



# STATE OF IOWA

## IOWA DENTAL BOARD

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

JILL STUECKER  
EXECUTIVE DIRECTOR

### **ANESTHESIA CREDENTIALS COMMITTEE**

#### **AGENDA**

September 10, 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 8<sup>th</sup> 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.; Jonathan DeJong, D.D.S. (alternate)*

- I. CALL MEETING TO ORDER – ROLL CALL**
- II. COMMITTEE MINUTES**
  - a. July 16, 2015 – Teleconference
- III. APPLICATION FOR GENERAL ANESTHESIA PERMIT**
  - a. Christopher M. Kepros, D.D.S.
- IV. APPLICATION FOR MODERATE SEDATION PERMIT**
  - a. Daniel J. Binkowski, D.D.S.
  - b. Jarod W. Johnson, D.D.S.
- V. OTHER BUSINESS**
  - a. 2016 Meeting Dates
- VI. OPPORTUNITY FOR PUBLIC COMMENT**
- VII. 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.



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### ANESTHESIA CREDENTIALS COMMITTEE

#### MINUTES

July 16, 2015

Conference Room  
400 S.W. 8<sup>th</sup> St., Suite D  
Des Moines, Iowa

#### Committee Members

Kaaren Vargas, D.D.S.  
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.

#### July 16, 2015

Present  
Absent  
Present  
Present  
Present  
Present  
Absent

#### Staff Member

Christel Braness

### I. CALL MEETING TO ORDER – JULY 16, 2015

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Tuesday, July 16, 2015. This meeting was held by conference call to review committee minutes and applications for general anesthesia and moderate sedation permits. It was impractical for the committee to meet in person with such a short agenda. A quorum was established with four members present.

Roll Call:

<u>Member</u>	<u>Burton</u>	<u>Clark</u>	<u>Frank</u>	<u>Horton</u>	<u>Roth</u>	<u>Westlund</u>	<u>Vargas</u>
Present		X	X	X	X		
Absent	X					X	X

### II. COMMITTEE MEETING MINUTES

- *January 15, 2015 – Teleconference*

- ❖ MOVED by ROTH, SECONDED by FRANK, to approve the minutes as submitted.  
Motion APPROVED unanimously.

➤ Dr. Vargas joined the meeting at 12:06 p.m.

▪ *March 10, 2015 – Teleconference*

❖ MOVED by ROTH, SECONDED by FRANK, to approve the minutes as submitted. Motion APPROVED unanimously.

▪ *June 11, 2015 – Teleconference*

❖ MOVED by FRANK, SECONDED by VARGAS, to approve the minutes as submitted. Motion APPROVED unanimously.

### **III. APPLICATION FOR GENERAL ANESTHESIA PERMIT**

▪ *Douglas E. Kendrick, D.D.S.*

Ms. Braness provided an overview of the application.

❖ MOVED by ROTH, SECONDED by CLARK, to APPROVE the application for moderate sedation permit. Motion approved unanimously.

### **IV. APPLICATIONS FOR MODERATE SEDATION PERMIT**

▪ *Kecia S. Leary, D.D.S.*

Ms. Braness provided an overview of the application. Dr. Leary has requested the qualification to sedate pediatric patients.

❖ MOVED by VARGAS, SECONDED by CLARK, to APPROVE the application for moderate sedation permit and to allow the sedation of pediatric patients. Motion approved unanimously.

▪ *Arwa I. Owais, D.D.S.*

Ms. Braness provided an overview of the application. Dr. Owais requested the qualifications to sedate pediatric and medically-compromised patients.

There was some discussion among the committee members as to whether to allow Dr. Owais to sedate medically-compromised patients due to her original training in sedation. Ms. Braness indicated that the committee could approve Dr. Owais for pediatric patients, and request additional information prior to approving the qualification for medically-compromised patients if they wished.

❖ MOVED by ROTH, SECONDED by FRANK, to APPROVE the application for moderate sedation permit and to allow the sedation of pediatric patients, and to deny the qualification to sedate medically-compromised patients. If Dr. Owais wishes to sedate medically-

compromised patients, she may submit a request for reconsideration provided Dr. Owais can document sufficient training in this area.

Prior to the vote, Dr. Vargas stated that guidelines would not allow for the oral sedation of ASA 3-4 patients.

❖ Vote taken. Motion APPROVED unanimously.

#### **V. OPPORTUNITY FOR PUBLIC COMMENT**

No comments were received.

#### **VI. ADJOURN**

❖ MOVED by FRANK, SECONDED by VARGAS, to adjourn. Motion APPROVED unanimously.

The Anesthesia Credentials Committee adjourned its meeting at 12:15 p.m.

#### **NEXT MEETING OF THE COMMITTEE**

The next meeting of the Anesthesia Credentials Committee is scheduled for September 10, 2015. The meeting will be held at the Board offices and by teleconference.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.



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

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AUG 28 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) <b>KEPROS, CHRISTOPHER, MICHAEL</b>				
Other Names Used: (e.g. Maiden)	Home E-mail: <b>CMKEPROS@YAHOO.COM</b>		Work E-mail: <b>CHRISTOPHER.M.KEPROS.MIL@MAIL.MIL</b>	
Home Address: <b>2250 8<sup>TH</sup> AVE</b>	City: <b>MARION</b>	State: <b>IA</b>	Zip: <b>52302</b>	Home Phone: <b>319-389-0569</b>
License Number: <b>08489</b>	Issue Date: <b>6/26/2007</b>	Expiration Date: <b>8/31/2016</b>	Type of Practice: <b>ORAL + MAXILLOFACIAL SURG.</b>	
SECTION 2 – LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED				
Principal Office Address: <b>1530 S. MONROE</b>	City: <b>MASON CITY</b>	Zip: <b>50401</b>	Phone: <b>(641) 424-1656</b>	Office Hours/Days: <b>MON-TUE 8-5 FRIDAY 8-3</b>
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			✓	<b>7/2007 - 6/2011</b>
Formal training in airway management			✓	<b>7/2007 - 6/2011</b>
Minimum of one year of advanced training in anesthesiology in a training program approved by the board			✓	<b>7/2007 - 6/2011</b>
SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION				
Name of Course: <b>ACLS PROVIDER COURSE</b>		Location: <b>MILITARY TRAINING NETWORK - FT. SAMPSON HOUSTON, TX</b>		
Date of Course: <b>7/4/2015</b>		Date Certification Expires: <b>7/2017</b>		
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

# 1503  
\$ 500.00

Name of Applicant CHRISTOPHER M. KEARNS

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE			
Name of Dental School: <u>UNIVERSITY OF IOWA</u>		From (Mo/Yr): <u>08/2003</u>	To (Mo/Yr): <u>06/2007</u>
City, State: <u>IOWA CITY, IA</u>		Degree Received: <u>DDS</u>	
POST-GRADUATE TRAINING. Attach a copy of your certificate of completion for each postgraduate program you have completed.			
Name of Training Program: <u>EISENHOWER ARMY MED CENTER</u>	Address: <u>300 EAST HOSPITAL ROAD</u>	City: <u>FORT GORDON</u>	State: <u>GA</u>
Phone: <u>(706) 787-2478</u>	Specialty: <u>ORAL + MAXILLOFACIAL SURGERY</u>	From (Mo/Yr): <u>07/2007</u>	To (Mo/Yr): <u>06/2011</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 SURGERY RESIDENCY - EISENHOWER ARMY MED CENTER</u>	<u>07/2007</u>	<u>06/2011</u>	
<u>ORAL SURGEON - WILLIAM BEAUFORT ARMY MED CENTER - EL PASO, TX</u>	<u>07/2011</u>	<u>04/2015</u>	
<u>ORAL SURGEON - SAM ANTONIO MILITARY MED CENTER - SAM ANTONIO, TX</u>	<u>05/2015</u>	<u>PRESENT</u>	
SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE			
<input checked="" type="checkbox"/> YES <input 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): <u>TEXAS 29021</u>		
<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 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>IV SEDATION UTILIZING MIDAZOLAM AND FENTANYL ALONG WITH OCCASIONAL USE OF PROPOFOL AND KETAMINE ANESTHETIC MEDICATIONS</u>			

Name of Applicant CHRISTODHER M. KEPPOS

Facility Address 1530 S. MONROE, MASON CITY

**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:
AIMEE LEE, RN	XDA-05932	7/30/14	7/31/16
ANGELA STRICKER, RN	XDA-10947	7/30/14	7/31/16
MIKKY WYBORNYY, RDA	RDA-12200	7/30/14	7/31/16
LARAE RONGEY, RDA	RDA-08509	7/30/14	7/31/16
DAWN HOSS, RDA	RDA-06737	7/30/14	7/31/16
SARAH HEFT, RDA	RDA-11550	7/30/14	7/31/16
KIRSTEN BUTLER, RDA	RDA-11941	7/30/14	7/31/16
LIMOSAY ROLLEFSON, RDA	RDA-08763	7/30/14	7/31/16

**SECTION 8 - FACILITIES & EQUIPMENT**

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

YES	NO	Is your dental office properly maintained and equipped with the following:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<u>6</u>	<input type="checkbox"/>	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>TEXAS</u>	COUNTY: <u>BEXAR</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 <u>13<sup>th</sup></u> DAY OF <u>August</u> , YEAR <u>2015</u>	
	NOTARY PUBLIC SIGNATURE	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	MY COMMISSION EXPIRES:
	<u>Nancy G. Castillo</u>	<u>4 June 2017</u>

# HEALTHCARE PROVIDER



**CHRISTOPHER KEPROS**

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.

**APR 14**

Issue Date

**APR 16**

Renewal Date

# ACLS PROVIDER

Military Training Network  
Resuscitative Medicine Programs



**CHRISTOPHER M. KEPROS**

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 Advanced Cardiovascular Life Support Program. The MTN is an authorized provider of American Heart Association Emergency Cardiovascular Care Courses.

**07/2015**

Issue Date

**07/2017**

Renewal Date

# PALS PROVIDER

Military Training Network  
Resuscitative Medicine Programs



**Christopher Kepros**

This card certifies that the above individual has successfully completed the national cognitive and skills evaluation in accordance with the curriculum of the American Heart Association for the Pediatric Advanced Life Support Program. The MTN is an authorized provider of American Heart Association Emergency Cardiovascular Care Courses.

**Feb 2014**

Issue Date

**Feb 2016**

Expiration Date

For Authorized Use Only

**MTN/WBAMC**

Name of Military Training Network Affiliate

**JOHN BRICKER RN BLS PD**

Signature of Program Director

Holder's Signature

For Authorized Use Only

**MTN-FSHTX 78234-6200**

Name of Military Training Network Affiliate

**PERRY C. RUIZ, LTC, MSN (PD)**

Signature of Program Director

Holder's Signature

FOR AUTHORIZED USE ONLY

Name of Military Training Affiliate

**MTN/WBAMC**

Signature of Program Director

**HENRIKE LANGAN RN PALS PD**

Holder's Signature

# U.S. ARMY MEDICAL DEPARTMENT



*This is to certify that*

CHRISTOPHER M. KEPROS, DDS  
CAPTAIN, DENTAL CORPS

*has successfully completed training in*

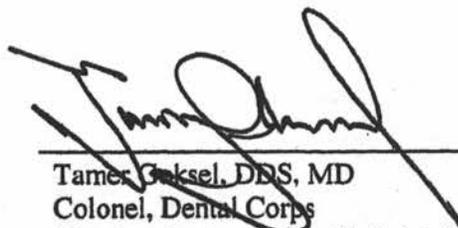
ORAL AND MAXILLOFACIAL SURGERY RESIDENCY TRAINING

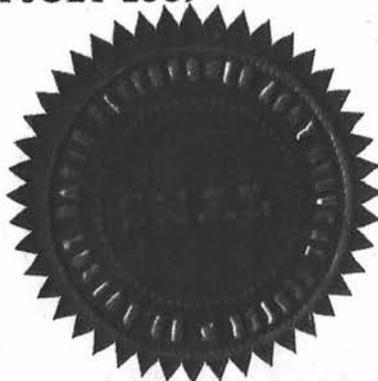
*at*

DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER

*from* 1 JULY 2007

*to* 30 JUNE 2011

  
\_\_\_\_\_  
Tamer Goksel, DDS, MD  
Colonel, Dental Corps  
Director, Oral and Maxillofacial Surgery  
Residency Program



  
\_\_\_\_\_  
W. Bryan Gamble  
Brigadier General, US Army  
Commander



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

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IOWA DENTAL BOARD

PLEASE TYPE OR PRINT LEGIBLY IN INK.

**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): **CHRISTOPHER MICHAEL KEAROS**

MAILING ADDRESS: **2250 8<sup>TH</sup> AVE**

CITY: **MARION** STATE: **IA** ZIP CODE: **52302** PHONE: **(319) 389-0569**

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: **27 JULY 2015**

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

NAME OF POSTGRADUATE PROGRAM DIRECTOR: **Travis Austin, DDS - LTC DG US Army**

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: **EISENHOWER ARMY MEDICAL CENTER FT. GORDON, GA** PHONE: **706-787-2478**

DATES APPLICANT PARTICIPATED IN PROGRAM ▶ FROM (MO/YR): **7/2007** TO (MO/YR): **6/2011** DATE PROGRAM COMPLETED: **6/30/2011**

- 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: **7AUG 2015**



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

RECEIVED

JUL 31 2015

IOWA DENTAL BOARD

APPLICATION FOR MODERATE SEDATION PERMIT

SECTION 1 - APPLICANT INFORMATION

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

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

Binkowski, Daniel, Joseph

Other Names Used: (e.g. Maiden)

Home E-mail:

djb51373@gmail.com

Work E-mail:

same

Home Address:

4115 Vally View Rd

City:

Ames

State:

IA

Zip:

50010

Home Phone:

515 5201367

License Number:

DDS-09236

Issue Date:

22 July 2015

Expiration Date:

31 August 2016

Type of Practice:

General Dentistry

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

Principal Office Address:

1903 EP Trne Parkway

City:

West Des Moines

Zip:

50265

Phone:

515-224-1618

Office Hours/Days:

8-5M-F

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

SECTION 3 - BASIS FOR APPLICATION

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

Check if completed.

DATE(S):

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

Completed

July 2011 - 2 Aug 2012

ADA-accredited Residency Program that includes moderate sedation training

Completed

July 2011 - Aug 2012

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

Formal training in airway management; OR

Completed

Moderate sedation experience at graduate level, approved by the Board

Completed

July 2011 - Aug 2012

SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

ACLS (USA MEDDAC-AK)

Location:

Ft. Wainwright, Alaska

Date of Course:

5 May 2015

Date Certification Expires:

May 2017

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 Daniel J Binkowski

**SECTION 5 - MODERATE SEDATION TRAINING INFORMATION**

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

Name of Training Program: Offutt Air Force Base Advanced Education in general Anesthesiology Address: 2501 Capehart Rd City: Offutt AFB State: NE

Type of Experience: 60 hours didactic with hands on training → IV starts → Intubation on manopalmic, 4 successful intubations @ 1st rotation, 45 surgical cases w/ IV sedation

Length of Training: 1 Year Date(s) Completed: 3 Aug 2012

Number of Patient Contact Hours: 86 hours Total Number of Supervised Sedation Cases: 43

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? \*see attached letter  
 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? ← only if pt response to drug causes this. Ideally I want mild enteral 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.

IV moderate sedation  
- Fentanyl  
- Versed  
- Decadron  
- Ketorolac

Enteral mild sedation  
- Triazolam only

Name of Applicant Daniel Binkowski Facility Address 1903 EP True Parkway

**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>Aubrey McDougall</u>	<u>ODA-12033</u>	<u>5/13/14</u>	<u>5/30/16</u>
<u>Jessica Wissler</u>	<u>ODA-10092</u>	<u>2/27/15</u>	<u>2/27/17</u>
<u>Lindsey Cook</u>	<u>ODA-11828</u>	<u>2/27/15</u>	<u>2/27/17</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:

**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)?
<input type="checkbox"/>	<input checked="" 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: Alaska COUNTY: North Star Borough

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.

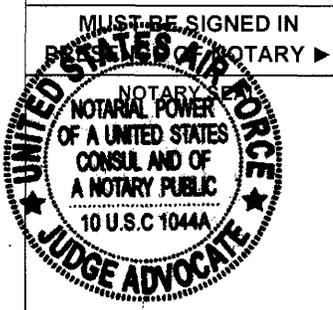
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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	<i>David Pinker</i>
	SUBSCRIBED AND SWORN BEFORE ME, THIS	17 DAY OF July, YEAR 2015
	NOTARY PUBLIC SIGNATURE	<i>[Signature]</i>
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	Chris Mounier, Notary USAA
	MY COMMISSION EXPIRES:	July 10 U.S.C. 1044g



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS, 55TH WING (ACC)  
OFFUTT AIR FORCE BASE, NEBRASKA

23 July 2015

MEMORANDUM FOR MS. CHRISTEL BRANESS

FROM: COL ROBERT GAMBLE

SUBJECT: MODERATE SEDATION APPLICATION FOR DR. DANIEL BINKOWSKI

This letter is to further explain my 'No' response to Section 2, Question #4 (Does the program include clinical experience in managing compromised airways?) of the Iowa Dental Board Verification of Moderate Sedation Training in a Postgraduate Residency Program form.

The curriculum of this program includes didactic and clinical training in pain and anxiety control and moderate sedation. The didactic portion is provided in-house by our Oral and Maxillofacial Surgeons and clinical supervision is provided by our surgeons and Periodontists. Our residents also complete modules on airway management (to include oro- and naso-pharyngeal airway placement and endo-tracheal intubation) via mannequin simulation training as well as a formal Advanced Cardiac Life Support class and practicum for certification which they are required to achieve prior to being privileged to administer moderate sedation services in the Air Force and must maintain current in order to remain sedation providers.

Finally, our residents attend a one-week enrichment experience at the local Veteran's Administration hospital, under the direct supervision of the Anesthesiology Department. In this environment they gain exposure to intravenous sedation, general anesthesia, and airway management in an operating room setting. There is no curriculum requirement to perform live intubations; residents may/may not gain practical experience, based upon their respective abilities, willingness to participate, and the permission of the attending Anesthesiologist or Nurse Anesthetist. Specifically, Dr. Binkowski reported four completed intubations during this rotation.

I hope that this information is what you need for clarification. If you have any further questions, please don't hesitate to contact me (402-232-9121).

  
ROBERT F. GAMBLE, Col, USAF, DC  
Offutt AFB AEGD Residency Program Director

*The Sun Never Sets on the Fightin' Fifty-Fifth*



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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

**SECTION 1 - APPLICANT INFORMATION**

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

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

Daniel, Joseph, Binkowski

MAILING ADDRESS:

4115 Valley View Rd

CITY:

Ames

STATE:

IA

ZIP CODE:

50010

PHONE:

(515) 520-1367

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:

*Daniel Binkowski*

DATE:

26 July 2015

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

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Col (Dr) Robert F. Gamble  
 Director, AEGD Residency Program

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:

55<sup>th</sup> Dental Squadron  
 Offutt Air Force Base Advanced Education in General Dentistry Pgm  
 2501 Capital Rd, Offutt AFB NE 68113

PHONE:

(402) 232-9121

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

Aug 2011

TO (MO/YR):

Aug 2012

DATE PROGRAM COMPLETED:

3 Aug 2012

- 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:

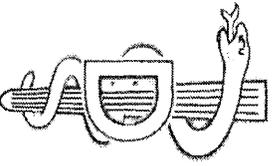
*R. Gamble*

DATE:

11 May 2015

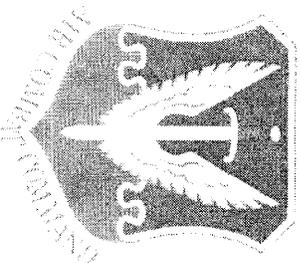
# 55th Medical Group

Upon Recommendation of the Faculty  
This Certificate is Awarded to



**Daniel J. Brinkowski**

for Successfully Completing the



**Advanced Education in General Dentistry Residency**

from 6 August 2011 To 3 August 2012

In Witness Whereof, this Certificate is Awarded  
at Office Air Force Base, Debarka  
on this 3rd Day of August 2012

ROBERT F. GAMBLE, Col, USAF, DC  
AEGD Program Director

Handwritten signature of Robert F. Gamble.

DOUGLAS L. RISK, Col, USAF, DC  
Commander, 55th Dental Squadron

Handwritten signature of Douglas L. Risk.

Stephen M. Mounts, Col, USAF, MSC  
Commander, 55th Medical Group

Handwritten signature of Stephen M. Mounts.



# The United States Air Force



CERTIFIES THAT

***Daniel J. Binkowski***

HAS SUCCESSFULLY COMPLETED THE

**Didactic and Clinical Requirements for Certification in Intravenous--Conscious Sedation**

AND IS HEREWITH AWARDED THIS

# *Certificate of Training*

55th Medical Group  
Offutt Air Force Base, Nebraska

ERIC SCHMIDT, Lt Col, USAF, DC  
Chairman, Department of Oral and Maxillofacial Surgery

3 August 2012

DATE

**HEALTHCARE  
PROVIDER**



**DANIEL BINKOWSKI**

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.

**MAY 12 2015**

Issue Date

**MAY 12 2017**

Renewal Date

**ACLS  
PROVIDER**

Member, American Heart Association  
Resuscitation Education Programs



**DANIEL BINKOWSKI**

This individual 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.

**MAY 2015**

Issue Date

**MAY 2017**

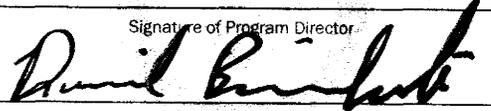
Renewal Date

BLS

For Authorized Use Only  
354th MDG

Name of Military Training Network Affiliate  
AMBER M. GREEN, SSgt, USAF  
354th MDG, BLS Program Director

Signature of Program Director



Holder's Signature

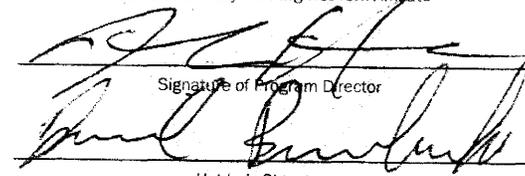
ACLS

For Authorized Use Only

USA MEDDAC-AK

Name of Military Training Network Affiliate

Signature of Program Director



Holder's Signature



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

**RECEIVED**

AUG 31 2015

IOWA DENTAL BOARD

## APPLICATION FOR MODERATE SEDATION PERMIT

### SECTION 1 - APPLICANT INFORMATION

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

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

Johnson, Jarod, William

**Other Names Used: (e.g. Maiden)**

N/A

**Home E-mail:**

jarod.w.johnson@gmail.com

**Work E-mail:**

dr.jarod@arcticdental.com

**Home Address:**

31 Coventry Ln #8

**City:**

Muscatine

**State:**

IA

**Zip:**

52761

**Home Phone:**

319-321-5634

**License Number:**

DDS-09044

**Issue Date:**

09/03/2013

**Expiration Date:**

08/31/2016

**Type of Practice:**

Pediatric Dentistry

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

**Principal Office Address:**

2023 Cedar Plaza Dr.

**City:**

Muscatine

**Zip:**

52761

**Phone:**

563-607-5979

**Office Hours/Days:**

8:00-5:00/M-F

**Other Office Address:**

N/A

**City:**

N/A

**Zip:**

N/A

**Phone:**

N/A

**Office Hours/Days:**

N/A

**Other Office Address:**

N/A

**City:**

N/A

**Zip:**

N/A

**Phone:**

N/A

**Office Hours/Days:**

N/A

**Other Office Address:**

N/A

**City:**

N/A

**Zip:**

N/A

**Phone:**

N/A

**Office Hours/Days:**

N/A

**Other Office Address:**

N/A

**City:**

N/A

**Zip:**

N/A

**Phone:**

N/A

**Office Hours/Days:**

N/A

### SECTION 3 - BASIS FOR APPLICATION

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

**Check if completed.**

**DATE(S):**

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

Completed

**ADA-accredited Residency Program that includes moderate sedation training**

Completed

07/2013-06/2015

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

**Formal training in airway management; OR**

Completed

**Moderate sedation experience at graduate level, approved by the Board**

Completed

07/2013-06/2015

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

**Name of Course:**

Pediatric Advanced Life Support (PALS)

**Location:** University Medical Center of So. NV

PO Box 90635 Henderson NV 89009

**Date of Course:**

June 10<sup>th</sup> 2015

**Date Certification Expires:**

June 2017

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

#1039  
\$ 800.00

Name of Applicant Jarod Johnson

**SECTION 5 – MODERATE SEDATION TRAINING INFORMATION**

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

Name of Training Program: UNLV School of Dental Medicine Address: 1700 W Charleston Blvd. City: Las Vegas State: NV

Type of Experience: Certificate in Pediatric Dentistry

Length of Training: Two years Date(s) Completed: 06/30/2015

Number of Patient Contact Hours: 173 Total Number of Supervised Sedation Cases: 28 (twenty eight)

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

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

**SECTION 6 – MODERATE SEDATION EXPERIENCE**

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

Inhalation - nitrous oxide/oxygen

Enteral - Meperidine - 2mg/kg (50mg maximum dose)

Midazolam - 0.5-0.7 mg/kg (15 mg maximum dose)

Diazepam - .25 mg/kg (10 mg maximum dose)

Hydroxyzine - 1-2 mg/kg (50mg maximum dose)

Parenteral (intranasal) - Midazolam - .2-.3 mg/kg

Name of Applicant Jarod Johnson

Facility Address 2023 Cedar Plaza Dr. Muscatine IA

52761

**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: <u>Heidi Jackson</u>	License/ Registration #: <u>QDA-07291</u>	BLS Certification Date: <u>08/19/2015</u>	Date BLS Certification Expires: <u>August 2017</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:
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Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

**SECTION 8 – FACILITIES & EQUIPMENT**

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

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

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.

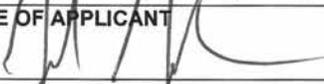
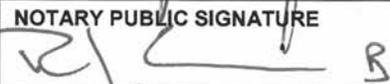
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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.

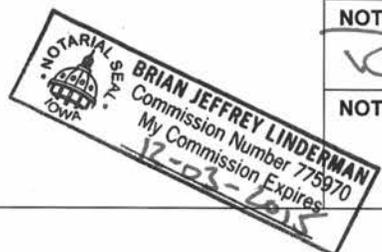
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation. I also understand that if moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

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.

<b>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</b>	SIGNATURE OF APPLICANT 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>28<sup>th</sup></u> DAY OF <u>AUGUST</u> , YEAR <u>2015</u>	
NOTARY SEAL	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>BRIAN J. LINDERMAN</u>	MY COMMISSION EXPIRES: <u>12-03-2015</u>





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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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

**SECTION 1 - APPLICANT INFORMATION**

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

**NAME (First, Middle, Last, Suffix, Former/Maiden):**  
 Jared William Johnson

**MAILING ADDRESS:**  
 31 Coventry Ln #8

**CITY:** Muscatine      **STATE:** IA      **ZIP CODE:** 52761      **PHONE:** 319-321-5034

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:** *[Signature]*      **DATE:** 08/05/2015

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

**NAME OF POSTGRADUATE PROGRAM DIRECTOR:** Cody C. Hughes, DMD

**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:** UNLV School of Dental Medicine, 1601 Shundar Lane, Las Vegas, NV 89106      **PHONE:** 702 774 2416

**DATES APPLICANT PARTICIPATED IN PROGRAM ▶** FROM (MO/YR): 7/2013 TO (MO/YR): 6/2015      **DATE PROGRAM COMPLETED:** 6/30/15

- 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:** *[Signature]*      **DATE:** 8/6/15

University of Nevada Las Vegas  
School of Dental Medicine

Advanced Education Program in Pediatric Dentistry

This is to certify that

Jarod W. Johnson

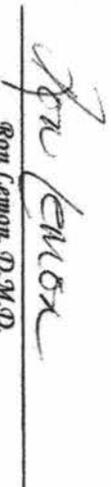
has successfully completed post-graduate training in

Pediatric Dentistry

7/1/2013 – 6/30/2015



Cody C. Hughes, D.M.D., M.S.D.  
Program Director



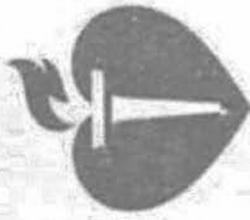
Ron Lemon, D.M.D.  
Associate Dean for Advanced Education





Karen West, D.M.D., M.P.H.  
Dean, UNLV School of Dental Medicine

June 30, 2015  
Date of Presentation



**American  
Heart  
Association®**

American Academy  
of Pediatrics



# PALS Provider

**Jarod Johnson**

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

**June 10, 2015**

Issue Date

**June 2017**

Recommended Renewal Date

# PEDIATRIC ADVANCED LIFE SUPPORT

Training

TC ID #

Center ~~Nan~~NATIONAL EMS ACADEMY NV15163

TC

TC

Info PO Box 90635 Henderson, NV 89009

Course

Location University Medical Center of So. NV

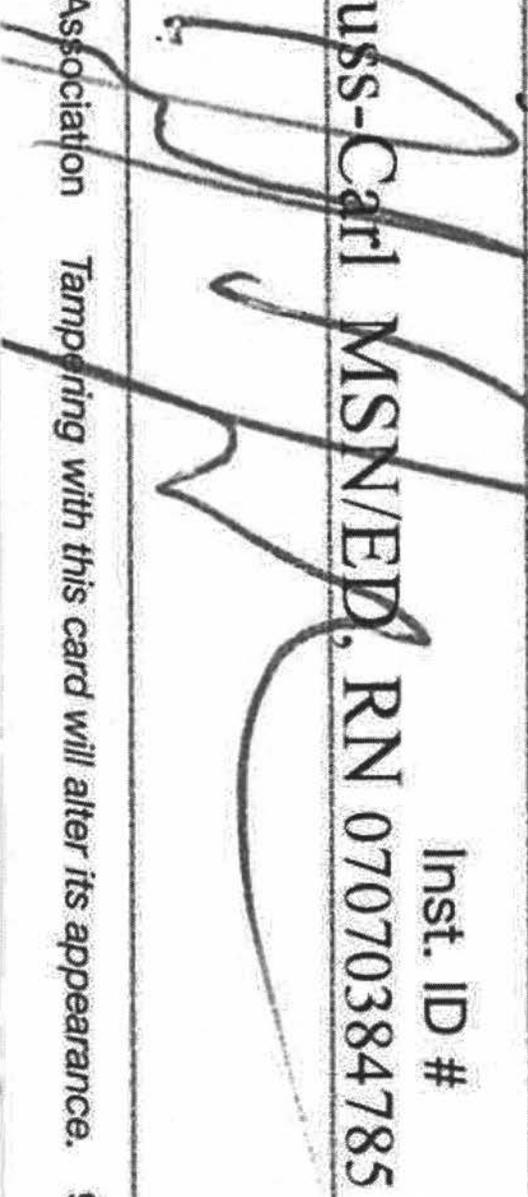
Instructor

Inst. ID #

Name Judy Fuss-Carl MSN/ED, RN 07070384785

Holder's

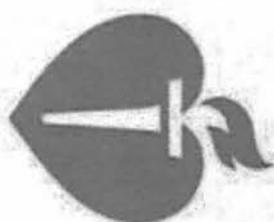
Signature



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Tampering with this card will alter its appearance. 90-1818

# Healthcare Provider



American  
Heart  
Association®

**JAROD JOHNSON**

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.

**JAN. 30, 2015**

Issue Date

**JAN. 2017**

Recommended Renewal Date

# HEALTH CARE PROVIDER

Training

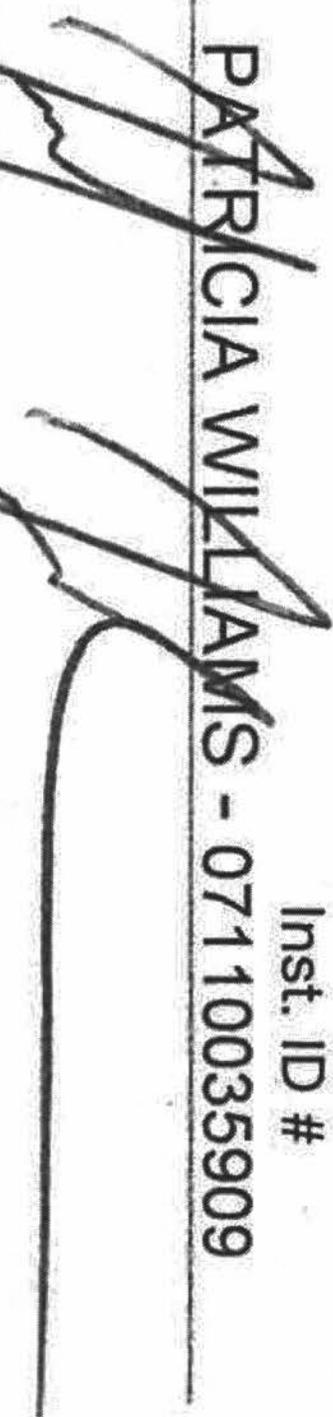
TC ID #

Center Name **CPR INSTITUTE, LLC**

TC Info **LAS VEGAS, NV 89131 702-234-6921**  
City, State ZIP Phone

Course **UNLV - SDM**  
Location

Instructor Name **PATRICIA WILLIAMS - 07110035909**  
Inst. ID #

Holder's Signature 

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