



STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

July 14, 2016

12:00 P.M.

Updated 7/11/2016

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. May 19, 2016 – Teleconference

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

- a. Lois I. Jacobs, D.D.S. (follow up)
b. Amine Bellil, D.M.D.
c. Jason M. Thompson, D.D.S.

IV. APPLICATION FOR MODERATE SEDATION PERMIT

**No applications received to date*

V. OTHER BUSINESS

- a. Discussion – American Academy of Pediatric Updates Guidelines of Sedation in Pediatric Patients
b. *Discussion – Definition of “Hospitalization” with Respect to Adverse Occurrences*

VI. OPPORTUNITY FOR PUBLIC COMMENT

VII. ADJOURN

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

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



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TERRY E. BRANSTAD, GOVERNOR
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EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES

May 19, 2016

Conference Room

University of Iowa College of Dentistry
Iowa City, Iowa

Committee Members

Steven Fuller, D.D.S.
Steven Clark, D.D.S.
John Frank, D.D.S.
Douglas Horton, D.D.S.
Gary Roth, D.D.S.
Kaaren Vargas, D.D.S.
Kurt Westlund, D.D.S.
Jonathan DeJong, D.D.S. (*alternate*)

May 19, 2016

Present
Present
Present
Present
Present
Present
Absent
Present

Staff Members

Christel Braness, Phil McCollum, David Schultz

I. CALL MEETING TO ORDER – MAY 19, 2016

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 2:44 p.m. on Thursday, May 19, 2016. The purpose of the meeting was to review committee minutes, applications for general anesthesia permits, and other committee business. A quorum was established with seven (7) members present.

Roll Call:

<u>Member</u>	<u>Clark</u>	<u>DeJong</u>	<u>Frank</u>	<u>Fuller</u>	<u>Horton</u>	<u>Roth</u>	<u>Vargas</u>	<u>Westlund</u>
Present	x	x	x	x	x	x	x	
Absent								x

II. COMMITTEE MEETING MINUTES

- *April 7, 2016 – Teleconference*

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

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

- *Lois I. Jacobs, D.D.S.*

Ms. Braness provided an update on the application. There was still a question as to the extent of Dr. Jacobs' anesthesia training. The records at the University of Iowa College of Dentistry are old enough that they cannot fully confirm the extent of the training.

Dr. Clark spoke about his training. Dr. Clark thought it might be helpful to ask other state about their verification process prior to issuing a permit.

Dr. Vargas and Dr. Roth believe that the committee should look at the experience she has sedating, given that she has provided sedation for over 30 years.

Ms. Braness stated that Dr. Jacob's application was not complete to date; however, she would proceed based on these recommendations.

- ❖ MOVED by ROTH, SECONDED by HORTON, to REQUEST paperwork for credentialing. Motion APPROVED unanimously.

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

Ms. Braness reported that the Board had not received any moderate sedation applications to date.

V. OTHER BUSINESS

- *Review and Discussion of Sedation Facility Inspection Form*
- *Discussion of Sedation Drugs*
 - *Recommended Emergency Drugs and Other Medications*

Mr. McCollum provided an overview of the inspection form. The committee agreed to go through the form in order to best discuss the items listed.

The committee members discussed some of the issues related to floor plans of the operatories and what type of space may be required. After further discussion, it was determined that an operatory should have sufficient room to fit a back board in the event of an emergency.

There was a discussion about how valuable light readings might be. Ultimately, the committee determined that this was not critical since there is a requirement for backup lighting in case of emergency. Typically, most offices use head lights; though, the committee noted that an office should maintain replacement batteries in the office.

Mr. McCollum inquired about how many face masks a general practice office should keep on hand. There was also a discussion of sizes that should be available. Dr. Vargas recommended that an

office have at least one of each size of adult mask; and should be replaced before expiration. Pediatric sizes should not be needed unless an office is allowed to sedate pediatric patients.

Mr. McCollum inquired about the committee's preference for positive-pressure forced-air system. The members stated that a bag valve mask would be sufficient for those purposes. The committee recommended that a minimum of two bags be maintained in each office.

Mr. McCollum asked about the use of laryngoscope mask airway (LMA) in place of laryngoscope and blades, or endotracheal tubes. Dr. Frank stated that the best standard would be to use endotracheal tubes. Though, LMAs are often safer unless practitioners place endotracheal tubes regularly. The committee recommended requiring one or the other.

Dr. Vargas asked if an AED could replace the EKG monitor. Dr. Vargas believed that the requirement for an EKG monitor was a burden on the pediatric community without added benefit. Dr. Frank asked Dr. Vargas about this. Dr. Vargas reported that the American Academy of Pediatric Dentistry (AAPD) only requires the use of an EKG for deep sedation. To start with, there are a number of restrictions to sedating pediatric patients. Dr. Frank asked about pre-operative vitals. Dr. Vargas reported that she used pulse-oximetry and capnography; however, she did not currently use an EKG. Mr. McCollum recommended changing the rule, or requiring pediatric doctors to request rule waivers of this requirement.

Mr. McCollum reported that the inspection form had been changed to referencing categories of drugs, as opposed to specific drugs since these may change.

In response to a question about emergency drugs needed, Mr. McCollum asked if moderate sedation permit holders would need to keep succinylcholine in the office. A number of committee members with sedation permits indicated that they did not feel comfortable using this drug even in an emergency, and would use valium or versed instead. Dr. Frank stated that succinylcholine is used for laryngospasms; though, he has not needed to employ its use in an office. Mr. McCollum stated that it has not been required of moderate sedation permit holders for several years.

Dr. Frank stated that sedation is a continuum, and permit holders should be prepared to handle the next level of sedation in the event of an emergency. Dr. Vargas agreed; though, she believed that the use of succinylcholine went beyond that.

Dr. DeJong and Dr. Frank reported that succinylcholine is the shortest acting drug to address emergencies such as these. Other medications have a much longer half-life.

Dr. Clark believed that most of the permit holders would not have used this. Dr. Vargas believed that the use of this drug could cause more harm than good.

Dr. Frank clarified that not all patients with whom succinylcholine is used require intubation; most do not.

- ❖ MOVED by ROTH, SECONDED by VARGAS, to maintain the current standard to *not* require for moderate sedation permit holders. Motion APPROVED 5-2; Dr. Frank and Dr. DeJong dissented.

Mr. McCollum asked about any other drugs that the committee members may want to have added to the list, or changed. Dr. Frank indicated that lidocaine was no longer necessary as an anti-arrhythmic. It could be maintained; though, it should not be required if other anti-arrhythmic drugs are available.

Mr. McCollum asked again for clarification on the types of muscle relaxant drugs that could be used for moderate sedation permit holders. Dr. Roth stated that versed should be sufficient.

Dr. Clark stated that a muscle relaxant and a neuromuscular blocking agent are two different things. Dr. Clark stated that valium would be used to break a seizure as a muscle relaxant, but would not be appropriate for laryngospasms.

Dr. Roth stated that the neuromuscular blocking agents are required for deep sedation/general anesthesia. Moderate sedation permit holders should have a muscle relaxant to break seizures. Versed or valium would be sufficient for the purposes of anti-seizure medication. Most offices will have these drugs on hand since they are implemented in the use of sedation.

- *Discussion of Sedation Drugs*
 - *Recommended Restrictions for Use in Moderate Sedation*

Ms. Braness provided an overview of the reason for discussion. Historically, drugs such as ketamine and hydromorphone have been restricted from use in moderate sedation given the level of sedation typically reached, or the post-operative observation required, due to a longer half-life of the medication.

After further discussion, the committee agreed that ketamine, propofol, and hydromorphone would continue to be prohibited in the use of moderate sedation. As new drugs are introduced, that may have similar effects, they may be added to this list.

- *Other Recommendations, If Any*

There weren't any other recommendations.

- *Discussion of Moderate Sedation Training in Continuing Education Courses*

Dr. Frank stated that he had reviewed some of the shorter moderate sedation courses available. In the courses that he has reviewed, there was often exposure to the use of versed in the course of treatment; though, there may be a question as to whether training would be sufficient for use of multiple drugs.

Dr. Roth and Dr. Vargas pointed out that training changes all of the time. To limit use of certain drugs to those in which training was received was a standard that is not applied in other areas of dentistry.

Dr. Roth believed that the changes already implemented are sufficient regarding pediatric patients and medically-compromised patients. Those who receive training in sedation should be able to recognize when they are having troubles and know how to respond accordingly.

The committee indicated that they would continue to review courses for approval upon request.

- *Discussion of Peer Evaluations*

- This agenda item was taken out of order due to the nature of the discussion and how it related to the previous agenda item.

Dr. Roth believed that it is a good idea to conduct peer evaluations of moderate sedation permit holders; however, there were issues to consider such as who would complete those evaluations, and the related costs.

Ms. Braness provided an overview of this agenda item. Dr. Westlund, historically, has recommended them; though, there has always been a question about who would complete these if they are required.

Dr. Vargas advocated doing peer evaluations, particularly, for pediatric dentists. It would be responsible of the committee to do this.

Dr. Horton asked about the possibility of increasing the fees to cover the costs related to this. Mr. McCollum and Ms. Braness indicated that fee increases would not likely be approved.

Dr. DeJong indicated that he completed some of those for the western part of the state, at his own cost.

Dr. Vargas asked if these could be completed over the phone. Mr. McCollum asked if a peer evaluation needed to be done by a dentist, or if it could be completed by Board staff since they are going into offices anyway.

There a number of concerns with all of the proposed options. The committee recommended that Board staff look into alternatives, and to bring this back to the committee at a later date.

- Dr. Vargas left the meeting at 4:23 p.m.

- *Review and Discussion of Application Updates – Moderate Sedation Permit and General Anesthesia Permit*

Ms. Braness asked if the committee members had any comments or suggestions related to the updated draft of the sedation application. The committee did not have any comments.

- *Discussion of ACLS/PALS Course Requirements*

Ms. Braness reported that the question has been raised about what ACLS/PALS courses are acceptable. Ms. Braness stated that renewal requirements for CPR required a hands-on course, and the Board has been applying the same standard to ACLS/PALS certification.

Dr. Horton reported that the ASDA has a sim-man course, which is a very beneficial course. Dr. Horton recommended making it a regular requirement. Ms. Braness stated that this would require a rule change; however, staff can add this to the list of suggestions if the committee was serious about requiring this. Dr. Frank stated that ACLS training is moving away from airway management, which is the big concern. The committee was in favor of requiring this once every five (5) years or so.

Dr. Frank inquired about minimal sedation and to what extent practitioners should be administering an anxiolytic in combination with nitrous or other drugs that may approach moderate sedation. Mr. McCollum clarified that this would be limited to patients ASA 1-2, age 13 years of age or older. Mr. McCollum stated that rules address intent. If the intention or belief is that moderate sedation would be reached, a permit would be required.

Ms. Braness stated that the topic can be discussed by the committee further at a later date.

VI. OPPORTUNITY FOR PUBLIC COMMENT

There weren't any comments received.

VII. ADJOURN

- ❖ **MOVED** by FRANK, **SECONDED** by DEJONG, to ADJOURN. Motion **APPROVED** unanimously.

The Anesthesia Credentials Committee adjourned its meeting at 4:38 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for July 11, 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
 Phone (515) 281-5157 Fax (515) 281-7969
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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>ORLI 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.

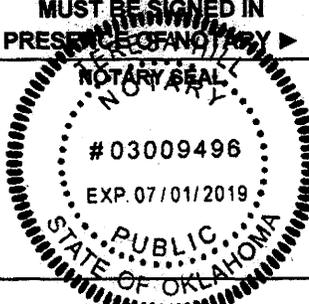
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency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

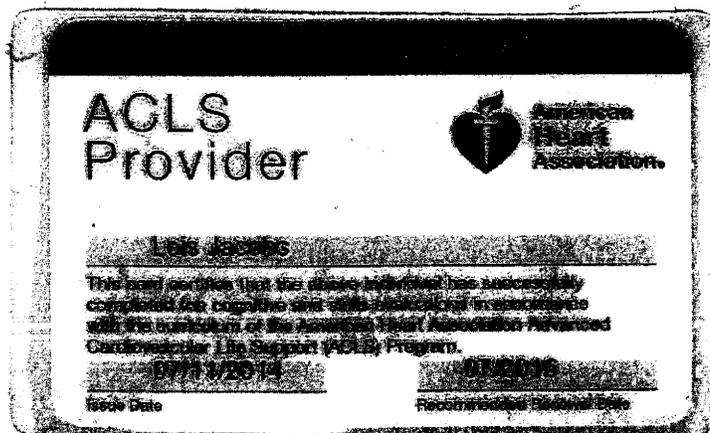
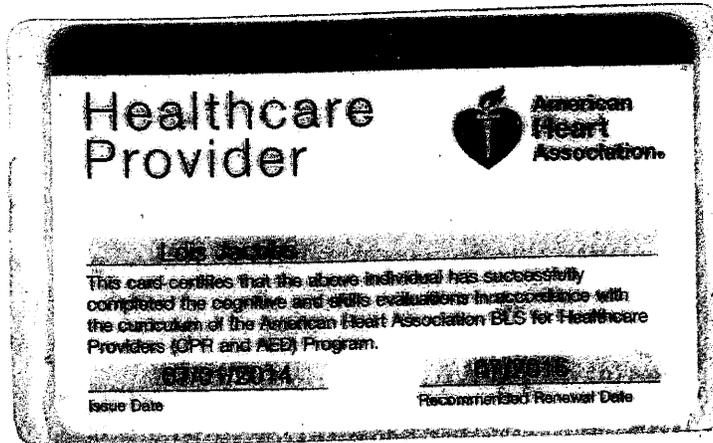
6/80

- 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:





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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):

Wols | Jacob | DDS

MAILING ADDRESS:

5874 S Kingston Avenue

CITY:

Tulsa

STATE:

OK

ZIP CODE:

74135-7656

PHONE:

918/491-1613

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APPLICANT'S SIGNATURE:

[Handwritten Signature]

DATE:

4/8/2016

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

unknown

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 + Clinics, Department of Anesthesia

PHONE:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

7 | 1978

TO (MO/YR):

7 | 1980

DATE PROGRAM COMPLETED:

- 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.

* Unable to provide answers to the aforementioned questions due to the age of the dates.

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

PROGRAM DIRECTOR SIGNATURE:

[Handwritten Signature]

DATE:

4/14/2016



Department of Anesthesia

200 Hawkins Drive
Iowa City, Iowa 52242-1009
319/356.2633 Tel
319/356.2940 Fax
www.uihealthcare.org

Facsimile

Date: 4/18/16

Time: 4:28 pm

To: Iowa dental Board

Tel: _____
Fax: ~~915-281-7969~~
615-281-7969

From: _____
Department of Anesthesia
University of Iowa Hospitals & Clinics
200 Hawkins Drive
Iowa City, IA 54424-1009

Tel: 319/356.2633
Fax: 319/356.2940

Re: _____

No. of
Pages: 2
(Including cover sheet)

Comments:

The documents accompanying this facsimile contain confidential information that may be legally privileged and protected by federal and state law. Please route this and the accompanying pages immediately to the individual named. Please call 319/356.2633 if there are any problems with the transmission of this document, or if you have received this facsimile in error. This information is intended for use only by the entity or individual whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner. The authorized recipient is prohibited from using this information for purposes other than intended, prohibited from disclosing this information to any other party unless required to do so by law or regulation, and is required to destroy the information after its stated need has been fulfilled. If you are in possession of protected health information and are not the intended recipient, you are hereby notified that any improper disclosure, copying, or distribution of the contents of this information is strictly prohibited. Please notify the owner of this information immediately and arrange for its return or destruction.

The University of Iowa

UNIVERSITY HOSPITALS AND CLINICS

THIS IS TO CERTIFY THAT
Lois J. Jacobs, D.D.S.
HAS COMPLETED THE SERVICE OF

Resident

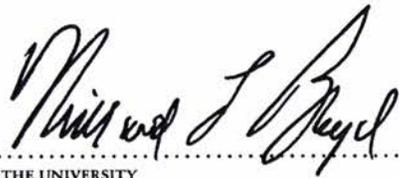
in the Department of

Anesthesia

July 1, 1978 to July 1, 1980

TO THE SATISFACTION OF THE
OFFICERS AND STAFF OF THE UNIVERSITY HOSPITALS AND CLINICS
IN WITNESS WHEREOF, THIS CERTIFICATE IS AWARDED AT IOWA CITY, IOWA.

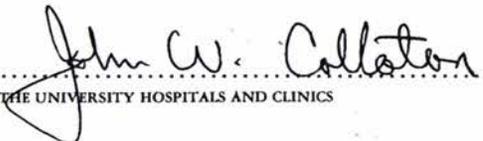
JULY 1, 1980



PRESIDENT OF THE UNIVERSITY



HEAD OF THE DEPARTMENT



DIRECTOR OF THE UNIVERSITY HOSPITALS AND CLINICS



DEAN OF THE COLLEGE OF MEDICINE



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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):

Wols | Jacob | DDS

MAILING ADDRESS:

5874 S Kingston Avenue

CITY:

Tulsa

STATE:

OK

ZIP CODE:

74135-7656

PHONE:

918/491-1613

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:

Jacob Wols

DATE:

4/8/2016

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

unknown

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 + Clinics, Department of Anesthesia

PHONE:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

7 | 1978

TO (MO/YR):

7 | 1980

DATE PROGRAM COMPLETED:

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.

* Unable to provide answers to the aforementioned questions due to the age of the dates.

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

PROGRAM DIRECTOR SIGNATURE:

[Signature]

DATE:

4/14/2016



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

RECEIVED

JUL 01 2016

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)

Amine Bellil

Other Names Used: (e.g. Maiden)		Home E-mail:		Work E-mail: a1iowadental@gmail.com	
		Bellil.DMD@gmail.com		Bellil.DMD@gmail.com	
Home Address:		City:	State:	Zip:	Home Phone:
1175 Farm Quarter Road		Mt. Pleasant	SC	29464	843-343-4156
License Number:		Issue Date:	Expiration Date:	Type of Practice:	
09277		4.13.2016	8.31.2016	Oral and Maxillofacial Surgery	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
A-1 IOWA DENTAL	ANKENY	50023	(515) 964-5602	
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	YES	7/2010-6/2016
Formal training in airway management	YES	7/2010-6/2016
Minimum of one year of advanced training in anesthesiology in a training program approved by the board	YES	7/2010-6/2016

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:	Advanced Cardiac Life Support	Location:	Bronx, NY, 10467
Date of Course:	5/4/2016	Date Certification Expires:	5/4/2018

Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee: #0086301801 \$500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: Medical University of South Carolina - College of Dental Medicine	From (Mo/Yr): 6/2006	To (Mo/Yr): 5/2010
City, State: Charleston, South Carolina	Degree Received: DMD	

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

Name of Training Program: Montefiore Medical Center Oral and Maxillofacial Surgery	Address: 111 East 210th Street	City: Bronx	State: NY
Phone: 718.920.2043	Specialty: Oral and Maxillofacial Surgery	From (Mo/Yr): 7/2012	To (Mo/Yr): 6/2016

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

Name of Training Program: Montefiore Medical Center General Practice Residency	Address: 111 East 210th Street	City: Bronx	State: NY
Phone: 718.920.2043	Specialty: General Practice Residency	From (Mo/Yr): 7/2010	To (Mo/Yr): 6/2012

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):
MMC General Practice Residency - Bronx, NY 10467	7/2010	6/2012
MMC Oral and Maxillofacial Surgery Residency - Bronx, NY 10467	7/2012	6/2016

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

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

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

IV - Propofol, Ketamine, Midazolam, Fentanyl
IH - Nitrous Oxide, Oxygen

Name of Applicant

AMINE BELLIL

Facility Address: 201 S Ankeny Blvd, Ankeny, IA 50023

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:
Higby, Desirae	QDA-12014	7.29.15	7.2017
Ollie, Robin	QDA-10459	2.13.15	2.2017
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

SECTION 8 – FACILITIES & EQUIPMENT

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

YES	NO	Is your dental office properly maintained and equipped with the following:
<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 checked="" type="checkbox"/>	<input type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input type="checkbox"/>	<input type="checkbox"/>	20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

1

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

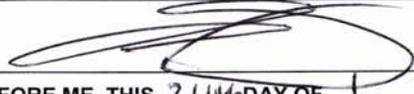
STATE: SOUTH CAROLINA COUNTY: CHARLESTON

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.

<p>MUST BE SIGNED IN PRESENCE OF NOTARY ►</p> 	SIGNATURE OF APPLICANT	
	AMINE BELLIL 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>24th</u> DAY OF <u>June</u> , YEAR <u>2016</u>	
NOTARY PUBLIC SIGNATURE		NOTARY PUBLIC NAME (TYPED OR PRINTED)
		MY COMMISSION EXPIRES:
Elconose Thomas		12/22/24

ADVANCED CARDIAC LIFE SUPPORT

**ACLS
Provider**



**ACLS
Certification
Institute™**

Amine Bellil

This card certifies that the person listed above has successfully completed the Advanced Cardiac Life Support examination and skills scenarios review based on the latest American Heart Association and ECC guidelines.

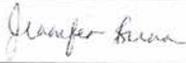
05/04/2016

05/04/2018

Issue Date

Renewal Date

ADVANCED CARDIAC LIFE SUPPORT

Training Center:	ACLS Certification Institute	Training Center #:	32633
Region:	Bronx, NY 10467	Provider #:	0846248429
Instructor:	Jennifer Bunn, RN	Instructor #:	01201746832
Instructor's Signature:		Provider's Signature:	



ALBERT EINSTEIN COLLEGE OF MEDICINE
of Yeshiva University
MONTEFIORE MEDICAL CENTER



DEPARTMENT OF DENTISTRY

This is to certify that

Amine Bellil, D.M.D.

having successfully completed a graduate program in

Fellow-Oral and Maxillofacial Surgery

*is awarded this certificate for achievement in:
research, patient care, and teaching*

In witness whereof, the undersigned have affixed their signatures this 30th day of June, 2011

Richard A. Grant
DEPARTMENTAL CHAIRPERSON

Richard A. Grant
PROGRAM DIRECTOR FOR





Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Montefiore
THE UNIVERSITY HOSPITAL

ALBERT EINSTEIN COLLEGE OF MEDICINE
of Yeshiva University
MONTEFIORE MEDICAL CENTER

DEPARTMENT OF DENTISTRY

This is to certify that

Amine Bellil, D.M.D.

having successfully completed a graduate program in

Fellow - Oral and Maxillofacial Surgery

*is awarded this certificate for achievement in
research, patient care, and teaching*

The witnesses whose the undersigned have affixed their signatures this 30th day of June 2012

Richard Shrant
DEPARTMENTAL CHAIRPERSON

Richard Shrant
PROGRAM DIRECTOR



EINSTEIN

Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Montefiore
THE UNIVERSITY HOSPITAL

This is to certify that

Amine Bellil, D.M.D.

has satisfactorily fulfilled the training program requirements of

Oral and Maxillofacial Surgery

in the capacity of: Resident

for the period of: July 1, 2012 to June 30, 2015

In Witness whereof, the undersigned have affixed their signatures this 30th day of June, 2015

Dean, Albert Einstein College of Medicine

Department Chairman

President and CEO, Montefiore Medical Center

Program Director



Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Montefiore
THE UNIVERSITY HOSPITAL

This is to certify that

Amine Bellil, D.M.D.

has satisfactorily fulfilled the training program requirements of

Oral and Maxillofacial Surgery

in the capacity of: Chief Resident

for the period of: July 1, 2015 to June 30, 2016

In Witness whereof, the undersigned have affixed their signatures this 30th day of June, 2016


Dean, Albert Einstein College of Medicine


Department Chairman


President and CEO, Montefiore Medical Center


Program Director



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

RECEIVED

PLEASE TYPE OR PRINT LEGIBLY IN INK.

JUL 06 2016

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

IOWA DENTAL BOARD

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):

AMINE BELLIL

MAILING ADDRESS:

1175 FARM QUARTER ROAD

CITY:

MT.PLEASANT

STATE:

SC

ZIP CODE:

29464

PHONE:

843-343-4156

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:

6.30.16

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Jairo Alfonso Bastidas

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:

PHONE:

Montefiore Medical Center Oral and Maxillofacial Surgery

718-920-2043

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

7/2012

TO (MO/YR):

6/2016

DATE PROGRAM COMPLETED:

6/30/2016

- 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:

[Handwritten Signature]

6/30/16



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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):

AMINE BELLIL

MAILING ADDRESS:

1175 Farm Quarter Road

CITY:

Mt. Pleasant

STATE:

SC

ZIP CODE:

29464

PHONE:

843-343-4156

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:

6.30.16

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Jairo Alfonso Bastidas

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:

Montefiore Medical Center Oral and Maxillofacial Surgery

PHONE:

718-920-2043

DATES APPLICANT

FROM (MO/YR):

7/2012

TO (MO/YR):

6/2016

DATE PROGRAM

PARTICIPATED IN PROGRAM ▶

COMPLETED: 6/30/2016

- 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:

6/30/16



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

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MAY 20 2016

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)

THOMPSON, JASON, MARK

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

jasonmarkthompson@gmail.com

Work E-mail:

jason-m-thompson@uiowa.edu

Home Address:

406 MONROE ST.

City:

IOWA CITY

State:

IA

Zip:

52246

Home Phone:

760 224 2836

License Number:

Issue Date:

Expiration Date:

Type of Practice:

ORAL MAXILLOFACIAL SURGERY

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

Principal Office Address:

1225 S GEAR AVE STE. 156

City:

WEST BURLINGTON

Zip:

52655

Phone:

319 752 2659

Office Hours/Days:

8AM-5PM M-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 & attach proof.

Check all that apply.

DATE(S):

Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia

X

July 2012 -
June 2016

Formal training in airway management

X

July 2012 -
June 2016

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

X

July 2012 -
June 2016

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

UIHC - EMSLRC TCCIA05137

Location:

UIHC - EMSLRC

Date of Course:

8/13/2014

Date Certification Expires:

8/31/2016

Office Use

Lic. #

Sent to ACC:

Peer Eval:

Fee

#158 \$800

Permit #

Approved by ACC:

State Ver.:

ACLS

Issue Date:

Temp #

Inspection:

Res. Ver Form

Brd Approved:

T. Issue Date:

Inspection Fee:

Res. Cert

Name of Applicant JASON MARK THOMPSON

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>UNIVERSITY OF CALIFORNIA - LOS ANGELES</u>	From (Mo/Yr): <u>JULY 2008</u>	To (Mo/Yr): <u>JUNE 2012</u>
City, State: <u>LOS ANGELES, CA</u>	Degree Received: <u>D.D.S.</u>	

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

Name of Training Program: <u>UNIVERSITY OF IOWA HOSPITALS & CLINICS</u>	Address: <u>200 HAWKINS DR</u>	City: <u>IOWA CITY</u>	State: <u>IA</u>
Phone: <u>319 356 1616</u>	Specialty: <u>ORAL MAXILLOFACIAL SURGERY</u>	From (Mo/Yr): <u>JULY 2012</u>	To (Mo/Yr): <u>JUNE 2016</u>

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

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

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

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>NO OTHER ACTIVITY THAN ABOVE LISTED SCHOOLING</u>		

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

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

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

IV - VERSED, FENTANYL, KETAMINE, PROPOFOL
INHALATION - NITROUS, POSSIBLE OTHER ANESTHETICS IN OR SETTING (NOT IN OFFICE)
PO - VERSED
IM - KETAMINE

Name of Applicant JASON MARK THOMPSON Facility Address 1225 S. GEAR AVE STE 156

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:
NICHOLE DAVIS	QDA-08975	3-2016	3-2018
ERIKA PRICE	QDA-07445	3-2016	3-2018
MOLLY LAMBERT	QDA-12568	12-2015	12-2017
JESSICA CURRY	QDA-06253	3-2016	3-2018
VIRGINIA LAYER	RDA-10849	3-2016	3-2018
MEGAN VICE	T-12889	3-2016	3-2018
ELLEN BRADLEY	112781 REGISTERED NURSE	3-2016	3-2018
JILLIAN IRELAND	129737	3-2016	3-2018

SECTION 8 – FACILITIES & EQUIPMENT

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

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

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

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

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

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	<input type="checkbox"/>	N/A <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"/>	N/A <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:	COUNTY:
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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.

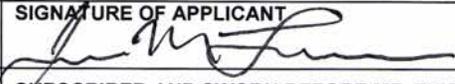
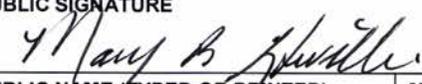
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency 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 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 18 th DAY OF May, YEAR 2016	
NOTARY SEAL	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) Mary B. Litwiler	MY COMMISSION EXPIRES: June 27, 2018



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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):
 JASON, MARK, THOMPSON

MAILING ADDRESS:
 406 MONROE ST.

CITY: IOWA CITY	STATE: IA	ZIP CODE: 52246	PHONE: 760 224 2836
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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: 5/2/16
-----------------------------------	------------------------

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:
 Steven L. Fletcher, DDS

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 & Clinics, Iowa City	PHONE: 319-356-7339
--	-------------------------------

DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/YR): 07/2012	TO (MO/YR): 06/2016	DATE PROGRAM COMPLETED: 6-30-16
--	---------------------------------	-------------------------------	---

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain. - Dr. Thompson is in good standing and will complete residency in June 2016
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

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

PROGRAM DIRECTOR SIGNATURE: 	DATE: 5-2-16
--	------------------------

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider



→
PEEL
HERE
→

Jason Thompson

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.
8/13/2014

8/31/2016

Issue Date

Recommended Renewal Date

Training Center Name	UIHC-EMSLRC	TC ID #	
TC Info	TCCIA05137	TC	
	2001 Hawkins Dr, Iowa City, IA 52242		
Course Location	319-353-7495		
	EMSLRC		
Instructor Name	Lee Ridge 03060026618	Inst. ID #	
Holder's Signature			

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

Jason Thompson
406 Monroe St.
Iowa City IA 52246

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

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AAP News

June 27, 2016

Report updates guidance on sedation in children undergoing medical, dental procedures

Charles J. Coté, M.D., FAAP and Stephen Wilson, D.M.D., M.A., Ph.D.

New guidance on pediatric sedation recommends more advanced skills on the part of practitioners, unifies guidelines for medicine and dentistry, and offers clarifications on monitoring modalities and other methods to improve safety and outcomes.

The AAP clinical report *Guidelines for Monitoring and Management of Pediatric Patients Before, During and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016*,

<http://pediatrics.aappublications.org/content/early/2016/06/24/peds.2016-1212>, is jointly issued with the American Academy of Pediatric Dentistry (AAPD). It will be published in the July issue of *Pediatrics*.

Highlights of practice recommendations

The report recommends the following:

- Practitioners who administer moderate sedation need to have the skills to rescue a child with apnea, laryngospasm and airway obstruction, and to perform successful bag/mask ventilation.
- Those administering deep sedation also must be able to perform tracheal intubation and cardiopulmonary resuscitation.
- Additionally, the skilled observer for either moderate or deep sedation must be trained in Pediatric Advanced Life Support.
- Most importantly, the use of capnography is highly encouraged for children who are moderately sedated and required for those who are deeply sedated.



Photo courtesy of Stephen Wilson, D.M.D., M.A., Ph.D.

The report recognizes that in some situations, capnography may not be possible until after the child is sedated, and the veracity of the numbers produced often will be unreflective of the actual arterial or expired carbon dioxide values. However, the real

issue is whether the child is breathing; if there is air exchange; whether the airway has become obstructed; and the effectiveness of airway maneuvers in correcting complications.

To aid clinicians, the report includes three decision trees to guide management of airway obstruction, laryngospasm and apnea.

Evolution of the guidance

The issue of safe sedation was raised in the 1980s following several deaths in dental offices. In 1985, the Academy developed the first sedation guideline by any organization. In 1991, it was determined that the guideline was not being followed because the title referred to “general anesthesia,” and practitioners thought this just applied to because the title contain the word “general anesthesia” and many practitioners thought this just apply to anesthesiologists. Therefore, the 1992 revision was retitled *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

In the interim, other organizations such as the American Society of Anesthesiologists and the Joint Commission issued additional guidelines. In 2002, an addendum to the AAP guideline was published, unifying language among these groups.

As a result, advanced airway skills — including the ability to perform bag mask ventilation, unobstruct an obstructed airway, ventilate the patient who had developed apnea, and perform cardiopulmonary resuscitation skills now were required. Children who were moderately sedated would be observed by an individual who could help with interruptible tasks; at least one person had to have advanced airway management skills. Children who were deeply sedated had to be observed by an independent observer whose only responsibility was to monitor the child.

The AAP-AAPD guideline updated in 2006 was a unified document that represented pediatric dentistry and general pediatrics with the same language, the same definitions and the same goals. It emphasized proper fasting for elective procedures, a focused airway examination, warnings about nutraceuticals and drug interactions on the cytochrome system. The guideline also recognized that children younger than 6 years of age generally require deep sedation.

Continuous quality improvement and simulation training for management of rare events were encouraged, as was familiarity with airway adjuncts such as supraglottic devices for rescue, e.g., laryngeal mask airway. The use of capnography was encouraged but not required.

This past year, the AAPD and the Academy began collaborating on the latest report that included capnography and the more rigorous training recommendations.

Overall, the update is a victory for children who require procedural sedation. Once individuals begin to use capnography, they will see great value in providing near-immediate recognition of respiratory compromise even before oxygen saturation changes. Just like many children have been rescued following an adverse sedation event because of pulse oximetry, capnography provides warning even before desaturation.

The acronym **SOAPME** is commonly used as a reminder in the planning and preparation for a sedation procedure:

S = suction

O = oxygen; an adequate reserve supply

A = airway; size-appropriate equipment to manage a non-breathing child

P = pharmacy; drugs needed to support life and appropriate reversal agents

M = monitors; size-appropriate oximeter probes, electrocardiogram, noninvasive blood pressure measurement

E = equipment; a defibrillator with appropriate size pads

Drs. Coté and Wilson are lead authors of the clinical report.

Related Articles

Guidelines for monitoring and management of pediatric patients during and after sedation for diagnostic and therapeutic procedures: an update.

Charles J Coté et al., Pediatrics, 2006

Guidelines for Monitoring and Management of Pediatric Patients Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016

Charles J. Coté et al., Pediatrics, 2016

Conscious sedation: reality or myth?

Jeffrey L Koh et al., Pediatr Rev, 2007

Pediatric Sedation Management

Sean Barnes et al., Pediatr Rev, 2016

NICU Follow-up: Medical and Developmental Management Age 0 to 3 Years

Joseph R. Hageman et al., Neoreviews, 2014

Updated AAP Guidelines Address Procedural Pain in Newborns

Nicola M. Parry, DVM, Medscape, 2016

AAP: New Bright Futures edition coming with added screenings

Christine Kilgore, Pediatric News, 2015

Some Kids Having Tonsil, Adenoid Surgery Should Be Inpatients

By Marilyn Larkin, Medscape, 2016

Sedation, Anesthesia Risk Doubled for Children Born Preterm

Troy Brown, RN, Medscape, 2016

New AAP ADHD Guideline Expands Age Range, Scope

By: Sharon Worcester, Pediatric News Digital Network, Pediatric News, 2011

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