



STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

May 19, 2016

2:30 P.M.

Location: Room S384, University of Iowa College of Dentistry, Iowa City, Iowa.

Members: *Steven Fuller, D.D.S. Chair; 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)*

- I. CALL MEETING TO ORDER – ROLL CALL**
- II. COMMITTEE MINUTES**
 - a. April 7, 2016 – Teleconference
- III. APPLICATION FOR GENERAL ANESTHESIA PERMIT**
 - a. Lois I. Jacobs, D.D.S. (follow up)
- IV. APPLICATION FOR MODERATE SEDATION PERMIT**

**No applications received to date*
- V. OTHER BUSINESS**
 - a. Review and Discussion of Sedation Facility Inspection Form
 - b. Discussion of Sedation Drugs
 - i. Recommended Emergency Drugs and Other Medications
 - ii. Recommended Restrictions for Use in Moderate Sedation
 - iii. Other Recommendations, If Any
 - c. Discussion of Moderate Sedation Training in Continuing Education Courses
 - d. Review and Discussion of Application Updates – Moderate Sedation Permit and General Anesthesia Permit
 - e. Discussion of ACLS/PALS Course Requirements
 - f. Discussion of Peer Evaluations
- 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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ANESTHESIA CREDENTIALS COMMITTEE

MINUTES

April 7, 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*)

April 7, 2016

Present
Present
Present
Absent
Absent
Present
Present
Present

Staff Member

Christel Branness, David Schultz

I. CALL MEETING TO ORDER – APRIL 7, 2016

Ms. Branness called the meeting of the Anesthesia Credentials Committee to order at 12:06 p.m. on Thursday, April 7, 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 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

- Dr. Vargas joined the teleconference after roll call was taken.

II. COMMITTEE MEETING MINUTES

- *January 21, 2016 – Teleconference*

❖ MOVED by WESTLUND, SECONDED by ROTH, 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 overview of the application. Ms. Braness reported that she had emailed Dr. Jacobs about the missing information from her application. At the time of the meeting, Ms. Braness had not received a response about the requested information.

Dr. Burton noted that residency verification form submitted with Dr. Jacobs' application was not complete. Ms. Braness clarified that this was referenced in the email to Dr. Jacobs indicating the items, which needed to be addressed prior to issuance.

Dr. Burton reported that based on the information that Dr. Jacobs provided in the application, he spoke with the GME (Graduate Medical Education) office and inquired about this. Dr. Jacobs' name is in their database. While Dr. Jacobs may have received sedation training, she could not have completed an anesthesia residency during the timeframe referenced. Dr. Burton indicated that the University of Iowa College of Dentistry may not have had an accredited program at that time. Dr. Jacobs will need to forward the form to the University of Iowa for completion.

❖ MOVED by ROTH, SECONDED by BURTON, to TABLE further discussion of the application until additional information is received. 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

- *Committee Meeting Dates*

Ms. Braness reported that the committee intended to schedule an in-person meeting to discuss items that were not particularly suited to teleconferences. Based on the responses received from the committee members, Thursday, May 19, 2016 was the best date to hold that meeting. Ms. Braness reported that Dr. Horton indicated that he could help reserve a room at the University of Iowa College of Dentistry for the meeting.

Dr. Westlund and Dr. Roth indicated that it would be best to meet after 2:00 p.m. Dr. Burton stated that he would try to arrange his schedule in order to allow him to participate. After further discussion, the committee members agreed to schedule the meeting for 2:30 p.m. Thursday, May 19, 2016.

- *Committee Appointments*

Ms. Braness reported that the Board would be reviewing committees at its May and July meetings. Ms. Braness stated that committee members, who did not wish to continue serving on the committee, should let her know.

- *ADA Members' Hearing: Anesthesia and Sedation Guidelines*

Ms. Braness reported that the Board office had been made aware of the upcoming hearing on anesthesia and sedation guidelines. Staff will continue to monitor this to see if there were developments, which might affect Iowa.

VI. OPPORTUNITY FOR PUBLIC COMMENT

No comments were received.

VII. ADJOURN

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

The Anesthesia Credentials Committee adjourned its meeting at 12:18 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for May 19, 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.



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>

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

Name of Applicant Lois Jacobs Facility Address to be determined

SECTION 7 - AUXILIARY PERSONNEL

A dentist administering conscious 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:

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 a waiver of any of these provisions. The Board may grant the waiver if it determines there is a reasonable basis for the waiver.

- YES NO Is your dental office properly maintained and equipped with the following:
- 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least 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.

to be determined

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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 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):
 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: *[Signature]* **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).

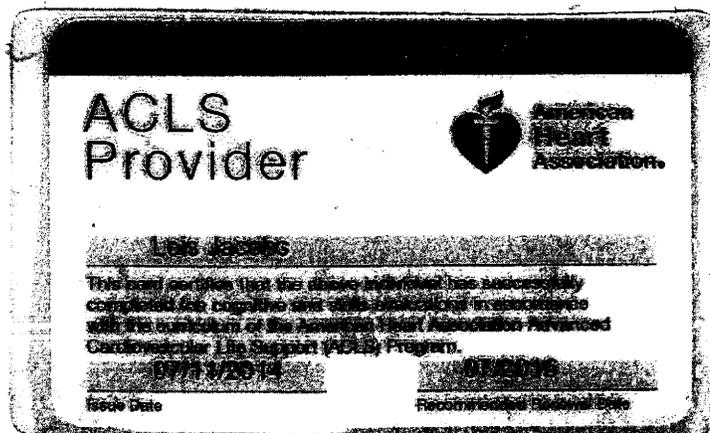
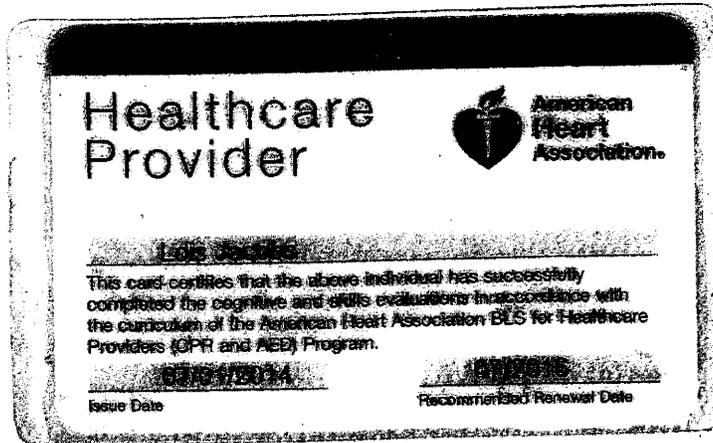
NAME AND LOCATION OF POSTGRADUATE PROGRAM: University of Iowa Hospitals and Clinics **PHONE:**

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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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



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.

Iowa Dental Board Sedation Inspection Form

Location inspected:

Date of Inspection: _____

Investigator _____

Time: Start _____ End _____

Mileage _____

Moderate or General inspection _____

Name of practitioners at this location:

License Number: _____ DEA/CSA _____

A. Office Facilities and Equipment

1. Operating Room

- a. Is the operating room large enough to adequately accommodate the patient on a table or in the operating chair? YES NO
- b. Does the operating room permit an operating team consisting of at least three individuals to freely move around the patient? YES NO

2. Operating Chair or Table

- a. Does the operating chair or table permit the patient to be positioned so the operating team can maintain the airway? YES NO
- i. Head position below the center of gravity? (e.g. Trendelenburg) YES NO
- ii. Horizontal? (CPR may be performed) YES NO
- iii. Does the operating chair or table provide a firm platform for the management of cardiopulmonary resuscitation? YES NO
- iv. Explanations: _____

- b. Does the operating chair or table permit the team to quickly alter the patient's position in an emergency? YES NO

Notes: _____

3. Lighting System

- a. Does the lighting system permit the evaluation of the patient's skin and mucosal color ? Light Reading: _____ foot candles: _____
- b. Is there a backup lighting system? YES NO
- Battery: _____ Generator: _____
- c. Type of backup lighting system: _____
- d. Is backup lighting system of sufficient intensity to permit completion of any operation underway at the time of general power failure: YES NO
- Power Failure – Light Reading: _____ foot candles: _____

4. Suction Equipment

- a. Does suction equipment permit aspiration of the oral and pharyngeal cavities? YES NO
- b. Is there a backup suction device available? YES NO
- c. Is backup suction device powered by independent or alternate power supply other than central electric supply source? YES NO

5. Oxygen Delivery System

- a. Does oxygen delivery system have adequate full face masks and appropriate connectors? YES NO
- Number of adult full face masks: _____
- Number of pediatric full face masks: _____
- b. Is it capable of delivering oxygen to the patient under positive pressure? YES NO
- Is there adequate backup oxygen? YES NO

c. Are main and spare oxygen/nitrous tanks stored and secured safely? YES NO

6. Ancillary Equipment

No: Yes (in room): Yes (in facility, not room):

Working laryngoscope with selection of blades, spare batteries, and bulb:			
Number of adult blades:			
Number of pediatric blades:			
Endotracheal tubes and connectors:			
Endotracheal tube forceps (Magill):			
Laryngeal mask airways			
Adult size- Pediatric size-			
Oral airways:			
Tonsillar or pharyngeal type suction tip adaptable to all office outlets: (Yankauer)			
Sphygmomanometer and stethoscope:			
Pulse Oximeter/Analyzer:			
Scavenging:			
Precordial/pretracheal stethoscope:			
Electrocardioscope/ EKG monitor:			
Defibrillator/AED:			
Adequate equipment for establishment of an intravenous infusion:			
Capnography (required for General):			
Other:			

Notes: _____

- 1. EKG Monitor YES NO
- 2. Defibrillator/AED YES NO
- 3. Positive Pressure Oxygen YES NO
- 4. Suction YES NO

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| 5. Laryngoscope and Blades | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Endotracheal Tubes | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. Magill Forceps | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. Oral Airways | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9. Stethoscope | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 10. Blood Pressure Monitoring Device | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 11. Pulse Oximeter | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 12. Emergency Drugs | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

Notes: _____

7. **Recovery Area** (Recovery area can be the operating room)
- | | | |
|--|------------------------------|-----------------------------|
| a. Does the recovery area have oxygen available? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| b. Does the recovery area have suction available? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| c. Does the recovery area have adequate lighting? | Light Reading: _____ | foot candles |
| d. Does the recovery area have adequate electrical outlets? | Number: _____ | |
| e. Can the patient be observed by a member of the staff at all times during the recovery period? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| *Photos, optional: | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

B. Records – Are the following records maintained?

- | | | |
|---|------------------------------|-----------------------------|
| 1. A physical evaluation of the patient? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. A medical history of the patient? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. Preoperative and postoperative vital signs? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. Drugs administered? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 5. Dosage administered? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 6. Anesthesia time (in minutes)? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 7. Recording of monitoring every 5 minutes? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 8. Anesthesia records showing: continuous monitoring of heart rate, blood pressure, and respiration using electrocardiographic monitoring and pulse oximetry? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 9. Evidence of continuous recovery monitoring, with notation of patient's Condition upon discharge and person to whom the patient was discharged? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 10. Records reflecting any complications of anesthesia? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

C. Drugs

1. Vasopressor drug available? *Ephedrine epinephrine phenylephrine*
2. Corticosteroid drug available? *Solu-Cortef dexamethasone hydrocortone*
3. Bronchodilator drug available? *albuterol inhaler*
4. Muscle relaxant drug available? *succinylcholine Anectine Quelicin*
5. Intravenous medication for treatment of cardiopulmonary arrest available? *Lidocaine Xylocaine*
6. Narcotic antagonist drug available? *Naloxone Narcan Evzio*
7. Benzodiazepine antagonist drug available? *Romazicon flumazenil*
8. Antihistamine drug available? *Benadryl diphenhydramine*
9. Antiarrhythmic drug available? *lidocaine Lidoderm Xylocaine amiodarone*
10. Anticholinergic drug available? *Atropine atropine sulfate*
11. Coronary artery vasodilator drug available? *Minitran nitro Nitrek*
12. Antihypertensive drug available? *metoprolol propranolol methyldopa esmolol*
13. Medication for treatment of low blood sugar? *Glucose Dextrose*

D. Sedation

1. What sedations medications will you administer? *Versed Nitrous Valium*
2. What procedures do you follow when disposing unused medication? *Logbook Two signatures*

Notes: _____



STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

Moderate Sedation Permit Application

Application Form and Fee

Please find enclosed the application for Iowa moderate sedation permit. When completing this application, please be advised of the following:

- The application fee (\$500) is non-refundable. Do not submit payment in cash.
- For specific application requirements, please refer to the Board's rules at Iowa Administrative Code 650—Chapter 29.
- Type or legibly print all information requested in the application. Complete all questions. If not applicable, please mark sections 'N/A'.
- All applications for moderate sedation permit are reviewed by the Anesthesia Credentials Committee. Permits are issued administratively following approval by the Anesthesia Credentials Committee. If the committee requires additional information prior to making a final recommendation for issuance, you will be provided an opportunity to respond.
 - The Anesthesia Credentials Committee meets approximately once per quarter. Meeting dates are posted on the Board calendar, which is available on the Board's website. Meetings are often scheduled in January, April, June, July, and October. Other meetings may be scheduled as deemed necessary.
- Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain an Iowa moderate sedation permit.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are licensed by the Board.**

Please be advised of the following:

Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry unless an active sedation permit has been issued by the Iowa Dental Board.

- **Moderate sedation** is defined in Board rules as *“a drug-induced depression of consciousness, either by enteral or parenteral means, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Prior to January 1, 2010, moderate sedation was referred to as conscious sedation.”*
- **Deep sedation/general anesthesia** is defined in Board rules as *“is a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or*

complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.”

- **Pediatric and Medically-Compromised Patients:** Part three of the ADA guidelines (2003) for teaching the comprehensive control of anxiety and pain in dentistry states that, *“Additional supervised clinical experience is necessary to prepare participants to manage children and medically compromised adults.”* Iowa Administrative Code 650—Chapter 29 requires that a dentist utilizing moderate sedation with pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients.
- Licensees are encouraged to seek pre-approval of any formal training in moderate sedation prior to completing the course and applying for a permit. To request approval of a course, submit a detailed copy of the course syllabus and related materials to the Board office.
- Each facility in which an applicant plans to provide moderate sedation is subject to an on-site evaluation prior to issuance of a permit. The actual costs associated with the on-site evaluation of the facility are the responsibility of the applicant. The cost to the licensee shall not exceed \$500 per facility.
- Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.
- Once issued, a permit must be renewed at the time of license renewal. Permit holders are required to maintain current ACLS or PALS certification and document six (6) hours of continuing education in the area of sedation for each renewal.
- **Equipment:** Effective January 1, 2015, Iowa Administrative Code 650—Chapter 29, requires all moderate sedation permit holders to use capnography or a pretracheal/precordial stethoscope at all facilities where they provide sedation.

Public Information

All or part of the information provided on the application form may be considered a public record under Iowa Code Chapter 22 and Iowa Administrative Code 650—Chapter 6. Information about misconduct and examination results may not be subject to disclosure.

Disclosure of Medical Conditions, Criminal History, Disciplinary Actions and Malpractice Claims

Be advised that the application for moderate sedation permit asks about any medical conditions you have that might impair your ability to practice the profession. The Board also considers any disciplinary actions and malpractice claims when issuing moderate sedation permits. As part of the application process you will be asked questions about prior disciplinary action and malpractice claims.

If you have any questions concerning these requirements, please notify the Board office. If any of these situations pertain to you, there may be delays at the time of licensure. We suggest you contact the Board office for information as to what documentation may be necessary. Contacting the Board office about any of these situations may avoid unnecessary delays.

Contact Us

If you have any questions, or need further assistance, please feel free to contact the Iowa Dental Board at (515) 281-5157 or IDB@iowa.gov.

Board website: www.dentalboard.iowa.gov.

Board rules and Iowa Code chapters: <http://www.dentalboard.iowa.gov/board/rules-policy/index.html>

Application Checklist

<input type="checkbox"/>	Application completely filled out; all questions answered.
<input type="checkbox"/>	Application fee paid: \$500
<input type="checkbox"/>	Notarized copy of marriage certificate or divorce decree (if applicant's name is different on diploma/documents)
<input type="checkbox"/>	On the basis for application, you must have completed parts one and three of the 2003 ADA guidelines AND one of the following: formal training in airway management; moderate sedation experience at the graduate level, approved by the board; or a formal training program approved by the Board.
<input type="checkbox"/>	Affidavit of Applicant
<input type="checkbox"/>	Evidence of possessing a valid, current certificate in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS).
<input type="checkbox"/>	Complete and mail the appropriate form to your program director to verify your moderate sedation training. <ul style="list-style-type: none"> ▪ Applicants who received their training in a postgraduate residency program must have their postgraduate program director complete Form A. ▪ Applicants who received their training in a formal continuing education program must have the program director complete Form B. ▪ Applicants who completed a postgraduate residency program must attach a copy of your certificate of completion of the postgraduate program.
<input type="checkbox"/>	Copy and complete the Facilities and Equipment section of the application for each facility in which you plan to provide moderate sedation. Each facility is subject to inspection.
<input type="checkbox"/>	If you have a permit to perform moderate sedation in any other state, request verification of your permit from each state. Please note that some states may require a processing fee.



APPLICATION FOR MODERATE SEDATION PERMIT

IOWA DENTAL BOARD

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

Ph. (515) 281-5157 <http://www.dentalboard.iowa.gov>

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle)			
Other Names Used: (e.g. Maiden Name)			
Home Address:			
City:	County:	State:	Zip:
Home Phone:		Home E-mail:	
Iowa Dental License Number:		Type of Practice:	

LOCATION(S) IN IOWA WHERE MODERATE SEDATION SERVICES WILL BE PROVIDED

Principal Office Street Address:			Office Hours/Days:
City:	Zip Code:	Phone Number:	Email Address:
Satellite Office Street Address:			Office Hours/Days:
City:	Zip Code:	Phone Number:	Email Address :
Satellite Office Street Address:			Office Hours/Days:
City:	Zip Code:	Phone Number:	Email Address :

For office use only:	Permit #:	Date Issued:	Approved by ACC:	Facility Inspection:	Fees:
-----------------------------	------------------	---------------------	-------------------------	-----------------------------	--------------

Name of Applicant: _____

BASIS FOR APPLICATION

Type of Training:	Mark if Completed:	Date(s):
Moderate sedation training program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences	<input type="checkbox"/> Completed	
ADA-accredited residency program that includes moderate sedation training	<input type="checkbox"/> Completed	
You must have training in moderate sedation AND one of the following: Formal training in airway management; OR Moderate sedation experience at graduate level, approved by the Board.	<input type="checkbox"/> Completed <input type="checkbox"/> Completed	

ADVANCED CARDIAC LIFE SUPPORT (ACLS) AND/OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS)

Name of Course:	Location:
Date of Course:	Date Certification Expires:

MODERATE SEDATION TRAINING INFORMATION

Type of Program: <input type="checkbox"/> Postgraduate Residency Program <input type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-Approved Program, specify:	
Name of Training Program:	Address:
City:	State:
Type of Experience:	
Length of Training:	Dates Completed:
Number of Patient Contact Hours:	Total Number of Supervised Sedation Cases:
<input type="checkbox"/> YES <input type="checkbox"/> NO	1. Did you satisfactorily complete the above training program?
<input type="checkbox"/> YES <input type="checkbox"/> NO	2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?
<input type="checkbox"/> YES <input type="checkbox"/> NO	3. Does the program comply with parts one and three of the 2003 American Dental Association guidelines for teaching the comprehensive control of anxiety and pain in dentistry?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	As part of the curriculum, are the following concepts and procedures taught: 4. Physical evaluation; 5. IV sedation; 6. Monitoring; and 7. Basic life support and emergency management.
<input type="checkbox"/> YES <input type="checkbox"/> NO	9. Does the program include clinical experience in managing compromised airways?
<input type="checkbox"/> YES <input type="checkbox"/> NO	10. Does the program provide training or experience in managing moderate sedation in pediatric patients (12 years of age or younger)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	11. Does the program provide training or experience in managing moderate sedation in medically compromised patients (ASA 3-4)?
Please attach the appropriate form to verify your moderate sedation training. The form should be completed by the residency/course instructor.	

Name of Applicant: _____

MODERATE SEDATION EXPERIENCE

<input type="checkbox"/> YES <input type="checkbox"/> NO	A. Do you have a license, permit, or registration to perform moderate sedation in any other state? If yes, specify state(s) and permit number(s): _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?
<input type="checkbox"/> YES <input type="checkbox"/> NO	C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?
<input type="checkbox"/> YES <input type="checkbox"/> NO	D. Do you plan to use moderate sedation in pediatric patients?
<input type="checkbox"/> YES <input type="checkbox"/> NO	E. Do you plan to use moderate sedation in medically compromised patients?
<input type="checkbox"/> YES <input type="checkbox"/> NO	F. Do you plan to engage in enteral moderate sedation?
<input type="checkbox"/> YES <input type="checkbox"/> NO	G. Do you plan to engage in parenteral moderate sedation?
<p>What major drugs and anesthetic techniques do you utilize or plan to utilize in your use of moderate sedation? <u>Provide details (IV, inhalation, etc.) and attach a separate sheet if necessary.</u></p>	

AUXILIARY PERSONNEL

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

Name:	License/Registration #:	BLS Certification Date:	Date BLS Certification Expires:

FACILITIES & EQUIPMENT

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

Is your dental office properly maintained and equipped with the following:

<input type="checkbox"/> YES <input type="checkbox"/> NO	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input type="checkbox"/> YES <input type="checkbox"/> NO	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 type="checkbox"/> YES <input type="checkbox"/> NO	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 type="checkbox"/> YES <input type="checkbox"/> NO	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input type="checkbox"/> YES <input type="checkbox"/> NO	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 type="checkbox"/> YES <input type="checkbox"/> NO	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input type="checkbox"/> YES <input type="checkbox"/> NO	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input type="checkbox"/> YES <input type="checkbox"/> NO	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail-safe mechanism?
<input type="checkbox"/> YES <input type="checkbox"/> NO	9. EKG monitor?
<input type="checkbox"/> YES <input type="checkbox"/> NO	10. Laryngoscope and blades?
<input type="checkbox"/> YES <input type="checkbox"/> NO	11. Endotracheal tubes?
<input type="checkbox"/> YES <input type="checkbox"/> NO	12. Magill forceps?
<input type="checkbox"/> YES <input type="checkbox"/> NO	13. Oral airways?
<input type="checkbox"/> YES <input type="checkbox"/> NO	14. Stethoscope?
<input type="checkbox"/> YES <input type="checkbox"/> NO	15. A blood pressure monitoring device?
<input type="checkbox"/> YES <input type="checkbox"/> NO	16. A pulse oximeter?
<input type="checkbox"/> YES <input type="checkbox"/> NO	17. Emergency drugs that are not expired?
<input type="checkbox"/> YES <input type="checkbox"/> NO	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	20. capnography or pretracheal/precordial stethoscope
_____	21. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

DEFINITIONS

Important! Read these definitions before completing the following questions.

“Ability to practice dentistry with reasonable skill and safety” means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

Name of Applicant: _____

“Medical condition” means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

“Chemical substances” means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

“Improper use of drugs or other chemical substances” means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

“Illegal use of drugs or other chemical substances” means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

If you answer yes to any of the questions below, attach a full explanation. Read the instructions for important definitions.	
<input type="checkbox"/> YES <input type="checkbox"/> 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"/> YES <input type="checkbox"/> NO	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
<input type="checkbox"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	5. Have you ever been requested to repeat a portion of any professional training program/school?
<input type="checkbox"/> YES <input type="checkbox"/> NO	6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?
<input type="checkbox"/> YES <input type="checkbox"/> NO	7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?
<input type="checkbox"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	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"/> YES <input type="checkbox"/> NO	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?

Name of Applicant: _____

AFFIDAVIT OF APPLICANT

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

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

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

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

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

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

I further state that I have read the rules related to the use of moderate 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 moderate sedation in the state of Iowa.

Signature of Applicant: _____

Date: _____

**FORM A: VERIFICATION OF MODERATE SEDATION TRAINING
ADA-ACCREDITED COLLEGE OF DENTISTRY**

Moderate Sedation Training Details:
 Residency Program Other, please specify: _____

SECTION 1 – APPLICANT INFORMATION

Instructions: Use this form if you received your training in moderate sedation from an ADA-accredited college of dentistry. Complete Section 1 and forward this form to the program director/instructor for verification of your having successfully completed training in moderate sedation.

Name (First, Middle, Last, Suffix): _____

Mailing Address: _____

City: _____	State: _____	Zip Code: _____	Phone or email address: _____
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To obtain a permit to administer moderate sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed Board-approved training in the area of moderate sedation. The applicant's signature below authorized the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address below.

Applicant's Signature: _____	Date: _____
-------------------------------------	--------------------

SECTION 2 – TO BE COMPLETED BY PROGRAM DIRECTOR/INSTRUCTOR

Name of program director/instructor: _____

This training 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)
- Education Committee of the American Osteopathic Association (AOA)

Name and Location of Training Program: _____	Phone or email address: _____
---	--------------------------------------

Dates Applicant Participated in Program: _____	From (Mo/Yr): _____	To (Mo/Yr): _____	Date Program Completed: _____
---	----------------------------	--------------------------	--------------------------------------

<input type="checkbox"/> YES <input type="checkbox"/> NO	1. Did the applicant satisfactorily complete the above post-graduate training program?
<input type="checkbox"/> YES <input type="checkbox"/> NO	2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?
<input type="checkbox"/> YES <input type="checkbox"/> NO	3. Does the program cover the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students?
<input type="checkbox"/> YES <input type="checkbox"/> NO	4. Does the program include clinical experience in managing compromised airways?
<input type="checkbox"/> YES <input type="checkbox"/> NO	5. Does the program include management of at least twenty (20) patients? If no, please provide a detailed explanation.
<input type="checkbox"/> YES <input type="checkbox"/> NO	6. Did the applicant ever receive a warning or reprimand, or was the applicant placed on probation during the training program? If yes, please explain.
<input type="checkbox"/> YES <input type="checkbox"/> NO	7. Was the applicant ever requested to repeat a portion of the training program?
<input type="checkbox"/> YES <input type="checkbox"/> NO	8. Does the program include additional clinical experience in providing moderate sedation for pediatric (ages 12 or younger) patients? If yes, please provide program details. <u>Training must have been completed as part of a formal residency training program.</u>
<input type="checkbox"/> YES <input type="checkbox"/> NO	9. Does the program include additional clinical experience in providing moderate sedation for medically-compromised (ASA Class 3-4) patients? If yes, please provide program details. <u>Training must have been completed as part of a formal residency training program.</u>

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

Program Director Signature: _____	Date: _____
--	--------------------

Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone: (515) 281-5157; Fax: (515) 281-7969; Email: IDB@Iowa.gov

**FORM B: VERIFICATION OF MODERATE SEDATION TRAINING
CONTINUING EDUCATION PROGRAM**

SECTION 1 – APPLICANT INFORMATION

Instructions: Use this form if you received your training in moderate sedation from an ADA-accredited college of dentistry. Complete Section 1 and forward this form to the program director/instructor for verification of your having successfully completed training in moderate sedation.

Name (First, Middle, Last, Suffix):

Mailing Address:

City:	State:	Zip Code:	Phone or email address:
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To obtain a permit to administer moderate sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed Board-approved training in the area of moderate sedation. The applicant's signature below authorized the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address below.

Applicant's Signature: _____ **Date:** _____

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

Name of Program Director:

Name and Location of Training Program: _____ **Phone:** _____

Email Address: _____ **Fax Number:** _____ **Website Address:** _____

Dates Applicant Participated in Program:	From (Mo/Yr):	To (Mo/Yr):	Date Program Completed:
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- | | |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 1. Did the applicant satisfactorily complete the above post-graduate training program? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 3. Does the program comply with the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 4. Does the program include clinical experience in managing compromised airways? If yes, please provide details of the airway management training provided. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 5. Does the program include management of at least twenty (20) patients? If no, please provide a detailed explanation. |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | 6. Does the program include training <i>and</i> patient experience in the use of multiple drugs during the administration of moderate sedation? (e.g. Versed and Fentanyl, in combination) |
| <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO | 7. As part of the curriculum, are the following concepts and procedures taught: <ul style="list-style-type: none"> ▪ Physical evaluation; ▪ IV Sedation; ▪ Monitoring; and ▪ Basic Life Support and emergency management. |

If no to any of the above, please provide a detailed explanation.

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

Program Director Signature: _____ **Date:** _____

Return Completed Form to:
 IOWA DENTAL BOARD
 400 S.W. 8th St, Suite D
 Des Moines, IA 50309-4687
 Phone: (515) 281-5157; Fax: (515) 281-7969; Email: IDB@Iowa.gov

CHAPTER 29
SEDATION AND NITROUS OXIDE INHALATION ANALGESIA
[Prior to 5/18/88, Dental Examiners, Board of[320]]

650—29.1(153) Definitions. For the purpose of these rules, relative to the administration of deep sedation/general anesthesia, moderate sedation, minimal sedation, and nitrous oxide inhalation analgesia by licensed dentists, the following definitions shall apply:

“*Antianxiety premedication*” means minimal sedation. A dentist providing minimal sedation must meet the requirements of rule 650—29.7(153).

“*ASA*” refers to the American Society of Anesthesiologists Patient Physical Status Classification System. Category 1 means normal healthy patients, and category 2 means patients with mild systemic disease. Category 3 means patients with moderate systemic disease, and category 4 means patients with severe systemic disease that is a constant threat to life.

“*Board*” means the Iowa dental board established in Iowa Code section 147.14(1)“*d.*”

“*Capnography*” means the monitoring of the concentration of exhaled carbon dioxide in order to assess physiologic status or determine the adequacy of ventilation during anesthesia.

“*Committee*” or “*ACC*” means the anesthesia credentials committee of the board.

“*Conscious sedation*” means moderate sedation.

“*Deep sedation/general anesthesia*” is a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

“*Facility*” means a dental office, clinic, dental school, or other location where sedation is used.

“*Maximum recommended dose (MRD)*” means the maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

“*Minimal sedation*” means a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. The term “minimal sedation” also means “antianxiety premedication” or “anxiolysis.” A dentist providing minimal sedation shall meet the requirements of rule 650—29.7(153).

“*Moderate sedation*” means a drug-induced depression of consciousness, either by enteral or parenteral means, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Prior to January 1, 2010, moderate sedation was referred to as conscious sedation.

“*Monitoring nitrous oxide inhalation analgesia*” means continually observing the patient receiving nitrous oxide and recognizing and notifying the dentist of any adverse reactions or complications.

“*Nitrous oxide inhalation analgesia*” refers to the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

“*Pediatric*” means patients aged 12 or under.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.2(153) Prohibitions.

29.2(1) Deep sedation/general anesthesia. Dentists licensed in this state shall not administer deep sedation/general anesthesia in the practice of dentistry until they have obtained a permit. Dentists shall only administer deep sedation/general anesthesia in a facility that has successfully passed inspection as required by the provisions of this chapter.

29.2(2) Moderate sedation. Dentists licensed in this state shall not administer moderate sedation in the practice of dentistry until they have obtained a permit. Dentists shall only administer moderate sedation in a facility that has successfully passed inspection as required by the provisions of this chapter.

29.2(3) Nitrous oxide inhalation analgesia. Dentists licensed in this state shall not administer nitrous oxide inhalation analgesia in the practice of dentistry until they have complied with the provisions of rule 650—29.6(153).

29.2(4) Antianxiety premedication. Dentists licensed in this state shall not administer antianxiety premedication in the practice of dentistry until they have complied with the provisions of rule 650—29.7(153).

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.3(153) Requirements for the issuance of deep sedation/general anesthesia permits.

29.3(1) A permit may be issued to a licensed dentist to use deep sedation/general anesthesia on an outpatient basis for dental patients provided the dentist meets the following requirements:

- a. Has successfully completed an advanced education program accredited by the Commission on Dental Accreditation that provides training in deep sedation and general anesthesia; and
- b. Has formal training in airway management; and
- c. Has completed a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program approved by the board; and
- d. Has completed a peer review evaluation, as may be required by the board, prior to issuance of a permit.

29.3(2) A dentist using deep sedation/general anesthesia shall maintain a properly equipped facility at each facility where sedation is administered. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

29.3(3) The dentist shall ensure that each facility where sedation services are provided is permanently equipped pursuant to subrule 29.3(2) and staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of general anesthesia. Auxiliary personnel shall maintain current certification in basic life support and be capable of administering basic life support.

29.3(4) A dentist administering deep sedation/general anesthesia must document and maintain current, successful completion of an Advanced Cardiac Life Support (ACLS) course.

29.3(5) A dentist who is performing a procedure for which deep sedation/general anesthesia was induced shall not administer the general anesthetic and monitor the patient without the presence and assistance of at least two qualified auxiliary personnel in the room who are qualified under subrule 29.3(3).

29.3(6) A dentist qualified to administer deep sedation/general anesthesia under this rule may administer moderate sedation and nitrous oxide inhalation analgesia provided the dentist meets the requirements of rule 650—29.6(153).

29.3(7) A licensed dentist who has been utilizing deep sedation/general anesthesia in a competent manner for the five-year period preceding July 9, 1986, but has not had the benefit of formal training as outlined in this rule, may apply for a permit provided the dentist fulfills the provisions set forth in 29.3(2), 29.3(3), 29.3(4), and 29.3(5).

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.4(153) Requirements for the issuance of moderate sedation permits.

29.4(1) A permit may be issued to a licensed dentist to use moderate sedation for dental patients provided the dentist meets the following requirements:

- a. Has successfully completed a training program approved by the board that meets the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and that consists of a minimum of 60 hours of instruction and management of at least 20 patients; and

- b. Has formal training in airway management; or
- c. Has submitted evidence of successful completion of an accredited residency program that includes formal training and clinical experience in moderate sedation, which is approved by the board; and
- d. Has completed a peer review evaluation, as may be required by the board, prior to issuance of a permit.

29.4(2) A dentist utilizing moderate sedation shall maintain a properly equipped facility. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography or pretracheal/precordial stethoscope, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

29.4(3) The dentist shall ensure that each facility where sedation services are provided is permanently equipped pursuant to subrule 29.4(2) and staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of moderate sedation. Auxiliary personnel shall maintain current certification in basic life support and be capable of administering basic life support.

29.4(4) A dentist administering moderate sedation must document and maintain current, successful completion of an Advanced Cardiac Life Support (ACLS) course. A dentist administering moderate sedation to pediatric patients may maintain current certification in Pediatric Advanced Life Support (PALS) in lieu of ACLS.

29.4(5) A dentist who is performing a procedure for which moderate sedation is being employed shall not administer the pharmacologic agents and monitor the patient without the presence and assistance of at least one qualified auxiliary personnel in the room who is qualified under subrule 29.4(3).

29.4(6) Dentists qualified to administer moderate sedation may administer nitrous oxide inhalation analgesia provided they meet the requirement of rule 650—29.6(153).

29.4(7) If moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

29.4(8) A dentist utilizing moderate sedation on pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients. A dentist who does not meet the requirements of this subrule is prohibited from utilizing moderate sedation on pediatric or ASA category 3 or 4 patients.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13; ARC 1810C, IAB 1/7/15, effective 2/11/15]

650—29.5(153) Permit holders.

29.5(1) No dentist shall use or permit the use of deep sedation/general anesthesia or moderate sedation for dental patients, unless the dentist possesses a current permit issued by the board. No dentist shall use or permit the use of deep sedation/general anesthesia or moderate sedation for dental patients in a facility that has not successfully passed an equipment inspection pursuant to the requirements of subrule 29.3(2). A dentist holding a permit shall be subject to review and facility inspection at a frequency described in subrule 29.5(10).

29.5(2) An application for a deep sedation/general anesthesia permit must include the appropriate fee as specified in 650—Chapter 15, as well as evidence indicating compliance with rule 650—29.3(153).

29.5(3) An application for a moderate sedation permit must include the appropriate fee as specified in 650—Chapter 15, as well as evidence indicating compliance with rule 650—29.4(153).

29.5(4) If a facility has not been previously inspected, no permit shall be issued until the facility has been inspected and successfully passed.

29.5(5) Permits shall be renewed biennially at the time of license renewal following submission of proper application and may involve board reevaluation of credentials, facilities, equipment, personnel, and procedures of a previously qualified dentist to determine if the dentist is still qualified. The appropriate fee for renewal as specified in 650—Chapter 15 of these rules must accompany the application.

29.5(6) Upon the recommendation of the anesthesia credentials committee that is based on the evaluation of credentials, facilities, equipment, personnel and procedures of a dentist, the board may determine that restrictions may be placed on a permit.

29.5(7) The actual costs associated with the on-site evaluation of the facility shall be the primary responsibility of the licensee. The cost to the licensee shall not exceed the fee as specified in 650—Chapter 15.

29.5(8) Permit holders shall follow the American Dental Association's guidelines for the use of sedation and general anesthesia for dentists, except as otherwise specified in these rules.

29.5(9) A dentist utilizing moderate sedation on pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients. A dentist who does not meet the requirements of this subrule is prohibited from utilizing moderate sedation on pediatric or ASA category 3 or 4 patients.

29.5(10) Frequency of facility inspections.

a. The board office will conduct ongoing facility inspections of each facility every five years, with the exception of the University of Iowa College of Dentistry.

b. The University of Iowa College of Dentistry shall submit written verification to the board office every five years indicating that it is properly equipped pursuant to this chapter.

29.5(11) Use of capnography required beginning January 1, 2014. Consistent with the practices of the American Association of Oral and Maxillofacial Surgeons (AAOMS), all general anesthesia/deep sedation permit holders shall use capnography at all facilities where they provide sedation beginning January 1, 2014.

29.5(12) Use of capnography or pretracheal/precordial stethoscope required for moderate sedation permit holders. Beginning January 1, 2015, all moderate sedation permit holders shall use capnography or a pretracheal/precordial stethoscope at all facilities where they provide sedation.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 0265C, IAB 8/8/12, effective 9/12/12; ARC 1194C, IAB 11/27/13, effective 11/4/13; ARC 1810C, IAB 1/7/15, effective 2/11/15]

650—29.6(153) Nitrous oxide inhalation analgesia.

29.6(1) A dentist may use nitrous oxide inhalation analgesia sedation on an outpatient basis for dental patients provided the dentist:

a. Has completed a board approved course of training; or

b. Has training equivalent to that required in 29.6(1) "a" while a student in an accredited school of dentistry, and

c. Has adequate equipment with fail-safe features and minimum oxygen flow which meets FDA standards.

d. Has routine inspection, calibration, and maintenance on equipment performed every two years and maintains documentation of such, and provides documentation to the board upon request.

e. Ensures the patient is continually monitored by qualified personnel while receiving nitrous oxide inhalation analgesia.

29.6(2) A dentist utilizing nitrous oxide inhalation analgesia shall be trained and capable of administering basic life support, as demonstrated by current certification in a nationally recognized course in cardiopulmonary resuscitation.

29.6(3) A licensed dentist who has been utilizing nitrous oxide inhalation analgesia in a dental office in a competent manner for the 12-month period preceding July 9, 1986, but has not had the benefit of formal training outlined in paragraph 29.6(1) "a" or 29.6(1) "b," may continue the use provided the dentist fulfills the requirements of paragraphs 29.6(1) "c" and "d" and subrule 29.6(2).

29.6(4) A dental hygienist may administer nitrous oxide inhalation analgesia provided the administration of nitrous oxide inhalation analgesia has been delegated by a dentist and the hygienist meets the following qualifications:

- a. Has completed a board-approved course of training; or
- b. Has training equivalent to that required in 29.6(4) “a” while a student in an accredited school of dental hygiene.

29.6(5) A dental hygienist or registered dental assistant may monitor a patient under nitrous oxide inhalation analgesia provided all of the following requirements are met:

- a. The hygienist or registered dental assistant has completed a board-approved course of training or has received equivalent training while a student in an accredited school of dental hygiene or dental assisting;
- b. The task has been delegated by a dentist and is performed under the direct supervision of a dentist;
- c. Any adverse reactions are reported to the supervising dentist immediately; and
- d. The dentist dismisses the patient following completion of the procedure.

29.6(6) A dentist who delegates the administration of nitrous oxide inhalation analgesia in accordance with 29.6(4) shall provide direct supervision and establish a written office protocol for taking vital signs, adjusting anesthetic concentrations, and addressing emergency situations that may arise.

29.6(7) If the dentist intends to achieve a state of moderate sedation from the administration of nitrous oxide inhalation analgesia, the rules for moderate sedation apply.
[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10]

650—29.7(153) Minimal sedation.

29.7(1) The term “minimal sedation” also means “antianxiety premedication” or “anxiolysis.”

29.7(2) If a dentist intends to achieve a state of moderate sedation from the administration of minimal sedation, the rules for moderate sedation shall apply.

29.7(3) A dentist utilizing minimal sedation and the dentist’s auxiliary personnel shall be trained in and capable of administering basic life support.

29.7(4) Minimal sedation for adults.

a. Minimal sedation for adults is limited to a dentist’s prescribing or administering a single enteral drug that is no more than 1.0 times the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. A single supplemental dose of the same drug may be administered, provided the supplemental dose is no more than one-half of the initial dose and the dentist does not administer the supplemental dose until the dentist has determined the clinical half-life of the initial dose has passed.

b. The total aggregate dose shall not exceed 1.5 times the MRD on the day of treatment.

c. For adult patients, a dentist may also utilize nitrous oxide inhalation analgesia in combination with a single enteral drug.

d. Combining two or more enteral drugs, excluding nitrous oxide, prescribing or administering drugs that are not recommended for unmonitored home use, or administering any intravenous drug constitutes moderate sedation and requires that the dentist must hold a moderate sedation permit.

29.7(5) Minimal sedation for ASA category 3 or 4 patients or pediatric patients.

a. Minimal sedation for ASA category 3 or 4 patients or pediatric patients is limited to a dentist’s prescribing or administering a single dose of a single enteral drug that can be prescribed for unmonitored home use and that is no more than 1.0 times the maximum recommended dose.

b. A dentist may administer nitrous oxide inhalation analgesia for minimal sedation of ASA category 3 or 4 patients or pediatric patients provided the concentration does not exceed 50 percent and is not used in combination with any other drug.

c. The use of one or more enteral drugs in combination with nitrous oxide, the use of more than a single enteral drug, or the administration of any intravenous drug in ASA category 3 or 4 patients

or pediatric patients constitutes moderate sedation and requires that the dentist must hold a moderate sedation permit.

29.7(6) A dentist providing minimal sedation shall not bill for non-IV conscious or moderate sedation.

29.7(7) A dentist shall ensure that any advertisements related to the availability of antianxiety premedication, anxiolysis, or minimal sedation clearly reflect the level of sedation provided and are not misleading.

[ARC 8614B, IAB 3/10/10, effective 4/14/10]

650—29.8(153) Noncompliance. Violations of the provisions of this chapter may result in revocation or suspension of the dentist's permit or other disciplinary measures as deemed appropriate by the board.

650—29.9(153) Reporting of adverse occurrences related to sedation, nitrous oxide inhalation analgesia, and antianxiety premedication.

29.9(1) Reporting. All licensed dentists in the practice of dentistry in this state must submit a report within a period of seven days to the board office of any mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, antianxiety premedication, nitrous oxide inhalation analgesia, or sedation. The report shall include responses to at least the following:

- a. Description of dental procedure.
- b. Description of preoperative physical condition of patient.
- c. List of drugs and dosage administered.
- d. Description, in detail, of techniques utilized in administering the drugs utilized.
- e. Description of adverse occurrence:
 1. Description, in detail, of symptoms of any complications, to include but not be limited to onset, and type of symptoms in patient.
 2. Treatment instituted on the patient.
 3. Response of the patient to the treatment.
- f. Description of the patient's condition on termination of any procedures undertaken.

29.9(2) Failure to report. Failure to comply with subrule 29.9(1), when the occurrence is related to the use of sedation, nitrous oxide inhalation analgesia, or antianxiety premedication, may result in the dentist's loss of authorization to administer sedation, nitrous oxide inhalation analgesia, or antianxiety premedication or in any other sanction provided by law.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.10(153) Anesthesia credentials committee.

29.10(1) The anesthesia credentials committee is a peer review committee appointed by the board to assist the board in the administration of this chapter. This committee shall be chaired by a member of the board and shall include at least six additional members who are licensed to practice dentistry in Iowa. At least four members of the committee shall hold deep sedation/general anesthesia or moderate sedation permits issued under this chapter.

29.10(2) The anesthesia credentials committee shall perform the following duties at the request of the board:

- a. Review all permit applications and make recommendations to the board regarding those applications.
- b. Conduct site visits at facilities under rule 650—29.5(153) and report the results of those site visits to the board. The anesthesia credentials committee may submit recommendations to the board regarding the appropriate nature and frequency of site visits.
- c. Perform professional evaluations and report the results of those evaluations to the board.
- d. Other duties as delegated by the board or board chairperson.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.11(153) Review of permit applications.

29.11(1) Review by board staff. Upon receipt of a completed application, board staff will review the application for eligibility. Following staff review, a public meeting of the ACC will be scheduled.

29.11(2) Review by the anesthesia credentials committee (ACC). Following review and consideration of an application, the ACC may at its discretion:

- a. Request additional information;
- b. Request an investigation;
- c. Request that the applicant appear for an interview;
- d. Recommend issuance of the permit;
- e. Recommend issuance of the permit under certain terms and conditions or with certain restrictions;

- f. Recommend denial of the permit;
- g. Refer the permit application to the board for review and consideration without recommendation;

or

- h. Request a peer review evaluation.

29.11(3) Review by executive director. If, following review and consideration of an application, the ACC recommends issuance of the permit with no restrictions or conditions, the executive director as authorized by the board has discretion to authorize the issuance of the permit.

29.11(4) Review by board. The board shall consider applications and recommendations from the ACC. The board may take any of the following actions:

- a. Request additional information;
- b. Request an investigation;
- c. Request that the applicant appear for an interview;
- d. Grant the permit;
- e. Grant the permit under certain terms and conditions or with certain restrictions; or
- f. Deny the permit.

29.11(5) Right to defer final action. The ACC or board may defer final action on an application if there is an investigation or disciplinary action pending against an applicant who may otherwise meet the requirements for permit until such time as the ACC or board is satisfied that issuance of a permit to the applicant poses no risk to the health and safety of Iowans.

29.11(6) Appeal process for denials. If a permit application is denied, an applicant may file an appeal of the final decision using the process described in rule 650—11.10(147).

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.12(153) Renewal. A permit to administer deep sedation/general anesthesia or moderate sedation shall be renewed biennially at the time of license renewal. Permits expire August 31 of every even-numbered year.

29.12(1) To renew a permit, a licensee must submit the following:

- a. Evidence of renewal of ACLS certification.
- b. A minimum of six hours of continuing education in the area of sedation. These hours may also be submitted as part of license renewal requirements.
- c. The appropriate fee for renewal as specified in 650—Chapter 15.

29.12(2) Failure to renew the permit prior to November 1 following its expiration shall cause the permit to lapse and become invalid for practice.

29.12(3) A permit that has been lapsed may be reinstated upon submission of a new application for a permit in compliance with rule 650—29.5(153) and payment of the application fee as specified in 650—Chapter 15.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.13(147,153,272C) Grounds for nonrenewal. A request to renew a permit may be denied on any of the following grounds:

29.13(1) After proper notice and hearing, for a violation of these rules or Iowa Code chapter 147, 153, or 272C during the term of the last permit renewal.

29.13(2) Failure to pay required fees.

29.13(3) Failure to obtain required continuing education.

29.13(4) Failure to provide documentation of current ACLS certification.

29.13(5) Failure to provide documentation of maintaining a properly equipped facility.

29.13(6) Receipt of a certificate of noncompliance from the college student aid commission or the child support recovery unit of the department of human services in accordance with 650—Chapter 33 or 650—Chapter 34.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

650—29.14(153) Record keeping.

29.14(1) Minimal sedation. An appropriate sedative record must be maintained and must contain the names of all drugs administered, including local anesthetics and nitrous oxide, dosages, time administered, and monitored physiological parameters, including oxygenation, ventilation, and circulation.

29.14(2) Moderate or deep sedation. The patient chart must include preoperative and postoperative vital signs, drugs administered, dosage administered, anesthesia time in minutes, and monitors used. Pulse oximetry, heart rate, respiratory rate, and blood pressure must be recorded continually until the patient is fully ambulatory. The chart should contain the name of the person to whom the patient was discharged.

29.14(3) Nitrous oxide inhalation analgesia. The patient chart must include the concentration administered and duration of administration, as well as any vital signs taken.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

These rules are intended to implement Iowa Code sections 153.33 and 153.34.

[Filed 5/16/86, Notice 3/26/86—published 6/4/86, effective 7/9/86]

[Filed 1/23/87, Notice 12/17/86—published 2/11/87, effective 3/18/87]

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[Filed 3/17/89, Notice 1/25/89—published 4/5/89, effective 5/10/89]

[Filed 1/29/92, Notice 11/13/91—published 2/19/92, effective 3/25/92]

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[Filed 2/5/07, Notice 11/22/06—published 2/28/07, effective 4/4/07]

[Filed ARC 8369B (Notice ARC 8044B, IAB 8/12/09), IAB 12/16/09, effective 1/20/10]

[Filed ARC 8614B (Notice ARC 8370B, IAB 12/16/09), IAB 3/10/10, effective 4/14/10]

[Filed ARC 0265C (Notice ARC 0128C, IAB 5/16/12), IAB 8/8/12, effective 9/12/12]

[Filed Emergency After Notice ARC 1194C (Notice ARC 1008C, IAB 9/4/13), IAB 11/27/13, effective 11/4/13]

[Filed ARC 1810C (Notice ARC 1658C, IAB 10/1/14), IAB 1/7/15, effective 2/11/15]

[◇] Two or more ARCs

¹ Effective date of 29.6(4) to 29.6(6) delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

² Effective date of 29.6(4) to 29.6(6) delayed until the end of the 2000 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held September 15, 1999. Subrules 29.6(4) and 29.6(5) were rescinded IAB 2/9/00, effective 3/15/00; delay on subrule 29.6(6) lifted by the Administrative Rules Review Committee at its meeting held January 4, 2000, effective January 5, 2000.