



STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

April 7, 2016
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.; Jonathan DeJong, D.D.S. (alternate)*

- I. CALL MEETING TO ORDER – ROLL CALL**
- II. COMMITTEE MINUTES**
 - a. January 21, 2016 – Teleconference
- III. APPLICATION FOR GENERAL ANESTHESIA PERMIT**
 - a. Lois I. Jacobs, D.D.S.
- IV. APPLICATION FOR MODERATE SEDATION PERMIT**

**No applications received to date*
- V. OTHER BUSINESS**
 - a. Committee Meeting Dates
 - b. ADA Members' Hearing: Anesthesia and Sedation Guidelines
- 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

January 21, 2016
Conference Room
400 S.W. 8th 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.
Jonathan DeJong, D.D.S. (*alternate*)

January 21, 2016

Present
Absent
Present
Absent
Present
Present
Present
Present

Staff Member

Christel Braness, Phil McCollum, David Schultz

I. CALL MEETING TO ORDER – JANUARY 21, 2016

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Thursday, January 21, 2016. This meeting was held by electronic means in compliance with Iowa Code section 21.8. The purpose of the meeting was to review committee minutes, applications for general anesthesia and moderate sedation permits, and other committee business. It was impractical for the committee to meet in person with such a short agenda. A quorum was established with five (5) members present.

Roll Call:

Member	Burton	Clark	DeJong	Frank	Horton	Roth	Westlund	Vargas
Present		x			x	x	x	x
Absent	x		x	x				

II. COMMITTEE MEETING MINUTES

- *October 15, 2015 – Teleconference*
- ❖ MOVED by ROTH, SECONDED by VARGAS to APPROVE the minutes as submitted. Motion APPROVED unanimously.

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

- *Michael Zachar, D.D.S.*

Ms. Braness provided an overview of the application. Dr. Zachar completed his residency training at Lackland Air Force Base. Dr. Zachar intends to join an oral surgery practice in Iowa following his service in the military.

- ❖ MOVED by VARGAS, SECONDED by WESTLUND, to APPROVE the application for general anesthesia permit as submitted. Motion approved unanimously.

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

- *Annalee Fencl, D.D.S.*

Ms. Braness provided an overview of the application. Dr. Fencl completed a pediatric residency program at the University of Iowa College of Dentistry, and has requested approval to sedate pediatric patients.

- ❖ MOVED by CLARK, SECONDED by VARGAS, to APPROVE the application for moderate sedation permit as submitted following successful completion of the facility inspection. Motion APPROVED unanimously.

- *Adam Holton, D.D.S.*

Ms. Braness provided an overview of the application. Dr. Holton did not complete a standard residency program; however, his training was completed at the University of Iowa College of Dentistry from July 2015 and August 2015.

Dr. Roth asked about the request to sedate pediatric and medically-compromised patients. Ms. Braness reported that Iowa Administrative Code 650—Chapter 29 required completion of an accredited residency program. Dr. Holton's training does not appear to meet that requirement.

- 12:12 pm Dr. DeJong joined the call.

Dr. Westlund stated that if Dr. Fridrich were to sign off on the training in the sedation of pediatric patients and medically-compromised patients, he would be in favor of approving a request for rule waiver should Dr. Holton request one.

- ❖ MOVED by ROTH, SECONDED by VARGAS, to APPROVE the application for moderate sedation permit to allow the moderate sedation of patients 13 years of age and older, who are ASA 1-2. Dr. Holton may request a rule waiver to sedation pediatric and medically-compromised patients if he wishes. Motion APPROVED unanimously.

V. OTHER BUSINESS

- *Schedule In-Person Meeting*

Ms. Braness reported that this meeting was intended to address topics, which require more in-depth discussion than a teleconference would allow. Ms. Braness proposed some dates in May 2016.

Dr. Vargas stated that she will be coming to the Iowa Dental Association's convention, it may work for the committee to meet then. Ms. Braness stated that she would send an email to the entire committee to confirm availability and schedule a meeting date after receiving responses from the committee.

VI. OPPORTUNITY FOR PUBLIC COMMENT

No comments were received.

VII. ADJOURN

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

The Anesthesia Credentials Committee adjourned its meeting at 12:19 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for April 7, 2016. The meeting will be held at the Board office and by teleconference.

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



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 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
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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)
 Jacobs Lois I

Other Names Used: (e.g. Maiden)	Home E-mail: 101stulsa@att.net	Work E-mail: N/A
Home Address: 5874 South Kingston Avenue	City: Tulsa	State: OK
License Number: 4184	Issue Date: r	Expiration Date:
		Zip: 74135
		Home Phone:
		Type of Practice: Anesthesia

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

Principal Office Address: to be determined	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:
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, such as a copy of your diplomate certificate.	Check all that apply.	DATE(S):
American Dental Association Council on Dental Education Guidelines (2003) Part 2		
You must have training in ADA Part 2 AND one of the following:		
Formal training in airway management; OR	X	
One year of advanced training in anesthesiology in board-approved program; OR	X	
Diplomate of American Board of Oral and Maxillofacial Surgery; OR		
Eligible for exam by American Board of Oral & Maxillofacial Surgery; OR		
Member of American Association of Oral & Maxillofacial Surgeons; OR		
Fellow of American Dental Society of Anesthesiology.		

SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS	Location: Tulsa, OK
Date of Course: 7/2014	Date Certification Expires: 7/2016

Office Use	Lic. #	Sent to ACC:	Fee \$500 & 500
	Permit #	Approved by ACC:	State Ver.: ACLS
	Issue Date:	Temp #	Inspection
	Brd Approved:	T. Issue Date:	Diplomate Cert
			Res. Ver Form
			Res Cert

Name of Applicant Wils J Jacob

SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: University of Iowa From (Mo/Yr): 8/74 To (Mo/Yr): 5/78

City, State: Iowa City, Iowa 52242 Degree Received: D.D.S.

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

Name of Training Program: Anesthesia Address: University of Iowa Hospital Clinics City: Iowa City State: IA

Phone: _____ Specialty: _____ From (Mo/Yr): July 1978 To (Mo/Yr): July 1980

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>Eric Baptist Hospital</u>	<u>9/80</u>	<u>10/81</u>
<u>ORU College of Dentistry</u>	<u>12/81</u>	<u>8/1985</u>
<u>Tulsa, Oklahoma</u>		
<u>Private Practice Dentist Anesthesiologist</u>	<u>8/85</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 anti-anxiety premedication, nitrous oxide inhalation analgesia, conscious 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 conscious sedation?

YES NO G. Do you plan to engage in parenteral conscious 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.

I.V., I.M.
Inhalation

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: <u>Oklahoma</u>	COUNTY: <u>Tulsa</u>
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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.

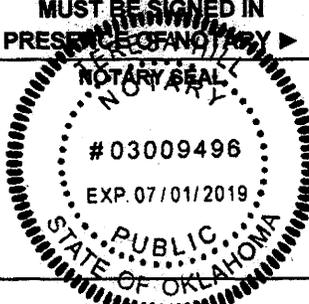
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency 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 deep sedation/general anesthesia, or conscious 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 conscious sedation, deep sedation/general anesthesia 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 deep sedation/general anesthesia in the state of Iowa.

<p>MUST BE SIGNED IN PRESENCE OF NOTARY</p> 	<p>SIGNATURE OF APPLICANT</p> <p><i>[Signature]</i></p>
	<p>SUBSCRIBED AND SWORN BEFORE ME, THIS <u>19th</u> DAY OF <u>January</u>, YEAR <u>2016</u></p>
	<p>NOTARY PUBLIC SIGNATURE</p> <p><i>[Signature]</i></p>
<p>NOTARY PUBLIC NAME (TYPED OR PRINTED)</p> <p><u>Teresa Hill</u></p>	<p>MY COMMISSION EXPIRES:</p> <p><u>July 1, 2019</u></p>



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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):

Lois T Jacob

MAILING ADDRESS:

5874 South Kington Avenue

CITY:

Tulsa

STATE:

OK

ZIP CODE:

74135-7656

PHONE:

918/492-6432

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:

Lois T Jacob

DATE:

1/19/16

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Wendell Stevens, M.D.

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

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

NAME AND LOCATION OF POSTGRADUATE PROGRAM:

University of Iowa Hospitals and Clinics

PHONE:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

7/1978

TO (MO/YR):

6/1980

DATE PROGRAM COMPLETED:

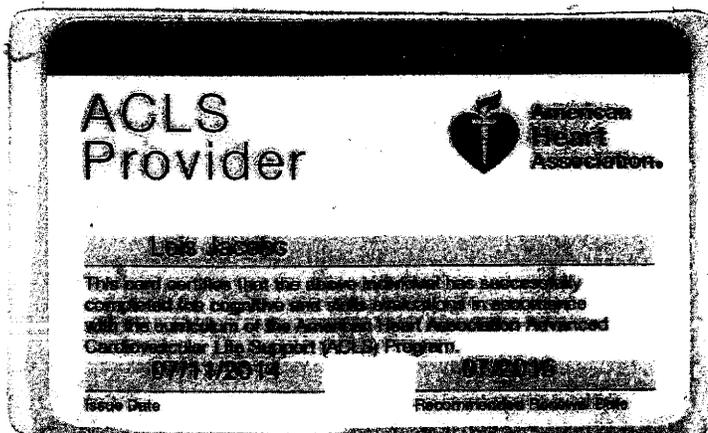
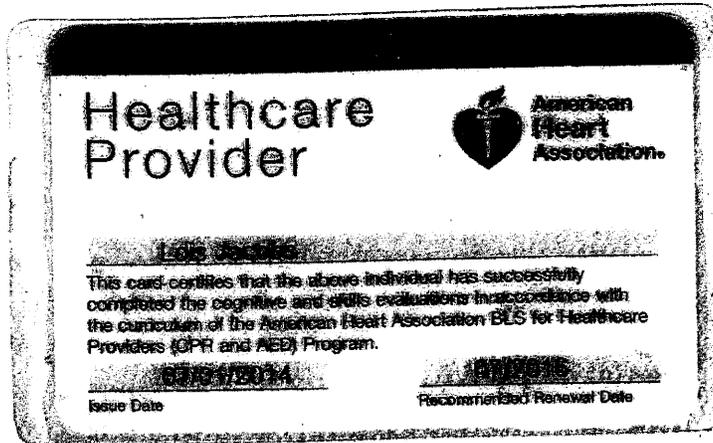
6/80

- 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, REPRIMAND, OR WAS THE APPLICANT 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 COVER PART 2 OF THE 2003 AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING THE COMPREHENSIVE CONTROL OF ANXIETY AND PAIN AT THE ADVANCED EDUCATION LEVEL? If no, please explain.
- YES NO 4. DOES THE PROGRAM INCLUDE ADDITIONAL TRAINING IN MANAGING PEDIATRIC OR MEDICALLY COMPROMISED PATIENTS? If yes, please provide details.

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

PROGRAM DIRECTOR SIGNATURE:

DATE:



This communique is being distributed to dental anesthesiology communities of interest on behalf of Dr. Daniel Gesek, Jr. Chair, Council on Dental Education and Licensure (CDEL) and, Dr. David Sarrett, Chair, CDEL Committee on Anesthesiology.

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