



STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

TELEPHONIC MEETING **IOWA DENTAL BOARD**

AGENDA

September 27, 2011
12:10 PM

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

Board Members: *Gary D. Roth, D.D.S., Chair; Marijo A. Beasler, R.D.H.; Mary Kelly, R.D.H.; Steven Bradley, D.D.S.; Lynn D. Curry, D.D.S.; Steven Fuller, D.D.S.; Michael J. Rovner, D.D.S.; Diane Meier; Kimberlee Spillers*

- I. CALL MEETING TO ORDER – ROLL CALL**
- II. PETITION FOR RULE WAIVER**
 1. Iowa Dental Foundation: Petition to Waive Portions of Rule 13.3(3) Re: Application Requirements for Temporary Volunteer Permit
- III. *LICENSURE/REGISTRATION APPLICATIONS**
 1. Dr. Dale Nixon, D.D.S. – Licensure by Credentials
 2. Shelly Simpson, DH - Licensure by Credentials ➤ Rec. from Dental Hygiene Comm.
 3. Kelly Van Wyk, DH - Licensure by Examination ➤ Rec. from Dental Hygiene Comm.
- IV. * ORDERS AND COMPLAINTS**
- V. OPEN SESSION ACTION ON CLOSED SESSION AGENDA ITEMS**
 1. Approval of Stipulation and Consent Orders
 2. Approval of Combined Notice of Hearing, Settlement Agreement & Final Orders
 3. Notice of Hearing and Statement of Charges
 4. Licensure/Registration Applications
 5. Other
- VI. 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 office of the Board at 515/281-5157.

*This portion of the meeting may be conducted in closed session to discuss confidential matters that may concern examination information, peace officers' investigative reports, attorney records related to litigation, patient records and reports on the condition, diagnosis, care or treatment of a patient, or investigation reports and other investigative information which is privileged and confidential under the provisions of Sections 22.7(2),

22.7(4), 22.7(5), 22.7(9), 22.7(19), and 272C.6(4) of the 2011 Code of Iowa.

These matters constitute a sufficient basis for the board to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2011 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code chapter 17A.

REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: September 27, 2011
RE: **Iowa Dental Foundation - Petition to Waive Portions of Subrule 13.3(3) Relating to Eligibility for Temporary Permit to Provide Volunteer Services**
SUBMITTED BY: Melanie Johnson, Executive Director
ACTION REQUESTED: Action on Rule Waiver Petition

Issue(s) for Board Review:

The Iowa Dental Foundation is requesting a waiver of portions of 650 IAC subrule 13.3(3) relating to eligibility for temporary permit to provide volunteer services.

Background:

The Iowa Dental Association's Foundation sponsors a free dental clinic, the Iowa Mission of Mercy (I-MOM). Dental professionals who volunteer at this event must apply for an Iowa temporary permit to provide the volunteer services. This year, representatives of the Board office and IDA have been working together to streamline the volunteer application process. While several changes were able to be handled administratively there are several application requirements that are in the Board's administrative rules. The IDA has submitted the attached request to waive certain portions of the rule requirements for the 2011 I-MOM event to be held in Sioux City in November.

Historical Treatment of Similar Situations:

There have not been any previous waivers relating to this subrule.

Attached for Review

- ❖ Petition for Waiver
- ❖ Excerpt of Board rule 650—13.3(3)
- ❖ Copy of current temporary volunteer permit application form

BEFORE THE IOWA DENTAL BOARD

Petition by Iowa Dental Foundation for)	PETITION FOR
the waiver of 650 IAC 13.3(3) relating to)	WAIVER
eligibility for a temporary permit to)	
provide volunteer services)	

1. The Petitioner is the Iowa Dental Foundation (the "Foundation"), 5530 West Parkway, Suite 100, Johnston, Iowa 50131, (515) 986-5605, on behalf of dentists who seek to volunteer in the 2011 Iowa Mission of Mercy ("2011 IMOM"), a free dental clinic sponsored by the Foundation. The Petitioner's legal counsel is the undersigned, Adam J. Freed and Rebecca A. Brommel, 666 Grand Avenue, Suite 2000, Des Moines, Iowa 50309, (515) 242-2400. Communications concerning the petition should be directed to the Petitioner's legal counsel.
2. The Petitioner seeks a waiver from 650 IAC § 13.3(3) (the "Rule"), which sets forth the requirements for issuance of a temporary permit for dentists and dental hygienists to provide volunteer services at a free or nonprofit dental clinic and who will not receive compensation for dental services provided.
3. The Petitioner seeks a waiver from the Rule for dentists participating in the 2011 IMOM for the duration of the 2011 IMOM, which is scheduled for November 18 and 19, 2011, at the Tyson Center, 401 Gordon Drive, Sioux City, Iowa. Specifically, the Petitioner seeks a waiver from paragraphs (1), (4), (5), (6), (7), and (8) of the Rule. In lieu of the requirements of paragraph (1) and (5) of the Rule, Petitioner proposes that the Board permit out-of-state dentists who wish to volunteer at the 2011 IMOM to provide a verification of license (or substantially similar document) from the appropriate licensing board of the dentist's home jurisdiction. In lieu of the requirements of paragraph (4) and (6) of the Rule, Petitioner proposes that the Dental Board perform a search of the National Practitioner Data Bank to determine whether any disciplinary actions have been taken against the dentist. In lieu of the requirements of paragraph (7) of the Rule, Petitioner proposes that the Board accept previous correspondence from the Foundation and the information provided herein related to the justification for the temporary permit, as well as the date and location of the 2011 IMOM. The Petitioner proposes that the Board include in an abbreviated application form the statement required by paragraph (8) of the Rule.
4. Each year, the Petitioner sponsors a free dental clinic for persons who may not otherwise be able to obtain quality dental care. The annual event has been named the "Iowa Mission of Mercy." Each year, the event takes place in a different region of Iowa. During the 2010 Iowa Mission of Mercy, volunteer dentists and dental hygienists

provided dental treatment at no cost to more than 1,500 low-income Iowans in Cedar Rapids. These services were valued at more than \$950,000.

Application of the Rule to the Petitioner with respect to the 2011 IMOM would result in undue hardship to the Petitioner. The 2011 IMOM is scheduled in Sioux City. As a result of the location's proximity to Minnesota, Nebraska, and South Dakota, many dentists from those states have expressed an interest in volunteering their time to provide free dental care to patients of the 2011 IMOM. In order to provide dental services at the 2011 IMOM, however, these dentists would be required to obtain a temporary permit to provide volunteer services. Obtaining the documentation required under the Rule would impose undue hardship on these dentists.

The waiver of the requirements of the Rule would not prejudice the substantial legal rights of any person. The waiver of the requirements of the Rule would allow the Petitioner to provide dental care to more patients who may not otherwise be able to afford that dental care.

The provisions of the Rule subject to this Petition for Waiver are not specifically mandated by statute or another provision of law. Iowa Code section 153.19 provides that the Dental Board may issue a temporary permit to practice dentistry if, "in the opinion of the board, a need exists and the person possesses qualifications prescribed by the board for the permit." That section further provides that "[n]one of the requirements for regular licensure under [chapter 153] are mandatory for a temporary permit except as specifically designated by the board."

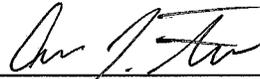
Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the Rule. The provision of license verification from the appropriate licensing board of the out-of-state dentist's jurisdiction, along with a search of the National Practitioner Data Bank, will ensure that patients of the 2011 IMOM receive care from qualified dentists.

The Petitioner, through the signature of the undersigned counsel for the Petitioner, hereby attests to the accuracy of the facts provided in this petition.

5. Except as set forth above, there are no other prior contacts between the Board and the Petitioner that would be affected by the waiver.
6. The Petitioner is unaware of any similar prior circumstances in which the Board has acted.
7. The Petitioner is unaware of any public agency or political subdivision that also regulates the activity in question or that might be affected by the grant of a waiver.
8. The Petitioner is unaware of any person that would be adversely affected by the granting of a waiver.

9. Except the Petitioner's legal counsel set forth above, no other person has knowledge of relevant facts relating to the proposed waiver.
10. Except the Petitioner's legal counsel set forth above, no other person has knowledge of relevant facts relating to the proposed waiver. As a result, the Petitioner has provided no releases of information.

Dated this 23 day of September, 2011.



REBECCA A. BROMMEL
ADAM J. FREED

BROWN, WINICK, GRAVES, GROSS,
BASKERVILLE AND SCHOENEBAUM, P.L.C.
666 Grand Avenue, Suite 2000
Des Moines, IA 50309-2510
Telephone: 515-242-2400
Facsimile: 515-283-0231
Email: brommel@brownwinick.com
Email: freed@brownwinick.com

ATTORNEYS FOR PETITIONER

Original delivered to Iowa Dental Board.

Current Board rules concerning application for volunteer permit:

13.3(3) Eligibility for a temporary permit to provide volunteer services.

a. A temporary permit to provide volunteer services is intended for dentists and dental hygienists who will provide volunteer services at a free or nonprofit dental clinic and who will not receive compensation for dental services provided. A temporary permit issued under this subrule shall be valid only at the location specified on the permit, which shall be a free clinic or a dental clinic for a nonprofit organization, as described under Section 501(c)(3) of the Internal Revenue Code.

b. An application for a temporary permit shall be filed on the form provided by the board and must be completely answered, including required credentials and documents. To be eligible for a temporary permit to provide volunteer services, an applicant shall provide all of the following:

(1) Satisfactory evidence of graduation with a DDS or DMD degree for applicants seeking a temporary permit to practice dentistry or satisfactory evidence of graduation from a dental hygiene school for applicants seeking a temporary permit to practice dental hygiene.

(2) The nonrefundable application fee for a temporary permit to provide volunteer services as specified in 650—Chapter 15.

(3) Evidence that the applicant possesses a valid certificate in a nationally recognized course in cardiopulmonary resuscitation.

(4) A statement disclosing and explaining any disciplinary actions, investigations, complaints, malpractice claims, judgments, settlements, or criminal charges against the applicant.

(5) Evidence that the applicant holds an active, permanent license to practice in at least one United States jurisdiction and that no formal disciplinary action is pending or has even been taken.

(6) Certification from the appropriate examining board from each jurisdiction in which the applicant has ever held a license. At least one license must be issued on the basis of clinical examination.

(7) A request for the temporary permit from those individuals or organizations seeking the applicant's services that establishes, to the board's satisfaction, the justification for the temporary permit, the dates the applicant's services are needed, and the location or locations where those services will be delivered.

(8) A statement from the applicant seeking the temporary permit that the applicant shall practice only in a free dental clinic or dental clinic for a nonprofit organization and that the applicant shall not receive compensation directly or indirectly for providing dental services.



STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING APPLICATION FOR TEMPORARY IOWA PERMIT

Enclosed is an application for a temporary permit to practice dentistry in Iowa. When completing this application, please be advised of the following.

- For specific permit requirements, please refer to the Board's rules at Iowa Administrative Code 650—13.3(153).
- A temporary permit is designed to fulfill an urgent need in the state of Iowa, to serve an educational purpose, or to provide volunteer services. A temporary permit is NOT intended as a way to practice before a permanent license is granted or as a means to practice because the applicant does not fulfill the requirements for permanent licensure. A temporary permit may be granted on a case-by-case basis.
- A temporary permit to provide volunteer services is intended for dentists or dental hygienists who will provide volunteer services at a free or nonprofit dental clinic and who will not receive compensation for dental services provided. A temporary permit for volunteer services is valid only at the location specified on the permit, which shall be a free clinic or a dental clinic for a nonprofit organization, as described under Section 501(c)(3) of the Internal Revenue Code.
- The issuance of a temporary permit has NO long-term implications for licensure. If the need changes or if a permit holder wishes to continue in short-term assignments in other Iowa locations, the permit holder is expected to seek permanent licensure.
- The board may issue a temporary permit authorizing the permit holder to practice at a specific location or locations in Iowa for a specified period up to three months. Following expiration of the permit, a permit holder shall be required to obtain a new temporary permit or a permanent license in order to practice dentistry or dental hygiene in Iowa.
- Dentists practicing in the state of Iowa cannot administer deep sedation/general anesthesia or conscious sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Board of Dental Examiners. The application form for a permit is available on the Board website.
- 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 on misconduct, criminal history, and examination results is not subject to disclosure.
- Applications are issued administratively following review of a completed application and all required credentials, unless the application warrants referral to the license and examination committee, the full Board, or unless a personal appearance is required.
- The application fee is non-refundable.
- Applications are valid for only six months from the date of receipt. If a permit has not been issued within six months, a new application will have to be submitted.
- **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.**

To assist you in completing the application, please utilize the following checklist and be sure that you have responded to each item.

Type or legibly print the application.

Complete each question on the application. If not applicable, answer N/A.

On page 1, indicate the specific location, dates needed, and reason/need for the temporary permit.

- Attach a practice reference for each practice location in the last three years. Attach at least one practice reference per location.
- For each "Yes" answer to questions 1 through 22 in section 8, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).
- Attach a photograph to the application that is suitable for positive identification.
- The application must be notarized.
- Include the original or a notarized copy of your National Board card reflecting your scores.
- Include a copy of your scores from any national, regional, or state licensing examination. If you have taken a clinical examination more than once, you must submit scores from each examination.
- Enclose a notarized copy of your diploma from dental school.
- Complete and enclose the form "Authorization for Release of Personal Information."
- Forward the form "Certificate of Dental Education" to your dental school and request the completed form be submitted directly to the Board office.
- Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your diploma or other documents.
- Include evidence of possessing a valid, current certificate in a nationally recognized course in cardiopulmonary resuscitation (such as a photocopy of the front and back of your current CPR card).
- Request a license certification from each state in which you have ever been licensed. Mail the enclosed form to each state and request that the certification be forwarded directly to the Board office. Please note that some states require a fee to process the enclosed form.
- Submit a letter to the Board stating: a) the reason why you need a temporary permit and your practice plans; b) whether or not you dispense drugs as part of your practice; c) whether or not your practice includes the administration of general anesthesia or conscious sedation; d) that you understand that a temporary permit is not meant as a way to practice before a permanent license is granted or as a means to practice because the applicant does not fulfill the requirements for permanent licensure; and e) that you understand that if the permit is issued it is valid for no more than three months. If you are seeking a temporary permit for volunteer services, your letter should also state that you understand that you can only practice at a free dental clinic or dental clinic for a nonprofit organization and that you shall not receive compensation for providing dental services.
- Include a letter from the person or organization seeking your services that establishes the need for the temporary permit, the dates your services are needed, and the location or locations where those services will be delivered. For volunteer services, the letter must also indicate whether the clinic is a free clinic or nonprofit organization, and whether the applicant will receive compensation for services delivered.
- Enclose the non-refundable application fee made payable to Iowa Board of Dental Examiners. The fee for a temporary permit for an urgent need or to serve an educational purpose is \$100. The fee for a temporary permit to provide volunteer services is \$25.

APPLICATION FOR TEMPORARY IOWA 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>



Please read the accompanying instructions prior to completing this application.

1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix)			
Other Names Used: (e.g. Maiden)			
Home Address:			Telephone:
City:	County:	State:	Zip:
Work Address:			Telephone:
City:	County:	State:	Zip:
Home Fax:	Home E-mail:	Work Fax:	Work E-mail:
Social Security Number:	Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.		
Height:	Weight:	Hair Color:	Eye Color:
Identifying Marks:		U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Visa Type or Alien Registration Number:
Date of Birth:	City of Birth:	State of Birth:	Country of Birth:
Father's Full Name:		Mother's Full Name:	
Full Name & Address of Nearest Relative Not Living With You:			

2. BASIS FOR APPLICATION

National Board Examination (Attach original or a notarized copy of National Board card reflecting scores.)	<input type="checkbox"/> Passed	Dates:
Examinations: List all National, Regional, or State Licensure Examinations Taken _____ _____	<input type="checkbox"/> Passed	Dates:
Temporary Permit Practice Location: _____	Dates From:	To:
Reason/Need for Temporary Permit: _____ _____ _____		

Office Use	Lic. #	Diploma	Fee	Cert. Ed
	Book# pg.	Nat'l Bd	Cert. Lic	Ref
	Date issued	Date approved	CRDTS	Juris
	Marriage Cert.	CPR	Fingerprints	

Name of Applicant _____

3. PRELIMINARY EDUCATION

Name of High School:	City, State:	From (Mo, Yr):	To (Mo, Yr):
Name of College:	City, State:	From (Mo, Yr):	To (Mo, Yr):
Name of College:	City, State:	From (Mo, Yr):	To (Mo, Yr):

4. DENTAL/DENTAL HYGIENE EDUCATION

Institution	City, State, Country	From (Mo, Yr):	To (Mo, Yr):
Year (1)			
Year (2)			
Year (3)			
Year (4)			
Degree Received:		Date of Degree:	

5. POST-GRADUATE TRAINING

Institution:	Specialty:	From (Mo, Yr):	To (Mo, Yr):
Address:	City:	State/Province:	

6. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental/dental hygiene 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. Attach a practice reference for each practice location in the last three (3) years.

Activity & Location	From (Mo, Yr):	To (Mo, Yr):

7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)

DEFINITIONS FOR SECTION 8. 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.

“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.

SECTION 8. In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH “YES” ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 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 type="checkbox"/> | 2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances? |
| <input type="checkbox"/> | <input 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 type="checkbox"/> | 4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice dentistry, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever been terminated or requested to withdraw from any dental school or training program? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever been requested to repeat a portion of any professional training program/school? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever been denied a license to practice dentistry? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11a. 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? |

YES NO

- 12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
- 13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
- 14. 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?
- 15. Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
- 16. Are any malpractice claims or complaints in process/pending against you?
- 17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
- 18. Are charges or an investigation currently pending relative to your dental license in any other state?
- 19. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
- 20. 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?
- 21. Do you have professional liability suits in process or pending?
- 22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
- 23. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

9. AFFIDAVIT OF APPLICANT

STATE OF _____ COUNTY OF _____

I, _____, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a permit/license to practice dentistry is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

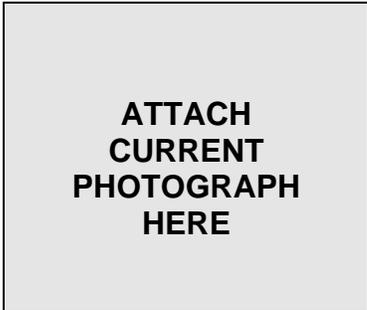
I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury 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 hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant _____

Sworn to before me this _____ day of _____, _____

Signature of Notary Public _____



NOTARY SEAL

AUTHORIZATION TO RELEASE INFORMATION

I, _____, do hereby authorize a disclosure of records concerning myself to the Iowa Dental Board (IDB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IDB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IDB relating to substance abuse or dependence and/or mental health.

I further agree that the IDB may receive confidential information and records, including but not limited to the following records:

- Medical records
- Education records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Residency or fellowship training records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IDB deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any dental school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IDB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IDB, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective through the completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IDB has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

Signature of Dentist

Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

CERTIFICATION OF EDUCATION

As part of the license application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental or dental hygiene education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ **SS#** _____

Signature _____ **Date** _____

This portion of the form should be completed by the school.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

RECEIVED DENTAL/DENTAL HYGIENE EDUCATION AT _____
(Circle One) (Name of School)

LOCATED AT _____
(Full Address of School)

FROM _____ **To** _____
(Month/Year) (Month/Year)

GRANTED A DIPLOMA WITH THE DEGREE OF _____

DATE DIPLOMA RECEIVED _____
(Month/Year)

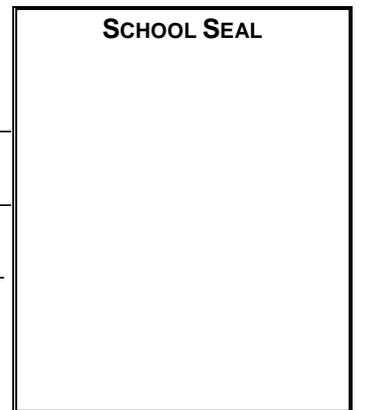
Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes _____ **No** _____

President, Dean, Secretary, or Registrar:

Print Name _____ **Title** _____

Signature _____ **Date** _____

Phone # _____ **Fax #** _____



Return Completed Form to:
IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157

CERTIFICATION OF LICENSURE

As part of the license application process, the Iowa Dental Board requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name _____ **License #** _____

Signature _____ **Date** _____

This portion of the form should be completed by the state licensing board.

IT IS HEREBY CERTIFIED THAT _____
(Name of Applicant)

WAS GRANTED LICENSE NUMBER _____ **DATE ISSUED** _____

TO PRACTICE _____ **IN THE STATE OF** _____

DATE LICENSE EXPIRES _____ **LICENSE STATUS** _____

BASIS FOR LICENSURE:

- NATIONAL BOARD EXAM
- ENDORSEMENT/RECIPROCITY
- STATE BOARD PREPARED WRITTEN AND/OR PRACTICAL EXAM
- REGIONAL CLINICAL EXAM, NAME OF TESTING AGENCY _____

Scores are recorded as follows:

SUBJECT	PERCENT	SUBJECT	PERCENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Scores are no longer available, however, I certify that it is apparent the applicant received a score sufficient to meet the licensure requirements of this state at that time; and these requirements were substantially equivalent to the requirements for licensure in Iowa.

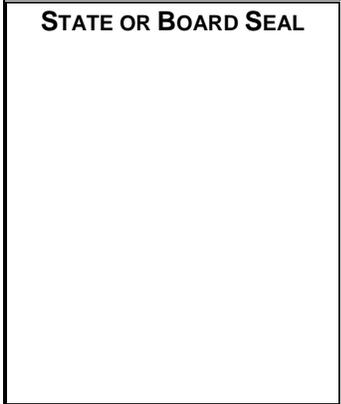
YES **No** **Disciplinary action ever been initiated, pending, or taken?**

Print Name _____ **Title** _____

Signature _____ **Date** _____

Phone # _____ **Fax #** _____

Return completed form to: IOWA DENTAL BOARD
400 S.W. 8th St, Suite D
Des Moines, IA 50309-4687
Phone (515) 281-5157



REPORT TO THE IOWA DENTAL BOARD

ACTION

DATE OF MEETING: September 27, 2011
RE: Application for Iowa Dental License by Credentials – Dr. Dale Nixon
SUBMITTED BY: Christel Braness, Administrative Assistant
ACTION REQUESTED: Action on Applicant’s Reported Practice History

Topic(s) for Board Review

Should the Board approve the practice history of Dr. Dale Nixon and allow him to be licensed on the basis of credentials?

Background

The Board’s administrative rules allow the Board discretion in approving the practice history of an application on the basis of credentials:

650—11.3(2)(153) Dental licensure by credentials.

- e. Certification by a state board of dentistry, or equivalent authority, from a state in which applicant has been licensed for at least three years immediately preceding the date of application and evidence of having engaged in the practice of dentistry in that state for three years immediately preceding the date of application or evidence of three years of practice satisfactory to the board.

June 1987	Dr. Nixon graduated from the dental school at the University of Minnesota.
July 1987	Dr. Nixon obtained a license in the state of Wisconsin.
July 1987 - January 2008	Dr. Nixon practiced at 3 locations within Wisconsin.
February 2008 - present	Dr. Nixon indicates in his application that he has been “traveling, etc.”
March 14, 2011	Board office received application for license by credentials
July 2010	Board received a letter of recommendation from a former co-worker.
August 1, 2011	The Board received a letter of explanation regarding his absence from practice.

Historical Treatment of Similar Situations

The Board, historically, has approved applications for dental license on the basis of credentials when the Board members have determined that the overall practice history is sufficient to ensure the safe practice of dentistry and maintain the protection of the public.

In at least one instance, where there was a rather lengthy departure from the practice of dentistry, the Board determined that the practice history was not satisfactory to the Board and the license was not granted.

Staff Recommendations

Given the recent change to Iowa law regarding the requirements for license by credentials, staff would recommend that Dr. Nixon be granted a license since his absence from the practice of dentistry was less than five years.

Historically, five years has been the timeline used to determine when a clinical examination would be required given an absence from the practice of dentistry. Dr. Nixon was absent from the practice of dentistry for approximately three years. Dr. Nixon resumed the practice of dentistry in Wisconsin earlier this summer.

August 1, 2011

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

Dear Iowa Board of Dental Examiners,

Thank you for allowing me to provide clarification regarding my gap in active practice.

I had always had the desire to travel and explore new areas, live styles and opportunities; which many of my family members didn't have an opportunity to do as many of my male family members have passed away at very early ages. I didn't want to miss my chance as well; therefore, after I sold my dental practice in Ashland in 2008, I traveled to China, Spain, Portugal, Central America and Alaska over the past few years. I spent the majority of the summers on a fishing vessel in Alaska as a Captain. I also remodeled an entire house and spent quality time with my elderly parents between my journeys.

Having had the chance to enjoy the traveling with friends and family, I have intertwined my traveling and my professional career in dentistry together. The opportunity that has presented is to work for a dental group where I can continue to enjoy different areas while providing quality dental care. Since my initial application was submitted; I began practicing dentistry in Wisconsin, covering maternity leave coverage at Midwest Dental in Fond du Lac which started on June 6, 2011 and is scheduled to be finished on August 22, 2011. I then plan to cover another maternity leave at Midwest Dental in Mondovi, WI from November 21, 2011 through February 13, 2012. It is my plan to continue to provide quality dental care in dental offices where there otherwise could be an absence, resulting in limited the access to care.

Thank you for your time in reviewing my application and considering me to be eligible for licensure in your state. If you have any questions or concern, please feel free to contact me at (715)453-8780 or lostcanoe@gmail.com.

Sincerely,



Dr. Dale T. Nixon

Anne Wickman
621 Vaughn Ave
Ashland, WI 54806

715-682-9162
awickman@centurytel.net

July 10, 2011

Christel Braness, Administrative Assistant
[Iowa Dental Board](#)
400 SW 8th St., Suite D
Des Moines, IA 50309

Christel.Braness@iowa.gov

To whom may concern,

I am the retired office manager for Lakeview Dental Center in Ashland, WI, a family orientated general practice. I worked under the partnership that included Dale Nixon, DDS. I am pleased to write this letter of recommendation for him as a past employee and patient.

Dr. Nixon has excellent patient skills. He communicates his treatment recommendations to the patients/guardians well. He is thoughtful and intuitive of the patient needs such as needing more explanation of a procedure. He concentrates on his patient and the procedure being done and works quickly. When he came to Lakeview Dental Center, I was a clinical assistant. He trained us in maximizing our skills. He introduced scheduling utilizing assistant and doctor time and we were able to accommodate more patients on a daily basis.

Dr. Nixon had foresight as an owner to grow the clinic and utilize the technology to benefit the patients. Under his leadership the clinic was totally remodeled and converted to a paperless chart dental practice. He is a very trustworthy and confidential person.

He is missed by his staff and patients.

Sincerely,

Anne Wickman

APPLICATION FOR IOWA DENTAL LICENSE

IOWA DENTAL BOARD

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



Please read the accompanying instructions prior to completing this application.

Application by: _____ Examination Credentials

RECEIVED
MAR 14 2011
IOWA DENTAL BOARD

1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix) Nixon, Dale, Taylor			
Other Names Used: (e.g. Maiden) N/A OB 3/28/11			
Home Address: W8620 State Highway 86		Telephone: 715-453-8780	
City: Tomahawk	County: Lincoln	State: Wisconsin	Zip: 54487
Work Address: NA		Telephone: NA	
City: NA	County: NA	State: NA	Zip: NA
Home Fax: NA	Home E-mail: lostcanoe@gmail.com	Work Fax: NA	Work E-mail: NA
Social Security Number: [REDACTED]	<small>Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.</small>		
Height: 6' 2"	Weight: 230	Hair Color: Blonde/Light Brown	Eye Color: Green
Identifying Marks: NA	U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If No, Visa Type or Alien Registration Number:
Date of Birth: 5/12/1959	City of Birth: De Pere	State of Birth: Wisconsin	Country of Birth: USA
Father's Full Name: Deceased		Mother's Full Name: Rita Jarvis	
Full Name & Address of Nearest Relative Not Living With You: Rita Jarvis 906 Georgia Drive, De Pere WI 54115			Phone/Email Address: 920-336-3388

2. BASIS FOR APPLICATION

EXAMINATION	PASS	DATE(S):
National Board Examination (Attach original or a notarized copy of National Board card reflecting scores.)	<input checked="" type="checkbox"/> Passed	1987
Central Regional Dental Testing Service (CRDTS)	<input checked="" type="checkbox"/> Passed	1987
Western Regional Examining Board (WREB)	<input type="checkbox"/> Passed	
American Board of Dental Examiners (ADEX) (Attach scores from each examination attempt.)	<input type="checkbox"/> Passed	
Iowa Jurisprudence Examination (Required by every applicant.)	<input type="checkbox"/> Passed	
Other National, Regional, or State Licensure Examinations (List all other examinations taken. Include the date and scores.)	<input checked="" type="checkbox"/> Passed	1986

not yet scheduled @ time app was submitted. OB 3/28/11

Office Use	Lic. #	Fee: CK# 2200 \$ 596	CPR: <input checked="" type="checkbox"/>	Cert. License: <input checked="" type="checkbox"/>
	Date issued:	F-prints: Mailed 3-14-11	Clinical Exam(s): <input checked="" type="checkbox"/>	References:
	Marriage Cert: N/A	Cert. Education: <input checked="" type="checkbox"/>	Nat'l Bd: <input checked="" type="checkbox"/> 7/85, 12/86	3 Yrs. Practice (Cred): refer to bd.
	Letter/Authorization: <input checked="" type="checkbox"/>	Diploma: <input checked="" type="checkbox"/>	Juris: <input checked="" type="checkbox"/>	NPDB: <input checked="" type="checkbox"/>

Name of Applicant Dale Taylor Nixon

3. PRELIMINARY EDUCATION

Name of High School: East De Pere High School	City, State: De Pere, WI	From (Mo, Yr): 9/1973	To (Mo, Yr): 5/1977
Name of College: University of Wisconsin	City, State: Stevens Point, WI	From (Mo, Yr): 9/1977	To (Mo, Yr): 5/1978
Name of College: University of Wisconsin	City, State: Madison, WI	From (Mo, Yr): 9/1978	To (Mo, Yr): 5/1982

4. DENTAL EDUCATION

Institution	City, State, Country	From (Mo, Yr):	To (Mo, Yr):
Year (1) University of Minnesota	Minneapolis, MN USA	9/1983	5/1984
Year (2) University of Minnesota	Minneapolis, MN USA	9/1984	5/1985
Year (3) University of Minnesota	Minneapolis, MN USA	9/1985	5/1986
Year (4) University of Minnesota	Minneapolis, MN USA	9/1986	5/1987
Degree Received: DDS		Date of Degree: 6/1987	

5. POST-GRADUATE DENTAL TRAINING

Institution: <i>N/A per history ↓ CB 3/28/11</i>	Specialty:	From (Mo, Yr):	To (Mo, Yr):
Address:	City:	State/Providence:	

6. 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. Attach a practice reference for each practice location in the last three (3) years.

Activity & Location	From (Mo, Yr):	To (Mo, Yr):
Webster Dental - Green Bay WI Private Practice General Dentist	7/87	6/93
Phaller Dental - Woodruff, WI Private Practice General Dentist	7/93	9/95
Lakeview Dental - Ashland, WI Private Practice General Dentist	10/95	1/2008
Traveling, etc	2/2008	Current

7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)
WI/USA	3829	7/15/1987	Permanent	Examination

DEFINITIONS FOR SECTION 8. 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.

“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.

SECTION 8. In answering each of the following questions, please check the appropriate box next to each question. FOR EACH “YES” ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).

- | | | |
|--------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | |
| YES | NO | |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 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 type="checkbox"/> | 4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice dentistry, reduce or eliminate 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"/> | 6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 7. Have you ever been terminated or requested to withdraw from any dental school or training program? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Have you ever been requested to repeat a portion of any professional training program/school? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 9. Have you ever received a warning, reprimand, or placed on probation or disciplined during a professional training program/school? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 10. Have you ever been denied a license to practice dentistry? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11a. 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? |

YES NO

- 12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
- 13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
- 14. 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?
- 15. Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
- 16. Are any malpractice claims or complaints in process/pending against you?
- 17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
- 18. Are charges or an investigation currently pending relative to your dental license in any other state?
- 19. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
- 20. 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?
- 21. Do you have professional liability suits in process or pending?
- 22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
- 23. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

9. AFFIDAVIT OF APPLICANT

STATE OF Wisconsin COUNTY OF Lincoln

I, Dale Nixon, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a license to practice dentistry is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

I declare, under penalty of perjury, 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. I also declare under penalty of perjury 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 hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant [Signature]

Sworn to before me this 24th day of February, 2011

Signature of Notary Public Amy M. Swan



My Commission Expires 8/23/11
NOTARY SEAL
AMY SWAN
Notary Public
State of Wisconsin

AUTHORIZATION TO RELEASE INFORMATION

I, Dale Taylor Nixon, do hereby authorize a disclosure of records concerning myself to the Iowa Dental Board (IDB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IDB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IDB relating to substance abuse or dependence and/or mental health.

I further agree that the IDB may receive confidential information and records, including but not limited to the following records:

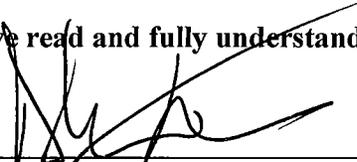
- Medical records
- Education records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Residency or fellowship training records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IDB deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any dental school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IDB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IDB, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective through the completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IDB has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."



Signature of Dentist

2/28/11

Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

REPORT TO THE DENTAL HYGIENE COMMITTEE

ACTION

DATE OF MEETING: September 27, 2011
RE: Application for Iowa Dental Hygiene License – Shelly Simpson, D.H.
SUBMITTED BY: Christel Braness, Administrative Assistant
ACTION REQUESTED: Action on Applicant’s Reported Criminal History

Topic(s) for Board Review

Should the Board approve the dental hygiene license of Ms. Shelly Simpson given her reported criminal history?

Background

6/1993	Ms. Simpson was charged with felony theft in the state of Illinois.*
5/1994	Ms. Simpson pled guilty the charge and was sentenced to probation, community service and restitution. (Ms. Simpson reports completing all court-ordered requirements in a timely manner.)
8/1994-5/1996	Ms. Simpson was in dental hygiene school.
5/1996	Ms. Simpson graduated with a degree in dental hygiene.
5/1996-9/1997	Ms. Simpson practiced as a dental assistant in Illinois.
12/1996-4/1998	Ms. Simpson practiced as a dental hygienist in Illinois.
5/1998-2/2000	Ms. Simpson practiced as a dental hygienist in Michigan.
4/2000-1/2002	Ms. Simpson practiced as a dental hygienist in New York.
1/2002-3/2004	Ms. Simpson stayed home with her children.
5/2004-5/2011	Ms. Simpson practiced as a dental hygienist in Kansas.
8/2011-present	Ms. Simpson moved to Iowa and applied for an Iowa dental hygiene license.

Historical Treatment of Similar Situations

The Dental Hygiene Committee has reviewed these cases and made recommendations on an individual basis depending upon the nature of the crime. Licenses have been issued to the applicants in some situations.

Staff Recommendations

Staff would recommend that a license be issued to Ms. Simpson. *Board staff has verified that the threshold for felony theft in Illinois is \$150. In Iowa, the threshold for felony theft is \$1000. Due to the low threshold for a felony charge in Illinois, and given the fact that theft occurred 18 years ago without any other reported incidents of criminal history, staff feels that a license could be issued to her.

APPLICATION FOR IOWA DENTAL HYGIENE LICENSE

IOWA DENTAL BOARD

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

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



RECEIVED

AUG 08 2011

Please read the accompanying instructions prior to completing this application.

Application by: _____ Examination Credentials

1. IDENTIFYING INFORMATION

IOWA DENTAL BOARD

Full Legal Name: (Last, First, Middle, Suffix) Simpson, Shelly, Lynn			
Other Names Used: (e.g. Maiden) Harrigan Shelly Lynn			
Home Address: 2794 NE 94th Place			Telephone: (913) 530-4861
City: Ankeny	County: Polk	State: Iowa	Zip: 50021
Work Address: N/A			Telephone: N/A
City: N/A	County: N/A	State: N/A	Zip: N/A
Home Fax:	Home E-mail: shelsimp68@gmail.com	Work Fax: N/A	Work E-mail: N/A
Social Security Number: <div style="background-color: black; width: 100px; height: 15px;"></div>	<small>Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 2721.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.</small>		
Height: 5'6	Weight: 165	Hair Color: Blonde	Eye Color: Green
Identifying Marks:		U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If No, Visa Type or Alien Registration Number:
Date of Birth: 10/1/68	City of Birth: Murray	State of Birth: KY	Country of Birth: USA
Father's Full Name: Thomas Neal Harrigan		Mother's Full Name: Linda Kathryn Harrigan	
Full Name & Address of Nearest Relative Not Living With You: Tom & Linda Harrigan 1604 Chandler Danville, IL 61832		Phone/Email Address: bandude1@comcast.net (217) 260-1912 or (217) 474-1912	

2. BASIS FOR APPLICATION

EXAMINATION	PASS	DATE(S):
National Board Examination (Attach original or a notarized copy of National Board card reflecting scores.)	<input checked="" type="checkbox"/> Passed	April 1996
Central Regional Dental Testing Service (CRDTS) Western Regional Examining Board (WREB) (Attach scores of examination.)	<input type="checkbox"/> Passed <input type="checkbox"/> Passed	NA
Iowa Jurisprudence Examination (Required by every applicant.)	<input type="checkbox"/> Passed	(not yet completed. CB 9/13/11)
Other National, Regional, or State Licensure Examinations (List all other examinations taken. Include the date and scores.)	<input checked="" type="checkbox"/> Passed	April 1996

North East Regional Board
Exam. Results to be sent
directly to Iowa Board

Office Use	Lic. #	Fee: CK# 3035 \$290	CPR: <input checked="" type="checkbox"/>	Cert. License: <input checked="" type="checkbox"/>
	Date issued:	F-prints: Mailed 8-8-11	Clinical Exam(s): <input checked="" type="checkbox"/>	References: <input checked="" type="checkbox"/>
	Marriage Cert:	Cert. Education:	Nat'l Bd: ✓ 1996	3 Yrs. Practice (Cred): ✓ KS
	Letter/Authorization: <input checked="" type="checkbox"/>	Diploma: <input checked="" type="checkbox"/>	Juris:	NPDB: <input checked="" type="checkbox"/>

Name of Applicant Shelly L. Simpson

3. PRELIMINARY EDUCATION

Name of High School: <u>Danville High School</u>	City, State: <u>Danville, Illinois</u>	From (Mo, Yr): <u>8/82</u>	To (Mo, Yr): <u>6/86</u>
Name of College: <u>Illinois State University</u>	City, State: <u>Normal, Illinois</u>	From (Mo, Yr): <u>8/86</u>	To (Mo, Yr): <u>5/91</u>
Name of College:	City, State:	From (Mo, Yr):	To (Mo, Yr):

4. DENTAL HYGIENE EDUCATION

Year	Institution	City, State, Country	From (Mo, Yr):	To (Mo, Yr):
Year (1)	<u>Parkland College</u>	<u>Champaign, Illinois U.S.</u>	<u>8/94</u>	<u>8/95</u>
Year (2)	<u>Parkland College</u>	<u>Champaign, Illinois U.S.</u>	<u>8/95</u>	<u>5/96</u>
Year (3)				
Year (4)				
Degree Received: <u>Associate's of Applied Science in Dental Hygiene</u>		Date of Degree: <u>May 1996</u>		

5. POST-GRADUATE DENTAL HYGIENE TRAINING

Institution: <u>N/A</u>	Specialty:	From (Mo, Yr):	To (Mo, Yr):
Address:	City:	State/Province:	

6. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental hygiene and non-dental hygiene activities from the date of your graduation from dental hygiene 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. Attach a practice reference for each practice location in the last three (3) years.

Activity & Location	From (Mo, Yr):	To (Mo, Yr):
<u>Dr. Jeffrey Frenichs, DDS General Dentist Champaign, IL PT Dental Asst</u>	<u>5/96</u>	<u>12/96</u>
<u>Dr. Morgan Powell Orthodontist Champaign, IL Temporary Ortho Asst</u>	<u>4/97</u>	<u>9/97</u>
<u>Dr. Jeffrey Frenichs DDS General Dentist Champaign, IL PT Dental Hygienist</u>	<u>12/96</u>	<u>4/98</u>
<u>Dr. Greg Martin DDS General Dentist Champaign, IL PT Dental Hygienist</u>	<u>11/97</u>	<u>4/98</u>
<u>Dr. Mark Halboth DDS General Dentist Livonia, MI FT Dental Hygienist</u>	<u>5/98</u>	<u>2/00</u>
<u>Dr. Russell DiPalma, DDS General Dentist Fredonia, NY PT Dental Hygienist</u>	<u>4/00</u>	<u>1/02</u>
<u>(*) (*) See additional attached sheet (*) (*)</u>		

7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, <u>Permanent</u>)	How Obtained (e.g. Credentials, <u>Exam</u>)
<u>Illinois</u>	<u>020008794</u>	<u>12/6/1996</u>	<u>Permanent</u>	<u>Credentials</u>
<u>Michigan</u>	<u>2902011559</u>	<u>4/9/1998</u>	<u>Permanent</u>	<u>Credentials</u>
<u>New York</u>	<u>51 022232</u>	<u>3/16/2000</u>	<u>Permanent</u>	<u>Credentials</u>
<u>Kansas</u>	<u>10438</u>	<u>4/2/2004</u>	<u>Permanent</u>	<u>Credentials</u>

Chronology of Activities (cont)

<u>Activity + Location</u>	<u>From</u>	<u>To</u>
Stayed at home with my oldest daughter whose age ranged from 1 mos to 2 1/2 yr during this time. I also had my 2nd daughter 9/03.	1/02	3/04
During this time, from approx 1/03 to 12/03, I worked as a weight loss consultant for Jenny Craig, part time. I was located in Fort Worth, TX, until moving to Kansas 3/04		
Dr. Don Nielson, DDS General Dentist FT Hygienist	5/04	--- 4/07
Dr. Nick Prater, DDS Pediatric Dentist PT Hygienist	4/07	--- 5/11
⊕ Letter of Recommendation enclosed ⊕		
Moved to Iowa, time home with daughters, unpacking, getting house in order	5/11	--- 8/11

DEFINITIONS FOR SECTION 8. Important! Read these definitions before completing the following questions.

"Ability to practice dental hygiene with reasonable skill and safety" means ALL of the following:

1. The cognitive capacity to make 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 hygiene examinations and dental hygiene procedures.

"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.

SECTION 8. In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH "YES" ANSWER TO QUESTIONS 1 THROUGH 18, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

YES NO

- | | | |
|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dental hygiene 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 dental hygiene 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. If YES to any of the above, does your field of practice, the setting, or the manner in which you have been chosen to practice dental hygiene, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 7. Have you ever been terminated or requested to withdraw from any dental hygiene school or training program? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 8. Have you ever been requested to repeat a portion of any professional training program/school? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 9. Have you ever received a warning, reprimand, or placed on probation or disciplined during a professional training program/school? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 10. Have you ever been denied a license to practice dental hygiene? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency? |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11a. 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? |

Name of Applicant

Shelly L. Simpson

YES NO

- 12. 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?
- 13. Are any professional liability or malpractice claims or complaints in process/pending against you?
- 14. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dental hygiene?
- 15. Are charges or an investigation currently pending relative to your dental hygiene license in any other state?
- 16. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
- 17. 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?
- 18. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
- 19. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

9. AFFIDAVIT OF APPLICANT

STATE OF Iowa COUNTY OF Polk

I, Shelly L. Simpson, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dental hygiene as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a license to practice dental hygiene is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

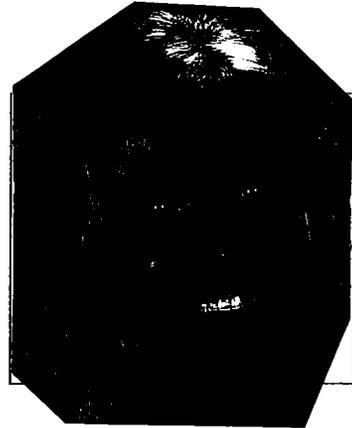
I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury 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 hereby agree to abide by the laws and rules pertaining to the practice of dental hygiene in the state of Iowa.

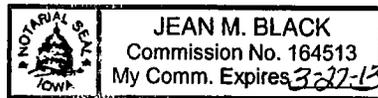
Signature of Applicant Shelly L. Simpson

Sworn to before me this 3 day of August, 2011

Signature of Notary Public Jean M. Black



NOTARY SEAL



Shelly L. Simpson
2792 NE 94th Place
Ankeny, Iowa 50021

July 24th, 2011

Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

To Whom It May Concern:

I am applying for licensure as a Dental Hygienist in the state of Iowa and have completed the application. While answering question #6 in Section 8, I replied "yes," and this is my statement giving details of my response.

I started working at Lerner New York in Normal, Illinois in 1991 after college graduation, starting as Assistant Manager, and then moving up to Store Manager. While working there, it was common practice for employees to change into clothes from the sales floor prior to starting their shift, and wear them home after the shift was over. Sometimes the items would get paid for that day and sometimes not, with the understanding that they would be paid for the next day or after the next pay period. I took part in this practice, although I have to stress that I always intended to pay for any items and never intended to steal from the company. Most of the clothing/accessories did get paid for, however some did not, whether it was because I simply forgot, or waited too long and felt that it would be more harmful to do the right thing. I knew it wasn't right, but never considered it to be theft.

In late June of 1993, company loss control showed up at our store. Employees, including myself, were questioned and I was totally up front and honest about everything. I went home to retrieve items that I thought hadn't been paid for, and in retrospect, even returned some things that probably had been. When the items were totaled up, it came to an amount that constituted felony theft, and I was arrested. I was devastated, thinking that because I had returned the items and been honest, all would be forgiven other than my job.

After about a year, I pleaded guilty to felony theft in May, 1994, and was sentenced to probation, community service, and restitution. I knew that it would go on my record and would affect me the rest of my life, but felt that I had to move on at the time and pay for what I had done. I paid my restitution monthly until paid in full, and completed probation and all of my community service without incident.

In the Fall of 1994, I started the Dental Hygiene program at Parkland College in Champaign, IL, and graduated in May of 1996. I have successfully practiced in 4 other states prior to moving to Iowa and

feel that I would be beneficial as a hygienist here as well. I truly enjoy what I do and appreciate what the hygiene field has to offer me, and hope that I can share what I have to offer here in Iowa.

I am truly sorry for what I did and I cannot change it. However, I feel that over the last 17 years, I have done everything I can to become a good, upstanding and contributing member of society, and hope you will help me in continuing to do so.

Thank you for your time. Please do not hesitate to contact me if needed for additional information.

Sincerely,

A handwritten signature in cursive script that reads "Shelly Simpson". The signature is written in black ink and is positioned above the printed name and phone number.

Shelly L. Simpson
(913)530-4861

*Occurred in Normal, Illinois

*Case number 1993CF000558 in McLean County, Illinois

*Guilty of Retail Theft/Display Merchandise Greater than \$150

*Plead date May 26, 1994, Sentenced to 30 months probation, restitution, and community service

*My attorney was Steven Skelton of Bloomington, Illinois (309)820-9599

*** No materials available for open session**

Kelly Van Wyk, DH - Licensure by Examination