STATE OF IOWA
IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE
AGENDA

July 19, 2012
12:00 p.m.

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa

Committee Members: ***Lynn Curry, D.D.S. Chair****; Richard, Burton, D.D.S.; Steven Clark, D.D.S.; Douglas Horton, D.D.S.; Gary Roth, D.D. S.; Kaaren Vargas, D.D.S.; Kurt Westlund, D.D.S*

OPEN SESSION

I. CALL MEETING TO ORDER - ROLL CALL *Lynn Curry*

II. APPROVAL OF OPEN SESSION MINUTES (none)

III. * MODERATE SEDATION PERMIT APPLICATIONS

a. Dr. Kimberly Pingel, D.D.S.

IV. * GENERAL ANESTHESIA PERMIT APPLICATIONS

a. Dr. Luke Freml, D.D.S

V. OPEN SESSION ACTION, IF ANY, ON CLOSED SESSION AGENDA ITEMS

VI. OPPORTUNITY FOR PUBLIC COMMENT

VII. OTHER BUSINESS

a. Committee Meeting Schedule

b. Process for Committee Review & Recommendation to Board

VIII. 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 committee 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.

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.

REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE (ACC)

RECOMMENDATION

DATE OF MEETING:	July 12, 2012
RE:	**Moderate Sedation Application**
SUBMITTED BY:	Christel Braness, Administrative Assistant
ACTION REQUESTED:	Recommendation regarding application

Background

The Anesthesia Credentials Committee is a peer review committee appointed by the Board to assist the Board. The administrative rules provide that one of the duties of the Committee is to:

> *a.* Review all permit applications and make recommendations to the board regarding those applications.

The following practitioner has applied for a moderate sedation permit:

- **Dr. Kimberly Pingel, D.D.S.**

Added Qualifications: (Pediatric, medically-compromised patients (ASA-3-4))

Dr. Pingel is asking that she be allowed to provide moderate sedation to pediatric and medically compromised (ASA 3-4) patients. Dr. Pingel will be completing a residency program at the end of June 2012.

Committee Recommendation

Should the applicant(s) above be granted a moderate sedation permit?

Should the applicant be granted the added qualifications as requested?

Staff Recommendation

I recommend that Dr. Pingel be issued a moderate sedation permit as requested following the successful completion of any/all inspections and evaluations deemed necessary.

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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 MODERATE SEDATION PERMIT

SECTION 1 – APPLICANT INFORMATION

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

Full Legal Name: (Last, First, Middle, Suffix) Pingel, Kimberly, Victoria				
Other Names Used: (e.g. Maiden) Kim	**Home E-mail:** Kimberlypingel@gmail.com		**Work E-mail:** ping0032@umn.edu	
Home Address: 820 Emerald St #304	**City:** St. Paul	**State:** MN	**Zip:** 55114	**Home Phone:** 612 219 4351
License Number: 08897	**Issue Date:** 3/23/2012	**Expiration Date:** 8/31/2012	**Type of Practice:** Oral and Maxillofacial Surgery	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
100 Bryant St.	Dubuque, IA	52003	563-557-1440	8-5/M-F
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
511 S. 4th St	Clinton	52732	563-259-4349	8-4/T, Th, Fr.
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.	Check if completed.	DATE(S):
Moderate Sedation Training Program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences	☐ Completed	
ADA-accredited Residency Program that includes moderate sedation training	☑ Completed	06/30/2012
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☐ Completed	
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS Provider	**Location:** Minneapolis VAHCS
Date of Course: 07/05/2011	**Date Certification Expires:** 07/2013

Office Use				
	Lic. # 08897	Sent to ACC:	Inspection	Fee
	Permit # MS0078*	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

* Lapsed 8/31/08, reapplying

Name of Applicant Kimberly Pingel

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:

☒ Postgraduate Residency Program ☐ Continuing Education Program ☐ Other Board-approved program, specify:

Name of Training Program:	Address:	City:	State:
OMFS University of Minnesota	7-174 Moos tower 515 Delaware St SE	Minneapolis	MN

Type of Experience: 4 months dedicated anesthesia training, anesthesia class 4-years daily sedation cases

Length of Training:	Date(s) Completed:
4 years	6/30/12
Number of Patient Contact Hours: 6240	**Total Number of Supervised Sedation Cases:** 248

☒ YES ☐ NO **1. Did you satisfactorily complete the above training program?**

☒ YES ☐ NO **2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?**

☒ YES ☐ NO **3. Does the program include management of at least 20 clinical patients?**

As part of the curriculum, are the following concepts and procedures taught:

☒ YES ☐ NO **4. Physical evaluation;**

☒ YES ☐ NO **5. IV sedation;**

☒ YES ☐ NO **6. Airway management;**

☒ YES ☐ NO **7. Monitoring; and**

☒ YES ☐ NO **8. Basic life support and emergency management.**

☒ YES ☐ NO **9. Does the program include clinical experience in managing compromised airways?**

☒ YES ☐ NO **10. Does the program provide training or experience in managing moderate sedation in pediatric patients?**

☒ YES ☐ NO **11. Does the program provide training or experience in managing moderate sedation in ASA category 3 or 4 patients?**

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

SECTION 6 – MODERATE SEDATION EXPERIENCE

☐ YES ☒ NO **A. Do you have a license, permit, or registration to perform moderate sedation in any other state?**

If yes, specify state(s) and permit number(s):_____

☒ YES ☐ NO **B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?**

☐ YES ☒ NO **C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?**

☒ YES ☐ NO **D. Do you plan to use moderate sedation in pediatric patients?**

☒ YES ☐ NO **E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients?**

☒ YES ☐ NO **F. Do you plan to engage in enteral moderate sedation?**

☒ YES ☐ NO **G. Do you plan to engage in parenteral moderate sedation?**

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

IV sedation drugs used: versed, valium, fentanyl, Ketamine, propotol, Brevital,

techniques: light sedation: versed + fentanyl
moderate sedation: versed, fentanyl, propotol
versed, Ketamine

Name of Applicant Kimberly Pingel Facility Address 100 Bryant St., Dubuque, IA 511 S. 4th St. Clinton, IA

SECTION 7 – AUXILIARY PERSONNEL

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

Name: See attached list.	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

SECTION 8 – FACILITIES & EQUIPMENT

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

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

COPY FORM AND SUBMIT FOR EACH FACILITY.

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EMPLOYEE LICENSE RENEWAL INFORMATION

	Dental Assistant #	BLS Certification	BLS Expires
Kelly Bergfeld, Surgical Assisant	Q04453	09/.27/2011	09/.27/2013
Mary Beth Bowden, RN	X10104	09/.27/2011	09/.27/2013
Sharon Braem, Dental Assistant	Q00443	09/.27/2011	09/.27/2013
Kristy (Breiner) DuPont, Dental Assistant	Q09197	09/.27/2011	09/.27/2013
Susan Curwen, Dental Assistant	Q02492	09/.27/2011	09/.27/2013
Mary Jo Dalen, Dental Assistant	Q00441	09/.27/2011	09/.27/2013
Alyssa Ann Danner, Dental Asst.	Q10749	09/.27/2011	09/.27/2013
Stephanie DenBesten, RN	T11285	09/.27/2011	09/.27/2013
Heidi (Huseman) Duehr, RN	X03040	09/.27/2011	09/.27/2013
Cindy Evans, RN	X06126	09/.27/2011	09/.27/2013
Susan Baskerville Gerhard	Q04357	09/.27/2011	09/.27/2013
Tanya Harwell, Dental Assistant	Q09995	09/.27/2011	09/.27/2013
Carol Glesne-Koppes, Dental Asst	Q00212	09/.27/2011	09/.27/2013
Tanya Kluesner, RN	X09448	09/.27/2011	09/.27/2013
Trisha (Losh) Reck, Dental Assistant	Q07587	09/.27/2011	09/.27/2013
Beth Mohr, Dental Assistant	Q02389	09/.27/2011	09/.27/2013
Kerry Newland, Dental Assistant	Q05977	09/.27/2011	09/.27/2013
Holly Ann O'Connell, Dental Asst.	Q10275	09/.27/2011	09/.27/2013
Lindsey Jo (Schilling) Schueller	Q09977	09/.27/2011	09/.27/2013
Judy Zahren-Kalb, Dental Asst.	Q00676	09/.27/2011	09/.27/2013

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?	☐	☑
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐	☑
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?	☐	☑
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?	☐	☑
5. Have you ever been requested to repeat a portion of any professional training program/school?	☐	☑
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	☐	☑
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	☐	☑
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?	☐	☐
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?	☐	☑
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?	☐	☑
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?	☐	☑
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?	☐	☑

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: MN **COUNTY:** Hennepin

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

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

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

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

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

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

I further state that I have read the rules related to the use of sedation and nitrous oxide inhalation analgesia, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and moderate sedation in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ▶

SIGNATURE OF APPLICANT

NOTARY SEAL

CHRISTINE C THOMPSON
NOTARY PUBLIC - MINNESOTA
MY COMMISSION EXPIRES 1/31/2015

SUBSCRIBED AND SWORN BEFORE ME, THIS 26 **DAY OF** April **, YEAR** 2012

NOTARY PUBLIC SIGNATURE

Christine C. Thompson

NOTARY PUBLIC NAME (TYPED OR PRINTED)

Christine C. Thompson

MY COMMISSION EXPIRES:

31 January 2015

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider

PEEL HERE

Kimberly Pingel

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

Jul 5, 2011
Issue Date

Jul 2013
Recommended Renewal Date

Training Center Name: Minneapolis VAHCS
TC ID #: MN04709
TC Info: 1 Veterans Drive, Minneapolis, MN 55417 (City, State, ZIP)
TC Phone: (612) 467-3019
Course Location: Minneapolis, MN
Instructor Name: John M. Deal
Inst. ID #: 6070376255
Holder's Signature

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

This card contains unique security features to protect against forgery.

90-1801 3/11

ADVANCED CARDIOVASCULAR LIFE SUPPORT ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

PEEL HERE

Kimberly Pingel

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

Jul 5, 2011
Issue Date

Jul 2013
Recommended Renewal Date

Training Center Name: Minneapolis VAHCS
TC ID #: MN04709
TC Info: 1 Veterans Drive, Minneapolis, MN 55417 (City, State, ZIP)
TC Phone: (612) 467-3019
Course Location: Minneapolis, MN
Instructor Name: John M. Deal
Inst. ID #: 6070376255
Holder's Signature

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This card contains unique security features to protect against forgery.

90-1806 3/11

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Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

PLEASE TYPE OR PRINT LEGIBLY IN INK.

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

SECTION 1 – APPLICANT INFORMATION

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

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

MAILING ADDRESS: 820 Emerald St Apt 416

CITY:	STATE:	ZIP CODE:	PHONE:
St. Paul	MN	55114	612-219-4351

To obtain a permit to administer moderate sedation in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:	DATE:
	5/1/12

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: DR. Pamela Hughes

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

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

NAME AND LOCATION OF POSTGRADUATE PROGRAM:	PHONE:
University of Minnesota Minneapolis, MN	612-624-9959

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	07/2008	07/2012	06/30/2012

☒ YES ☐ NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM?

☒ YES ☐ NO 2. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?

☒ YES ☐ NO 3. DOES THE PROGRAM COVER THE AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS AND DENTAL STUDENTS?

☒ YES ☐ NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE IN MANAGING COMPROMISED AIRWAYS?

☒ YES ☐ NO 5. DOES THE PROGRAM INCLUDE MANAGEMENT OF AT LEAST 20 PATIENTS?

(If no to above, please provide a detailed explanation.)

☐ YES ☒ NO 6. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR WAS THE APPLICANT PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.

☐ YES ☒ NO 7. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.

☒ YES ☐ NO 8. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR PEDIATRIC (AGE 12 OR YOUNGER) PATIENTS? If yes, please provide details.

☒ YES ☐ NO 9. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR MEDICALLY COMPROMISED (ASA CLASS 3 OR 4) PATIENTS? If yes, please provide details.

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

PROGRAM DIRECTOR SIGNATURE:	DATE:
	5/10/12

REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE (ACC)

RECOMMENDATION

DATE OF MEETING:	July 12, 2012
RE:	**General Anesthesia Application**
SUBMITTED BY:	Christel Braness, Administrative Assistant
ACTION REQUESTED:	Recommendation regarding application

Background

The Anesthesia Credentials Committee is a peer review committee appointed by the Board to assist the Board. The administrative rules provide that one of the duties of the Committee is to:

> *a.* Review all permit applications and make recommendations to the board regarding those applications.

The following practitioner has applied for a deep sedation/general anesthesia permit:

- **Dr. Luke J. Freml, D.D.S.**

Committee Recommendation

Should the applicant(s) above be granted a deep sedation/general anesthesia permit?

Staff Recommendation

I recommend that Dr. Freml be issued a deep sedation/general anesthesia permit following the successful completion of any/all inspections and evaluations deemed necessary.

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APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION

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

Full Legal Name: (Last, First, Middle, Suffix) Freml, Luke, J				
Other Names Used: (e.g. Maiden) N/A	**Home E-mail:** lukejf@comcast.net		**Work E-mail:** N/A	
Home Address: 120 N. Oak Park #320	**City:** Oak Park	**State:** IL	**Zip:** 60301	**Home Phone:** (319)541-3573
License Number: 08794	**Issue Date:** 2/28/11	**Expiration Date:** 8/31/12	**Type of Practice:** Oral Surgery	

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

Principal Office Address: 7400 Fleur Drive, Ste. 200	**City:** Des Moines	**Zip:** 50321	**Phone:** 287-7773	**Office Hours/Days:** 7:30-4:30 W/F
Other Office Address: 3940 Ingersoll Ave.	**City:** Des Moines	**Zip:** 50312	**Phone:** 274-9151	**Office Hours/Days:** 7:30-4:30 M/Th
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed & attach proof.	Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia	✓	7/1/08-6/30/12
Formal training in airway management	✓	7/1/08-6/30/12
Minimum of one year of advanced training in anesthesiology in a training program approved by the board	✓	7/1/08-6/30/12

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS Provider	**Location:** Maywood, IL 60153 Loyola University Medical Center
Date of Course: October 2010	**Date Certification Expires:** October 2012

Office Use				
	Lic. # 08794	Sent to ACC:	Peer Eval:	Fee #23338 $500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

Name of Applicant Luke J. Frem

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School:	From (Mo/Yr):	To (Mo/Yr):
The University of Iowa College of Dentistry	8/2004	6/2008
City, State: Iowa City, IA	**Degree Received:** Doctor of Dental Surgery	

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

Name of Training Program:	Address:	City:	State:
Loyola University Medical Center	2160 S. 1st Ave	Maywood	IL
Phone: 708-216-9000	**Specialty:** Oral + Maxillofacial Surgery	**From (Mo/Yr):** 7/2008	**To (Mo/Yr):** 6/2012

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):
Oral + Maxillofacial Surgery Residency	7/2008	6/2012

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

☐ YES ☒ NO **A. Do you have a license, permit, or registration to perform sedation in any other state?**

If yes, specify state(s) and permit number(s):_____

☒ YES ☐ NO **B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?**

☐ YES ☒ NO **C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?**

☒ YES ☐ NO **D. Do you plan to use deep sedation/general anesthesia in pediatric patients?**

☒ YES ☐ NO **E. Do you plan to use deep sedation/general anesthesia in medically compromised patients?**

☒ YES ☐ NO **F. Do you plan to engage in enteral moderate sedation?**

☒ YES ☐ NO **G. Do you plan to engage in parenteral moderate sedation?**

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

I plan to provide moderate + deep/general anesthesia for my patients if required
I use the following classes of medications in my practice:
- Benzodiazepines → versed, valium in both PO + IV form
- Narcotics → fentanyl, remifentanyl, demerol in IV form
- Barbiturates → brevital in IV form
- General Anesthetics → propofol, ketamine in IV form, ketamine IM form

Name of Applicant Luke J. Frem l Facility Address 7400 Fleur Dr. Ste 200

SECTION 7 – AUXILIARY PERSONNEL

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

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

SECTION 8 – FACILITIES & EQUIPMENT

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

YES	NO	Is your dental office properly maintained and equipped with the following:
☒	☐	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)?
5		20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

COPY FORM AND SUBMIT FOR EACH FACILITY.

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

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	☐	☒
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐	☒
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?	☐	☒
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?	☐	☐
5. Have you ever been requested to repeat a portion of any professional training program/school?	☐	☒
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	☐	☒
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	☐	☒
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?	☐	☐
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?	☐	☒
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?	☐	☒
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?	☐	☒
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?	☐	☒

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Iowa	COUNTY: Polk

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

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

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

I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation.

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

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

I further state that I have read the rules related to the use of sedation, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and deep sedation/general anesthesia in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ▶	SIGNATURE OF APPLICANT
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS 17th DAY OF May, YEAR 2012
OFFICIAL SEAL LORENA GONZALEZ NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES:04/25/16	NOTARY PUBLIC SIGNATURE Lorena Gonzalez
	NOTARY PUBLIC NAME (TYPED OR PRINTED): Lorena Gonzalez — MY COMMISSION EXPIRES: 4/25/2016

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

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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): Luke James Freml

MAILING ADDRESS: 120 N Oak Park Ave, Apt 320

CITY:	STATE:	ZIP CODE:	PHONE:
Oak Park	IL	60301	319-541-3573

To obtain a permit to administer deep sedation/general anesthesia in Iowa, the Iowa Dental Board requires that the applicant submit evidence of having completed an approved postgraduate training program or other formal training program approved by the Board. The applicant's signature below authorizes the release of any information, favorable or otherwise, directly to the Iowa Dental Board at the address above.

APPLICANT'S SIGNATURE:	DATE:
	5/2/2012

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Mark J Steinberg, DDS, MD

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

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

NAME AND LOCATION OF POSTGRADUATE PROGRAM:	PHONE:
Loyola University Medical Center Maywood, IL 60513	708-216-3678

DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	7/2008	6/2012	6/30/2012

☑ YES ☐ NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain.

☐ YES ☒ NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.

☐ YES ☒ NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.

☑ YES ☐ NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.

☑ YES ☐ NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

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

PROGRAM DIRECTOR SIGNATURE:	DATE:
DDS, MD.	5/14/2012

American Heart Association

Learn and Live

ACLS Provider

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.

OCTOBER 2010	OCTOBER 2012
Issue Date	Recommended Renewal Date

Training Center	Loyola University Health Systems
TC Address Contact Info	AHA – ILLINOIS REGION 2160 South First Avenue
Course Location	Maywood, Illinois 60153 Loyola University Medical Center
Instructor	Bruce Johnson, MD
Holder's Signature	

© 2000 American Heart Association Tampering with this card will alter its appearance. 70-2920

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Iowa Dental Board
400 SW 8th St, Suite D, Des Moines, IA 50309

Gary Roth, D.D.S.
Board Chair

Melanie Johnson, J.D.
Executive Director

This is to certify renewal of license **#08794**.
This card shall be displayed with the original license.

License Type: Dentist
Status: Active
Effective: 2/28/2011 to 8/31/2012

Luke James Freml, D.D.S.
120 N Oak Park Ave. #320
Oak Park, IL 60301

Expires
2012

Iowa Dental Board
400 SW 8th St, Suite D, Des Moines, IA 50309
Gary Roth, D.D.S., Chair Melanie Johnson, J.D., Exec. Dir.

Luke James Freml, D.D.S.

Has renewed license # **08794**
License Type: Dentist
Status: Active
Effective: 2/28/2011 to 8/31/2012

Expires
2012

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Applicant's Name _____ Iowa Dental License No. _____

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The following is a listing of all auxiliary personnel trained in basic life support.

Name: Justine Wolfe
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 9/93
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Caryl Burke
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 5/94
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Mary Tiernan
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 9/94
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Dawn Stewart
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 10/93
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Denise Bell
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 4/93
Date of Recertification: 3/26/12
Date of Expiration: 3/14

Name: Ronda Ceynar
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 5/96
Date of Recertification: 3/26/12
Date of Expiration: 3/14

Name: Lynnette Hickman
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 5/99
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Jennifer Cook
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321
Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Joyce Warren
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Shanna Donahue
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Emily Lindsey
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Libby Geistkemper
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Tammy Gaulke
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/8/06
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Laura Brockett
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 2/9/11
Date of Recertification:
Date of Expiration: 2/13

Name: Rachel Logsdon
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 2/9/11
Date of Recertification:
Date of Expiration: 2/13

Name: Erin Lewachowicz
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certification: 5/03
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Kerry Hottinger
Address: 7400 Fleur Drive, Suite 200
Des Moines, IA 50321

Date of Certication: 9/01
Date of Recertification: 2/9/11
Date of Expiration: 2/13

Name: Julie Soyer

Address: 7400 Fleur Drive, Suite 200

Des Moines, IA 50321

Date of Certification: 4/08

Date of Recertification: 2/9/11

Date of Expiration: 2/13