



# STATE OF IOWA

## IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.  
EXECUTIVE DIRECTOR

### ANESTHESIA CREDENTIALS COMMITTEE

#### AGENDA

May 2, 2013

12:00 p.m.

Updated 4/29/13

**Location:** Iowa Dental Board, 400 SW 8<sup>th</sup> St., Suite D, Des Moines, Iowa  
(Committee Members May Participate in Person or by Telephone)

**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, D.D.S.*
- II. **COMMITTEE MEETING MINUTES**
  - a. *January 24, 2013 – Teleconference*
- III. **GENERAL ANESTHESIA PERMIT APPLICATIONS**
  - a. *Joel S. Reynolds, D.D.S.*
  - b. *Ryan B. Lee, D.D.S. (\*added 4/29/13)*
  - c. *Benjamin L. Fuller, D.D.S. (\*added 4/29/13)*
- IV. **OTHER BUSINESS**
  - a. *2013 Committee Appointments*
  - b. *Other business as necessary*
- V. **OPPORTUNITY FOR PUBLIC COMMENT**
- 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.

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.



# STATE OF IOWA

## IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.  
EXECUTIVE DIRECTOR

**MJ 4/25/13 edits**

### ANESTHESIA CREDENTIALS COMMITTEE

- TELEPHONIC MEETING -

#### MINUTES

**January 24, 2013**  
**Conference Room**  
**400 S.W. 8<sup>th</sup> St., Suite D**  
**Des Moines, Iowa**

#### **Committee Members**

Lynn Curry, D.D.S.  
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.

#### **January 24, 2013**

Present  
Present  
Present  
Present  
Present  
Absent  
Absent

#### **Staff Member**

Christel Braness

#### **I. CALL TO ORDER FOR JANUARY 24, 2013**

Dr. Curry called the meeting of the Anesthesia Credentials Committee to order at 12:06 p.m. on Thursday, January 24, 2013. This meeting was held by conference call to review Committee minutes, an application for moderate sedation permit, and requests for course approval. It was impossible for the Committee to schedule a meeting on such short notice and impractical for the Committee to meet with such a short agenda. A quorum was established with five (5) members present.

Roll Call:

<u>Member</u>	<u>Curry</u>	<u>Burton</u>	<u>Clark</u>	<u>Horton</u>	<u>Roth</u>	<u>Vargas</u>	<u>Westlund</u>
Present	x	x	x	x	x		
Absent						x	x

## II. OPEN SESSION MINUTES

- *October 18, 2012 – Committee Minutes*
- ❖ MOVED by ROTH, by SECONDED by HORTON, to APPROVE the minutes of the October 18, 2012 meeting as submitted. Motion APPROVED unanimously.
- *December 19, 2012 – Committee Minutes*
- ❖ MOVED by ROTH, by SECONDED by CLARK, to APPROVE the minutes of the December 19, 2012 meeting as submitted. Motion APPROVED unanimously.

## III. MODERATE SEDATION PERMIT APPLICATIONS

- *Bradley Jordan, D.D.S.*

Dr. Burton reported that after reviewing the application that he would recommend approval of the permit following successful completion of a facility inspection and peer evaluation. Ms. Braness reported that Dr. Jordan had been in contact with the Board office and should be aware of the inspection and evaluation that may be required prior to issuance.

Dr. Roth expressed some concerns regarding the amount of training, within a general practice residency, provided relating to ASA 3-4 patients. Dr. Burton agreed with the Dr. Roth. Dr. Burton reported that the University Of Iowa College Of Dentistry rarely provides training in sedation on ASA 3 patients, and even less frequently on ASA 4 patients.

Dr. Horton asked if the Committee could recommend approving the permit for all patients 13 years of age or older, who are classified ASA 1-2. The Committee members indicated that Dr. Jordan could submit further documentation for review if Dr. Jordan wishes to pursue sedation for ASA 3-4 patients.

Ms. Braness stated that due to the provisions of Iowa Administrative Code 650—Chapter 29, regarding the required training for pediatric and medically-compromised patients, the Committee could recommend limiting the patients that Dr. Jordan would be allowed to sedate.

- ❖ MOVED by ROTH, SECONDED by HORTON, to recommend approval of a moderate sedation permit for patients 13 years of age and older, who are category ASA 1-2 following completion of a facility inspection and peer evaluation. Motion APPROVED unanimously.

#### **IV. MODERATE SEDATION COURSE APPROVAL REQUEST**

- *UCLA School of Dentistry & Wendel Family Dental Centre*

Dr. Curry and Ms. Braness provided an overview of this request. At the last meeting of the Committee, the members asked for additional information regarding the clinical portion of the course prior to making a final decision on this request.

- ❖ MOVED by ROTH, SECONDED by CLARK, to approve the course based on the additional clarification provided by the sponsor. Motion APPROVED unanimously.

- *Duquesne University of Milan School of Pharmacy, IV Moderate Sedation for Dentistry*

Ms. Braness reported that Dr. Kava, is a licensee, who wanted to complete a course in moderate sedation. Dr. Kava indicated that the University of Minnesota was no longer offering the moderate sedation course, which the Committee had approved previously. Dr. Kava became aware of the training provided by Duquesne University of Milan School of Pharmacy, and requested Committee-approval of this course.

Dr. Burton expressed some concerns about the course since there were no references to the instruction of the course in the materials provided.

Dr. Roth clarified that the course materials provided some guidelines about the didactic portion of the course; however, there was almost no information provided concerning the clinical training. Dr. Roth recommended that the additional information be obtained concerning the instructors and the clinical portion of the training. Dr. Burton agreed with Dr. Roth since it is unclear who developed the course and who would be providing the instruction.

- ❖ MOVED by ROTH, SECONDED by BURTON, to request additional information concerning the clinical portion of the course and possible instructors prior to making a final decision. Motion APPROVED unanimously.

#### **V. OPPORTUNITY FOR PUBLIC COMMENT**

Dr. Horton asked how to schedule the peer evaluations of the licensees, whose recent applications had been recommended for approval.

Ms. Braness indicated that she would email the information to the Committee members and ask who would be available to complete those evaluations. In order to comply with the interpretation

of open meetings law, Dr. Roth reminded the Committee members to reply only to Ms. Braness and to not to reply to all Committee members.

❖ MOVED by ROTH, SECONDED by HORTON, to adjourn the meeting. Motion APPROVED unanimously.

## **VI. ADJOURNMENT**

The Anesthesia Credentials Committee adjourned its meeting at 12:27 p.m.

## **NEXT MEETING OF THE COMMITTEE**

The next meeting of the Anesthesia Credentials Committee is scheduled for May 2, 2013. The meeting will be held at the Board offices and by teleconference.

Respectfully submitted,

Melanie Johnson, J.D.  
Executive Director

MJ/cb

RECEIVED

APR 15 2013



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

IOWA DENTAL BOARD

**APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT**

**SECTION 1 - APPLICANT INFORMATION**

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

Full Legal Name: (Last, First, Middle, Suffix)

Reynolds, Joel, Steven

Other Names Used: (e.g. Maiden)

Home E-mail:

joelreynolds@gmail.com

Work E-mail:

joelreynolds@christianacave.org

Home Address:

405 Stanley Plaza Blvd.

City:

Newark

State:

DE

Zip:

19713

Home Phone:

License Number:

G3-0000359 <sup>Certistry -</sup>  
<sub>Resident License</sub>

Issue Date:

6/30/12

Expiration Date:

6/30/13

Type of Practice:

Oral & Maxillofacial Surgery

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

Principal Office Address:

1469 29th St

City:

West Des Moines

Zip:

50266

Phone:

(515) 223-6529

Office Hours/Days:

7:30-4 M-F

Other Office Address:

3310 E. Euclid Ave.

City:

Des Moines

Zip:

50317

Phone:

(515) 262-6039

Office Hours/Days:

7:30-4 M-F

Other Office Address:

231 NW School St.

City:

Aulcumy

Zip:

50021

Phone:

(515) 964-7908

Office Hours/Days:

7:30-4 M-F

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

X

06/09 - 06/13

Formal training in airway management

X

06/09/06/13

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

**SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION**

Name of Course:

ACLS

Location:

Christianacave, Newark, DE

Date of Course:

4/9/13

Date Certification Expires:

4/2015

Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee #545236 \$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 Joel Reynolds

**SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE**

Name of Dental School: <u>University of Iowa</u>	From (Mo/Yr): <u>08/09</u>	To (Mo/Yr): <u>06/09</u>
City, State: <u>Iowa City, IA</u>	Degree Received: <u>DDS</u>	

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

Name of Training Program: <u>Christiana Care Health System</u>	Address: <u>501 W. 14th St.</u>	City: <u>Wilmington</u>	State: <u>DE</u>
Phone: <u>(302) 428-6458</u>	Specialty: <u>Oral &amp; Maxillofacial Surgery</u>	From (Mo/Yr): <u>06/09</u>	To (Mo/Yr): <u>06/13</u>
Type of Training: <input type="checkbox"/> Intern <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			

Name of Training Program:	Address:	City:	State:
Phone:	Specialty:	From (Mo/Yr):	To (Mo/Yr):
Type of Training: <input type="checkbox"/> Intern <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			

**CHRONOLOGY OF ACTIVITIES**

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>OMFS Residency, Christiana Care, Wilmington, DE</u>	<u>06/09</u>	<u>06/13</u>

**SECTION 6 - DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE**

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

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

IV - versed, fentanyl, propofol, ketamine

Inhalational - Nitrous oxide

Majority of cases will involve IV versed and fentanyl plus or minus propofol or ketamine as needed. Nitrous oxide may be administered as well depending on case.

Name of Applicant Joel Reynolds Facility Address 1469 29th St. West Des Moines IA 50266

**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			
attached			
list.			

**SECTION 8 - FACILITIES & EQUIPMENT**

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

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

	A	B	E	F
1	Name	Licence #	BLS Date	BLS Exp
2	Gina Crane	95805	Apr-12	Apr-14
3	Suzanne Davis	69918	Apr-12	Apr-14
4	Bryn Hilgenberg	110641	Apr-12	Apr-14
5	Stephanie Mansur	89542	Apr-12	Apr-14
6	Pam Stoermer	51423	Apr-12	Apr-14
7	Amy Stroud	94868	Apr-12	Apr-14
8	Jennifer Svoboda	87079	Apr-12	Apr-14
9	Paula Truitt	95970	Apr-12	Apr-14
10	Manda VanderpolEs	101616	Apr-12	Apr-14
11	Erin Lowe	123340	Apr-12	Apr-14
12	Heather Tingley	110294	Apr-12	Apr-14
13	Emily Nguyen	121679	May-11	May-13
14	Tammy Brant	115382	Dec-11	Dec-13

Name of Applicant Joel Reynolds Facility Address 231 NW School St. Ankeny Iowa 50023

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<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
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<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<u>2</u>		20. In the space provided, list the number of nitrous oxide Inhalation analgesia units in your facility.

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Name of Applicant Joel Reynolds Facility Address 3310 E Euclid Ave  
Des Moines IA 50317

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<u>4</u>		20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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13	Emily Nguyen	121679	May-11	May-13
14	Tammy Brant	115382	Dec-11	Dec-13

# ACLS Provider



**JOEL REYNOLDS**

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.

**APR 2013**  
Issue Date

**APR 2015**  
Recommended Renewal Date

Training Center Name **CHRISTIANA CARE #DE05711** TC ID #

TC Info **NEWARK DE 19718 (302) 733 1055** TC Phone  
City, State Zip

Course Location **DELAWARE**

Instructor Name **Bill Marshall #05060098721** Inst. ID #

Holder's Signature

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1806

→  
**PEEL  
HERE**  
→

This card contains unique security features to protect against forgery.

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

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

**SECTION 10 – AFFIDAVIT OF APPLICANT**

STATE: Delaware COUNTY: Newcastle

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

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

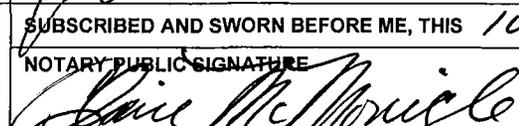
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency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

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

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

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

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

<p><b>MUST BE SIGNED IN PRESENCE OF NOTARY</b></p> 	<p>SIGNATURE OF APPLICANT</p> 
	<p>SUBSCRIBED AND SWORN BEFORE ME, THIS <u>10</u> DAY OF <u>APRIL</u>, YEAR <u>2013</u></p> <p>NOTARY PUBLIC SIGNATURE</p> 
<p>NOTARY PUBLIC NAME (TYPED OR PRINTED)</p> <p><u>CLAIRE McMONIGLE</u></p>	<p>MY COMMISSION EXPIRES:</p> <p><u>3-6-2016</u></p>

RECEIVED

APR 16 2013

IOWA DENTAL BOARD



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 - APPLICANT INFORMATION

Instructions - Complete Section 1 and mail this form to the Postgraduate Program Director for verification of your postgraduate training.

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

Joel Steven Reynolds

MAILING ADDRESS:

405 Stanley Plaza Blvd

CITY:

Newark

STATE:

DE

ZIP CODE:

19713

PHONE:

(302) 598-3786

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:

*[Handwritten Signature]*

DATE:

4/10/13

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Daniel J. Meara, MD, DMD

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

- American Dental Association; CODA
- 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:

Christiana Care Health Sys Team  
 501 W. 14<sup>th</sup> Street, Suite SW 42, Wilmington, DE 19801

PHONE:

302-428-6458

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):  
7/2009

TO (MO/YR):  
6/2013

DATE PROGRAM COMPLETED:

6/2013

- 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:

*[Handwritten Signature]*

DATE:

4/10/13



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

**RECEIVED**

APR 25 2013

IOWA DENTAL BOARD

**APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT**

**SECTION 1 – APPLICANT INFORMATION**

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

Full Legal Name: (Last, First, Middle, Suffix)

Lee, Ryan Bumper

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

hla

Work E-mail:

springparkoms@hotmail.com

Home Address: 3400 Spencer Dr.

~~1314 Hollywood Blvd~~

City: Bettendorf

~~Iowa City~~

State:

IA

Zip: 52722

~~52240~~

Home Phone:

319-530-9898

License Number:

DB664

Issue Date:

09-01-2010

Expiration Date:

08-31-2014

Type of Practice:

oral surgery

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

Principal Office Address:

5345 Spring Street

City:

Davenport

Zip:

IA

Phone:

52807

Office Hours/Days:

8-5 M thru F

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

**SECTION 3 – BASIS FOR APPLICATION**

Check each box to indicate the type of training you have completed & attach proof.

Check all that apply.

DATE(S):

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

Formal training in airway management

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

**SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION**

Name of Course:

ACLS Provider

Location:

Iowa City, IA

Date of Course:

06-21-2011

Date Certification Expires:

06-30-2013

Office Use

Lic. #

08664

Sent to ACC:

5/2/13

Peer Eval:

N/A

Fee #

71498 \$500

Permit #

Approved by ACC:

State Ver.:

N/A

ACLS

✓

Issue Date:

Temp #

Inspection:

N/A

Res. Ver Form

Brd Approved:

T. Issue Date:

Inspection Fee:

N/A

Res. Cert

Name of Applicant Lee, Dr. Ryan B.

**SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE**

Name of Dental School: <u>University of IA College of Dentistry</u>	From (Mo/Yr): <u>08/2005</u>	To (Mo/Yr): <u>06/2009</u>
City, State: <u>Iowa City, IA</u>	Degree Received: <u>DDS</u>	

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

Name of Training Program: <u>Oral Surgery Residency</u>	Address: <u>Un of IA College of Dentistry</u>	City: <u>Iowa City</u>	State: <u>IA</u>
Phone: <u>319-335-7232</u>	Specialty: <u>Oral surgery</u>	From (Mo/Yr): <u>07/2009</u>	To (Mo/Yr): <u>06/2013</u>

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

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):

**SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE**

- YES  NO A. Do you have a license, permit, or registration to perform sedation in any other state?  
If yes, specify state(s) and permit number(s): \_\_\_\_\_
- YES  NO B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?
- YES  NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of anti-anxiety premedication, nitrous oxide inhalation analgesia, 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.

Intravenous: midazolam, fentanyl, propofol, ketamine, methohexital  
 Inhalation: nitrous oxide  
 Intramuscular: ketamine

Name of Applicant Lee, Dr Ryan B Facility Address 5345 Spring, Davenport

**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:
<u>please see</u>			
<u>attached</u>			
<u>list</u>			

**SECTION 8 – FACILITIES & EQUIPMENT**

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

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

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

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

**SECTION 10 – AFFIDAVIT OF APPLICANT**

STATE: Iowa COUNTY: Scott

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

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

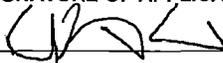
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency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

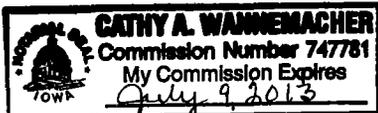
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation.

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

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

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

MUST BE SIGNED IN PRESENCE OF NOTARY ►	SIGNATURE OF APPLICANT 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>23<sup>rd</sup></u> DAY OF <u>April</u> , YEAR <u>2013</u>	
NOTARY SEAL	NOTARY PUBLIC SIGNATURE <u>Cathy A. Wannemacher</u>	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Cathy A. Wannemacher</u>	MY COMMISSION EXPIRES: <u>July 9, 2013</u>





# ACLS Provider



American  
Heart  
Association

Ryan Lee

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.

6/21/2011

6/30/2013

Issue Date

Recommended Renewal Date

Training Center Name	UIHC-EMSLRC	TC ID #	
TC Info	TCCIA05137		
Course Location	200 Hawkins Dr, Iowa City IA 52242		
	319-353-7495		
Instructor Name	Michele Lewis-Sells	Inst. ID #	
Holder's Signature			

© 2011 American Heart Association. Tampering with this card will alter its appearance. 60-1805

ACLS renewal class is 06-12-2013



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

**RECEIVED**  
 APR 29 2013  
**IOWA DENTAL BOARD**

## APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

### SECTION 1 – APPLICANT INFORMATION

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

Full Legal Name: (Last, First, Middle, Suffix)

*Fuller Benjamin Luke*

Other Names Used: (e.g. Maiden)	Home E-mail:	Work E-mail:
	<i>benjaminlukefuller@gmail.com</i>	<i>benjamin-fuller@auhs.edu</i>

Home Address:	City:	State:	Zip:	Home Phone:
<i>4917 NW 163rd St</i>	<i>Edmond</i>	<i>OK</i>	<i>73013</i>	<i>(319) 321-1486</i>

License Number:	Issue Date:	Expiration Date:	Type of Practice:
<i>08986</i>	<i>2/26/13</i>	<i>8/31/14</i>	<i>Dentistry</i>

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
<i>835 3rd Ave SW</i>	<i>Cedar Rapids</i>	<i>52403</i>	<i>(319) 366-8277</i>	<i>8-5 M-F</i>
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

### SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed & attach proof.	Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia	<input checked="" type="checkbox"/>	<i>7/2009 - 6/2013</i>
Formal training in airway management	<input checked="" type="checkbox"/>	<i>7/2009 - 6/2013</i>
Minimum of one year of advanced training in anesthesiology in a training program approved by the board	<input checked="" type="checkbox"/>	<i>7/2009 - 6/2013</i>

### SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:	Location:
<i>Genesis ACLS</i>	<i>University of Oklahoma College of Dentistry</i>
Date of Course:	Date Certification Expires:
<i>8/29/2011</i>	<i>8/2013</i>

Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee
	<i>08986</i>	<i>5/2/13</i>		<i>#5622 #500</i>
	Permit #	Approved by ACC:	State Ver.:	ACLS
			<i>NA</i>	<input checked="" type="checkbox"/>
	Issue Date:	Temp #	Inspection:	Res. Ver Form
			<i>N/A</i>	
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert
			<i>N/A</i>	

Name of Applicant Ben Fuller

**SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE**

Name of Dental School: <u>University of Iowa College of Dentistry</u>	From (Mo/Yr): <u>6/2005</u>	To (Mo/Yr): <u>6/2009</u>
City, State: <u>Iowa City, IA</u>	Degree Received: <u>DDS</u>	

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

Name of Training Program: <u>University of Oklahoma Dept of OMS</u>	Address: <u>1201 N Stonewall Ave</u>	City: <u>Oklahoma City</u>	State: <u>OK</u>
Phone: <u>(405) 271 4079</u>	Specialty: <u>Oral + Maxillofacial Surgery</u>	From (Mo/Yr): <u>6/2009</u>	To (Mo/Yr): <u>6/2013</u>

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

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

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

**CHRONOLOGY OF ACTIVITIES**

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>University of Oklahoma Dept of oral + maxillofacial surgery</u>	<u>6/2009</u>	<u>6/2013</u>

**SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE**

- YES  NO A. Do you have a license, permit, or registration to perform sedation in any other state?  
If yes, specify state(s) and permit number(s): \_\_\_\_\_
- YES  NO B. Do you consider yourself engaged in the use of deep sedation/general anesthesia in your professional practice?  
As a resident I routinely perform deep sedations/general anesthetics
- YES  NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of anti-anxiety premedication, nitrous oxide inhalation analgesia, 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 perform sedation using IV agents. I do not plan to employ volatile anesthetic agents (inhalational agents). Typically the drugs employed include fentanyl, midazolam, and propofol titrated to effect. In select cases ketamine is also employed. This is consistent with the technique I have employed successfully as resident over the past 4 years.

Name of Applicant Ben Fei

Facility Address 835 3rd Ave SW

Cedar Rapids IA 52403

**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:
<u>Kathy Jo Ruby</u>	<u>Q0410Z</u>	<u>12/19/12</u>	<u>2014</u>
<u>Stacy Jo Swanson</u>	<u>Q05453</u>	<u>12/19/12</u>	<u>2014</u>
<u>Melody Anne Bildstein</u>	<u>1207766</u>	<u>12/19/12</u>	<u>2014</u>

**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)?
- 3 20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

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

**SECTION 10 – AFFIDAVIT OF APPLICANT**

STATE: Oklahoma COUNTY: Oklahoma

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

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

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

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

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

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

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

<p><b>MUST BE SIGNED IN PRESENCE OF NOTARY ►</b></p>	SIGNATURE OF APPLICANT	
	<p><i>Ben Feller</i></p>	
	SUBSCRIBED AND SWORN BEFORE ME, THIS	
	<p>DAY OF <u>4/12/13</u>, YEAR <u>2013</u></p>	
	NOTARY PUBLIC SIGNATURE	
<p><i>Lisa Nichols</i></p>		NOTARY PUBLIC NAME (TYPED OR PRINTED)
<p><u>Lisa Nichols</u></p>		MY COMMISSION EXPIRES:
		<p><u>November 24, 2016</u></p>



# ACLS Provider

Ben Fuller

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.

8-29-2011  
Issue Date

8-2013  
Recommended Renewal Date

Training Center Genesis

TC Address Contact Info 405-642-3383

Course Location OUSOD

Instructor Bill Justice, NREMT-P

Holder's Signature Ben Fuller

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70-2920 R1/08

# Healthcare Provider



Ben Fuller

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.

8-29-2011  
Issue Date

8-2013  
Recommended Renewal Date

Training Center Name Genesis TC ID # 5988

TC Info City, 405-642-3383 TC Phone

Course Location OUSOD

Instructor Name Bill Justice Inst. ID # 5988

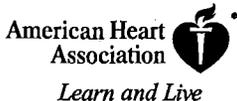
Holder's Signature Ben Fuller

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This card contains unique security features to protect against forgery.

90-1801 3/11



# PALS Provider

Ben Fuller

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 Pediatric Advanced Life Support Program.

8-2011  
Issue Date

8-2013  
Recommended Renewal Date

Training Center OU BOARD OF REGENTS

TC Address Contact Info 940 NE 13th, EMSC

Course Location OKC, OK 73104

Instructor Michael Conover

Holder's Signature Ben Fuller

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70-2918 R1/08