens

HIV: the risk of acquiring HIV infection, following a needlestick contaminated with HIV-infected blood, is about 0.3% (approximately 1 in 300). Occupational infections have occurred via mucous membrane or non-intact skin exposures, but the risk from these exposures is much lower. If seroconversion occurs, an individual may be free from symptoms and opportunistic infection but HIV can be transmitted to others via

sexual contact, blood contact and perinatally to a new born.

Hepatitis B virus (HBV): exposure to HBV results in a 6-30% risk of HBV infection. After an asymptomatic incubation period of 2-6 months, 35% of infected persons develop clinical hepatitis with jaundice, and the other 65% have mild or no symptoms. 5 -10% of HBV infected persons become chronic carriers who never clear the infection and can transmit HBV to others indefinitely (via sex, blood contact, or perinatally). 25% of chronic carriers develop chronic hepatitis with associated risk of cirrhosis, liver cancer, and death.

Hepatitis C virus (HCV): exposure to HCV via needlestick results in a 3 - 6% risk of HCV infection. Some infections will cause clinical hepatitis after an average 45-day incubation period, while others remain asymptomatic. Chronic liver disease is very common following HCV infection. There is no vaccine against HCV.

Hepatitis B prevention through vaccination:

HBV vaccine is highly effective and safe
Vaccination consists of 3 injections in the arm over a 6 month period
Immunity develops in 80-95% of persons vaccinated
Side effects may include soreness, slight swelling, and redness at the injection site; malaise and mild fever are uncommon reactions
HBV vaccine is a recombinant product made from yeast (contains no live virus and no human serum or other human substances)
Vaccination is contraindicated in persons allergic to yeast or any component of the vaccine.

HBV vaccination is highly recommended and must be offered by employers at no charge to employees whose work involves risk of exposure to blood and body fluids. Consent is required, and persons refusing vaccination must sign a declination statement.

C. Post-exposure management:

Every step must be executed with complete confidentiality (patient and health care worker)

1. Health care workers must promptly report blood/body fluid exposures to infection control, occupational health, or a supervisor in accordance with the Exposure Control Plan at their hospital, clinic, or office practice.
2. Evaluation of the exposure includes documentation of:
Date, time, and location of exposure
Route of exposure and type of potentially infectious material
Detail of exposure incident, task being performed, etc.
Identification of the source person, if known.
3. The source person is informed of the health care worker exposure and the importance of HIV, hepatitis B and hepatitis C testing. HIV, HBV and HCV testing of the source is performed after appropriate consent is obtained; informed, written consent and counseling are required for HIV testing. The rapid HIV test may be available to screen source patients. Persons already known to be HIV, HBV and/or HCV infected need not be retested.
4. Medical evaluation, treatment and follow-up of the exposed health care worker includes

Review of HBV vaccination status

Baseline serologic testing for HBV, (if necessary) and HIV (after counseling and written consent)

When a source is found to be hepatitis C antibody positive, additional follow-up testing is recommended (such as LFTs and hepatitis C viral studies)

Counseling about the risk of infection resulting from the exposure, recommended post-exposure treatment and follow-up, and precautions to prevent possible HIV transmission to others

D. Post-exposure prophylaxis. Examples:

HBV exposure: HBV vaccination and HBV immune globulin (HBIG) are recommended for unvaccinated health care workers and known non-immune individuals. Previously vaccinated health care workers may require HBV vaccine booster.

HIV exposure: combination anti-retroviral prophylaxis should be recommended.

HCV exposure: No effective prophylaxis for HCV is available.

E. Post-exposure follow-up:

Report acute illness during 12 weeks after exposure, especially if characterized by fever, rash, muscle aches, malaise, or lymph node enlargement, which may signify recent HIV infection

Following a documented or suspected HIV exposure, repeat HIV testing of the health care worker is recommended, usually at time of exposure, 1 month and 6 months

A health care worker who has been exposed to hepatitis C should follow-up with serologic testing and be referred to a physician if positive

Post-exposure management when the source is a health care worker:

When a patient or health care worker sustains a blood/body fluid exposure and the source is a health care worker, the hospital/ clinic/practice has an ethical obligation to notify the exposed patient or health care worker.

The exposed patient or health care worker, and the source health care worker, are approached for counseling, consent, testing, treatment, and follow-up in the same manner as described above for a source patient and exposed health care worker.

IV. Health Care Workers infected with blood borne pathogens

NY State Department of Health policy on HIV testing of health care workers:

1. Mandatory HIV screening of health care workers is discouraged;
2. Voluntary HIV, HBV and HCV screening of health care workers at risk for infection is encouraged so they may benefit from medical intervention; all health care workers who have been potentially exposed to HIV, HBV or HCV through personal risk behavior, blood products or occupational accidents should be strongly advised to seek testing.
3. Health care workers are not required to inform patients or employers if they are HIV, HBV or HCV positive. Employers should be informed if infection results in impairment affecting job performance. A patient should be informed if that patient has sustained a significant exposure to the health care workers blood.

Evaluation of infected health care workers for risk of transmission

1. HIV, HBV or HCV infection alone does not justify limiting health care workers professional duties.
2. Limitations, if any, should be determined on a case-by-case basis considering the factors that influence transmission risk, including:

Nature and scope of professional practice

Techniques used in invasive procedures which may pose a risk to patients

Compliance with infection control standards

Presence of weeping dermatitis or skin lesions

Overall health status: physical and cognitive function.

Expert panel: each hospital or institution must establish an expert panel to confidentially evaluate cases of blood borne disease infected health care workers with respect to work-related issues. An expert panel of the NY State Department of Health can also perform this evaluation. A panel can recommend practice limitations, modifications or restrictions where the evidence suggests there is a significant risk to patients.

Any modification of work practice must seek to impose the least restrictive alternative in accordance with federal disability laws.

ELEMENT VII

ANTIBIOTIC RESISTANT ORGANISMS. HOW DID THEY HAPPEN? HOW IS IT PREVENTED?

I. How Did They Happen?

Antibiotics kill or inhibit the growth of susceptible bacteria. Sometimes some of the bacteria survives the antibiotic regimen because they have the ability to neutralize or evade the effect of the antibiotic. Those few bacteria can then multiply and replace all the bacteria that were killed off.

Thus, over-use and inappropriate use of antibiotics has led in the past few decades to the situation in recent years, that virtually all important bacterial infections in the United States and throughout the world are becoming resistant. Some examples are:

Methicillin-resistant Staphylococcus Aureus (MRSA)

Staph infections, including MRSA, occur most frequently among persons in hospitals and healthcare facilities who have compromised immune systems

Vancomycin-resistant Enterococci (VRE)

Enterococci are bacteria that are normally present in the human digestive tract Vancomycin is commonly used to treat infections caused by enterococci. Most VRE infections occur in hospitals

VISA / VRSA: Vancomycin-Intermediate/Resistant Staphylococcus aureus

While most staph bacteria are susceptible to vancomycin, but in recent years some have developed resistance. To date, all VISA and VRSA isolates have been susceptible to other Food and Drug Administration (FDA) approved drugs

II. How Are They Prevented?

While antibiotics should be used to treat bacterial infections, they are not effective against viral infections like the common cold, most sore throats, and the flu. Smart use of antibiotics is the key to controlling the spread of resistance.

Some recommendations for patients to help combat antibiotic resistance

[http://www.onlinernprograms.com/resources/nurses-guide-to-antibiotic-resistance/:](http://www.onlinernprograms.com/resources/nurses-guide-to-antibiotic-resistance/)

1. Talk with your health care provider about antibiotic resistance
2. Ask whether an antibiotic is likely to be beneficial for your illness
3. Ask what else you can do to feel better sooner
4. Do not take an antibiotic for a viral infection like a cold or the flu
5. Do not save some of your antibiotic for the next time you get sick
6. Take an antibiotic exactly as the doctor tells you
7. Do not take an antibiotic that is prescribed for someone else

The CDC has developed an A Public Health Action Plan to Combat Antimicrobial Resistance with a well defined approach to combat this increasingly dangerous public health problem. Following is the Executive Summary of the plan, reprinted with permission from the CDC.

Executive Summary

This Public Health Action Plan to Combat Antimicrobial Resistance (Action Plan) was developed by an interagency Task Force on Antimicrobial Resistance that was created in 1999. The Task Force is co-chaired by the Centers for Disease Control and Prevention, the Food and Drug Administration, and the National Institutes of Health and also includes the Agency for Healthcare Research and Quality, the Health Care Financing Administration, the Health Resources and Services Administration, the Department of Agriculture, the Department of Defense, the Department of Veterans Affairs, and the Environmental Protection Agency.

The Action Plan reflects a broad-based consensus of federal agencies on actions needed to address antimicrobial (a) resistance (AR). Input from state and local health agencies, universities, professional societies, pharmaceutical companies, health care delivery organizations, agricultural producers, consumer groups, and other members of the public was important in developing the plan. While some actions are already underway, complete implementation of this plan will require close collaboration with all of these partners (b), a major objective of the process. The plan will be implemented incrementally, dependent on the availability of resources.

The Action Plan provides a blueprint for specific, coordinated federal actions to address the emerging threat of antimicrobial resistance. This document is Part I of the Action Plan, focusing on domestic issues. Since AR transcends national borders and requires a global approach to its prevention and control, Part II of the plan, to be developed subsequently, will identify actions that more specifically address international issues. The Action Plan, Part I (Domestic Issues), includes four focus areas: Surveillance, Prevention and Control, Research, and Product Development. A summary of the top priority goals and action items in each focus area follows.

Surveillance

Unless AR problems are detected as they emerge — and actions are taken quickly to contain them — the world may soon be faced with previously treatable diseases that have again become untreatable, as in the

pre-antibiotic era.

Priority Goals and Action Items in this focus area address ways to:

Develop and implement a coordinated national plan for AR surveillance;

Ensure the availability of reliable drug susceptibility data for surveillance;

Monitor patterns of antimicrobial drug use; and

Monitor AR in agricultural settings to protect the public's health by ensuring a safe food supply as well as animal and plant health.

A coordinated national surveillance plan for monitoring AR in microorganisms that pose a threat to public health will be developed and implemented. The plan will specify activities to be conducted at national, state, and local levels; define the roles of participants; promote the use of standardized methods; and provide for timely dissemination of data to interested parties, e.g., public health officials, clinicians, and researchers. Needed core capacities at state and local levels will be defined and supported. When possible, the plan will coordinate, integrate, and build on existing disease surveillance infrastructure. All surveillance activities will be conducted with respect for patient and institutional confidentiality.

The availability of reliable drug susceptibility data is essential for AR surveillance. The accuracy of AR detection and reporting will be improved through training and proficiency testing programs for diagnostic laboratories and by promoting and further refining standardized methods for detecting drug resistance in important pathogens, including bacteria, parasites, fungi, and viruses. Public and private sector partners will address barriers to AR testing and reporting, e.g., barriers due to changes in health care delivery.

A plan to monitor patterns of antimicrobial drug use will be developed and implemented as an important component of the national AR surveillance plan. This information is essential to interpret trends and variations in rates of AR, improve our understanding of the relationship between drug use and resistance, identify and anticipate gaps in availability of existing drugs, and identify interventions to prevent and control AR.

Improved surveillance for AR in agricultural settings will allow early detection of resistance trends in pathogens that pose a risk to animal and plant health, as well as in bacteria that enter the food supply. Agricultural surveillance data will also help improve understanding of the relationship between antimicrobial drug and pesticide use and the emergence of drug resistance.

Prevention and Control

The prevention and control of drug-resistant infections requires measures to promote the appropriate use (c) of antimicrobial drugs and prevent the transmission of infections (whether drug-resistant or not). Priority Goals and Action Items in this focus area address ways to:

Extend the useful life of antimicrobial drugs through appropriate use policies that discourage overuse and misuse;

Improve diagnostic testing practices;

Prevent infection transmission through improved infection control methods and use of vaccines;

Prevent and control emerging AR problems in agriculture, human and veterinary medicine; and

Ensure that comprehensive programs to prevent and control AR involve a wide variety of nonfederal partners and the public so these programs become a part of routine practice nationwide.

Appropriate drug-use policies will be implemented through a public health education campaign on appropriate antimicrobial drug use as a national health priority. Other actions in support of appropriate drug use will include reducing inappropriate prescribing through development of clinical guidelines and computer-assisted decision support, considering regulatory changes, supporting other interventions promoting education and behavior change among clinicians, and informing consumers about the uses and limitations of antimicrobial drugs.

Improved diagnostic practices will be promoted by encouraging the use of rapid diagnostic methods to guide drug prescribing, facilitating direct consultation between clinicians and laboratory personnel with appropriate expertise and authority, and promoting the use of appropriate laboratory testing methods. Guidelines, training, and regulatory and reimbursement policies will be utilized to promote improved diagnostic practices.

Reduced rates of infection transmission will be addressed through public health campaigns that promote vaccination and hygienic practices such as hand washing, safe food handling, and other behaviors associated with prevention of infection transmission. Infection control in health care settings will be enhanced by developing new interventions based on rapid diagnosis, improved understanding of the factors that promote cross-infection, and modified medical devices or procedures that reduce the risk of infection.

The prevention and control of AR in agriculture and veterinary medicine requires 1) improved understanding of the risks and benefits of antimicrobial use and ways to prevent the emergence and spread of resistance; 2) development and implementation of principles for appropriate antimicrobial drug use in the production of food

animals and plants; 3) improved animal husbandry and food-production practices to reduce the spread of infection; and 4) a regulatory framework to address the need for antimicrobial drug use in agriculture and veterinary medicine while ensuring that such use does not pose a risk to human health.

Comprehensive, multifaceted programs involving a wide variety of nonfederal partners and the public are required to prevent and control AR. The AR Task Force agencies will ensure ongoing input from, review by, and collaboration with nonfederal partners. The appropriate agencies will support demonstration projects that use multiple interventions to prevent and control AR (e.g., through surveillance, appropriate drug use, optimized diagnostic testing, immunization practice, and infection control). The Task Force agencies will encourage the incorporation of effective programs into routine practice by implementing model programs in federal health care systems and promoting the inclusion of AR prevention and control activities as part of quality assurance and accreditation standards for health care delivery nationwide.

Research

Understanding the fundamental processes involved in antimicrobial resistance within microbes and the resulting impact on humans, animals, and the environment forms an important basis for influencing and changing these processes and outcomes. Basic and clinical research provides the fundamental knowledge necessary to develop appropriate responses to antimicrobial resistance emerging and spreading in hospitals, communities, farms, and the food supply. Priority Goals and Action Items in this focus area address ways to: Increase understanding of microbial physiology, ecology, genetics and mechanisms of resistance; Augment the existing research infrastructure to support a critical mass of researchers in AR and related fields; and Translate research findings into clinically useful products, such as novel approaches to detecting, preventing, and treating antimicrobial resistant infections.

Needs in the field of AR research will be identified and addressed through a government-wide program review with external input. Additional research is needed, for example, on the epidemiology of resistance genes; on mechanisms of AR emergence, acquisition, spread, and persistence; and on the effects of antibiotics used as agricultural growth promotants on microbes that live in animals, humans, plants, soil and water. Further study is also required to determine whether variations in drug use regimens may stimulate or reduce AR emergence and spread. Improved understanding of the causes of AR emergence will lead to the development of tools for reducing microbial resistance, as well as for predicting where AR problems are likely to arise.

A comprehensive research infrastructure will help ensure a critical mass of AR researchers who will interact, exchange information, and stimulate new discoveries. This aim will be achieved through the appropriate strategies and scientific conferences that promote research on AR. The AR Task Force agencies will work with the academic and industrial research communities to attract AR researchers, prioritize needs, identify key opportunities, and optimize the utilization of resources to address AR problems.

The translation of research findings into innovative clinical products to treat, prevent, or diagnose drug-resistant infections is an area in which the federal government can play an important role, focusing on gaps not filled by the pharmaceutical industry or by other nongovernment groups. Special efforts will be placed on the identification, development and testing of rapid, inexpensive, point-of-care diagnostic methods to facilitate appropriate use of antimicrobials. The AR Task Force agencies will also encourage basic research and clinical testing of diagnostic methods, novel treatment approaches, new vaccines, and other prevention approaches for resistant infections.

Product Development

As antimicrobial drugs lose their effectiveness, new products must be developed to prevent, rapidly diagnose, and treat infections. The Priority Goals and Action Items in this focus area address ways to: Ensure that researchers and drug manufacturers are informed of current and projected gaps in the arsenal of antimicrobial drugs, vaccines, and diagnostics and of potential markets for these products (designated here as "AR products"); Stimulate the development of priority AR products for which market incentives are inadequate, while fostering their appropriate use; and Optimize the development and use of veterinary drugs and related agricultural products that reduce the transfer of resistance to pathogens that can infect humans.

Current and projected gaps in the arsenal of AR products and potential markets for these products will be reported to researchers and drug manufacturers through an interagency working group convened to identify and publicize priority public health needs.

The development of urgently needed AR products will be stimulated throughout the process from drug discovery through licensing. The regulatory process for AR products will continue to be streamlined, and incentives that promote the production and appropriate use of priority AR products can be evaluated in pilot programs that monitor costs and assess the return on the public investment.

The production of veterinary AR products that reduce the risk of development and transfer of resistance to drugs used in human clinical medicine will be expedited through a streamlined regulatory and approval process. As with drugs for the treatment of human infections, pilot programs can be initiated to evaluate incentives that encourage the development and appropriate use of priority products that meet critical animal and plant health needs.

Private and public partners will also evaluate ways to improve or reduce the agricultural use of particular antimicrobial drugs, as well as ways to prevent infection, such as the use of veterinary vaccines, changes in animal husbandry, and the use of competitive exclusion products (i.e., treatments that affect the intestinal flora of food animals).

The CDC plan also calls for addressing the top priority items in the Action Plan:

Top Priorities

All 13 items have top priority, regardless of their order in the list)

1. Surveillance

With partners, design and implement a national AR surveillance plan that defines national, regional, state, and local surveillance activities and the roles of clinical, reference, public health, and veterinary laboratories. The plan should be consistent with local and national surveillance methodology and infrastructure that currently exist or are being developed.

(Action Item #2)

2. Develop and implement procedures for monitoring patterns of antimicrobial drug use in human medicine, agriculture, veterinary medicine, and consumer products.

(Action Item #5)

3. Prevention and Control

Conduct a public health education campaign to promote appropriate antimicrobial use as a national health priority.

(Action Item #25)

4. In collaboration with many partners, develop and facilitate the implementation of educational and behavioral interventions that will assist clinicians in appropriate antimicrobial prescribing.(Action Item #26)

5. Evaluate the effectiveness (including cost-effectiveness) of current and novel infection-control practices for health care and extended care settings and in the community. Promote adherence to practices proven to be effective.

(Action Item #39)

6. In consultation with stakeholders, refine and implement the proposed FDA framework for approving new antimicrobial drugs for use in food-animal production and, when appropriate, for re-evaluating currently approved veterinary antimicrobial drugs.

(Action Item #58)

7. Support demonstration projects to evaluate comprehensive strategies that use multiple interventions to promote appropriate drug use and reduce infection rates, in order to assess how interventions found effective in research studies can be applied routinely and most cost-effectively on a large scale.

(Action Item #63)

8. Research

Provide the research community genomics and other powerful technologies to identify targets in critical areas for the development of new rapid diagnostics methodologies, novel therapeutics, and interventions to prevent the emergence and spread of resistant pathogens.

(Action Item #70)

9. In consultation with academia and the private sector, identify and conduct human clinical studies addressing AR issues of public health significance that are unlikely to be studied in the private sector (e.g., novel therapies, new treatment regimens, and other products and practices).

(Action Item #75)

10. Identify, develop, test, and evaluate new rapid diagnostic methods for human and veterinary uses with partners, including academia and the private sector. Such methods should be accurate, affordable, and easily implemented in routine clinical settings (e.g., tests for resistance genes, point-of-care diagnostics for patients with respiratory infections and syndromes, and diagnostics for drug resistance in microbial pathogens, including in nonculture specimens).

(Action Item #76)

11. Encourage basic and clinical research in support of the development and appropriate use of vaccines in human and veterinary medicine in partnership with academia and the private sector.

(Action Item #77)

12. Product Development

Create an Interagency AR Product Development Working Group to identify and publicize priority public health needs in human and animal medicine for new AR products (e.g., innovative drugs, targeted spectrum antibiotics, point-of-care diagnostics, vaccines and other biologics, anti-infective medical devices, and disinfectants).

(Action Item #79)

13. Identify ways (e.g., financial and/or other incentives or investments) to promote the development and/or appropriate use of priority AR products, such as novel compounds and approaches, for human and veterinary medicine for which market incentives are inadequate.

(Action Item #80)

All material on this site is Copyright © 2005 - 2012 Laboratory Consultation Services, Inc. except as noted.

Sample Course Material

You can review the course material without logging in, but in order to complete the course you will need to register and login to this site. Go to the **Online Course** Section.

Frequently Asked Questions

Need Help? Check out our **FAQ** section to get you started.

INFECTION CONTROL

for the

CALIFORNIA DENTAL PROFESSIONAL

The following Infection Control course is designed to allow the Dental professional to master the information herein in a calm, relaxed atmosphere, proceeding at a comfortable pace. The coursework need not be completed in one sitting, but can be broken up and studied at your convenience. At the end of the course material there is a short quiz designed primarily as a self-assessment.

Incorrect answers on any of the questions should indicate the need to review the pertinent information in the text. Completion of this course qualifies the Dental professional for Continuing Education (CE) credits. The number of credits is dependent on the number of hours devoted to the study of this material.

Each Dental professional is responsible for applying appropriate infection control principles based upon his/her individual specialty and practice.

In order to receive credit for the course and CE credits, the Dental professional must register for the course by completing the demographic information where indicated. All demographic information is stored in secure format to ensure confidentiality. No information will be disclosed to any entity other than the California State Dental Board except with the written consent of the licensee.

The information contained in this course reflects currently accepted scientific practice in Infection Control. This course is reviewed periodically and updated as needed. Laboratory Consultation Services, Inc. encourages and appreciates customer comments, input and suggestions so that this course will be effective, interesting and above all, be instrumental in minimizing or eliminating the risk of infection transmission.

The material in this course is based on the Infection Control Regulations of the Dental Board of California, California Code of Regulations, Title 16, Section 1005.

“A copy of this regulation shall be conspicuously posted in each dental office.”

A copy of the regulations may be obtained [here](#)

INTRODUCTION

“In the United States, an estimated 9 million persons work in health-care professions, including approximately 168,000 dentists, 112,000 registered dental hygienists, 218,000 dental assistants, and 53,000 dental laboratory technicians” (Guidelines for Infection Control in Dental Health-Care Settings—2003, Center for Disease Control and Prevention). Most, if not all, of these dental health-care professionals will be occupationally exposed to bloodborne pathogens.

The purpose of this course is to heighten the awareness of dental professionals who might be exposed to infectious materials, including blood, saliva, other body substances, contaminated equipment, environmental surfaces, water, or air in order to minimize their risk of exposure.

Dental professionals include dentists (all specialties), dental hygienists, dental assistants, dental laboratory technicians, students and trainees, and other persons whether directly or indirectly involved in patient care, but potentially exposed to infectious materials (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

Maintaining good infection control practices will prevent or minimize the potential spread of disease transmission from patient to dental professional, from dental professional to patient, and from patient to patient. These recommended infection-control practices are applicable to all settings in which dental treatment is provided.

Licensees shall comply with infection control precautions mandated by the California Division of Occupational Safety and Health (Cal-DOSH).

Licensees are required to complete a minimum of 50 hours of continuing education every dental period of 2 years, including 2 hours of Infection Control, 2 hours of California Dental Law and Basic Life Support.

All licensees shall comply with and enforce the following minimum precautions to minimize the transmission of pathogens in health care settings.

California law requires dental professionals to adhere to scientifically accepted principles of infection control procedures. Failure to comply can result in charges of professional misconduct.

Definitions

The following terms will be defined in the body of the text:

Standard precautions / Universal Precautions

Critical instruments

Semi-critical instruments

Non-critical instruments and devices

Low-level disinfection

Intermediate-level disinfection

High-level disinfection

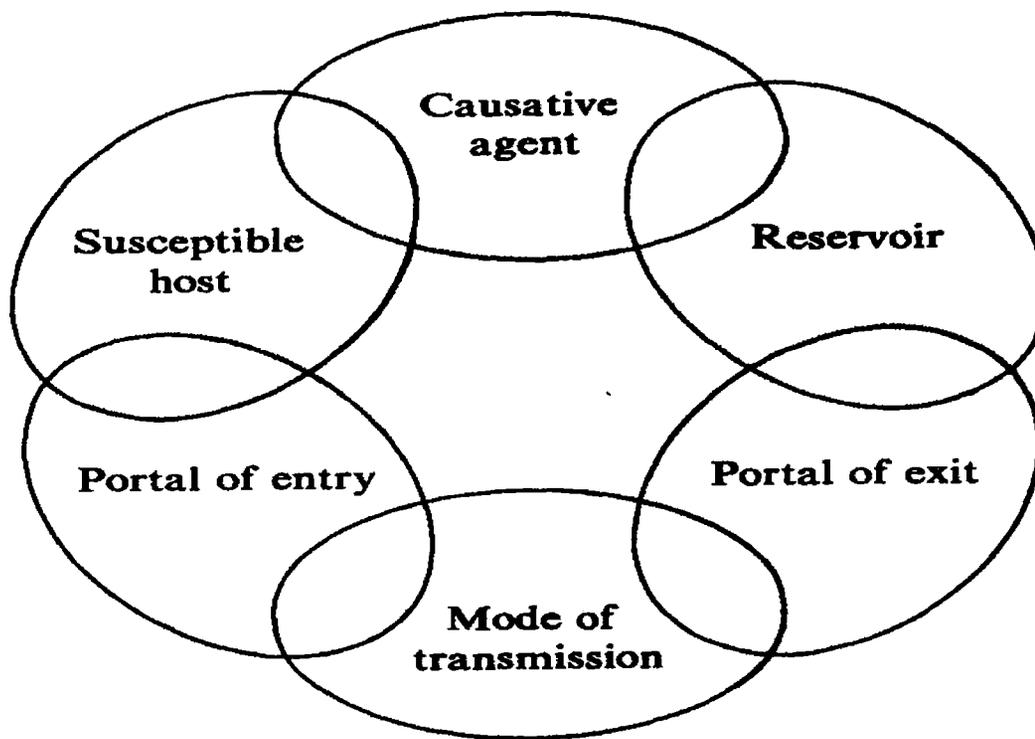
Sterilization

Personal Protective Equipment

Other Potentially Infectious Materials (OPIM)

The Chain of Infection

In order to understand the principles of infection control it is important to understand the 6 components of the infectious disease process (chain of infection), as illustrated in the chain of infection:



Chain of Infection

Causative Agent – This is the organism (pathogen) that is responsible for causing the disease. These can include:

- **Bacteria** (e.g. Staphylococcus, Streptococcus, Mycobacteria)
- **Viruses** (e.g. Hepatitis B, Hepatitis C, Herpes Types I & II, Cytomegalovirus, HIV),
- **Fungi** (including yeast and molds)
- **Parasites** (e.g. Protozoa, helminthes)

These organisms can colonize or infect the oral cavity or respiratory tract and be transmitted in the dental setting through

1. direct contact with blood, saliva or other body fluids;
2. indirect contact with contaminated objects (e.g., instruments, equipment, or environmental surfaces);
3. contact of conjunctival, nasal, or oral mucosa with droplets (e.g., spatter) containing microorganisms generated from an infected person and propelled a short distance (e.g., by coughing, sneezing, or talking) or
4. inhalation of airborne microorganisms that can remain suspended in the air for long periods.

Reservoir – These are the places where the pathogens survive and are capable of transmitting their infection. The three common reservoirs are:

- **Humans** – may present as acutely ill or asymptomatic. May also be incubatory carriers during the prodromal period (e.g. chickenpox, rubella), convalescent carriers (e.g. Salmonella), chronic carriers (e.g. Hepatitis B) or intermittent carriers (e.g. Staphylococcus aureus).
- **Environmental** – countertops, instruments, equipment and other environmental surfaces.
- **Animals or Insects**

Portal of Exit – The path by which an infectious agent leaves the reservoir. The portals of exit associated with humans and animals are:

- Respiratory tract including oral cavity
- Gastrointestinal tract
- Genitourinary tract
- Skin / Mucous membranes
- Blood and other body fluids
- Bites and stings

Mode of Transmission - The mechanism by which the infectious agent is transferred from the reservoir to a susceptible host. The major modes of transmission are:

- **Direct Contact** – person-to-person contact, physical contact with source of pathogen
- **Indirect Contact** – contact with contaminated intermediate object (e.g. contaminated instruments or handpiece)
- **Droplet Infection** – Airborne pathogens spread through the air by coughing, sneezing and talking. Some pathogens can be suspended in the air for prolonged periods, while others may be spread by the ventilation system (Legionella).

- **Common Vehicle** – contaminated food which can infect many people (e.g. Salmonella, Hepatitis A).

Portal of Entry – The path by which the pathogen enters a susceptible host. These paths include:

- Respiratory tract including oral cavity
- Gastrointestinal tract
- Genitourinary tract
- Skin / Mucous membranes
- Percutaneous (needlesticks, cuts or punctures with sharp, contaminated objects)
- Bites and stings

Susceptible Host – A person that may not have sufficient resistance to an infectious agent. There are many factors that influence the susceptibility of a person to diseases. The following are the major factors:

- **Age** – many diseases are seen mostly in early childhood.
- **Sex** – reproductive diseases are sex-specific
- **Ethnicity**- genetic diseases seen in specific ethnic groups
- **Socioeconomic status** – ability to afford good healthcare, nutrition, etc.
- **Medical History** – e.g. diabetics are more prone to infection, immunodeficient people are at risk of infections.
- **Occupation** – some occupations have increased risk of exposure to pathogens.
- **Immunization status** – some diseases are preventable after exposure.
- **Trauma / Burns** – increases the risk of getting and fighting infections
- **Medications / Chemotherapy** – suppresses the body's immune system and increases the risk of infection.

It is the responsibility of the Dental professional to break this Chain of Infection in order to prevent the further spread of the causative agent, thereby maintaining INFECTION CONTROL.

Strategies for Eliminating or Minimizing Exposure to Infectious Agents

Effective 1992, the Occupational Safety and Health Administration (OSHA) of the Federal government and Cal OSHA established the Bloodborne Pathogen standards for the healthcare profession.

These standards require that each Dental office prepare a written Infection Control program to protect personnel from exposure to infectious material in the workplace. This program is to include at least the following elements:

- **Exposure Control Plan** – a written plan including policies and procedures in use in the dental office. This plan must include written protocols for instrument processing, operatory cleanliness and injury management.

The Exposure Control Plan must be made available to all employees. The Exposure Control plan should include Bloodborne Pathogen safety, Chemical Hazards safety, Fire and Evacuation safety, post exposure treatment and record keeping.

- **Engineering controls** - to minimize or eliminate the risk of exposure to potentially infectious material.

These include selection and use of barriers and/or personal protective clothing and equipment to protect the employee and patient from contact with potentially infectious body fluid, selection and use of safety devices such as safety needles, needleless syringes, ventilation systems, ultraviolet light, scavenging devices, backflow prevention valves, sharps containers, needle recapping devices, etc.

Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal.

Disposable needles, syringes, scalpel blades or other sharp items and instruments shall be placed into properly labeled sharps containers for disposal according to all applicable regulations.

- **Work Practice Controls** - where technology based engineering controls are not available, dental professionals should modify their behavior to incorporate safety concerns.

For example: recapping used needles using a one-hand method, not passing syringes with unsheathed needles to others, use of forceps to handle contaminated instruments for cleaning and sterilization.

In addition, all dental personnel must adhere to the principles of "Standard Precautions," a set of combined precautions that include the major components of Universal Precautions (designed to reduce the risk of transmission of blood borne pathogens) and body substance isolation (designed to reduce the risk of transmission of pathogens from moist body substances).

Similar to Universal Precautions, Standard Precautions are used for care of all patients regardless of their diagnoses or personal infectious status.

According to the Standard Precautions concept, **ALL** human blood, saliva (in dental procedures) and other potentially infectious material (OPIM) are to be treated as capable of transmitting HBV, HCV and HIV.

Included in OPIM are body fluids visibly contaminated with blood, all body fluids where it is difficult or impossible to differentiate from blood, HIV-containing cell or tissue cultures, organ culture and blood, or other tissues from experimental animals, as well as unfixed tissues and organs (other than intact skin) from a human being (living or dead).

Universal and Standard Precautions are to be implemented in the dental facility at all times for all patients in order to reduce the risk of exposure to infectious material.

■ **IMMUNIZATION**

Hepatitis B vaccination – The employer is responsible to offer the employee that may be exposed to blood and other potentially infectious body fluid the hepatitis B vaccine at no charge (to the employee).

The employee may accept the vaccination series, be exempt from the vaccine if it can be demonstrated that the employee has antibodies to Hepatitis B or decline the offer to be vaccinated. Employee who decline the vaccination may change their minds at any time and get the vaccination at no charge.

Dental Professionals' exposure to patients also place them at risk for acquiring other diseases that are preventable through vaccination. These include:

- Measles
- Mumps
- Rubella
- Varicella (Chicken pox)
- Some forms of pneumonia
- Influenza

Dental practices should consider establishing policies for staff immunization for these diseases as well.

- **Provide hand washing facilities** – Numerous studies have shown that frequent hand washing reduces the risk of transmission of pathogenic organisms.

Alcohol-based 'waterless' hand sanitizers are available for temporary use such as when hands are not visibly soiled or contaminated but should not replace careful hand washing.

Hands should be washed thoroughly (each surface, between fingers and around nails) with soap for 10 seconds per surface. Hands should be washed after going to the bathroom, after blowing your nose or coughing or sneezing, after removal of gloves, between patients, before eating, inserting contact lenses or applying makeup.

Health care workers who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition is resolved.

- **Post Exposure** - Specifies procedures to be made available to all employees who have had an exposure incident plus any laboratory tests to be conducted by an accredited laboratory at no cost to the employee.

Follow-up must include a confidential medical evaluation documenting the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood if he/she consents, post-exposure prophylaxis, counseling and evaluation of reported illnesses.

Healthcare professionals must be provided specific information to facilitate the evaluation. They should also be provided a written medical opinion on the need for hepatitis B vaccination following the exposure.

Information such as the employee's ability to receive the hepatitis B vaccine must be supplied to the employer. All employee medical information must remain confidential.

- **Training** - Mandates training of exposed employees, initially upon assignment and annually.

Employees who have received appropriate training within the past year need only receive additional training in items not previously covered.

Training must include making accessible a copy of the regulatory text of the standard and explanation of its contents, general discussion on bloodborne diseases and their transmission, exposure control plan, engineering and work

practice controls, personal protective equipment, hepatitis B vaccine, response to emergencies involving blood, how to handle exposure incidents, the post-exposure evaluation and follow-up program, signs/labels/color-coding.

There must be opportunity for questions and answers, and the trainer must be knowledgeable in the subject matter.

Personal Protective Clothing And Equipment

Standard and/or Universal precautions, work practice controls, and engineering controls are the primary methods for maintaining infection control in health care facilities. These practices can be enhanced through the use of personal protective clothing and equipment (PPCE).

Where there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices.

Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

The employer is required to provide PPCE in appropriate sizes and accessible locations. In addition, hypoallergenic gloves, glove liners, powder-free gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

Glove used by healthcare workers are to be labeled "Examination" gloves and must be worn whenever there is a potential for contact with mucous membranes, blood or OPIM. Studies have shown that gloves provide a barrier, but that neither vinyl nor latex gloves are completely impermeable.

Thus, handwashing after glove removal is required. Gloves must be discarded upon completion of treatment and before leaving laboratories or areas of patient care activities. Healthcare workers shall perform hand hygiene procedures after removing and discarding gloves. Gloves shall not be washed before or after use.

Health care workers shall wear surgical face masks in combination with either chin length plastic face shields or protective eyewear when treating patients whenever there is potential for splashing or spattering of blood or OPIM.

After each patient, and during patient treatment if applicable, masks shall be changed if moist or contaminated. After each patient, face shields and protective eyewear shall be cleaned and disinfected, if contaminated.

Health care workers shall wear reusable or disposable protective attire when their clothing or skin is likely to be soiled with blood or OPIM. Gowns must be changed daily or between patients if it should become moist or visibly soiled.

Protective attire must be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal-DOSH Bloodborne Pathogens Standards.

While many employees have traditionally provided and laundered their own uniforms or laboratory coats, if the item's intended function is to act as PPCE, it is the employer's responsibility to provide, clean, repair, replace, and/or dispose of it at no cost to the employee.

Home laundering is not permitted since the employer cannot guarantee that proper handling or laundering procedures are being followed; it could also lead to the transmission of contaminants to the home.

If the employee wishes to choose, wear, and maintain his/her own uniform or laboratory coat, then he/she would need to don additional employer-handled and employer-controlled PPCE when performing tasks where it is reasonable to anticipate exposure to blood or OPIM.

Instrument Cleaning, Disinfecting And Sterilization

Three types of instruments and devices are in use in the dental office:

- **Critical instruments** - surgical and other instruments used to penetrate soft tissue or bone.
- **Semi-critical instruments** - surgical and other instruments that are not used to penetrate soft tissue or bone, but contact oral tissue.
- **Non-critical instruments and devices** - instruments and devices that contact intact skin.

Due to the different levels of contamination and criticality of use, these undergo different processes before they can be used for patients, as follows:

STERILIZATION

Destroys: All forms of microbial life including high numbers of bacterial spores.

Methods: Steam under pressure (autoclave), gas (ethylene oxide), dry heat, or immersion in EPA-approved chemical sterilant, for prolonged period of time, e.g. 6-10 hours or according to manufacturers' instructions.

Note: Liquid chemical sterilants should be used only on those instruments that are impossible to sterilize or disinfect with heat.

Use: Heat stable critical and semi-critical instruments shall be cleaned and sterilized before use by using steam under pressure (autoclaving), dry heat, or chemical vapor. FDA cleared chemical sterilants/disinfectants shall be used for sterilization of heat-sensitive critical items and for high-level disinfection of heat-sensitive semi-critical items.

Critical and semi-critical instruments or containers of critical and semi-critical instruments sterilized by a heat or vapor method shall be packaged or wrapped before sterilization if they are not to be used immediately after being sterilized.

These packages or containers shall remain sealed unless the instruments within them are placed onto a setup tray and covered with a moisture impervious barrier on the day the instruments will be used and shall be stored in a manner so as to prevent contamination.

All high-speed dental hand pieces, low-speed hand piece components used intraorally, and other dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be heat sterilized between patients.

Single use disposable instruments (e.g. prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips) shall be used for one patient only and discarded.

Proper functioning of the sterilization cycle shall be verified at least weekly through the use of a biological indicator (such as a spore test). Test results must be maintained for 12 months. **NOTE: Appearance of temperature indicator strip on the sterilization pouch DOES NOT indicate sterility.**

Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone. Sterile coolants/irrigants must be delivered using a sterile delivery system.

HIGH LEVEL DISINFECTION:

Destroys: Some, but not necessarily all bacterial spores. This process kills *Mycobacterium tuberculosis var bovis*, bacteria, fungi, and viruses.

Methods: Hot water pasteurization (80-100°C for 30 minutes) or exposure to a Cal-EPA registered chemical as above, except for a short exposure time (10-15 minutes or as directed by the manufacturer).

Use: For reusable instruments or devices that come into contact with soft tissue or intact skin.

INTERMEDIATE LEVEL DISINFECTION:

Destroys: *Mycobacterium tuberculosis*, vegetative bacteria, most viruses, and most fungi, but does not kill bacterial spores.

Methods: EPA-registered "hospital disinfectant" chemical germicides that have a label claim for tuberculocidal activity; commercially available hard surface germicides or solutions containing at least 500 ppm (parts per million) free available chlorine (a 1:100 dilution of common household bleach - approximately 1/4 cup bleach per gallon of tap water).

Use: For those surfaces that come into contact only with intact skin. Surfaces must be pre-cleaned of visible material before the germicidal chemical is applied for disinfection.

LOW LEVEL DISINFECTION:

Destroys: Most bacteria, some viruses, some fungi, but not *Mycobacterium tuberculosis* or bacterial spores.

Methods: EPA-registered 'hospital disinfectants (no label claim for tuberculocidal activity).

Use: These agents are excellent cleaners and can be used for routine housekeeping or removal of soiling in the absence of visible blood contamination.

Environmental Disinfection

Environmental surfaces which have become soiled should be cleaned and disinfected using any cleaner or disinfectant agent which is intended for environmental use. Such surfaces include floors, walls, sinks, examination chairs, light handles, counter tops, etc.

If items or surfaces likely to be contaminated are difficult to clean and disinfect they shall be protected with disposable impervious barriers.

Important: To assure the effectiveness of any sterilization or disinfection process, equipment and instruments must first be thoroughly cleaned of all visible dirt and grime.

Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a Cal-EPA registered, hospital grade low- to intermediate-level disinfectant after each patient.

The low level disinfectants used shall be labeled effective against HBV and HIV. Use disinfectants in accordance with the manufacturer's instructions. All germicides must be used in accordance with intended use and label instructions.

Hazardous Waste

Hazardous waste in the dental office can include biohazard and chemical hazard. Proper handling and disposing of both biohazard and chemical waste is essential in preventing exposure incidents.

Biohazard waste can be soft waste where there is visible contamination with blood or OPIM that can be expressed from the soft matrix. This includes items such as gauze pads, cotton rolls, protective bibs, gowns, etc.

The disposable soft biohazard waste shall be stored in closed, leak-proof containers with the BIOHAZARD symbol prominently displayed in bright red or orange, labeled "BIOHAZARD".

Hazardous chemical disposal should be done in accordance with local and state regulations.

All hazards, biological and chemical must be prominently labeled indicating their respective hazards.

Liquid Waste

Liquid waste such as saliva and blood from dental procedures can be suctioned and / or washed into a sanitary sewer system.

Dental unit water lines shall be anti-retractable. At the beginning of each workday, dental unit lines shall be purged with air, or flushed with water for at least two (2) minutes prior to attaching handpieces, scalers and other devices.

The dental unit line shall be flushed between each patient for a minimum of twenty (20) seconds.

Dental unit water lines should be equipped with valves that prevent backflow of potential contaminants into the municipal water system.

Contaminated Solid Waste

Contaminated Solid Waste shall be disposed of according to applicable local, state, and federal environmental standards in properly labeled / color coded, leak proof containers.

Sharps

Sharps are defined as any instrument (e.g. needles, probes, glass ampule, orthodontic wires, etc.) that can penetrate a plastic bag. Sharps are to be placed in properly labeled sharps containers that are puncture resistant.

The sharps container should never be overfilled and should be placed in the office for easy access near the point of use. Carrying contaminated sharps, unprotected, throughout the dental office can be a source of accidental exposure and should be avoided.

Needles should NEVER be bent or broken. Recapping needles, where necessary, should be done with a recapping device or a one-hand scoop method.

Lab Areas

Splash shields and equipment guards must be used on dental laboratory lathes. Fresh pumice and a disinfected, sterilized, or new ragwheel shall be used for each patient.

Devices used to polish, trim or adjust contaminated intraoral devices must be disinfected or sterilized.

Intraoral items such as impressions, bite registrations, prosthetic and orthodontic appliances must be cleaned and disinfected with an intermediate-level disinfectant before manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

California Dental Practice Act: Auxiliaries

Article Index

- California Dental Practice Act: Auxiliaries
- Section I, Dental Auxiliaries
- Section II, Dental Auxiliaries
- Section III, Dental Auxiliaries
- Section IV, Dental Auxiliaries
- All Pages

Dental Auxiliaries

In order to meet the dental care needs of the state's citizens, the State legislature has taken action to provide several different classes of dental auxiliaries. These classes are intended to form a career ladder, permitting the advancement of persons to higher levels of licensure with additional training. The Dental Board of California in its Committee on Dental Auxiliaries governs these classes. The committee

1. Evaluates all dental auxiliary programs applying for board approval.
2. Evaluates complaints that might cause revocation of approval of a program or course.
3. Evaluates all applications for licensure in the various dental auxiliary categories to ascertain whether a candidate meets the appropriate licensing requirements specified by the board's regulations.
4. Advises the board as to the type of license examination it deems appropriate for the various dental auxiliary license categories. The committee also develops examinations in accordance with the board's instructions and periodically reports to the board on the progress of those examinations.
5. Advises the board as to appropriate standards of conduct for auxiliaries and any other enforcement-related matters that the board may delegate to the committee.

The board shall retain authority with respect to the enforcement of regulations, including complaint resolution, investigation, and disciplinary action against auxiliaries.

The committee shall consist of the following nine members:

- (a) One member who is a public member of the board.
- (b) One member who is a licensed dentist and who has been appointed by the board as an examiner.
- (c) One member who is a licensed dentist who is neither a board member nor appointed by the board as an examiner.
- (d) Three members who are licensed as registered dental hygienists, at least one of whom is actively employed in a private dental office.
- (e) Three members who are licensed as registered dental assistants; and, if available, an individual licensed as a registered dental hygienist in extended functions shall be appointed in place of one of the members licensed as a registered dental hygienist.
- (f) The public member of the board shall not have been licensed within five years of the appointment date and shall not have any financial interest in a dental-related business.

Definitions and Scope of Practice

Some definitions for purpose of this course:

- (a) "Board" means The Dental Board of California.
- (b) "Committee" means Committee on Dental Auxiliaries.
- (c) "Direct supervision" means supervision of dental procedures based on instructions given by a licensed dentist, who must be physically present in the treatment facility during the performance of those procedures.
- (d) "General supervision" means supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures.
- (e) "Dental auxiliary" means a person who may perform dental assisting or dental hygiene procedures.

A dental assistant is a person who may perform "basic supportive dental procedures" under the supervision of a licensed dentist or under the supervision of a registered dental hygienist in alternative practice.

"Basic supportive dental procedures" are those procedures that have technically elementary characteristics, are completely reversible, and are unlikely to cause hazardous conditions for the patient being treated. These basic supportive dental procedures may be performed under general supervision.

The supervising licensed dentist shall be responsible for determining the competency of the dental assistant to perform the basic supportive dental procedures.

The supervising licensed dentist shall be responsible for assuring that each dental assistant, registered orthodontic assistant, registered surgery assistant, registered restorative assistant, registered restorative assistant in extended functions, registered dental assistant, and registered dental assistant in extended functions, who is in his or her continuous employ for 120 days or more, has completed both of the following within a year of the date of employment:

- (1) Board-approved courses in Infection control and California dental law which may be found at www.nyscourses.com.
- (2) A course in basic life support offered by the American Red Cross, the American Heart Association, or any other course approved by the board as equivalent.

The practice of dental assisting does not include any of the following procedures:

- (1) Diagnosis and comprehensive treatment planning.
- (2) Placing, finishing, or removing permanent restorations.
- (3) Surgery or cutting on hard and soft tissue including the removal of teeth and the cutting and suturing of soft tissue.
- (4) Prescribing medication.
- (5) Starting or adjusting local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other.

Registration for orthodontic assistant, surgery assistant, and restorative assistant

The board shall license as a "registered orthodontic assistant," "registered surgery assistant," or "registered restorative assistant" any person who does either of the following:

- (1) Submits written evidence of satisfactory completion of a course or courses approved by the board that qualifies him or her in one of these specialty areas of practice and obtains a passing score on both of the following:
 - (A) A written examination approved by the board and administered by the Committee on Dental Auxiliaries.
 - (B) A practical examination for the specialty category for which the person is seeking licensure that is approved by the board and administered by the Committee on Dental Auxiliaries.
- (2) Completes a work experience pathway to licensure.

The board shall adopt regulations for the approval and recognition of courses that teach basic dental science. The regulations shall define the minimum education and training requirements necessary to achieve proficiency in the procedures authorized for each specialty registration, taking into account the combinations of classroom and practical instruction, clinical training, and supervised work experience that are most likely to provide the greatest number of opportunities for improving dental assisting skills efficiently.

The board may approve specialty registration courses and the board shall recognize the completion of these approved courses. The board may approve a course for the specialty registration that does not include instruction in coronal polishing. A person who holds a specialty registration shall be subject to the continuing education requirements established by the Board.

A registered orthodontic assistant may perform all of the following dental procedures:

- (1) Any duties that a dental assistant may perform.
- (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth.
- (3) Placing metal orthodontic separators.
- (4) Placing ligatures and arch wires.
- (5) Taking orthodontic impressions.
- (6) Sizing, fitting, cementing, and removal of orthodontic bands.
- (7) Selecting, repositioning, curing in a position approved by the supervising dentist, and removal of orthodontic brackets.
- (8) Coronal polishing.
- (9) Preparing teeth for bonding.
- (10) Applying bleaching agents and activating bleaching agents with non laser, light-curing devices.
- (11) Removal of excess cement from coronal surfaces of teeth under orthodontic treatment by means of a hand instrument or an ultra sonic scaler.
- (12) Taking face bow transfers and bite registrations for diagnostic models for case study only.

A registered surgery assistant may perform the following dental procedures:

- (1) Any duties that a dental assistant may perform.
- (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth.
- (3) Monitoring of patients during the preoperative, intraoperative, and postoperative phases.
 - (A) Patient monitoring includes the following:
 - (i) Selection and validation of monitoring sensors, selecting menus and default settings and analysis for electrocardiogram, pulse oximeter and capnograph, continuous blood pressure, pulse, and respiration rates.
 - (ii) Interpretation of data from noninvasive patient monitors including readings from continuous blood pressure and information from the monitor display for electrocardiogram waveform, carbon dioxide and end tidal carbon dioxide concentration, respiratory cycle data, continuous noninvasive blood pressure data, and pulse arterial oxygen saturation measurements, for the purpose of evaluating the condition of the patient during preoperative, intraoperative, and postoperative treatment.
 - (B) Patient monitoring does not include the following:
 - (i) Reading and transmitting information from the monitor display during the intraoperative phase of surgery for electrocardiogram wave form, carbon dioxide and end tidal carbon dioxide concentrations, respiratory cycle data, continuous noninvasive blood pressure data, or pulse arterial oxygen saturation measurements, for the purpose of interpretation and evaluation by a licensed dentist who shall be at chair side during this procedure.
 - (ii) Placing of sensors.
- (4) Taking impressions for surgical splints and occlusal guards.
- (5) Placement of surgical dressings.
- (6) Adding drugs, medications, and fluids to intravenous lines using a syringe, provided that a licensed dentist is present at the patient's chair side.
- (7) Removal of intravenous lines.

(8) Coronal polishing provided that evidence of satisfactory completion of a board-approved course in this function has been submitted to the board prior to the performance thereof.

A registered restorative assistant may perform all of the following dental procedures:

- (1) Any duties that a dental assistant may perform.
- (2) Mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, existing restorations, and missing teeth.
- (3) Sizing, fitting, adjusting, intraorally fabricating, temporarily cementing, and removing temporary crowns and other temporary restorations.
- (4) Placing bases and liners on sound dentin.
- (5) Removing excess cement from supragingival surfaces of teeth with a hand instrument or an ultrasonic scaler.
- (6) Taking face bow transfers and bite registrations for diagnostic models for case study only.
- (7) Taking impressions for space-maintaining appliances and occlusal guards.
- (8) Coronal polishing.
- (9) Applying pit and fissure sealants.
- (10) Applying bleaching agents and activating bleaching agents with nonlaser, light-curing devices.
- (11) Placement of surgical dressings.

The supervising dentist shall be responsible for determining the level of supervision required for registered assistants.

Work experience pathway to licensure training

A dentist who holds an active, current, and unrestricted license to practice dentistry may train and educate his or her employees, or employees of the dental office, primary care clinic, or hospital where the dentist is practicing and directly supervises the employees, without charge or cost to the employees, in all of the allowable duties for the purpose of licensure in one of the specialty licensure. A dentist may not begin the work experience training and education of an employee until his or her application for that particular employee is approved by the Committee on Dental Auxiliaries.

In order to train or educate, the dentist shall be subject to the following terms and conditions, which are applicable prior to commencing training for each employee:

- (A) On a completed and signed application form approved by the committee, the dentist shall provide the specialty dental assistant category in which the dentist will be training the employee and the name of the employee. When the committee provides a requested application to an employer, the committee shall also provide a copy of the regulations governing the education and training of the specialty assistants or provide access to the regulations on the committee's web site.
- (B) The education and training the dentist provides shall be in compliance with the regulations adopted by the board. The dentist shall not allow the employee to begin the clinical training on patients until the employee has completed the preclinical training, which includes non patient training on typodonts and other laboratory models, and a minimum of 120 days as a dental assistant in California or another state, which may include graduation from a regional occupational center or regional occupation program.
- (C) The dentist shall pay a fee to the committee to cover administrative costs not to exceed two hundred fifty dollars (\$250) for each employee he or she is training and educating. If a dentist is training and educating an employee in more than one of the specialty licensure categories at the same time, the dentist shall pay the fee for each category in which the employee is being trained and educated.
- (D) Prior to beginning employee training, the dentist shall complete a teaching methodology course approved by the board that is six hours in length and covers educational objectives, content, instructional methods, and evaluation procedures. The dentist shall be exempt from this requirement if he or she holds any one of the following degrees, credentials, or positions:
 - (i) A postgraduate degree in education.
 - (ii) A Ryan Designated Subjects Vocational Education Teaching Credential.
 - (iii) A Standard Designated Subjects Teaching Credential.
 - (iv) A Community College Teaching Credential.
 - (v) Is a faculty member of a dental school approved by the Commission on Dental Accreditation. The dentist shall provide to the board proof of one of these designations or shall submit a certificate of course completion in teaching methodology.

All duties performed by an employee shall be done in the dentist's presence. The dentist shall ensure that any patient treated by a student is verbally informed of the student's status. The work experience pathway for the employee shall not exceed a term of 18 months, starting on the date that the Committee on Dental Auxiliaries approves the application submitted by the dentist for that employee.

Upon successful completion of the work experience pathway period, the dentist shall certify in writing that the employee has successfully completed the educational program covering all procedures authorized for the specialty category for which the employee is seeking licensure.

The committee:

- (A) May inspect the dentist's facilities and practice at any time to ensure compliance with regulations adopted by the Board.
- (B) May revoke an approval for a dentist to provide training or education if the dentist fails to provide the training or education in accordance with the law and regulations governing the specialty licensure category, or fails to allow an inspection by the committee, or other good cause. A dentist whose approval is revoked may appeal the revocation to the committee's executive officer.
- (C) May limit by regulations the number of times a dentist may train or educate an individual employee in one or more of the specialty licensure categories.
- (D) May limit the number of employees a dentist may train during the same time period.
- (E) May require an applicant for licensure who has repeatedly failed to pass either the written or practical examination for the specialty licensure category to complete additional training and education before he or she is allowed to retake the examination.

An applicant who completes a work experience pathway shall do the following:

(1) Certify to the board that he or she has a minimum of 1600 hours of prior work experience as a dental assistant. The employee may begin the work experience pathway before he or she completes 1600 hours of work experience, but may not apply for licensure until that work experience is completed. The board shall give credit toward the 1600 hours of work experience to persons who have graduated from a dental assisting program in a postsecondary institution, secondary institution, regional occupational center, or regional occupation program that is not approved by the board. The credit shall equal the hours spent in classroom training and internship on an hour-for-hour basis not to exceed 400 hours.

(2) Certify to the board that he or she has completed the educational program covering all procedures authorized for the specialty category for which the applicant is seeking licensure.

(3) Obtain a passing score on a written examination that is approved by the board and administered by the Committee on Dental Auxiliaries or by an entity that is recommended by the committee. The committee may enter into a written agreement with a public or private organization for the administration of the examination.

(4) Obtain a passing score on the practical examination for the specialty category for which the employee is seeking licensure that is approved by the board and administered by the Committee on Dental Auxiliaries.

Regulations for procedures

The board, upon recommendation of the committee, shall adopt regulations governing the procedures that dental assistants, registered orthodontic assistants, registered surgery assistants, registered restorative assistants, registered dental assistants, registered restorative assistants in extended functions, and registered dental assistants in extended functions are authorized to perform. The board shall conduct an initial review of the procedures, supervision level, settings under which they may be performed, and utilization of extended functions dental auxiliaries. The board shall submit the results of its review to the Joint Committee on Boards, Commissions, and Consumer Protection. After the initial review, a review shall be conducted at least once every five to seven years thereafter and the board shall update regulations as necessary to keep them current with the state of dental practice.

Regular session relating to educational programs and courses for registered orthodontic assistants, registered surgery assistants, registered restorative assistants, registered dental assistants, registered restorative assistants in extended functions, and registered dental assistants in extended functions shall be made public on the same date in the same year.

A "registered dental assistant in extended functions" is an individual licensed who may perform basic restorative services and direct patient care. A "registered restorative assistant in extended functions" is an individual licensed who may perform basic restorative services and direct patient care.

Registered dental assistants

The board shall license as a registered dental assistant a person who files an application and submits written evidence of either one of the following requirements:

(1) Graduation from an educational program in dental assisting approved by the board, and satisfactory performance on written and practical examinations required by the board.

(2) Satisfactory work experience of more than 12 months as a dental assistant in California or another state and satisfactory performance on a written and practical examination required by the board. The board shall give credit for 12 months work experience to persons who have graduated from a dental assisting program in a post secondary institution approved by the Department of Education or in a secondary institution, regional occupational center, or regional occupational program, that are not, however, approved by the board.

The credit shall equal the total weeks spent in classroom training and Internship on a week-for-week basis not to exceed 16 weeks. The board, in cooperation with the Superintendent of Public Instruction, shall establish the minimum criteria for the curriculum of non board-approved programs. Additionally, the board shall notify those programs only if the program's curriculum does not meet established minimum criteria, as established for board-approved registered dental assistant programs, except any requirement that the program be given in a postsecondary institution. Each applicant for registered dental assistant licensure shall provide evidence of having successfully completed board-approved courses in radiation safety and coronal polishing as a condition of licensure. The length and content of the courses shall be governed by applicable board regulations.

An applicant who fails to pass the written and practical examinations shall not be eligible for further reexamination and must apply for and meet the requirements for registered dental assistant licensures. An applicant shall only be allowed to apply to take the written examination two times, and shall only be allowed to apply to take the practical examination two times.

A board-approved educational program in registered dental assisting is a program that has met the requirements for approval pursuant to board regulations. An educational program in registered dental assisting that has been approved by the board to teach the duties that a registered dental assistant was allowed to perform shall continue to be so approved if it has certified on a form specified by the board, that it shall provide instruction in all duties that registered dental assistants shall be allowed to perform with the exception of adding drugs, medications, and fluids to intravenous lines using a syringe and the monitoring of patients during the preoperative, intraoperative, and post operative phases.

The board may at any time conduct a thorough evaluation of an approved educational program's curriculum and facilities to determine whether the program meets the requirements for approval as specified in board regulations.

A person may apply for and be issued a license as a registered dental assistant upon obtaining a passing score on a written and practical examination required by the board and providing evidence to the board of one of the following:

(a) Successful completion of an educational program in registered dental assisting approved by the board to teach all functions with the exception of the duties of adding drugs, medications, and fluids to intravenous lines using a syringe and the monitoring of patients during the preoperative, intraoperative, and postoperative phases.

(b) Successful completion of:

(1) An educational program in registered dental assisting approved by the board to teach the duties that registered dental assistants were allowed to perform pursuant to board regulations.

(2) A board-approved course or courses in the following duties:

(A) Selecting, prepositioning, curing in a position approved by the supervising dentist, and removal of orthodontic brackets.

(B) Applying pit and fissure sealants.

(c) Successful completion of:

(1) Twelve months of satisfactory work experience as a dental assistant in California or another state. The board shall give credit toward the 12 months of work experience to persons who have graduated from a dental assisting program in a post secondary institution, secondary institution, regional occupational center, or regional occupation program that are not approved by the board. The credit shall equal the total weeks spent in classroom training and internship on a week-for-week basis not to exceed 16 weeks.

(2) The three board-approved specialty registration courses for registration as a registered orthodontic assistant, registered surgery assistant, and registered restorative assistant.

(3) A board-approved radiation safety program.

A registered dental assistant may perform all duties and procedures that a dental assistant, registered orthodontic assistant, registered surgery assistant and a registered restorative assistant are allowed to perform except for the following:

(a) A registered dental assistant who qualifies for licensure may only perform the registered surgery assistant duties of adding drugs, medications, and fluids to intravenous lines and the monitoring of patients during the preoperative, intraoperative, and postoperative phases after providing evidence of completion of a board-approved course or courses in these duties.

(b) A registered dental assistant may only perform the following duties after the completion of a board-approved course or courses in the following duties:

(1) Selecting, repositioning, curing in a position approved by the supervising dentist, and removal of orthodontic brackets.

(2) Monitoring of patients during the preoperative, intraoperative, and postoperative phases, using noninvasive instrumentation such as pulse oximeters, electrocardiograms, and capnography.

(3) Adding drugs, medications, and fluids to intravenous lines.

(4) Applying pit and fissure sealants.

The board shall license as a registered dental assistant in extended functions a person who submits written evidence of all of the following:

(1) Current licensure as a registered dental assistant, or completion of the requirements for licensure as a registered dental assistant.

(2) Successful completion of either of the following:

(A) An extended functions postsecondary program approved by the board.

(B) An extended functions postsecondary program approved by the board to teach the duties that registered dental assistants in extended functions were allowed to perform and a course approved by the board.

(3) Successful completion of board-approved courses in radiation safety and, within the last two years, courses in infection control, California dental law, and basic life support.

(4) Satisfactory performance on a written examination and a clinical or practical examination specified by the board. The board shall designate whether the written examination shall be administered by the committee or by the board-approved extended functions program.

The board shall license as a registered restorative assistant in extended functions a person who submits written evidence, satisfactory to the board, of all of the following:

(1) Completion of 12 months of satisfactory work experience as a dental assistant in California or another state. The board shall give credit toward the 12 months of work experience to persons who have graduated from a dental assisting program in a postsecondary institution, secondary institution, regional occupational center, or regional occupation program that are not approved by the board. The credit shall equal the total weeks spent in classroom training and internship on a week-for-week basis, not to exceed 16 weeks.

(2) Successful completion of a board-approved course in radiation safety, and, within the last two years, courses in infection control, California dental law, and basic life support.

(3) Successful completion of a postsecondary program approved by the board for restorative dental assisting specialty registration.

(4) Successful completion of an extended functions postsecondary program approved by the board in all of the procedures.

(5) Satisfactory performance on a written examination and a clinical or practical examination specified by the board. The board shall designate whether the written examination shall be administered by the committee or by the board-approved extended functions program.

In approving extended functions postsecondary programs required to be completed for licensure, the board shall require that the programs be taught by persons having prior experience teaching the applicable procedures, or procedures otherwise authorized by the board, in a dental school approved either by the Commission on Dental Accreditation or a comparable organization approved by the board. Approved programs shall include didactic, laboratory, and clinical modalities.

A registered dental assistant in extended functions is authorized to perform all duties and procedures that a registered dental assistant is authorized to perform, and those duties that the board may prescribe by regulation. A registered dental assistant in extended functions is authorized to perform the following additional procedures under direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist:

(1) Cord retraction of gingivae for impression procedures.

(2) Taking impressions for cast restorations.

(3) Formulating indirect patterns for endodontic post and core castings.

(4) Fitting trial endodontic filling points.

(5) Drying canals previously opened by the supervising dentist, with absorbent points.

(6) Testing pulp vitality.

(7) Removing excess cement from subgingival tooth surfaces with a hand instrument.

(8) Fitting and cementing stainless steel crowns.

(9) Placing, condensing, and carving amalgam restorations.

(10) Placing class I, III, and V nonmetallic restorations.

(11) Taking face bow transfers and bite registrations for fixed prostheses.

(12) Taking final impressions for tooth-borne, removable prostheses.

(13) Placing and adjusting permanent crowns for cementation by the dentist.

(14) Applying etchants for bonding restorative materials.

(15) Other procedures authorized by regulations adopted by the board.

A registered restorative assistant in extended functions is authorized to perform all duties and procedures that a registered restorative assistant is authorized to perform. All procedures required to be performed under direct supervision shall be checked and approved by the supervising dentist prior to the patient's dismissal from the office.

A registered dental assistant may apply pit and fissure sealants under the general supervision of a licensed dentist, after providing evidence to the board of having completed a board-approved course in that procedure.

The board, upon recommendation of the committee, shall adopt regulations relating to the functions that may be performed by registered dental assistants under direct or general supervision, and the settings within which registered dental assistants may work. At least once every seven years, the board shall review the list of functions performable by registered dental assistants, the supervision level, and settings under which they may be performed, and shall update the regulations as needed to keep them current with the state of the practice.

The board shall license as a registered dental assistant in extended functions a person who satisfies all of the following requirements:

(1) Has a status as a registered dental assistant.

(2) Completes clinical training approved by the board in a facility affiliated with a dental school under the direct supervision of the dental school faculty.

(3) Satisfies performance on an examination required by the board.

Each person who holds a license as a registered dental assistant in extended functions may only perform those procedures that a registered dental assistant is allowed to perform until he or she provides evidence of having completed a board-approved course or courses in the additional procedures.

The following functions may be performed by a registered dental hygienist:

(a) All functions that may be performed by a dental assistant or a registered dental assistant.

(b) All persons holding a license as a registered dental hygienist are authorized to perform the duties of a registered dental assistant.

The practice of dental hygiene includes dental hygiene assessment, development, planning, and implementation of a dental hygiene care plan. It also includes oral health education, counseling, and health screenings. The practice of dental hygiene does not include any of the following procedures:

(1) Diagnosis and comprehensive treatment planning.

(2) Placing, condensing, carving, or removal of permanent restorations.

(3) Surgery or cutting on hard and soft tissue including the removal of teeth and the cutting and suturing of soft tissue.

(4) Prescribing medication.

(5) Administering local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other.

A dental hygienist is authorized to perform the following procedures under direct supervision, after submitting to the board evidence of satisfactory completion of a board-approved course of instruction in the procedures:

(a) Soft-tissue curettage.

(b) Administration of local anesthesia.

(c) Administration of nitrous oxide and oxygen, whether administered alone or in combination with each other.

A dental hygienist is authorized to perform the following procedures under general supervision:

(a) Preventive and therapeutic interventions, including oral prophylaxis, scaling, and root planing.

(b) Application of topical, therapeutic, and subgingival agents used for the control of caries and periodontal disease.

(c) The taking of impressions for bleaching trays and application and activation of agents with non laser, light-curing devices.

(d) The taking of impressions for bleaching trays and placements of in-office, tooth-whitening devices.

A dental hygienist may provide, without supervision, educational services, oral health training programs, and oral health screenings. A dental hygienist shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. In any public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, a dental hygienist may provide, without supervision, dental hygiene preventive services in addition to oral screenings, including, but not limited to, the application of fluorides and pit and fissure sealants.

Any procedure performed or service provided by a dental hygienist that does not specifically require direct supervision shall require general supervision, so long as it does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

A dental hygienist may perform any procedure or provide any service within the scope of his or her practice in any setting, so long as the procedure is performed or the service is provided under the appropriate level of supervision. A dental hygienist may use any material or device approved for use in the performance of a service or procedure within his or her scope of practice under the appropriate level of supervision, if the dental hygienist has the appropriate education and training required to use the material or device.

No person other than a licensed dental hygienist or a licensed dentist may engage in the practice of dental hygiene or perform dental hygiene procedures on patients, including supragingival and subgingival scaling, dental hygiene assessment, and treatment planning, except for the following persons:

(a) A student enrolled in a dental or a dental hygiene school who is performing procedures as part of the regular curriculum of that program under the supervision of the faculty of that program.

(b) A dental assistant acting in accordance with the rules of the board in performing the following procedures:

(1) Applying non aerosol and non caustic topical agents.

(2) Applying topical fluoride.

(3) Taking impression for bleaching trays.

(c) A registered dental assistant acting in accordance with the rules of the board in performing the following procedures:

(1) Polishing the coronal surfaces of teeth.

(2) Applying bleaching agents.

(3) Activating bleaching agents with a non laser light-curing device.

(d) A registered dental assistant in extended functions acting in accordance with the rules of the board in applying pit and fissure sealants.

(e) A registered dental hygienist licensed in another jurisdiction performing a clinical demonstration for educational purposes.

The board shall license as a registered dental hygienist a person who satisfies all of the following requirements:

(1) Completion of an educational program for registered dental hygienists, approved by the board, and accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution.

(2) Satisfactory performance on an examination required by the board.

(3) Satisfactory completion of a national written dental hygiene examination approved by the board.

The board may grant a license as a registered dental hygienist to an applicant who has not taken an examination before the board if the applicant submits all of the following to the board:

(1) A completed application form and all fees required by the board.

(2) Proof of a current license as a registered dental hygienist issued by another state that is not revoked, suspended, or otherwise restricted.

(3) Proof that the applicant has been in clinical practice as a registered dental hygienist or has been a full-time faculty member in an accredited dental hygiene education program for a minimum of 750 hours per year for at least five years preceding the date of his or her application. The clinical practice requirement shall be deemed met if the applicant provides proof of at least three years of clinical practice and commits to completing the remaining two years of clinical practice by filing with the board a copy of a pending contract to practice dental hygiene in any of the following facilities:

(A) A primary care clinic.

(B) A clinic owned or operated by a public hospital or health system.

(C) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role of the Welfare and Institutions Code.

(4) Proof that the applicant has not been subject to disciplinary action by any state in which he or she is or has been previously licensed as a registered dental hygienist or dentist. If the applicant has been subject to disciplinary action, the board shall review that action to determine if it warrants refusal to issue a license to the applicant.

(5) Proof of graduation from a school of dental hygiene accredited by the Commission on Dental Accreditation.

(6) Proof of satisfactory completion of the Dental Hygiene National Board Examination and of a state or regional clinical licensure examination.

(7) Proof that the applicant has not failed the examination for licensure to practice dental hygiene under this chapter more than once or once within five years prior to the date of his or her application for a license.

(8) Documentation of completion of a minimum of 25 units of continuing education earned in the two years preceding application, including completion of any continuing education requirements imposed by the board on registered dental hygienists licensed in this state at the time of application.

(9) Any other information as specified by the board to the extent that it is required of applicants for licensure by examination.

The board may periodically request verification of compliance with the requirements and may revoke the license upon a finding that the employment requirement or any other requirement has not been met.

The board shall provide in the application packet to each out-of-state dental hygienist the following information:

(1) The location of dental manpower shortage areas in the state.

(2) Any not-for-profit clinics, public hospitals, and accredited dental hygiene education programs seeking to contract with licensees for dental hygiene service delivery or training purposes.

The board shall review the impact of this section on the availability of actively practicing dental hygienists in California and report to the appropriate policy and fiscal committees of the Legislature. The report shall include a separate section providing data specific to dental hygienists who intend to fulfill the alternative clinical practice requirements.

The report shall include the following:

(1) The number of applicants from other states who have sought licensure.

(2) The number of dental hygienists from other states licensed, the number of licenses not granted, and the reason why the license was not granted.

(3) The practice location of dental hygienists licensed.

(4) The number of dental hygienists licensed who establish a practice in a rural area or in an area designated as having a shortage of practicing dental hygienists or no dental hygienists or in a safety net facility

(5) The length of time dental hygienists practiced in the reported location.

In identifying a dental hygienist's location of practice, the board shall use medical service study areas or other appropriate geographic descriptions for regions of the state.

The board shall license as a registered dental hygienist a third- or fourth-year dental student who is in good standing at an accredited California dental school and who satisfies the following requirements:

- (A) Satisfactorily performs on an examination required by the board.
- (B) Satisfactorily completes a national written dental hygiene examination approved by the board.

A dental student who is granted a registered dental hygienist license may only practice in a dental practice that serves patients who are insured under Denti-Cal, the Healthy Families Program, or other government programs, or a dental practice that has a sliding scale fee system based on income.

Upon receipt of a license to practice dentistry, a registered dental hygiene license issued is automatically revoked. The dental hygiene license is granted for two years upon passage of the dental hygiene examination, without the ability for renewal. If a dental student fails to remain in good standing at an accredited California dental school, or fails to graduate from the dental program, a registered dental hygiene license shall be revoked. The student shall be responsible for submitting appropriate verifying documentation to the board.

The board shall license as a registered dental hygienist in extended functions a person who meets all of the following requirements:

- (a) Holds a valid license as a registered dental hygienist.
- (b) Completes clinical training approved by the board in a facility affiliated with a dental school under the direct supervision of the dental school faculty.
- (c) Performs satisfactorily on an examination required by the board.

The board, in consultation with the committee, shall adopt regulations necessary to define the functions that may be performed by registered dental hygienists in extended functions, whether the functions require direct or general supervision, and the settings within which registered dental hygienists in extended functions may work.

A licensed dentist may simultaneously utilize in his or her practice no more than two dental auxiliaries in extended functions

A licensed dentist may simultaneously utilize in his or her practice no more than three dental auxiliaries in extended functions.

Any person, other than a person who has been issued a license by the board, who holds himself or herself out as a registered dental assistant, registered dental assistant in extended functions, registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice, or uses any other term indicating or implying he or she is licensed by the board is guilty of a misdemeanor.

The board shall seek to obtain an injunction against any dental hygienist who provides services in alternative practice if the board has reasonable cause to believe that the services are being provided to a patient who has not received a prescription for those services from a dentist or physician and surgeon licensed to practice in this state.

The board shall license as a registered dental hygienist in alternative practice a person who demonstrates satisfactory performance on an examination required by the board and who meets either of the following requirements:

- (1) Holds a current California license as a dental hygienist and meets the following requirements:
 - (A) Has been engaged in clinical practice as a dental hygienist for a minimum of 2,000 hours during the immediately preceding 36 months.
 - (B) Has successfully completed a bachelor's degree or its equivalent from a college or institution of higher education that is accredited by a national agency recognized by the Council on Postsecondary Accreditation or the United States Department of Education, and a minimum of 150 hours of additional educational requirements that are consistent with good dental and dental hygiene practice, including dental hygiene technique and theory including gerontology and medical emergencies, and business administration and practice management.
- (2) Has received a letter of acceptance into the employment utilization phase of the Health Manpower Pilot.

A person licensed as a registered dental hygienist who has completed the prescribed classes through the Health Manpower Pilot Project and who has established an independent practice shall be deemed to have satisfied the licensing requirements and shall be authorized to continue to operate the practice he or she presently operates, so long as he or she follows the requirements for prescription and functions.

A registered dental hygienist in alternative practice may perform preventive and therapeutic functions as an employee of a dentist or of another registered dental hygienist in alternative practice, or as an independent contractor, or as a sole proprietor of an alternative dental hygiene practice, or as an employee of a primary care clinic or specialty clinic, or as an employee of a clinic owned or operated by a public hospital or health system.

A registered dental hygienist in alternative practice may perform dental hygiene services in the following settings:

- (1) Residences of the homebound.
- (2) Schools.
- (3) Residential facilities and other institutions.
- (4) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines.

A registered dental hygienist in alternative practice shall not do any of the following:

- (1) Infer, purport, advertise, or imply that he or she is in anyway able to provide dental services or make any type of dental health diagnosis.
- (2) Hire a registered dental hygienist to provide direct patient services other than a registered dental hygienist in alternative practice.

A registered dental hygienist in alternative practice may submit or allow to be submitted any insurance or third-party claims for patient services.

A registered dental hygienist in alternative practice may hire other registered dental hygienists in alternative practice to assist in his or her practice.

A registered dental hygienist in alternative practice shall provide to the board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services.

A dental hygienist in alternative practice may provide services to a patient without obtaining written verification that the patient has been examined by a dentist or physician and surgeon licensed to practice in this state.

If a dental hygienist in alternative practice provides services to a patient 18 months or more after the first date that he or she provides services to a patient, he or she shall obtain written verification that the patient has been examined by a dentist or physician and surgeon licensed to practice in this state. The verification shall include a prescription for dental hygiene services.

A registered dental hygienist in alternative practice may perform dental hygiene services for a patient who presents to the registered hygienist in alternative practice a written prescription for dental hygiene services issued by a dentist or physician and surgeon licensed to practice in this state. The prescription shall be valid for a time period based on the dentist's or physician and surgeon's professional judgment, but not to exceed two years from the date that it was issued.

While employed by or practicing in a primary care clinic or specialty clinic in a primary care clinic or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role of the Welfare and Institutions Code, a registered dental assistant or a registered dental assistant in extended functions may perform procedures under the direct supervision of a registered dental hygienist or a registered dental hygienist in alternative practice.

California Dental Practice Act: Dentists

Article Index

- California Dental Practice Act: Dentists
- Course Description
- Section I
- Section II
- Section III, Dental Practice Act
- Section IVm, Dental Practice Act
- All Pages

Overview of Course

Dental practice in California is governed by the Dental Board of California. The laws and regulations by which it is governed are contained in the Dental Practice Act.

One provision of that act is the continuing education requirement of 50 hours per renewal period in order to renew a dental license. Two of those hours must be in Infection Control and two more must be in California Dental Law. The requirements for California Dental Law may be satisfied with this course, and the requirements for infection control may be satisfied with an online course at www.nyscourses.com.

Dental Auxiliaries

This course includes material to satisfy the requirements for dental auxiliaries, meaning dental hygienists, as well as

- dental assistants
- registered orthodontic assistant
- registered surgery assistant
- registered restorative assistant
- registered restorative assistant in extended functions
- registered dental assistant
- registered dental assistant in extended functions

If you need to satisfy the dental auxiliaries requirement click [here](#).

The Dental Board of California

The Dental Board of California is one of several dozen boards, bureaus, and commissions in the department of Consumer Affairs that were established to ensure that private businesses and professions that engage in activities which have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California.

To this end, the Dental Board established minimum qualifications and levels of competency that persons desiring to engage in the occupations they regulate must meet. Additionally, the Board provides certification to practitioners to ensure performance according to accepted professional standards.

The Board functions as an oversight committee and provides a means for redress of grievances by investigating allegations of unprofessional conduct, incompetence, fraudulent action, or unlawful activity brought to their attention by members of the public. The Board also institutes disciplinary actions against persons licensed under the provisions of this code when such action is warranted. In addition, they conduct periodic checks of licensees, registrants, or otherwise certified persons in order to ensure compliance with the rules of the Board.

The board consists of eight practicing dentists, one registered dental hygienist, one registered dental assistant, and four public members. Of the eight practicing dentists, one shall be a member of a faculty of a California dental college and one shall be a dentist practicing in a nonprofit community clinic.

The practicing dentists of the board must have been actively and legally engaged in the practice of dentistry in the State of California for at least the preceding five years from date of their appointment. The dental hygienist member and the dental assistant member must have been registered in their respective fields for the preceding five years from the date of their appointment.

The public members shall not be licentiates of the board or of any other board under this division or of any board referred to in Sections 1000 and 3600 of the California Business and Professions Code. No more than one member of the board shall be a member of the faculty of a dental college or dental department of any medical college in the State of California. None of the members, including the public members, shall have any financial interest in any such college.

Licensing

Any person over 18 years of age is eligible to take an examination for a license to practice dentistry upon submitting a complete application and meeting all of the following requirements:

- (a) Paying the examination fee.
- (b) Furnishing satisfactory evidence of having graduated from a dental college approved by the board.
- (c) Furnishing satisfactory evidence of financial responsibility or liability insurance for injuries sustained or claimed to be sustained by a dental patient in the course of the examination as a result of the applicant's actions.
- (d) If the applicant has been issued a degree of doctor of dental medicine or doctor of dental surgery by a foreign dental school, he or she shall provide all of the following documentation to the board:
 - (1) That he or she has completed, in a dental school or schools approved by the board, a resident course of professional instruction in dentistry for the full number of academic years required for graduation.

(2) That he or she has been issued by the dental school a dental diploma or a dental degree, as evidence of the successful completion of the course of dental instruction required for graduation.

Practice Without a License

Any person, company, or association is guilty of a misdemeanor and if convicted shall be punished by imprisonment in the county jail not less than 10 days and not more than one year, or by a fine of not less than one hundred dollars (\$100) or not more than one thousand five hundred dollars (\$1,500), or by both fine and imprisonment, who:

- (a) Assumes the degree of "doctor of dental surgery," "doctor of dental science," or "doctor of dental medicine" or appends the letters "D.D.S.," or "D.D.Sc." or "D.M.D." to his or her name without having a diploma from a recognized dental college or school legally empowered to confer such a title.
- (b) Assumes any title, or appends any letters to his or her name, with the intent to represent falsely that he or she has received a dental degree or license.
- (c) Engages in the practice of dentistry without causing to be displayed in a conspicuous place the name of every person practicing dentistry.
- (d) Within 10 days after demand is made by the executive officer of the board, fails to furnish to the board the name and address of all persons practicing or assisting in the practice of dentistry in the office of the person, company, or association, at any time within 60 days prior to the demand, together with a sworn statement showing under what license or authority this person, company, or association and any employees are or have been practicing dentistry.
- (e) Is under the influence of alcohol or a controlled substance while engaged in the practice of dentistry on patients to an extent that impairs his or her ability to conduct the practice of dentistry with safety to patients and the public.

Foreign Credentials

Any applicant who has been issued a dental diploma from a foreign dental school that has not, at the time of his or her graduation from the school, been approved by the board shall not be eligible for examination until the applicant has successfully completed a minimum of two academic years of education at a dental college approved by the board.

Subdivision (a) does not apply to a person who has been issued a degree of doctor of dental medicine or doctor of dental surgery by a foreign dental school accredited by a body that has a reciprocal accreditation agreement with any commission or accreditation organization whose findings are accepted by the board.

The board shall be responsible for the approval of foreign dental schools. The board may contract with outside consultants or a national professional organization to survey and evaluate foreign dental schools. The consultant or organization shall report to the board regarding its findings in the survey and evaluation.

The board shall establish a technical advisory group to review and comment upon the survey and evaluation of a foreign dental school. The technical advisory group shall be selected by the board and shall consist of four dentists, two of whom shall be selected from a list of five recognized United States dental educators recommended by the foreign school seeking approval. None of the members of the technical advisory group shall be affiliated with the school seeking certification.

Any foreign dental school that wishes to be approved shall make application to the board for approval, which shall be based upon a finding that the educational program of the foreign dental school is equivalent to that of similar accredited institutions in the United States and adequately prepares its students for the practice of dentistry. Curriculum, faculty qualifications, student attendance, facilities, and other relevant factors shall be reviewed and evaluated. The board, with the cooperation of the technical advisory group, shall identify the standards and review procedures to be used in the approval process consistent with this subdivision.

The board shall not grant approval if deficiencies found are of such magnitude as to prevent the students in the school from receiving an educational base suitable for the practice of dentistry. Periodic surveys and evaluations of all approved schools shall be made to ensure continued compliance.

Approval shall include provisional and full approval. The provisional form of approval shall be for a period determined by the board, not to exceed three years, and shall be granted to an institution, in accordance with rules established by the board, to provide reasonable time for the school seeking permanent approval to overcome deficiencies found by the board. Prior to the expiration of a provisional approval and before the full approval is granted, the school shall be required to submit evidence that deficiencies noted at the time of initial application have been remedied.

A school granted full approval shall provide evidence of continued compliance with this section. In the event that the board denies approval or reapproval, the board shall give the school a specific listing of the deficiencies that caused the denial and the requirements for remedying the deficiencies, and shall permit the school, upon request, to demonstrate by satisfactory evidence, within 90 days, that it has remedied the deficiencies listed by the board.

A school shall pay a registration fee established by rule of the board, not to exceed one thousand dollars (\$1,000), at the time of application for approval and shall pay all reasonable costs and expenses the board incurs to conduct the approval survey.

The board shall renew approval upon receipt of a renewal application, accompanied by a fee not to exceed five hundred dollars (\$500). Each fully approved institution shall submit a renewal application every seven years. Any approval that is not renewed shall automatically expire.

A person who has been issued a degree of doctor of dental medicine or doctor of dental surgery by a foreign dental school that is not approved by the board shall be exempt from the requirements if he or she meets all of the following requirements:

- (1) He or she furnishes documentary evidence satisfactory to the board of both of the following:
 - A) That he or she has completed in a dental school or schools a resident course of professional instruction in dentistry for the full number of academic years required for graduation.
 - B) That he or she has been issued by the dental school a dental diploma or a dental degree, as evidence of successful completion of the course of dental instruction required for graduation.
- (2) He or she passed Parts I and II of the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations or its predecessor on or before December 31, 2003.
- (3) He or she has passed an examination, on or before December 31, 2008, in which the applicant is required to demonstrate his or her skill in restorative technique.

It is the intent of the Legislature that the restorative technique examination provided for by this section be a continuation of the restorative technique examination provided for in Section 1636 and that an applicant for the examination have no more than a total of four attempts to take the restorative technique examination.

Probationary and Limited Licenses

The board may, upon an applicant's successful completion of the board examination, issue a probationary license to an applicant for licensure as a dentist or dental auxiliary.

The board may require, as a term or condition of issuing the probationary license, the applicant to do any of the following:

- (1) Successfully complete a professional competency examination.
- (2) Submit to a medical or psychological evaluation.
- (3) Submit to continuing medical or psychological treatment.
- (4) Abstain from the use of alcohol or drugs.
- (5) Submit to random fluid testing for alcohol or controlled substance abuse.
- (6) Submit to continuing participation in a board approved rehabilitation program.
- (7) Restrict the type or circumstances of practice.
- (8) Submit to continuing education and coursework.
- (9) Comply with requirements regarding notification to employer and changes of employment.
- (10) Comply with probation monitoring.
- (11) Comply with all laws and regulations governing the practice of dentistry.
- (12) Limit practice to a supervised structured environment in which the licensee's activities shall be supervised by another dentist.
- (13) Submit to total or partial restrictions on drug prescribing privileges.

The probation shall be for three years and the licensee may petition the board for early termination, or modification of a condition of, the probation.

Denial, Suspension and Revocation of Licenses Denial of Licenses

The board may deny a license on the grounds that the applicant has one of the following:

- (1) Been convicted of a crime. A conviction means a plea or verdict of guilt. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal.
- (2) Done any act involving dishonesty, fraud or deceit with the intent to substantially benefit him or another, or substantially injure another.
- (3) Done any act which would be grounds for suspension or revocation of license. The board may deny a license only if the crime or act is substantially related to the qualifications, functions or duties of the business or profession for which application is made.
- (4) Secured the license by cheating, deceit, or making a knowing misrepresentation of a material fact on the license application.

No person shall be denied a license solely on the basis that he has been convicted of a felony if he has obtained a certificate of rehabilitation or if he has met all applicable requirements of the criteria of rehabilitation developed by the board.

Upon Denial

Upon denial of an application for a license, the board shall do either of the following:

- (a) Notify the applicant that the application is denied, and
 - (1) Provide the applicant with a statement of the determinative issues.
 - (2) Inform the applicant of the right to a hearing if written request for hearing is made within 60 days.

Where the board has denied an application for a license, it shall, in its decision inform the applicant of the following:

- (a) The earliest date on which the applicant may reapply for a license which shall be one year from the effective date of the decision unless the board prescribes an earlier date or a later date is prescribed.
- (b) That all competent evidence of rehabilitation presented will be considered upon a reapplication.

If a hearing is requested by the applicant, the board shall conduct a hearing within 90 days from the date the hearing is requested unless the applicant shall request or agree in writing to a postponement or continuance of the hearing.

Upon a showing of good cause, the Office of Administrative Hearings may order, or on, grant a request for up to 45 additional days within which to conduct a hearing, except in cases involving alleged examination or licensing fraud, in which cases the period may be up to 180 days. In no case shall more than two such orders be made or requests be granted.

Following a hearing requested by an applicant, the board may take any of the following actions:

- (a) Grant the license effective upon completion of all licensing requirements by the applicant.
- (b) Immediately revoke the license or impose probationary conditions on the license, which may include suspension.
- (c) Deny the license.
- (d) Take other action in relation to denying or granting the license as the board in its discretion may deem proper.

The board shall develop criteria to evaluate the rehabilitation of a person when:

- (a) Considering the denial of a license by the board; or
- (b) Considering suspension or revocation of a license

The board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee.

Suspension and Revocation of Licenses

The board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. A conviction means a plea or verdict of guilty. Any action which a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal.

The board may suspend a license if a licensee is not in compliance with a child support order or judgment.

Upon suspension or revocation of a license by a board on one or more of the grounds specified above, the board shall:

- (a) Send a copy of the laws that were violated to the ex-licensee.
- (b) Send a copy of the criteria relating to rehabilitation to the ex-licensee.

A board or an administrative law judge sitting alone may issue an Interim order suspending any licensee or imposing license restrictions, including mandatory biological fluid testing, supervision, or remedial training.

The petition shall include affidavits that demonstrate both of the following:

(1) The licensee has engaged in acts or omissions constituting a violation of this code or has been convicted of a crime substantially related to the licensed activity.

(2) Permitting the licensee to continue to engage in the licensed activity, or permitting the licensee to continue in the licensed activity without restrictions, would endanger the public health, safety, or welfare.

No interim order shall be issued without notice to the licensee unless it appears from the petition and supporting documents that serious injury would result to the public before the matter could be heard on notice.

In general, the licensee shall be given at least 15 days' notice of the hearing on the petition for an interim order. The notice shall include documents submitted to the board in support of the petition.

If the order was initially issued without notice, the licensee shall be entitled to a hearing on the petition within 20 days of the issuance of the interim order without notice. The licensee shall be given notice of the hearing within two days after issuance of the initial interim order, and shall receive all documents in support of the petition. The failure of the board to provide a hearing within 20 days following the issuance of the interim order without notice, unless the licensee waives his or her right to the hearing, shall result in the revocation of the interim order.

At the hearing on the petition for an interim order, the licensee may:

- (1) Be represented by counsel.
- (2) Have a record made of the proceedings, copies of which shall be available to the licensee upon payment of costs.
- (3) Present affidavits and other documentary evidence.
- (4) Present oral argument.

The board, or an administrative law judge sitting alone shall issue a decision on the petition for interim order within five business days following submission of the matter. The standard of proof required to obtain an interim order shall be a preponderance of the evidence standard. If the interim order was previously issued without notice, the board shall determine whether the order shall remain in effect, be dissolved, or modified.

The board shall file an accusation within 15 days of the issuance of an interim order. In the case of an interim order issued without notice, the time shall run from the date of the order issued after the noticed hearing. If the licensee files a Notice of Defense, the hearing shall be held within 30 days of the agency's receipt of the Notice of Defense. A decision shall be rendered on the accusation no later than 30 days after submission of the matter.

Consumer Complaints

Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

In addition to the regulation of the licensed professions by each board, bureau or commission, the location of these boards in the Department of Consumer Affairs gives the Director of the department the right and obligation to receive complaints from consumers concerning

- (a) unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in the conduct of any trade or commerce;
- (b) the production, distribution, sale, and lease of any goods and services undertaken by any person which may endanger the public health, safety, or welfare;
- (c) violations of provisions of this code relating to businesses and professions licensed by any agency of the department; and
- (d) other matters consistent with the purposes of this chapter, whenever appropriate.

Upon receipt of any complaint, the director may notify the person against whom the complaint is made of the nature of the complaint and may request appropriate relief for the consumer. The director shall also transmit any valid complaint to the local, state or federal agency whose authority provides the most effective means to secure the relief. The director shall, if appropriate, advise the consumer of the action taken on the complaint and of any other means which may be available to the consumer to secure relief.

If the director receives a complaint or receives information from any source indicating a probable violation of any law, rule, or order of any regulatory agency of the state, or if a pattern of complaints from consumers develops, the director shall transmit any complaint he or she considers to be valid to any appropriate law enforcement or regulatory agency and any evidence or information he or she may have concerning the probable violation or pattern of complaints or request the Attorney General to undertake appropriate legal action.

D&C Records

The Dental Board of California maintains a central file of the names of persons who hold a license or certificate, from that board, with the following information:

- (1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct
- (2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars (\$3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services.
- (3) Any other public complaints or disciplinary information reported.

Impairment Due to Illness

The Board may also act to limit or prevent the practice of dentistry by a practitioner whose physical or mental health may impair his performance so as to cause harm to patients.

Whenever it appears that any person holding a license may be unable to practice his or her profession safely because the licensee's ability to practice is impaired due to mental illness, or physical illness affecting competency, the licensing agency may order the licensee to be examined by one or more physicians and surgeons or psychologists designated by the agency. The report of the examiners shall be made available to the licensee and may be received as direct evidence in proceedings conducted on his or her license suspension or revocation.

If a licensing agency determines that its licensee's ability to practice his or her profession safely is impaired because the licensee is mentally ill or physically ill affecting competency, the licensing agency may take action by any one of the following methods:

- (a) Revoking the licensee's certificate or license.
- (b) Suspending the licensee's right to practice.
- (c) Placing the licensee on probation.
- (d) Taking such other action in relation to the licensee as the licensing agency in its discretion deems proper.

The licensing agency shall not reinstate a revoked or suspended certificate or license until it has received competent evidence of the absence or control of the condition which caused its action and until it is satisfied that with due regard for the public health and safety the person's right to practice his or her profession may be safely reinstated.

In reinstating a certificate or license which has been revoked or suspended, the licensing agency may impose terms and conditions to be complied with by the licensee after the certificate or license has been reinstated. The authority of the licensing agency to impose terms and conditions includes the following:

- (a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training.
- (b) Requiring the licensee to pass an oral, written, practical, or clinical examination, to determine his or her present fitness to engage in the practice of his or her profession.
- (c) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons or psychologists appointed by the licensing agency. If the licensing agency requires the licensee to submit to such an examination, the licensing agency shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons or psychologists of the licensee's choice.
- (d) Requiring the licensee to undergo continuing treatment.
- (e) Restricting or limiting the extent, scope or type of practice of the licensee.

Other Grounds for Denial, Suspension or Revocation

The board may fine a currently licensed healthcare practitioner if he or she is in default on a United States Department of Health and Human Services education loan, including a Health Education Assistance Loan and retain the money from these fines for deposit into its appropriate fund.

The board may deny a license to an applicant to be a healthcare practitioner or deny renewal of a license if he or she is in default on a United States Department of Health and Human Services education loan, including a Health Education Assistance Loan, until the default is cleared or until the applicant or licensee has made satisfactory repayment arrangements.

In determining whether to fine a health care practitioner or to deny a license to an applicant to be a health care practitioner or to deny the renewal of a license, a board shall take into consideration the population served by the health care practitioner as well as the health care practitioner's economic status.

Public Reprimand

When suspending or revoking a license, the board may publicly reprove a licensee for any act that would constitute grounds to suspend or revoke a license or certificate.

Reporting of Suspensions and Revocations

A board shall report, within 10 working days, to the State Department of Health Services the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive by the licensee, or placed in another category that prohibits the licensee from practicing his or her profession.

Inactive Status Licenses

The board shall issue, upon application and payment of the normal renewal fee, an inactive license or certificate to a current holder of an active license or certificate whose license or certificate is not suspended, revoked, or otherwise punitively restricted by that board.

The holder of an inactive license or certificate shall not engage in any activity for which an active license or certificate is required.

An inactive license or certificate shall be renewed during the same time period at which an active license or certificate is renewed. In order to renew a license or certificate, the holder need not comply with any continuing education requirement for renewal of an active license or certificate. The renewal fee for a license or certificate in an active status shall apply also for renewal of a license or certificate in an inactive status.

In order for the holder of an inactive license or certificate to restore his or her license or certificate to an active status, the holder of an inactive license or certificate shall comply with all the following:

- (a) Pay the renewal fee
- (b) If the board requires completion of continuing education for renewers of an active license or certificate, complete continuing education equivalent to that required for a single license renewal period.

Registration

Every person who is licensed to practice dentistry in this state shall register on forms prescribed by the board, his or her place of practice with the Executive Officer of the State Board of Dental Examiners, or, if he or she has more than one place of practice, all of the places of practice, or, if he or she has no place of practice, to so notify the executive officer of the board. This registration must take place within 30 days after the date of his or her license.

Dentists who change their place of practice or add an additional place of practice must so notify; in addition, dentists renewing their licenses must state if their place of practice has changed since the last renewal.

This section shall not apply to a licensee who practices dentistry outside his or her registered place of practice in any of the following places:

- (1) Facilities licensed by the State Department of Health Services.
- (2) Licensed health facilities.
- (3) Clinics that are licensed.
- (4) Licensed community care facilities.
- (5) Schools of any grade level, whether public or private.
- (6) Public institutions, including, federal, state, and local correctional facilities.
- (7) Mobile units that are operated by a public or governmental agency or a nonprofit or charitable organization and are approved by the Board, provided that the mobile units meet all statutory or regulatory requirements.
- (8) The home of a nonambulatory patient when a physician or registered nurse has provided a written note that the patient is unable to visit a dental office.

A licensed dentist may operate one mobile dental clinic or unit registered as a dental office or facility. The mobile dental clinic or unit shall be registered and operated in accordance with regulations established by the board.

License Renewal

A licensee shall, upon his or her initial licensure and any subsequent application for renewal, report the completion of any advanced educational program accredited by the Committee on Dental Accreditation in a dental specialty recognized by the American Dental Association.

The licensee shall also report, upon his or her initial licensure and any subsequent application for renewal, the practice or employment status of the licensee, designated as one of the following:

- (1) Full-time practice or employment in a dental practice of 32 hours per week or more in California.
- (2) Full-time practice or employment in a dental practice outside of California.
- (3) Part-time practice or employment in a dental practice for less than 32 hours per week in California.
- (4) Dental administrative employment that does not include direct patient care, as may further be defined by the board.
- (5) Retired.
- (6) Other practice or employment status, as may be further defined by the board

To renew an unexpired license, the licensee shall, before the time at which the license would otherwise expire, apply for renewal on a form prescribed by the board and pay the renewal fee. The receipt of the executive officer shall be indispensable evidence that payment has been made.

An expired license may be renewed at any time within five years after its expiration on filing of application for renewal on a form prescribed by the board, and payment of all accrued renewal and delinquency fees. If the license is renewed more than 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay a delinquency fee. Renewal shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee is paid, whichever last occurs. If so renewed, the license shall continue in effect through the regular expiration date.

A suspended license is subject to expiration and may be renewed as a regular license, but the renewal does not entitle the licensee to engage in the licensed activity, or in any other activity or conduct in violation of the order or judgment by which the license was suspended.

A revoked license is subject to expiration, but it may not be renewed. If it is reinstated after its expiration, the licensee, as a condition precedent to its reinstatement, shall pay a reinstatement fee.

A license which is not renewed within five years after its expiration may not be renewed, restored, reinstated, or reissued, but the holder of the license may apply for and obtain a new license if the following requirements are satisfied:

- (1) No circumstance, or condition exists which would justify denial of licensure.
- (2) He or she pays all of the fees which would be required of him or her if he or she were then applying for the license for the first time and all renewal and delinquency fees which have accrued since the date on which he or she last renewed his or her license.
- (3) He or she takes and passes the examination, which would be required of him or her if he or she were then applying for the license for the first time, or otherwise establishes to the satisfaction of the board that with due regard for the public interest, he or she is qualified to practice the profession or activity in which he or she again seeks to be licensed.

Radiographic Equipment

Every dentist licensed to practice dentistry in the state and any person working in a dentist's office who operates dental radiographic equipment shall meet at least one of the following requirements:

- (a) Pass a course, approved by the board, in radiation safety which includes theory and clinical application in radiographic technique, to be taught by persons qualified in radiographic technique and meeting board regulations specifying the qualifications for course instructors.
- (b) Have passed a radiation safety examination conducted by the board prior to January 1, 1985.

Professional Conduct

Identification

A healthcare practitioner shall disclose, while working, his or her name and practitioner's license status on a nametag in at least 18-point type. A health care practitioner in a practice or an office, whose license is prominently displayed, may opt to not wear a name tag.

Unprofessional Conduct

1. Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both fine and imprisonment.

2. The engagement of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action. This section shall not apply to sexual contact between a physician and surgeon and his or her spouse or person in an equivalent domestic relationship when that physician and surgeon provides medical treatment, other than psychotherapeutic treatment, to his or her spouse or person in an equivalent domestic relationship.
3. It is unprofessional conduct and a crime, for a physician and surgeon, osteopathic physician, dentist, or podiatrist to direct or supervise the performance of acupuncture involving the application of a needle to the body of a human being by a person licensed under this division who is not licensed pursuant to the Acupuncture Licensure Act.

It is unprofessional conduct and a crime, for a person licensed under this division who is not licensed pursuant to the Acupuncture Licensure Act to perform acupuncture involving the application of a needle to the body of a human being at the direction or under the supervision of a physician and surgeon, osteopathic physician, dentist, or podiatrist.

Any person licensed, certified, registered, or otherwise subject to regulation pursuant to this division who engages in, or who aids or abets in, prostitution, pandering, operating a house of prostitution or gambling, indecent exposure, public lewdness, occurring in the work premises of, or work area under the

direct professional supervision or control of, that person, shall be guilty of unprofessional conduct. The license, certification, or registration of that person shall be subject to denial, suspension, or revocation by the appropriate regulatory entity under this division.

In addition to any penalty provided by law, a violation shall subject the person to a civil penalty in an amount not to exceed two thousand five hundred dollars (\$2,500) for the first offense, and not to exceed five thousand dollars (\$5,000) for each subsequent offense, which may be assessed and recovered in a civil action brought by any district attorney. If the action is brought by a district attorney, the penalty recovered shall be paid to the treasurer of the county in which the judgment was entered.

4. A physician and surgeon and a dentist shall refund any amount that a patient has paid for services rendered that has subsequently been paid to the physician and surgeon or dentist by a third-party payor and that constitutes a duplicate payment. The refund shall be made as follows:
 - a. If the patient requests a refund, within 30 days following the request from that patient for a refund if the duplicate payment has been received, or within 30 days of receipt of the duplicate payment if the duplicate payment has not been received.
 - b. If the patient does not request a refund, within 90 days of the date the physician and surgeon or dentist knows, or should have known, of the receipt of the duplicate payment, the physician and surgeon or dentist shall notify the patient of the duplicate payment, and the duplicate payment shall be refunded within 30 days unless the patient requests that a credit balance be retained.
 - c. Violation of this section shall constitute unprofessional conduct. Disciplinary proceedings shall be conducted.
5. No licensee shall obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation constitutes unprofessional conduct by the licensee and shall subject the licensee to disciplinary or administrative action by his or her licensing agency.

A licensee shall dispense drugs and devices pursuant to a prescription unless one of the following circumstances exists:

- a. Based solely on the licensee's professional training and judgment, dispensing pursuant to the prescription is contrary to law, or the licensee determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.
- b. The prescription drug or device is not in stock. If an order or prescription cannot be dispensed because the drug or device is not in stock, the licensee shall take one of the following actions: (A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner. (B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device. (C) Return the prescription to the patient and refer the patient.

The licensee shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

- c. A licensee may decline to dispense a prescription drug or device on ethical, moral, or religious grounds only if the licensee has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licensee's employer can provide a reasonable accommodation of the licensee's objection.

The licensee's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licensee's refusal to dispense the prescription or order.

Death or Incapacitation of a Dentist

Upon the incapacity or death of a dentist, where the dental practice is a sole proprietorship or where an incapacitated or deceased dentist is the sole shareholder of a professional dental corporation, a person may enter into a contract with one or more dentists licensed in the state to continue the operations of the incapacitated or deceased dentist's dental practice for a period of no more than 12 months from the date of death or incapacity, or until the practice is sold or otherwise disposed of, if all of the following conditions are met:

(1) The person delivers to the board a notification of death or incapacity that includes all of the following information:

- (A) The name and license number of the deceased or incapacitated dentist.
- (B) The name and address of the dental practice.
- (C) If the dentist is deceased, the name, address, and tax identification number of the estate or trust.
- (D) The name and license number of each dentist who will operate the dental practice.
- (E) A statement that the information provided is true and correct.

The statement shall also provide that if the person required to make this notification willfully states as true any fact that he or she knows to be false, he or she shall be subject to a civil penalty of up to ten thousand dollars (\$10,000) in an action brought by any public prosecutor. A civil penalty imposed under this subparagraph shall be enforced as a civil judgment.

(2) The dentist or dentists who will operate the practice shall be licensed by the board and that license shall be current, valid, and shall not be suspended, restricted.

(3) Within 30 days after the death or incapacity of a dentist, notification of the death or incapacity should be sent by mail to the last known address of each current patient of record with an explanation of how copies of the patient's records may be obtained. This notice may also contain any other relevant information concerning the continuation of the dental practice. The failure to comply with the notification requirement within the 30-day period shall be grounds for terminating the operation of the dental practice. The contracting dentist or dentists shall obtain a form signed by the patient, or the patient's guardian or legal representative that releases the patient's confidential dental records to the contracting dentist or dentists prior to use of those records.

California Dental Practice Act

Definition of Dentistry

Dentistry is the diagnosis or treatment, by surgery or other method, of diseases and lesions and the correction of malpositions of the human teeth, alveolar process, gums, jaws, or associated structures; and such diagnosis or treatment may include all necessary related procedures as well as the use of drugs, anesthetic agents, and physical evaluation.

A practicing dentist may do anyone or more of the following:

- (a) By card, circular, pamphlet, newspaper or in any other way advertise himself or represents himself to be a dentist.

(b) Perform, or offers to perform, an operation or diagnosis of any kind, or treats diseases or lesions of the human teeth, alveolar process, gums, jaws, or associated structures, or corrects malposed positions.

(c) Indicate that he will perform by himself or his agents or servants any operation upon the human teeth, alveolar process, gums, jaws, or associated structures, or in any way indicates that he will construct, alter, repair, or sell any bridge, crown, denture or other prosthetic appliance or orthodontic appliance.

(d) Make, or offers to make, an examination of, with the intent to perform or cause to be performed any operation on the human teeth, alveolar process, gums, jaws, or associated structures.

(e) Manage or conduct as manager, proprietor, conductor, lessor, or otherwise, a place where dental operations are performed.

Dental Practice and Licensing

The following practices, acts and operations, may be performed without a dental license:

(a) The practice of oral surgery by a physician and surgeon licensed under the Medical Practice Act.

(b) The operations, in dental schools approved by the board, of students of dentistry or dental hygiene in the school's clinical departments or laboratories or in a dental extension program approved by the board or in an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association.

(c) The practice of dentistry by licensed dentists of other states or countries while appearing and operating as clinicians or instructors in dental colleges approved by the Dental Board of California.

(d) The practice of dentistry by licensed dentists of other states or countries in conducting or making a clinical demonstration before any dental or medical society, association, or convention; provided, however, the consent of the Dental Board of California to the making and conducting of the clinical demonstration shall be first had and obtained.

(e) The construction, making, verification of shade taking, alteration or repairing of bridges, crowns, dentures, or other prosthetic appliances, or orthodontic appliances, when the casts or impressions for this work have been made or taken by a licensed dentist, but a written authorization signed by a licensed dentist shall accompany the order for the work or it shall be performed in the office of a licensed dentist under his or her supervision.

The burden of proving written authorization or direct supervision is upon the person practicing without a license.

(f) The manufacture or sale of wholesale dental supplies.

(g) The practice of dentistry or dental hygiene by applicants during a licensing examination conducted in this state by the licensing agency of another state which does not have a dental school; provided, however, that the consent of the board to the conducting of the examination shall first have been obtained and that the examination shall be conducted in a dental college accredited by the board.

(h) The practice by personnel of the Air Force, Army, Coast Guard, or Navy or employees of the United States Public Health Service, Veterans' Administration, or Bureau of Indian Affairs when engaged in the discharge of official duties.

In addition to the exemptions set forth above, the operations by students of registered dental assisting, registered dental assisting in extended functions, and registered dental hygiene in extended functions in the clinical departments or the laboratory of an educational program or school approved by the board, including operations by unlicensed students while engaged in clinical externship programs that have been approved by an approved educational program or school, and that are under the general programmatic and academic supervision of that educational program or school.

Oral and Maxillofacial Surgery

"Oral and maxillofacial surgery" means the diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects which involve both functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Any person licensed under the Medical Practice Act as a physician and surgeon who possesses, or possessed, a license to practice dentistry in another state, but is not licensed to practice dentistry under this chapter may apply to the board on a form prescribed by the board for an oral and maxillofacial surgery permit.

The board may issue an oral and maxillofacial surgery permit to an applicant who has furnished evidence satisfactory to the board that he or she is currently certified or eligible for certification in oral and maxillofacial surgery by a specialty board recognized by the Commission on Accreditation of the American Dental Association and holds a current license in good standing to practice medicine in the state.

An application shall be accompanied by an application fee of one hundred fifty dollars (\$150) and two classifiable sets of fingerprints on forms provided by the board.

Facial Cosmetic Surgery

A person licensed who wishes to perform elective facial cosmetic surgery shall first apply for and receive a permit to perform elective facial cosmetic surgery from the board. A permit issued shall be valid for a period of two years and must be renewed by the permit holder at the time his or her license is renewed. Every six years, prior to renewal of the permit holder's license and permit, the permit holder shall submit evidence acceptable to the credentialing committee that he or she has maintained continued competence to perform the procedures authorized by the permit.

A licensee may obtain a permit to perform elective facial cosmetic surgery by furnishing all of the following information on an application form approved by the board:

(1) Proof of successful completion of an oral and maxillofacial surgery residency program accredited by the Commission on Dental Accreditation of the American Dental Association.

(2) Proof that the applicant has satisfied the criteria specified in either subparagraph (A) or (B):

(A) (i) Is certified, or is a candidate for certification, by the American Board of Oral and Maxillofacial Surgery.

(ii) Submits to the board a letter from the program director of the accredited residency program, or from the director of a post residency fellowship program accredited by the Commission on Dental Accreditation of the American Dental Association, stating that the licensee has the education, training, and competence necessary to perform the surgical procedures that the licensee intends to perform.

(iii) Submits documentation to the board of at least 10 operative reports from residency training or proctored procedures that are representative of procedures that the licensee intends to perform from both of the following categories:

(I) Cosmetic contouring of the osteocartilaginous facial structure, which may include, rhinoplasty and otolaryngology.

(II) Cosmetic soft tissue contouring or rejuvenation, which may include, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation.

(iv) Submits documentation to the board showing the surgical privileges the applicant possesses at any licensed general acute care hospital and any licensed outpatient surgical facility in this state.

(B) (i) Has been granted privileges by the medical staff at a licensed general acute care hospital to perform the surgical procedures set forth in paragraph (A) at that hospital.

(ii) Submits to the board the documentation described in clause (iii) of subparagraph (A).

(3) Proof that the applicant is on active status on the staff of a general acute care hospital and maintains the necessary privileges.

The board shall appoint a credentialing committee to review the qualifications of each applicant for a permit. Upon completion of the review of an applicant, the committee shall make a recommendation to the board on whether to issue or not issue a permit to the applicant. The permit may be unqualified, entitling the permit holder to perform any facial cosmetic surgical procedure, or it may contain limitations.

The credentialing committee shall be comprised of five members, as follows:

A) A physician and surgeon with a specialty in plastic and reconstructive surgery who maintains active status on the staff of a licensed general acute care hospital.

(B) A physician and surgeon with a specialty in otolaryngology who maintains active status on the staff of a licensed general acute care hospital.

(C) Three oral and maxillofacial surgeons licensed by the board who are board certified by the American Board of Oral and Maxillofacial Surgeons, and who maintain active status on the staff of a licensed general acute care hospital.

Emergency Dental Care

No licensed practitioner who renders emergency care at the scene of an emergency occurring outside the place of that person's practice shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.

A dentist shall not be liable for damages for injury or death caused in an emergency situation occurring in the dentist's office or in a hospital on account of a failure to inform a patient of the possible consequences of a dental procedure where the failure to inform is caused by any of the following:

(1) The patient was unconscious.

(2) The dental procedure was undertaken without the consent of the patient because the dentist reasonably believed that a dental procedure should be undertaken immediately and that there was insufficient time to fully inform the patient.

(3) A dental procedure was performed on a person legally incapable of giving consent, and the dentist reasonably believed that a dental procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of a person authorized to give consent for the patient.

This section is applicable only to actions for damages for injuries or death arising because of a dentist's failure to inform, and not to actions for damages arising because of a dentist's negligence in rendering or failing to render treatment.

General Anesthesia

No dentist shall administer or order the administration of general anesthesia on an outpatient basis for dental patients unless the dentist either possesses a current license in good standing to practice dentistry in this state and holds a valid general anesthesia permit issued by the board or possesses a valid general anesthesia permit issued by the board.

No dentist shall order the administration of general anesthesia unless the dentist is physically within the dental office at the time of the administration.

A general anesthesia permit shall expire on the date provided unless it is renewed.

This article does not apply to the administration of local anesthesia or to conscious-patient sedation.

Application for a Permit

A dentist who desires to administer or order the administration of general anesthesia shall apply to the board on an application form prescribed by the board. The dentist must submit an application fee and produce evidence showing that he or she has successfully completed a minimum of one year of advanced training in anesthesiology and related academic subjects approved by the board.

The application for a permit shall include documentation that equipment and drugs required by the board are on the premises.

Any dentist holding a permit shall maintain medical history, physical evaluation, and general anesthesia records as required by board regulations.

Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may require an onsite inspection and evaluation of the licensee and the facility, equipment, personnel, and procedures utilized by the licensee. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation.

Every dentist issued a permit shall have an onsite inspection and evaluation at least once every five years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

The board may contract with public or private organizations or individual experts in dental outpatient general anesthesia to perform onsite inspections and evaluations.

A permittee shall be required to complete 24 hours of approved courses of study related to general anesthesia as a condition of renewal of a permit. Those courses of study shall be credited toward any continuing education required by the board.

The application fee for a permit or renewal under this article shall not exceed two hundred fifty dollars (\$250). The fee for an onsite inspection shall not exceed three hundred fifty dollars (\$350).

Anesthesia and Conscious Sedation

In dental practice, there is a continuum of sedation used which cannot be adequately defined in terms of consciousness and general anesthesia. The administration of sedation through this continuum results in different states of consciousness that may or may not be predictable in every instance. In most instances, the level of sedation will result in a predictable level of consciousness during the entire time of sedation. Achieving the degree of sedation commonly referred to as "light conscious sedation," where a margin of safety exists wide enough to render unintended loss of consciousness unlikely, requires educational standards appropriate to the administration of the resulting predictable level of consciousness.

"Conscious sedation" means a minimally depressed level of consciousness produced by a pharmacologic or non pharmacologic method, or a combination thereof, that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command. "Conscious sedation" does not include the administration of oral medications or the administration of a mixture of nitrous oxide and oxygen, whether administered alone or in combination with each other.

The drugs and techniques used in conscious sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli shall not be considered to be in a state of conscious sedation. For the very

young or handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

Application for a Permit

No dentist shall administer or order the administration of, conscious sedation on an outpatient basis for dental patients unless one of the following conditions is met:

- (1) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.
- (2) The dentist possesses a current permit and either holds a valid anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer conscious sedation.

This article shall not apply to the administration of local anesthesia or to general anesthesia.

A dentist who orders the administration of conscious sedation shall be physically present in the treatment facility while the patient is sedated.

A dentist, who desires to administer or order the administration of conscious sedation, shall apply to the board on an application form prescribed by the board. The dentist shall submit an application fee and produce evidence showing that he or she has successfully completed a course of training in conscious sedation that meets the requirements below.

The application for a permit shall include documentation that equipment and drugs required by the board are on the premises.

A course in the administration of conscious sedation shall be acceptable if it meets all of the following as approved by the board:

- (1) Consists of at least 60 hours of instruction.
- (2) Requires satisfactory completion of at least 20 cases of administration of conscious sedation for a variety of dental procedures.
- (3) Complies with the requirements of the Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry of the American Dental Association.

A permittee shall be required to complete 15 hours of approved courses of study related to conscious sedation as a condition of renewal of a permit. Those courses of study shall be credited toward any continuing education required by the board.

(a) Prior to the issuance or renewal of a permit to administer conscious sedation, the board may require an onsite inspection and evaluation of the licensee and the facility, equipment, personnel, and procedures utilized by the licensee. The permit of any dentist who has failed an on site inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure unless, within that time period, the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit shall have an onsite inspection and evaluation at least once in every six years.

Administration of Conscious Sedation

A physical evaluation and medical history shall be taken before the administration of conscious sedation. Any dentist holding a permit shall maintain records of the physical evaluation, medical history, and conscious sedation procedures used as required by board regulations.

(b) An applicant who has successfully completed the course may be granted a one-year temporary permit by the board prior to the onsite inspection and evaluation. Failure to pass the inspection and evaluation shall result in the immediate and automatic termination of the temporary permit.

(c) The board may contract with public or private organizations or individuals expert in dental outpatient conscious sedation to perform onsite inspections and evaluations.

Administration of Oral Conscious Sedation-Minor

For very young or handicapped individuals, incapable of the usually expected verbal response, a minimally depressed level of consciousness should be maintained

Licensing for Oral Conscious Sedation-Minor

A dentist may not administer oral conscious sedation on an outpatient basis to a minor patient unless one of the following conditions is met:

- (1) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, conscious sedation permit, or has been certified by the board to administer oral sedation to minor patients.
- (2) The dentist possesses a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to minor patients in compliance with this article.

This section shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

A dentist who desires to administer oral conscious sedation for minor patients, who does not hold a general anesthesia permit or a conscious sedation permit shall register his or her name with the board on a board-prescribed registration form.

The dentist shall submit the registration fee and evidence showing that he or she satisfies any of the following requirements:

- (a) Satisfactory completion of a postgraduate program in oral and maxillofacial surgery or pediatric dentistry approved by either the Commission on Dental Accreditation or a comparable organization approved by the board.
- (b) Satisfactory completion of a periodontics or general practice residency or other advanced education in a general dentistry program approved by the board.
- (c) Satisfactory completion of a board-approved educational program on oral medications and sedation.

A certificate holder shall be required to complete a minimum of 7 hours of approved courses of study related to oral conscious sedation of minor patients as a condition of certification renewal as an oral conscious sedation provider. Those courses of study shall be accredited toward any continuing education required by the board.

Licensing for Oral Conscious Sedation-Adult

A dentist may not administer oral conscious sedation on an outpatient basis to an adult patient unless one of the following conditions is met:

- (1) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, conscious sedation permit, or has been certified by the board to administer oral sedation to minor patients.

(2) The dentist possesses a current permit and either holds a valid general anesthesia permit, or conscious sedation permit, or possesses a certificate as a provider of oral conscious sedation to adult patients in compliance with this article. Possession of a certificate to provide oral conscious sedation to minors certifies the holder to administer oral conscious sedation to adults as well.

This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

A dentist who desires to administer, or order the administration of, oral conscious sedation for adult patients, who does not hold a general anesthesia permit or a conscious sedation permit shall register his or her name with the board on a board-prescribed registration form.

The dentist shall submit the registration fee and evidence showing that he or she satisfies any of the following requirements:

- (a) Satisfactory completion of a postgraduate program in oral and maxillofacial surgery approved by either the Commission on Dental Accreditation or a comparable organization approved by the board.
- (b) Satisfactory completion of a periodontics or general practice residency or other advanced education in a general dentistry program approved by the board.
- (c) Satisfactory completion of a board-approved educational program on oral medications and sedation.
- (d) For an applicant who has been using oral conscious sedation in connection with the treatment of adult patients, submission of documentation as required by the board of 10 cases of oral conscious sedation satisfactorily performed by the applicant on adult patients in any three-year period.

A certificate holder shall be required to complete a minimum of 7 hours of approved courses of study related to oral conscious sedation of adult patients as a condition of certification renewal as an oral conscious sedation provider. Those courses of study shall be accredited toward any continuing education required by the board.

Dental Restoration Materials

For each new patient, and for established patients prior to dental restoration work, the dentist must provide a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect.

The fact sheet shall include:

- (1) A description of the materials that is available to the profession for restoration of an oral condition or defect.
- (2) A comparison of the relative benefits and detriments of each group of materials.
- (3) A comparison of the cost considerations associated with each group of materials.
- (4) A reference to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.

The fact sheet shall be made available by the Board of Dental Examiners of California to all licensed dentists. The Board of Dental Examiners of California shall update the fact sheet as determined necessary by the board.

The dentist needs to provide the fact sheet to each patient only once. An acknowledgment of the receipt of the fact sheet by the patient shall be signed by the patient and a copy of it shall be placed in the patient's dental record. If updates to the fact sheet are made by the board, the updated fact sheet shall be given to patients in the same manner.

This does not apply to any surgical, endodontic, periodontic, or orthodontic dental procedures in which dental restorative materials are not used.

Identification of Dental Lab Materials

Every complete upper or lower denture fabricated by a licensed dentist, or fabricated pursuant to the dentist's work order, shall be marked with the patient's name, unless the patient objects. The initials of the patient may be shown alone, if use of the name of the patient is not practical. The markings shall be done during fabrication and shall be permanent, legible, and cosmetically acceptable. The exact location of the markings and the methods used to implant or apply them shall be determined by the dentist or dental laboratory fabricating the denture.

The dentist shall inform the patient that the markings are to be used for identification only and that the patient shall have the option to decide whether or not the dentures shall be marked.

The dentist shall retain the records of those marked dentures and shall not release the records to any person except to enforcement officers, in the event of an emergency requiring personal identification by means of dental records, or to anyone authorized by the patient.

Resources

<http://caselaw.lp.findlaw.com/cacodes/pen.html>

<http://www.dbc.ca.gov/lawsregs/laws.shtml>

CREATED BY RULE:

COMMITTEE:	<u>Continuing Education Advisory Committee</u>
# OF MEMBERS:	7
COMPOSITION:	Committee established by rule, composition set by rule, committee members appointed by the full Board and Committee Chair is appointed by Board Chair: <i>Composition:</i> 1 member of the Iowa Dental Board 2 licensed dentists with expertise in the area of professional continuing education 2 licensed dental hygienists with expertise in the area of professional continuing education 2 registered dental assistants with expertise in the area of professional continuing education.
TERM:	1 year, May 1 – April 30 Board reviews annually; may reappoint current members or appoint new members
VACANCY:	1 dentist member w/con. ed. expertise; Chair must be a Board member
RESPONSIBILITIES:	Review and advise the Board with respect to: <ul style="list-style-type: none">- Applications for approval of sponsors- Applications for approval of activities- Requests for post approval of activities
SUBJECT TO OPEN MEETINGS LAW?	Yes
ESTABLISHED BY RULE, STATUTE?	By rule: 650—25.1(153) Definitions. For the purpose of these rules on continuing education, definitions shall apply: “Advisory committee.” An advisory committee on continuing education shall be formed to review and advise the board with respect to applications for approval of sponsors or activities and requests for post approval of activities. Its members shall be appointed by the board and consist of a member of the board, two licensed dentists with expertise in the area of professional continuing education, two licensed dental hygienists with expertise in the area of professional continuing education, and two registered dental assistants with expertise in the area of professional continuing education. The advisory committee on continuing education may tentatively approve or deny applications or requests submitted to it pending final approval or disapproval of the board at its next meeting.
ARE THE MEMBERS APPOINTED BY THE BOARD CHAIR OR FULL BOARD?	Full Board appoints the Committee members
DOES THE BOARD CHAIR APPOINT THE COMMITTEE CHAIR OR DOES THE COMMITTEE ELECT A CHAIR?	Committee Chair is appointed by the Board Chair, per rule: 1.3(5) Committees of the board may be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons. Committees of the board may include the executive committee, licensure committee, grievance committee, continuing education advisory committee, and dental assistant committee.