



STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

June 11, 2015
12:00 P.M.

Location: The public can participate in the public session of the teleconference by speakerphone at the Board's office, 400 SW 8th St., Suite D, Des Moines, Iowa. The public can also participate by telephone using the call-in information below:

- | |
|--|
| 1. Dial the following number to join the conference call: 1-866-685-1580 |
| 2. When promoted, enter the following conference code: 0009990326# |

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

- I. CALL MEETING TO ORDER – ROLL CALL**
- II. APPLICATION FOR GENERAL ANESTHESIA PERMIT**
 - a. Jared Dye, D.M.D.
 - b. Jarom Maurer, D.M.D.
- III. APPLICATION FOR MODERATE SEDATION PERMIT**
 - a. Brandon Peterson, D.D.S.
- IV. OPPORTUNITY FOR PUBLIC COMMENT**
- V. ADJOURN**

*Committee members may participate by telephone or in person.

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.



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

RECEIVED

APR 2 2015

IOWA DENTAL BOARD

APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION

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

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

Dye, Jared, Eric

Other Names Used: (e.g. Maiden)	Home E-mail: jareddye@gmail.com	Work E-mail: jared-dye@uiowa.edu
Home Address: 930 Twilight Dr	City: North Liberty	State: Iowa
	Zip: 52317	Home Phone: (702) 672-3611
License Number: DDS-09171	Issue Date: March 10 th , 2015	Expiration Date: August 31 st , 2016
	Type of Practice: Oral & Maxillofacial Surgery	

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

Principal Office Address: 1000 Lincoln Circle SE	City: Orange City	Zip: 51041	Phone: (605) 242-0107	Office Hours/Days: 8am - 5pm / Wednesdays
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed & attach proof.	Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia	✓	7/2011 to 6/2015
Formal training in airway management	✓	11/2011 to 2/2012
Minimum of one year of advanced training in anesthesiology in a training program approved by the board		

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Advanced Cardiovascular Life Support	Location: University of Iowa (UIHC-EMSLRC)
Date of Course: 10/8/2014	Date Certification Expires: 10/31/2016

Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

CK# 5227
\$500

Name of Applicant Jared E. Dye

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>University of Nevada, Las Vegas, School of Dental Medicine</u>	From (Mo/Yr): <u>8/2007</u>	To (Mo/Yr): <u>5/2011</u>
City, State: <u>Las Vegas, Nevada</u>	Degree Received: <u>DMD (Doctor of Dental Medicine)</u>	

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

Name of Training Program: <u>University of Iowa Hospitals & Clinics</u>	Address: <u>200 Hawkins Dr.</u>	City: <u>Iowa City</u>	State: <u>IA</u>
Phone: <u>(319) 356-7339</u>	Specialty: <u>Oral & Maxillofacial Surgery</u>	From (Mo/Yr): <u>7/2011</u>	To (Mo/Yr): <u>6/2015</u>

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

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

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

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>Started oral & maxillofacial surgery residency after graduating dental school</u>	<u>7/2011</u>	<u>Present</u>

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

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

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

1000 Lincoln Circle SE
Orange City, Iowa, 51041

Name of Applicant Jared E. Dye

Facility Address

SECTION 7 – AUXILIARY PERSONNEL

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

Name: <u>-Will be sent Separately</u>	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

SECTION 8 – FACILITIES & EQUIPMENT

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

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

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: *Iowa* COUNTY: *Johnson*

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

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

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

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

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

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

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

MUST BE SIGNED IN PRESENCE OF NOTARY ► NOTARY SEAL	SIGNATURE OF APPLICANT <i>Jared Dye</i>	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <i>30th</i> DAY OF <i>March</i> , YEAR <i>2015</i>	
	NOTARY PUBLIC SIGNATURE <i>Mary B. Litwiler</i>	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <i>Mary B. Litwiler</i>	MY COMMISSION EXPIRES: <i>June 27, 2015</i>

March 23, 2015

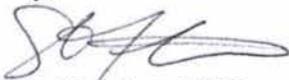
RE: Jared Dye, D.M.D.

To Whom It May Concern,

Jared Dye, D.M.D., is currently in his fourth year of our oral & maxillofacial surgery residency program at the University of Iowa Hospitals & Clinics. Dr. Dye will graduate from our program on June 30, 2015, and is in good standing. This is a four year comprehensive training program with extensive training in moderate and deep sedation as well as outpatient general anesthesia. As part of his training, Dr. Dye did a four month rotation in the department of anesthesia and was trained in moderate and deep sedation, as well as general anesthesia. His training included comprehensive pre-anesthetic patient evaluation, advanced airway management (intubation, fiber-optic intubation, surgical airways, etc.), use of reversal agents, administration of pharmacologic agents used during sedation and general anesthesia, venipuncture, recognition and treatment of complications associated with moderate and deep sedation and the ability to manage patients who enter a deeper or obtunded state of anesthesia. During those four months Dr. Dye performed over 300 general anesthetics and placed over 150 advanced airways. In addition, Dr. Dye is competent in the use of cardiac and vasoactive agents for management of abnormalities of blood pressure, heart rate or rhythm.

In our oral surgery clinics, Dr. Dye has performed over 750 moderate and deep sedations. These cases include over 130 pediatric moderate to deep sedations. These cases total more than 100 hours of sedation. He is competent in administering all levels of sedation and anesthesia and in managing any associated complications. Dr. Dye is an excellent surgeon who has had comprehensive training in outpatient anesthesia encompassing all levels of sedation. Please contact me if you require further information.

Sincerely,



Steven L. Fletcher, DDS
Assistant Professor, Graduate Program Director
SLF/ml

ACLS Provider



→
PEEL
HERE
→

Jared Dye

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

10/8/2014
Issue Date

10/31/2016
Recommended Renewal Date

Jared Dye
930 Twilight Drive
North Liberty IA 52317

Training Center Name	UIHC-EMSLRC	TC ID #
TC Info	TCCIA05137	
	200 Hawkins Dr, Iowa City, IA 52242	
	319-353-7495	
Course Location	EMSLRC	
Instructor Name	Lee Ridge 03060026618 Inst. ID #	
Holder's Signature		

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

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

ORAL SURGERY & IMPLANT SPECIALISTS
301 OAK TREE LANE
DAKOTA DUNES, SD 57049
PHONE 605-242-0107
FAX 605-242-0145

FACSIMILE TRANSMITTAL SHEET

TO: *Christel Brans* FROM: *Clinton North*
COMPANY: DATE: *4/1/15*
FAX NUMBER: *(515) 281-7969* TOTAL NO. OF PAGES INCLUDING COVER: *3*
PHONE NUMBER: *605-242-0107*
RE: *Jared Dye* YOUR REFERENCE NUMBER:

URGENT FOR REVIEW PLEASE COMMENT PLEASE REPLY PLEASE RECYCLE

This transmission is considered Confidential and is intended only for the use of the person or office to which it is addressed. Receipt of this message is not for distribution or copying except by addressee. If you have received this transmission in error, please notify us immediately at the phone number above.



STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

January 20, 2012

Clinton E. Norby, D.D.S.
2800 Pierce St. #202
Sioux City, IA 51104

Dear Dr. Norby:

The Iowa Dental Board has approved your application for issuance of a permit to administer deep sedation/general anesthesia at your facilities. The enclosed permit issued pursuant to Iowa Administrative Code Section 650-29(153) is evidence of this authorization. Enclosed for your information is a copy of Iowa Administrative Code 650 – Chapter 29.

This permit was issued with an effective date of July 29, 2011, and is valid until August 31, 2012. The general anesthesia permit may be renewed following proper application for renewal and approval of the board. This permit allows you to administer deep sedation/general anesthesia at the following facilities:

2800 Pierce St. #202
Sioux City, IA

819 Flindt Dr.
Storm Lake, IA

115 4th St.
Orange City, IA

In the event there is any change in the location of the above stated facilities you are required to immediately notify this office so that an on-site evaluation of the new facility can be performed.

Sincerely,

Melanie Johnson, J.D.
Executive Director

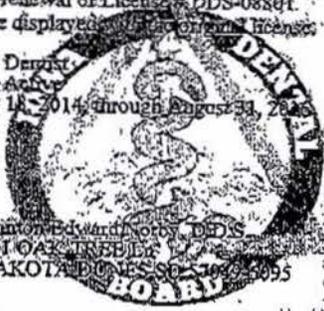
MJ/cb

Enclosure: IAC 650 – Chapter 29

Iowa Dental Board
 400 SW 8th Street, Suite D, Des Moines, IA 50309-4687
 Steven P. Bradley, DDS Board Chair
 Phil McCollum Interim Director

This is to certify renewal of License # DDS-08801.
 This card shall be displayed with the original license.

License Type: Dentist
 Status: Active
 Effective: July 18, 2014 through August 31, 2016



Clinton Edward Norby, DDS
 301 OAK TREE BLVD
 DAKOTA DUNES, IA 50309-5095

Expires
 Aug 31,
 2016

Iowa Dental Board
 400 SW 8th Street, Suite D, Des Moines, IA 50309-4687
 Steven P. Bradley, DDS, Chair Phil McCollum, Interim Director

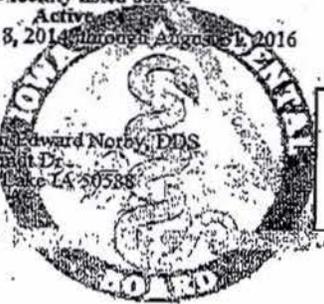
Clinton Edward Norby, D.D.S.
 Has renewed License # DDS-08801
 License Type: Dentist
 Status: Active
 Effective: July 18, 2014, through August 31, 2016

Expires Aug 31,
 2016

Iowa Dental Board
 400 SW 8th Street, Suite D, Des Moines, IA 50309-4687
 Steven P. Bradley, D.D.S. Board Chair
 Phil McCollum Interim Director

This is to certify renewal of GA-0124.
 This card shall be displayed with the original permit.

License Type: General Anesthesia Permit
 Valid only at the facility listed below.
 Status: Active
 Effective: July 18, 2014 through August 31, 2016



Clinton Edward Norby, DDS
 819 Fern Dr.
 Storm Lake, IA 50588

Expires
 Aug 31,
 2016

Iowa Dental Board
 400 SW 8th Street, Suite D, Des Moines, IA 50309-4687
 Steven P. Bradley, D.D.S., Chair Phil McCollum, Interim Director

Clinton Edward Norby, DDS
 Has renewed GA-0124.
 Valid only at approved and inspected facilities specified.

License Type: General Anesthesia Permit
 Status: Active
 Effective: July 18, 2014, through August 31, 2016

Expires Aug 31,
 2016

American Association of Oral and Maxillofacial Surgeons

Grants this

CERTIFICATE OF OFFICE ANESTHESIA EVALUATION

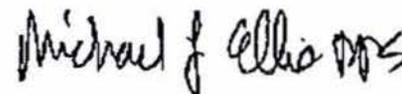
To

Clinton E. Norby, DDS

*for successful completion of
AAOMS Office Anesthesia Evaluation Program*



Eric T. Geist, DDS
President



Michael L. Ellis, DDS
Chairman, Committee on Anesthesia

Date of Issuance
October, 2013





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

RECEIVED
 APR 06 2015
 IOWA DENTAL BOARD

APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION				
Instructions – Please read the accompanying instructions prior to completing this form. Answer each question. If not applicable, mark "N/A."				
Full Legal Name: (Last, First, Middle, Suffix) <i>Maurer, Jarom, Enoch</i>				
Other Names Used: (e.g. Maiden)	Home E-mail: <i>jarom-maurer@hotmail.com</i>		Work E-mail: <i>jarom-maurer@oahse.edu</i>	
Home Address: <i>2311 melody drive</i>	City: <i>Edmond</i>	State: <i>OK</i>	Zip: <i>73012</i>	Home Phone: <i>405-285-5014</i>
License Number: <i>DDG-09173</i>	Issue Date: <i>3-12-2015</i>	Expiration Date: <i>08-31-2016</i>	Type of Practice: <i>OMFS</i>	
SECTION 2 – LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED				
Principal Office Address: <i>835 3rd Ave SE</i>	City: <i>Ledoux Knolls</i>	Zip: <i>52403</i>	Phone: <i>319-366-8277</i>	Office Hours/Days: <i>8am-5pm Mon-Fri</i>
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
SECTION 3 – BASIS FOR APPLICATION				
Check each box to indicate the type of training you have completed & attach proof.			Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia			<input checked="" type="checkbox"/>	<i>7/1/11 – 6/30/15</i>
Formal training in airway management			<input checked="" type="checkbox"/>	<i>7/1/11 – 6/30/15</i>
Minimum of one year of advanced training in anesthesiology in a training program approved by the board			<input checked="" type="checkbox"/>	<i>7/1/11 – 6/30/15</i>
SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION				
Name of Course: <i>Advanced cardiac life support</i>		Location: <i>University of Oklahoma College of Dentistry</i>		
Date of Course: <i>1-6-2015</i>		Date Certification Expires: <i>1-2017</i>		
Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

*CK # 2261
\$500*

Name of Applicant Jaron Maurer

SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE			
Name of Dental School: <u>Nevada Las Vegas School of Dental Medicine</u>		From (Mo/Yr): <u>9/2007</u>	To (Mo/Yr): <u>5/2011</u>
City, State: <u>Las Vegas, Nevada</u>		Degree Received: <u>OMD</u>	
POST-GRADUATE TRAINING. Attach a copy of your certificate of completion for each postgraduate program you have completed.			
Name of Training Program: <u>OUHSC Oral & Maxillofacial Surgery Residency</u>	Address: <u>1201 N. Stone wall</u>	City: <u>Oklahoma City</u>	State: <u>OK</u>
Phone: <u>271-4441</u>	Specialty: <u>Oral & maxillofacial Surgery</u>	From (Mo/Yr): <u>7/2011</u>	To (Mo/Yr): <u>6/2015</u>
Type of Training: <input type="checkbox"/> Intern <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			
Name of Training Program:	Address:	City:	State:
Phone:	Specialty:	From (Mo/Yr):	To (Mo/Yr):
Type of Training: <input type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			
CHRONOLOGY OF ACTIVITIES			
Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you.			
Activity & Location	From (Mo/Yr):	To (Mo/Yr):	
<u>Oral and maxillofacial surgery residency OKC, OK</u>	<u>7-1-11</u>	<u>6-30-15</u>	
<u>Anesthesia rotation, OU department of Anesthesiology OKC, OK</u>	<u>9/11</u>	<u>3/12</u>	
<u>General surgery rotation, OU dept. of Surgery OKC, OK</u>	<u>3/13</u>	<u>7/13</u>	
<u>Plastic surgery rotation, OU dept of Plastic Surgery OKC, OK</u>	<u>4/14</u>	<u>5/14</u>	
SECTION 6 - DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO A. Do you have a license, permit, or registration to perform sedation in any other state? If yes, specify state(s) and permit number(s): _____			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of anti-anxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO D. Do you plan to use deep sedation/general anesthesia in pediatric patients?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. Do you plan to use deep sedation/general anesthesia in medically compromised patients?			
<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO F. Do you plan to engage in enteral moderate sedation?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO G. Do you plan to engage in parenteral moderate sedation?			
What major drugs and anesthetic techniques do you utilize or plan to utilize for sedation purposes? Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.			
<u>I.V. anesthetics including, fentanyl, versed, Propofol, Ketamine, Brexital, Demerol or other narcotic and sedation medications for the use of analgesia and moderate and deep sedation, with or without the use of nitrous oxide inhalational anesthetic.</u>			

Name of Applicant Jarom Maurer

Facility Address _____

SECTION 7 - AUXILIARY PERSONNEL

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

Name:	License/Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Kathy Rulay	QDA-04102	11/19/2014	11/2016
Stacy Swanson	QDA-05453	11/19/2014	11/2016
Melody Bildstein	QDA-07766	11/2014	11/2016
Jaclyn Hall	QDA-07777	11/2014	11/2016
Brandi Stillions	QDA-09725	11/2014	11/2016
Alyssa Danner	QDA-10749	11/2014	11/2016
Amy Schmidt	QDA-07789	11/2014	11/2016
Swann Stewart	QDA office staff	11/2014	11/2016

SECTION 8 - FACILITIES & EQUIPMENT

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

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: <u>Oklahoma</u>	COUNTY: <u>Oklahoma</u>
------------------------	-------------------------

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

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

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

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

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

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

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

	MUST BE SIGNED IN PRESENCE OF NOTARY ▶		SIGNATURE OF APPLICANT
			SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF <u>3/31/2015</u> , YEAR <u>2015</u>
			NOTARY PUBLIC SIGNATURE
			NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Lisa Nichols</u>

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS
Provider



Jarom Maurer

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

1-6-2015
Issue Date

1-2017
Recommended Renewal Date

ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name GENESIS TC ID # 5988

TC Info OKC, OK 73172 465.642.3383
City, State ZIP Phone

Course Location OUHSC

Instructor Name Bill Justice Inst. ID # 5988

Holder's Signature [Signature]

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1806

→
PEEL
HERE
→

This card contains unique security features to protect against forgery.

90-1806 3/11

HEALTHCARE PROVIDER

Healthcare
Provider



Jarom Maurer

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

1-6-2015
Issue Date

1-2017
Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name GENESIS TC ID # 5988

TC Info OKC, OK 73172 465.642.3383
City, State ZIP Phone

Course Location OUHSC

Instructor Name Bill Justice Inst. ID # 5988

Holder's Signature [Signature]

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1801

→
PEEL
HERE
→

This card contains unique security features to protect against forgery.

90-1801 3/11



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

RECEIVED

MAY 18 2015

PLEASE TYPE OR PRINT LEGIBLY IN INK.

IOWA DENTAL BOARD

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 – APPLICANT INFORMATION

Instructions – Complete Section 1 and mail this form to the Postgraduate Program Director for verification of your postgraduate training.

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

Jarom Enoch Maurer

MAILING ADDRESS:

2511 melody Drive

CITY:

Edmond

STATE:

OK

ZIP CODE:

73012

PHONE:

435-668-9032

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

APPLICANT'S SIGNATURE:

DATE:

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

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

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

NAME AND LOCATION OF POSTGRADUATE PROGRAM:

*University of Oklahoma Health Science Center
 Oral and Maxillofacial Surgery*

PHONE:

405-271-4079

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

7/1/2011

TO (MO/YR):

6/30/2015

DATE PROGRAM COMPLETED:

6/30/15

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain.
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

I further certify that the above named applicant has demonstrated competency in airway management and deep sedation/general anesthesia.

PROGRAM DIRECTOR SIGNATURE:

DATE:

5/8/15

The Oklahoma State Regents for Higher Education

The University of Oklahoma Health Sciences Center

acting through
James F. Hamner, M.D., M.P.H.

has served as

Resident in Oral and Maxillofacial Surgery

from July 1, 2011 through June 30, 2015

Given under the Seal of the University of Oklahoma
at the Health Sciences Center,
Oklahoma City, Oklahoma.

For the State Regents

For the University



[Signature]
Chairman

[Signature]
Secretary

[Signature]
Chairman

[Signature]
Chairman, Board of Regents

[Signature]
President of the University

[Signature]
Professor and Dean





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

RECEIVED
 MAY 27 2015
 IOWA DENTAL BOARD

SCANNED
 MAY 27 2015

APPLICATION FOR MODERATE SEDATION PERMIT

SECTION 1 – APPLICANT INFORMATION

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

Full Legal Name: (Last, First, Middle, Suffix)
 PETERSON, BRANDON, KEITH

Other Names Used: (e.g. Maiden)		Home E-mail: petersonbk@yahoo.com	Work E-mail:	
Home Address: 9832 BROOKVIEW DR	City: URBANDALE	State: IA	Zip: 50322	Home Phone: 3194358140
License Number: DDS-08288	Issue Date: MAY 2015	Expiration Date: 31 AUG 16	Type of Practice: PERIODONTAL	

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

Principal Office Address: 6600 WESTOWN PWKY, STE 170	City: WEST DES MOINES	Zip: 50266	Phone: 5152239700	Office Hours/Days: 7-5/M-F
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.	Check if completed.	DATE(S):
Moderate Sedation Training Program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences	<input type="checkbox"/> Completed	
ADA-accredited Residency Program that includes moderate sedation training	<input checked="" type="checkbox"/> Completed	JUN 2012
You must have training in moderate sedation AND one of the following:		
Formal training in airway management; OR	<input type="checkbox"/> Completed	
Moderate sedation experience at graduate level, approved by the Board	<input checked="" type="checkbox"/> Completed	JUN 2012

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS Provider		Location: Naval Hospital Okinawa		
Date of Course: SEP 2014		Date Certification Expires: SEP 2016		
Office Use	Lic. #	Sent to ACC:	Inspection	Fee
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

Name of Applicant PETERSON, BRANDON, K

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program: MUSC CDM PERIODONTICS	Address: 173 ASHLEY AVE, 119 BSB	City: CHARLESTON	State: SC
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Type of Experience:
PERIODONTICS POST-GRADUATE RESIDENCY PROGRAM

Length of Training: 3 YEARS	Date(s) Completed: JUN 29 2012
--------------------------------	-----------------------------------

Number of Patient Contact Hours: <i>In Sedation: 300 hours</i>	Total Number of Supervised Sedation Cases: <i>62</i>
---	--

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

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

SECTION 6 – MODERATE SEDATION EXPERIENCE

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

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

For enteral moderate sedation I plan on using oral benzodiazepam (example: Halcion). I plan on utilizing nitrous oxide for inhalation as an adjunctive. I will use Versed and Fentanyl for IV moderate sedation cases.

Name of Applicant Brandon Peterson

Facility Address 6600 Westown Pkwy, STE 170

West Des Moines, IA 50266

SECTION 7 - AUXILIARY PERSONNEL

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

Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
<u>TANA BELGARDE</u>	<u>QDA-02144</u>	<u>02/18/15</u>	<u>02/17</u>
<u>Connie Marshall</u>	<u>QDA-00778</u>	<u>2/18/15</u>	<u>02/17</u>
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

SECTION 8 - FACILITIES & EQUIPMENT

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

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

COPY FORM AND SUBMIT FOR EACH FACILITY.

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: IOWA	COUNTY: POLK
----------------	-----------------

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

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

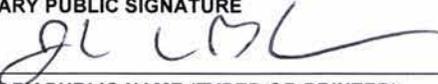
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and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

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

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

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

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

MUST BE SIGNED IN PRESENCE OF NOTARY ►	SIGNATURE OF APPLICANT 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS 21 DAY OF MAY, YEAR 2015	
	NOTARY PUBLIC SIGNATURE 	
NOTARY SEAL	NOTARY PUBLIC NAME (TYPED OR PRINTED) J. F. LABARRERA LT, MSC, USN LEGAL OFFICER	MY COMMISSION EXPIRES: Indefinite

4
3D DEN BN/USNDC OKINAWA
Notary per Iowa SC 1014 a

ACLS PROVIDER

Military Training Network
Resuscitation Medicine Programs



PETERSON, BRANDON K. USN/DC

Has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program. The MTN is an authorized provider of American Heart Association Emergency Cardiovascular Care Courses.

SEP 2014

Issue Date

SEP 2016

Expiration Date

HEALTHCARE PROVIDER



BRANDON PETERSON

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the BLS for Healthcare Providers (CPR & AED) Program. The MTN is an authorized provider of American Heart Association Emergency Cardiovascular Care Courses.

AUG 2014

Issue Date

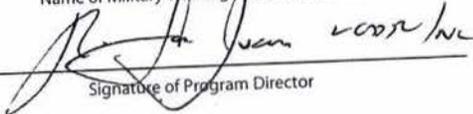
AUG 2016

Renewal Date

For Authorized Use Only

MILITARY TRAINING NETWORK
U.S. NAVAL HOSPITAL OKINAWA

Name of Military Training Network Affiliate



Signature of Program Director

Holder's Signature

For Authorized Use Only

3D DENBN/USNDC OKINAWA

Name of Military Training Network Affiliate



Signature of Program Director

Holder's Signature



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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

SECTION 1 – APPLICANT INFORMATION

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

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

MAILING ADDRESS: 9832 BROOKVIEW DR

CITY: URBANDALE

STATE: IA

ZIP CODE: 50322

PHONE: 319-435-8140

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

APPLICANT'S SIGNATURE:

DATE: 7 MAY 2015

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: JOE W. KRAYER, DDS, MS

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

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

NAME AND LOCATION OF POSTGRADUATE PROGRAM: 173 Ashley Avenue
BSB 119 MSC 507
Charleston, SC 29425

PHONE:

843-792-7612

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

JULY 2009

TO (MO/YR):

JUNE 2012

DATE PROGRAM COMPLETED:

6/30/12

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM?
 YES NO 2. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?
 YES NO 3. DOES THE PROGRAM COVER THE AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS?
 YES NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE IN MANAGING COMPROMISED AIRWAYS?
 YES NO 5. DOES THE PROGRAM INCLUDE MANAGEMENT OF AT LEAST 20 PATIENTS?
(If no to above, please provide a detailed explanation.)
 YES NO 6. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR WAS THE APPLICANT PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
 YES NO 7. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
 YES NO 8. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR PEDIATRIC (AGE 12 OR YOUNGER) PATIENTS? If yes, please provide details.
 YES NO 9. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR MEDICALLY COMPROMISED (ASA CLASS 3 OR 4) PATIENTS? If yes, please provide details.

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

PROGRAM DIRECTOR SIGNATURE:

DATE:

5/18/15



College of Dental Medicine
Department of Stomatology
Division of Periodontics

173 Ashley Avenue
BSB 119 MSC 507
Charleston SC 29425
Tel 843 792-3907
Fax 843 792-7809

www.musc.edu

RECEIVED

MAY 26 2015

IOWA DENTAL BOARD

May 18, 2015

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

To Whom It May Concern:

I have been asked by Dr. Brandon Peterson to provide verification of his training in moderate sedation during the Post-Doctoral Periodontics Program he completed with us.

I have attached your form and the following comments relate to Question 8.

Our clinical program includes training in moderate sedation consistent with the ADA guidelines and the accreditation standards for Post-Doctoral Periodontics programs. The training includes experiences with a wide range of patients. In regard to Question 8, the training included experience with ASA Class 3 patients, as well as ASA Class 1 and 2. It is my policy however, that ASA Class 4 patients are not managed by our Residents. These cases are managed jointly with a Dental Anesthesiologist or are seen in a Hospital setting with an MD Anesthesiologist.

I hope this information is sufficient for you to proceed with Dr. Peterson's application. If you need additional information from me, please do not hesitate to contact me.

Sincerely,

Joe W. Kraye, D.D.S., M.S.
Associate Professor
Director, Post-Doctoral Periodontics
kraye@musc.edu
843-792-7612

Medical University of South Carolina

College of Dental Medicine

Charleston, South Carolina

This is to certify that

Brandon R. Peterson, D.D.S., M.S.D.

has successfully completed the Postdoctoral Program of Instruction in

Periodontics

*This program qualifies the recipient for limited practice, and provides
eligibility for examination by the American Board of Periodontology.*

Dated in Charleston, South Carolina this 30th day of June, 2012.

Bruce Kraus, D.D.S., F.A.C.D.
Director, Postdoctoral Program in Periodontics



Robert B. Gellin, D.M.D., M.H.S.
Chair, Department of Stomatology

John J. Anderson, D.D.S.
Dean, College of Dental Medicine