STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

*Updated 10/21/2013
New Materials in red

AGENDA

October 24, 2013

12:00 p.m.

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

(Committee Members May Participate in Person or by Telephone)

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

OPEN SESSION

I. CALL MEETING TO ORDER – ROLL CALL Kaaren Vargas

II. COMMITTEE MEETING MINUTES

a. July 25, 2013 – Teleconference

b. September 19, 2013 – Teleconference

III. GENERAL ANESTHESIA PERMIT APPLICATIONS

a. Gregory S. Sears, D.D.S.

IV. MODERATE SEDATION PERMIT APPLICATIONS

a. Rachel A. Revell, D.D.S.
b. Jack T. Warrington, D.D.S. (*Received updated information)
c. William E. Skinner, D.D.S.
d. Brandon M. Syme, D.D.S.
e. Other applications, if received

V. OTHER BUSINESS

a. 2014 Committee Meeting Dates

b. 2014 Application Deadlines

c. Adopted and Filed –Final Amendments to Chpt. 29, "Sedation and Nitrous Oxide Inhalation Analgesia" (NOIA ARC #1008C, 9/4/13 IAB)

d. Committee Vacancy

VI. OPPORTUNITY FOR PUBLIC COMMENT

VII. ADJOURN

- **NEXT MEETING: TBD**

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.

ANESTHESIA CREDENTIALS COMMITEE

DRAFT July 25, 2013 Minutes
(Subject to final ACC approval)

- TELEPHONIC MEETING –

MINUTES
July 25, 2013
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**July 25, 2013**
Kaaren Vargas, D.D.S.	Present
Richard Burton, D.D.S.	Present
Steven Clark, D.D.S.	Present
Lynn Curry, D.D.S.	Absent
Douglas Horton, D.D.S.	Present
Gary Roth, D.D.S.	Present
Kurt Westlund, D.D.S.	Present

Staff Member
Christel Braness, Phil McCollum, Melanie Johnson

OPEN SESSION

I. CALL TO ORDER FOR JULY 25, 2013

Dr. Vargas called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Thursday, July 25, 2013. This meeting was held by conference call to review applications for general anesthesia and moderate sedation permits, and review proposed changes to Iowa Administrative Code 650—Chapter 29. 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:

Member	Vargas	Burton	Clark	Curry	Horton	Roth	Westlund
Present	x	x			x	x	x
Absent			x	x			

II. COMMITTEE MEETING MINUTES

- *May, 2, 2013 – Teleconference*

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

➢ Dr. Clark joined the meeting at 12:06 p.m.

- *July 9, 2013 – Teleconference*

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

III. GENERAL ANESTHESIA PERMIT APPLICATIONS

- *Jeffrey Dean, D.D.S.*

Dr. Horton reported that he knows Dr. Dean from Loma Linda University. Dr. Dean is an examiner in anesthesia medicine with the American Association of Oral and Maxillofacial Surgeons (AAOMS).

❖ MOVED by WESTLUND SECONDED by ROTH, to recommend approval of the application to the Board.

IV. MODERATE SEDATION PERMIT APPLICATIONS

- *Richard Kava, D.D.S.*

Dr. Roth inquired about Dr. Kava's facility inspection. Mr. McCollum and Ms. Braness reported that the facility inspection has been completed, and all deficiencies addressed.

❖ MOVED by ROTH, SECONDED by VARGAS, to recommend approval of the application to the Board.

- *Karl Kohlgraf, D.D.S.*

Ms. Braness reported that Dr. Kohlgraf is working with the University of Iowa College of Dentistry.

❖ MOVED by ROTH, SECONDED by VARGAS, to recommend approval of the application to the Board. Motion APPROVED.

Dr. Westlund asked for clarification on the data provided with the sedation applications, which are submitted electronically. Mr. McCollum stated that he could generate a report to better address

some of the information the committee may wish to review, in a format that is more easily reviewed.

V. OTHER BUSINESS

- *Chapter 29, "Sedation and Nitrous Oxide Inhalation Analgesia" Proposed Rule Amendments*

Ms. Johnson provided a brief history of the reason for these proposed changes. Some of these recommendations are older proposals that were not acted upon previously.

Mr. McCollum explained that some of the proposed amendments address the frequency of inspection, capnography, clarification on application standards, and some general clean-up of the rules.

Dr. Westlund recommended that the proposed capnography and equipment changes should be required for all general anesthesia permit holders, as opposed to only requiring it in "oral surgery offices". Mr. McCollum agreed.

Dr. Burton reported that the University of Iowa College of Dentistry is already working towards meeting these proposed changes.

Ms. Johnson recommended also updating 29.5(11) and the list of required equipment to address this proposed change.

Dr. Burton agreed with the requirement to require capnography for all deep sedation/general anesthesia permit providers.

Mr. McCollum reported that a number of the changes address the requirements for facilities and facility inspections. One of the recommended changes to the rules would require sedation to be completed at "permanent" facilities. There are concerns regarding offices that may change locations and move equipment from one location to another. It is difficult to ensure that all equipment requirements are being met if locations and equipment move around.

Dr. Westlund asked about the proposed changes regarding provision permits. Mr. McCollum indicated that the language would allow the Board to make the final determination about completion of peer evaluations prior to issuance. The proposed rule changes are intended to be flexible. Dr. Westlund was comfortable with the proposed changes given the flexibility.

Ms. Johnson clarified that the Board had received legal advice concerning the issuance of provisional permits and advised that this was no longer an option. The Board would need to take final action on the issuance of permits.

Mr. McCollum reported that IAC 650-29.4(3) needs to be updated. It is a section addressing moderate sedation; however, there is a typographical error in the rule with a reference to general anesthesia in this section.

Dr. Roth suggested removing the reference to grandfathering practitioners who have prior experience with sedation. Mr. McCollum agreed that these rules could be updated to remove this provision. The "grandfathering" for sedation permits is referenced in IAC 650—29.3(7) and IAC 650—29.4(6).

IAC 650--29.5(1) is intended to reference all permit holders. Currently, the language only references deep sedation/general anesthesia. The second sentence should be updated to match the first sentence in this section.

Dr. Roth inquired about how quickly facility inspections can be completed. Mr. McCollum indicated that Board staff can complete those rather quickly. Mr. McCollum reported that he tries to assist Mr. Sedars with the inspections as he is able.

Dr. Westlund indicated that there would still be some situations where a peer evaluation should be required prior to issuance of a sedation permit. Mr. McCollum agreed, and indicated that staff has discussed updating the applications to include some of this information regarding the potential timelines required prior to issuance of a permit.

Ms. Johnson asked the Committee members how frequently the University of Iowa College of Dentistry needs to submit documentation regarding facility inspections. Dr. Burton recommended the 5-year standard as used in other areas of sedation since that seems to be the standard most commonly used.

Dr. Westlund stated that the Iowa Association of Oral and Maxillofacial Surgeons (IAOMS) are currently working to complete their peer reviews of a general anesthesia permit holders in compliance with AAOMS standards.

There was some discussion relating to the number of facilities and permit holders in the state. Dr. Westlund stated that it would be good to set up a plan to regularly follow up with all permit holders regarding facility inspections and peer evaluations.

Ms. Johnson provided some overview on the review process regarding 650 IAC 29.11. This section of the rules is intended to address the application process by which applications are reviewed and approved by the Anesthesia Credentials Committee and the Board. There is also an added provision to address the appeals process. Ms. Johnson reported that 650IAC 29.13 addresses the grounds for non-renewal of a permit.

- MOVED by HORTON, SECONDED by ROTH, to recommend changes as discussed. Motion APPROVED unanimously.

VI. OPPORTUNITY FOR PUBLIC COMMENT

Dr. Vargas allowed the opportunity for public comment.

VII. ADJOURN

The Anesthesia Credentials Committee adjourned its meeting at 12:31 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for October 24, 2013. The meeting will be held at the Board offices and by teleconference.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

ANESTHESIA CREDENTIALS COMMITEE

DRAFT Sept.19, 2013 Minutes
(Subject to final ACC approval)

- TELEPHONIC MEETING –

MINUTES
September 19, 2013
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**September 19, 2013**
Kaaren Vargas, D.D.S.	Present
Richard Burton, D.D.S.	Absent
Steven Clark, D.D.S.	Present
Douglas Horton, D.D.S.	Absent
Gary Roth, D.D.S.	Present
Kurt Westlund, D.D.S.	Present

Staff Member
Christel Braness, Phil McCollum, Melanie Johnson

OPEN SESSION

I. CALL TO ORDER FOR SEPTEMBER 19, 2013

Dr. Vargas called the meeting of the Anesthesia Credentials Committee to order at 12:04 p.m. on Thursday, September 19, 2013. This meeting was held by conference call to review an application for general anesthesia permit. 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 four (4) members present.

Roll Call:

Member	Vargas	Burton	Clark	Horton	Roth	Westlund	(vacancy)
Present	x		x		x	x	
Absent		x		x			

II. GENERAL ANESTHESIA PERMIT APPLICATIONS

- *Reda Taleb, D.M.D.*

Ms. Braness provided an overview of the application.

Dr. Roth questioned the use of volatile anesthetic and vaporizer. Dr. Westlund was familiar with the practice and indicated that it was not likely that the practice uses these; rather, Dr. Westlund thinks it may have been an incorrect response on the application.

Ms. Braness indicated that she could follow up on these items and verify the response.

- MOVED by VARGAS, SECONDED by ROTH, to recommend approval of the application to the Board. Motion APPROVED unanimously.

III. ADJOURN

The Anesthesia Credentials Committee adjourned its meeting at 12:09 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for October 24, 2013. The meeting will be held at the Board offices and by teleconference.

These minutes are respectfully submitted by Christel Braness, Program Planner 2, Iowa Dental Board.

RECEIVED

OCT 7 2013

IOWA DENTAL BOARD

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

APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION

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

Full Legal Name: (Last, First, Middle, Suffix) Sears, Gregory				
Other Names Used: (e.g. Maiden)	**Home E-mail:**		**Work E-mail:** gsears@omfacialsurgery.com.	
Home Address: 2304 Hardison Dr.	**City:** Norfolk	**State:** NE	**Zip:** 68701	**Home Phone:** 402-371-7579
License Number: 20156	**Issue Date:**	**Expiration Date:**	**Type of Practice:** Oral Surgery	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
201 Ridge St #308	Council Bluffs	51503	712-328-8882	M-F 7-4
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
718 Simon Ave	Carroll	51401	712-792-6086	M-WF 7-4
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
1501 E 10th St	Atlantic	50022	712-243-6390	T,Th 7-4
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	✓	
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	**Location:** Norfolk, NE
Date of Course: 9/2011	**Date Certification Expires:** 9/2013

scheduled to renew 9/30/13.

Office Use				
	Lic. #	Sent to ACC:	Peer Eval:	Fee
	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 Greg Sears.

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School:	From (Mo/Yr):	To (Mo/Yr):
Univ of Iowa	9/1966	6/1970
City, State: Iowa City, Iowa	Degree Received: DDS	

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:
St Anthony Hosp		Oklahoma City	OK
Phone:	Specialty: Dentistry	From (Mo/Yr): 7/1970	To (Mo/Yr): 6/1971

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

Name of Training Program:	Address:	City:	State:
Univ of Nebraska Med Center	42nd: Dewey	Omaha	NE
Phone:	Specialty: Oral Surgery	From (Mo/Yr): 7/1971	To (Mo/Yr): 6/1976

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):
Foster Oral Surgery	7/76	7/86
Oral Surgery Associates	7/86	current.

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): Nebraska. #5

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

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

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

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

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

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

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

IV, inhalation
Propofol, Versed, Fentanyl, Ketamine, Nitrous, Valium.

Council Bluffs, IA

Name of Applicant Gregory Sears Facility Address 201 Ridge St.

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:
Ashley Baurisaw	DDA-11154	3/12	3/14
Deb Deitchler	DDA-06302	3/12	3/14
Amy Grave	DDA-09038	2/13	2/15
Marita Jerman	DDA-07086	3/12	3/14
Mariah Lieferman	DDA-11866		
Samantha Brand	DDA-10971	2/12	2/14
Pat Macberry	DDA-06298	3/12	3/14
Heather Neuman	DDA-11836	3/12	3/14

Continued on additional page

SECTION 8 – FACILITIES & EQUIPMENT

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

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

COPY FORM AND SUBMIT FOR EACH FACILITY.

Auxillary Personnel cont

	License	BLS cert.	BLS exp.
Alex Petry	QDA 09205	2/12	2/14
Erin Cantwell	67739	6/12	6/14
Elise Feiereisel	095598	7/13	7/15
Jaclyn Loftus	123762	1/13	1/15

Carroll, IA.

Name of Applicant Gregory Sears Facility Address 718 Simon Ave.

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:
Vicki Lengeling	DDA-04139	9/12	9/14
Renae Scheidt	DDA-05805	9/12	9/14
Emily Shuler	DDA-10811	5/13	5/15
Cully Magner	109520	9/12	9/14

SECTION 8 – FACILITIES & EQUIPMENT

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

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

COPY FORM AND SUBMIT FOR EACH FACILITY.

Name of Applicant Gregory Sears Facility Address 1801 E 10th, Atlantic, IA 50022

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:
Rhea Freund	QDA-02191	5/13	5/15
Vicki Lengeling	QDA-04139	9/12	9/14
Emily Shuler	QDA-10811	5/13	5/15
Amy Potter	QDA-088324	5/13	5/15

SECTION 8 – FACILITIES & EQUIPMENT

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

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

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: Pottawattamie

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: Gregory Sears	
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME THIS 1	DAY OF October, YEAR 2013
GENERAL NOTARY-State of Nebraska JODI L. WHITTEN My Comm. Exp. July 14, 2014	NOTARY PUBLIC SIGNATURE: Jodi L Whitten	
	NOTARY PUBLIC NAME (TYPED OR PRINTED): Jodi L Whitten	MY COMMISSION EXPIRES: July 14, 2014

American Heart Association

Learn and Live

ACLS Provider

GREGORY SEARS

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.

9/2011
Issue Date

9/2013
Recommended Renewal Date

Training Center NECC NE012124

TC Address Contact Info NORFOLK NE 68702-0469

Course Location NORFOLK

Instructor DOUGLAS

Holder's Signature Gregory Sears

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

Just renewed on 9/30/13, new card not received yet.

70-2920 R1

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association.

Greg Sears

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.

10/3/12
Issue Date

10/2014
Recommended Renewal Date

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association. | American Academy of Pediatrics

PALS Provider

Gregory Sears

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 Pediatric Advanced Life Support (PALS) Program.

10/4/12
Issue Date

10/2014
Recommended Renewal Date

LICENSURE UNIT
P.O. BOX 94986, LINCOLN, NE 68509-4986
PHONE: (402) 471-2115 FAX: (402) 471-3577

State of Nebraska
Dave Heineman, Governor

Certification of Nebraska Licensure

IT IS HEREBY CERTIFIED THAT the information listed in this certification is accurate and correct as of the date created.

Date Certification Created: Thu Oct 3 09:49:47 2013
License Number: 5
Profession: Dentistry
License Type: General Anesthesia Permit

General License Information

Name on License	Gregory Scott Sears MD, DDS
Country	United States
Profession Name	Dentistry
License Type	General Anesthesia Permit
License Number	5
Date of Issuance	06/18/1993
Date of Expiration	06/18/2015
License Status	Active
Effective Date of Status	06/18/1993
Reason for License Status	X

School Information

School	Date
UNMC	05/26/1974
UNIV OF IOWA	05/28/1970

Disciplinary/Non-Disciplinary Information

Additional information may be obtained from the Licensure Unit (402) 471-2115 if actions are listed.

Start	End	Disciplinary/Non-disciplinary Action
None on record at this time		

Requested an Official Copy be sent to you.

DISCLAIMER

THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND CORRECT AS OF THE CERTIFICATION CREATION DATE LISTED ON THE TOP OF THIS FORM. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT THE UNIT.

Please reply to: Licensure Unit
PO Box 94986, Lincoln, NE 68509-4986
Phone (402) 471-2118
FAX (402) 471-8614

Department of Health & Human Services
DHHS
NEBRASKA

Division of Public Health

State of Nebraska
Dave Heineman, Governor

CERTIFICATION OF LICENSE

RECEIVED
OCT 9 2013
IOWA DENTAL BOARD

Iowa Dental Board
400 SW 8th St., Ste. D
Des Moines, IA 50309-4687

PROFESSION NAME: General Anesthesia Permit

Number: 5 Status: Active
Issuance Date: 06/18/1993 Expiration Date: 06/18/2015

Name: Gregory Scott Sears, MD, DDS
Address: 109 North 29th Street
Norfolk NE 68701

Credential Obtained by: Reciprocity

Exam Type: Exam Score:

School/Graduation Date: UNIV OF IOWA 05/28/1970

Date of Birth: 08/02/1946
Place of Birth: IOWA

Disciplinary Action:

To expedite the certification process, Licensure Unit is using the above format. There is no derogatory information in the professional's records if the Disciplinary Action section above is left blank.

Helen L. Meeks, Administrator
Licensure Unit

October 7, 2013

You may verify licenses under the following Internet Web Site Address:
http://www.nebraska.gov/LISSearch/search.cgi

(SEAL)

The only item missing is his current ACLS card. He passed the class on 9/30/13; we are waiting for the card. I will forward when I receive it.
Please process ASAP
He would like to schedule cases for 11/11/13. Thx

RECEIVED

AUG 5 2013

IOWA DENTAL BOARD

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

APPLICATION FOR 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) Revell, Rachael, Anne				
Other Names Used: (e.g. Maiden) —	**Home E-mail:** Rachael.a.revell@gmail.com		**Work E-mail:** dr.revell@dsmpd.com	
Home Address: 314 East 4th St. South	**City:** Newton	**State:** IA	**Zip:** 50208	**Home Phone:** 319-333-2105
License Number: 09012	**Issue Date:** 7/2/2013	**Expiration Date:** August 31st, 2014	**Type of Practice:** Pediatric	

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

Principal Office Address: 5950 Village View Drive Suite 200 Bldg C	**City:** West Des Moines	**Zip:** 50266	**Phone:**	**Office Hours/Days:** M-F 8-5
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.	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	6/2009-6/2011
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☑ Completed	6/2009-6/2011
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: PALS	**Location:** 11551 Forest Central Drive Ste 103 Dallas, Tx 75243 Emergency Management Resources
Date of Course: June 29th 2013	**Date Certification Expires:** June 30th, 2015

Office Use				
	Lic. #	Sent to ACC:	Inspection	Fee #1313 $500
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

Name of Applicant Rachael Revell

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:
Baylor College of Dentistry	3302 Gaston Rd	Dallas	TX

Type of Experience: Pediatric Dentistry

Length of Training:	Date(s) Completed:
24 months	06/2009 – 06/2011
Number of Patient Contact Hours:	**Total Number of Supervised Sedation Cases:**
100+	60

☑ 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): Texas

☑ 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.

Name of Applicant Rachael Revell Facility Address

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

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:	**COUNTY:**
Iowa	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 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** Bruhnel Rivell, DDS	
NOTARY SEAL	**SUBSCRIBED AND SWORN BEFORE ME, THIS** 21 **DAY OF** June **, YEAR** 2013	
ROB CESPEDES Notary Public STATE OF TEXAS My Comm. Exp.01-27-16	**NOTARY PUBLIC SIGNATURE**	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) Rob Cespedes	**MY COMMISSION EXPIRES:** 1-27-16

RECEIVED
MAY 6 2013
IOWA DENTAL BOARD

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

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): Rachael Anne Revell

MAILING ADDRESS: 2707 Cole Ave Apt. 214

CITY:	STATE:	ZIP CODE:	PHONE:
Dallas	Tx.	75204	319-333-2105

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:
Rachael Revell	4-25-13

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

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:
Texas A&M University Baylor College of Dentistry - Pediatric Dentistry	214 8288131

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	06/2009	06/2011	06/2011

☑ 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:
[signature]	4.25.13

TEXAS A&M UNIVERSITY
BAYLOR
COLLEGE OF DENTISTRY
Texas A&M Health Science Center

RECEIVED
MAY 6 2013
IOWA DENTAL BOARD

April 26, 2013

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

To Whom It May Concern:

I am writing this letter in support of the application of Dr. Rachael Anne Revell for an enteral sedation permit through the Iowa Dental Board. This is to certify that Dr. Revell completed the graduate program in Pediatric Dentistry at Baylor College of Dentistry in 2011. Dr. Revell attended the University of Iowa and graduated in 2009. This institution is accredited by the American Dental Association Commission on Dental Accreditation (CODA). Baylor College of Dentistry and the graduate program in pediatric dentistry are also both CODA accredited.

During her undergraduate dental education and postgraduate training, Dr. Revell has received approximately 60 didactic hours in courses associated with conscious sedation including the use of nitrous oxide:oxygen and oral sedative techniques with appropriate monitoring. She has also participated in, and successfully completed a five-week rotation in general anesthesia through Children's Medical Center in Dallas, Texas. Under the supervision of a licensed staff physician anesthesiologist, the general anesthesia training included performance of patient histories and physicals, intubations, administration of anesthetic drugs, airway management, and patient monitoring. While at Baylor, she was required to take and pass Pediatric Advanced Life Support (PALS).

Under the supervision of an attending pediatric dentist, Dr. Revell has administered sedation medications in approximately 50 conscious sedation cases. Dr. Revell is well trained in the use of agents commonly used for conscious sedation.

Her training has been in compliance with the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, Parts I or III, of the American Dental Association, October 2007.

If you need any further information, please contact me.

Sincerely,

Alton G. McWhorter, DDS, MS
Professor and Chairman

Department of Pediatric Dentistry
3302 Gaston Ave. I Dallas, TX 75246 I 214.828.8131 I FAX 214.874.4562 I www.bcd.tamhsc.edu

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association | American Academy of Pediatrics

PALS Provider

Rachael Revell

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 Pediatric Advanced Life Support (PALS) Program.

June 2013
Issue Date

June 2015
Recommended Renewal Date

PEDIATRIC ADVANCED LIFE SUPPORT

Training Center Name: Emergency Management Resources
TC ID # ID # TX05079

TC Info: P.O. Box 740275, Dallas, Texas 75374
Office (972) 235-8330 Fax (972) 235-8331
Email: tccordinator@emresources.net

Course Location: 11551 Forest Central Drive
Suite 103 Dallas, TX 75243

Instructor Name: Gregory Key
Inst. ID # ID # 02112272258
214-733-7213

Holder's Signature

© 2011 American Heart Association *Tampering with this card will alter its appearance.* 90-1818

Texas A&M University System Health Science Center

To all whom these presents may come Greeting

Be it Known that

Rachael Anne Revell

having completed the studies prescribed therefore by the faculty of the

Baylor College of Dentistry

and satisfied the requirements for the Certificate in

Pediatric Dentistry

has accordingly been awarded that Certificate with all the honors, rights and privileges belonging thereto.

Given under the seal of the Health Science Center on the

thirtieth day of June, A.D. two thousand and eleven

THE TEXAS A&M UNIVERSITY SYSTEM · HEALTH SCIENCE CENTER · 1999

Nancy W. Dickey MD
President of the Health Science Center

James B. Cole
Dean

Received Time Oct. 16. 2013 4:30PM No. 3528

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) Warrington, Jack, Thomas				
Other Names Used: (e.g. Maiden)	Home E-mail: jack.warrington@gmail.com		Work E-mail: dr.warrington@dsmpd.com	
Home Address: 5094 E. P. True Pkwy #201 ~~5950 Village View Dr STE 200~~	City: West Des Moines	State: IA	Zip: 50265	Home Phone: 319-330-6011
License Number: 08631	Issue Date: 06/12/2009	Expiration Date:	Type of Practice: Pediatric	

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

Principal Office Address: 5950 Village View Dr	City: West Des Moines	Zip: 50266	Phone: 515-225-1677	Office Hours/Days: Mon-Thurs 8-5 Fri 8-1
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.	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	06/20/2011-06/28/2013
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☑ Completed	06/20/2011-06/28/2013
Moderate sedation experience at graduate level, approved by the Board	☑ Completed	06/20/2011-06/22/2013

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: PALS - pediatric advanced life support	Location: Emergency Management Resources ID#: TX05079 PO Box 740275 Dallas TX 75374
Date of Course: 07/09/2013	Date Certification Expires: July 2015

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

Training Center Name: Emergency Management Resources
ID # TX05079 TC ID #
P.O. Box 740275, Dallas, Texas 75374

TC Info: Office (972) 235-8330 Fax (972) 235-8331
City, State Email: tccordinator@empresources.net

Course Location: 11551 Forest Central Drive
Suite 103 Dallas, TX 75243

Instructor Name: Gregory Key ID # 02112272258 Inst. ID #
214-733-7213

Holder's Signature: Jack Warrington

© 2011 American Heart Association Tampering with this card will alter its appearance. 80-1818

Received Time Oct. 16. 2013 4:30PM No. 3528

American Heart Association. | American Academy of Pediatrics

PALS Provider

Jack Warrington

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance the curriculum of the American Heart Association Pediatric Ac Life Support (PALS) Program.

July 2013 — Issue Date

July 2015 — Recommended Renewa

Name of Applicant Jack Warrington

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:
Baylor College of Dentistry Pediatric	3302 Gaston Rd	Dallas	Tx

Type of Experience: Pediatric Dentistry

Length of Training:	Date(s) Completed:
2 years	06/2011 - 06/2013
Number of Patient Contact Hours:	**Total Number of Supervised Sedation Cases:**
100+	45

☐ 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.

Name of Applicant Jack Warrington Facility Address 5950 Village View Dr STE 200 West Des Moines IA 50266

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:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
TBD, office under construction, no hired employees			
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.

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:	COUNTY:
IOWA, Notary in Texas, dallas 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 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	SUBSCRIBED AND SWORN BEFORE ME, THIS 28th DAY OF June, YEAR 2013
SHEKITA M BETTS NOTARY PUBLIC STATE OF TEXAS MY COMM. EXP. 10-15-2014	NOTARY PUBLIC SIGNATURE Shekita M. Betts
	NOTARY PUBLIC NAME (TYPED OR PRINTED): Shekita M. Betts — MY COMMISSION EXPIRES: 10-15-2014

RECEIVED

MAY 6 2013

IOWA DENTAL BOARD

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

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): Jack, Thomas Warrington

MAILING ADDRESS: 2707 Cole Ave Apt 214

CITY:	STATE:	ZIP CODE:	PHONE:
Dallas	Tx	75204	319-330-6011

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:
Jack Warrington	4/25/13

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

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:
Texas A&M University Baylor College of Dentistry - Pediatric Dentistry	214 828 8131

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	06/2011	06/2013	06/28/2013

☒ 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:
[signature]	4.25.13

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MAY 6 2013
IOWA DENTAL BOARD

TEXAS A&M UNIVERSITY
BAYLOR
COLLEGE OF DENTISTRY
Texas A&M Health Science Center

April 26, 2013

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

To Whom It May Concern:

I am writing this letter in support of the application of Dr. Jack Thomas Warrington for an enteral sedation permit through the Colorado Department of Regulatory Agencies. This is to certify that Dr. Warrington will complete the graduate program in Pediatric Dentistry at Baylor College of Dentistry in 2013. Dr. Warrington attended the University of Iowa and graduated in 2009. This institution is accredited by the American Dental Association Commission on Dental Accreditation (CODA). Baylor College of Dentistry and the graduate program in pediatric dentistry are also both CODA accredited.

During his undergraduate dental education and postgraduate training, Dr. Warrington has received approximately 60 didactic hours in courses associated with conscious sedation including the use of nitrous oxide:oxygen and oral sedative techniques with appropriate monitoring. He has also participated in, and successfully completed a five-week rotation in general anesthesia through Children's Medical Center in Dallas, Texas. Under the supervision of a licensed staff physician anesthesiologist, the general anesthesia training included performance of patient histories and physicals, intubations, administration of anesthetic drugs, airway management, and patient monitoring. While at Baylor, he was required to take and pass Pediatric Advanced Life Support (PALS).

Under the supervision of an attending pediatric dentist, Dr. Warrington has administered sedation medications in approximately 50 conscious sedation cases. Dr. Warrington is well trained in the use of agents commonly used for conscious sedation.

His training has been in compliance with the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, Parts I or III, of the American Dental Association, October 2007.

If you need any further information, please contact me.

Sincerely,

Alton G. McWhorter, DDS, MS
Professor and Chairman

Department of Pediatric Dentistry
3302 Gaston Ave. I Dallas, TX 75246 I 214.828.8131 I FAX 214.874.4562 I www.bcd.tamhsc.edu

Texas A&M University System Health Science Center

To all whom these presents may come Greeting

Be it Known that

Jack Thomas Warrington

having completed the studies prescribed therefore by the faculty of the

Texas A&M University Baylor College of Dentistry

and satisfied the requirements for the Certificate in

Pediatric Dentistry

has accordingly been awarded that Certificate with all the honors, rights and privileges belonging thereto.

Given under the seal of the Health Science Center on the

thirtieth day of June, A.D. two thousand and thirteen

Interim President of the Health Science Center

Dean

Program Director

RECEIVED
JUL 2 2013
IOWA DENTAL BOARD

TEXAS LICENSED DENTIST

JACK THOMAS WARRINGTON

is legally qualified to practice Dentistry in this State under the laws of Texas governing such practice

EXPIRATION DATE

February 28, 2014

LICENSE NUMBER 25036

Anesthesia Permits:
Level 1
Nitrous Oxide
Anesthesia Portability?No

Rodolfo G. Ramos Jr DDS
Presiding Officer

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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)				
Skinner William Eugene				
Other Names Used: (e.g. Maiden)	**Home E-mail:**		**Work E-mail:**	
Bill	billandkelly@mchsi.com		showusyoursmile@gmail.com	
Home Address:	**City:**	**State:**	**Zip:**	**Home Phone:**
8100 Chambery Blvd	Johnston	IA	50131	515-252-0015
License Number:	**Issue Date:**	**Expiration Date:**	**Type of Practice:**	
7913	9-1-12	8-31-14	General Dentistry	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
8501 Plum Drive	Urbandale	Iowa	515-278-2888	M-F 9-5:30
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.	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	May 2013 Aug 2013
ADA-accredited Residency Program that includes moderate sedation training	☐ Completed	
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:	Location:
ACLS	Mercy - River Hills - Des Moines, IA
Date of Course:	**Date Certification Expires:**
9-19-13	09-15

Office Use				
	Lic. #	Sent to ACC:	Inspection	Fee #5109 #500
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

Name of Applicant William Skinner

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:
Clinical IV Mod Sedation	925 West 34th St	Los Angeles	CA

Type of Experience: Didactic / clinical

Length of Training:	Date(s) Completed:
60+ hours Didactic	8-18-13
Number of Patient Contact Hours: 60++	**Total Number of Supervised Sedation Cases:** 20+

☑ 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 with midazolam or diazepam. Titrate to effect

Name of Applicant William E. Skinner Facility Address 8501 Plum Drive

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:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Sue Craumer	QDA-07652	8-15-12	08-14
Cathy Nelson	QDA-01107	08-15-12	08-14

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)?
6		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:**

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**	
NOTARIAL SEAL WILLIAM P. SIGLIN Commission Number 119209 My Commission Expires 11-9-14 IOWA	**SUBSCRIBED AND SWORN BEFORE ME, THIS** 3 **DAY OF** October, **YEAR** 2013	
	NOTARY PUBLIC SIGNATURE William P. Siglin 10/3/13	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) William P. Siglin	**MY COMMISSION EXPIRES:** 11-9-14

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

Bill Skinner

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.

09/19/13	09/2015
Issue Date	Recommended Renewal Date

ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name	Spencer Hospital	TC ID # IA20567
TC Info	Spencer, IA 51301 (712) 264-6517	
Course Location	Mercy River Hills – Des Moines, IA	
Instructor Name	Sheri Peters	Inst. ID # #04060077486
Holder's Signature		

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Ostrow School of Dentistry of USC

Stanley F. Malamed, D.D.S.
Dentist Anesthesiologist

18 August 2013

Iowa Dental Board
400 SW 8th Street, Suite D
Des Moines, IA 50309-4686

Re: Dr. William Skinner

Dear Board of Dentistry Members:

I am Professor of Anesthesia and Medicine at the Ostrow School of Dentistry of USC as well as course director for the continuing dental education program in Intravenous (parenteral) Moderate Sedation.

Doctor William Skinner enrolled in, and successfully completed, the Clinical Intravenous Moderate Sedation program offered at the Ostrow School of Dentistry of USC through the Department of Continuing Dental Education.

This program also exceeds the requirements as described in Part III of the American Dental Association (ADA) Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry (60 didactic hours, 20 clinical cases) as well as the guidelines established by the Iowa Dental Board (**IAC 650—29.4** for a Moderate Sedation permit.

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

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

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

The course includes both didactic and clinical experience in the following areas:

- 60 hours or more including training in:
- basic conscious sedation,
- physical evaluation,
- venipuncture,
- technical administration,
- recognition and management of complications and emergencies,
- monitoring, and
- supervised experience in providing moderate sedation to twenty or more patients.

Ostrow School of Dentistry of U.S.C.
925 West 34th Street, Los Angeles, California 90089-0641 • Tel: 213 740 1081 • Fax: 818.888.39734

An hour-by-hour summary of course content is appended to this letter.

The venue for the program was the Ostrow School of Dentistry of USC and was held on the following dates:

Module #1 (Prerequisites): May 2013 (Physical Evaluation; Emergency Medicine; Pharmacology; and Monitoring, Clinical Emergency Medicine (Sim-Man), and Basic Life Support) 35 hours

Module #2 (Clinical Intravenous Moderate Sedation): 9 – 11 and 15 – 18 August 2013. 49 hours (in actual fact about 70 hours (Clinical days start 7:00 AM and finish at about 7:00 PM), but California only permits a maximum of 7 CEU's per day). On the 17th of August Dr. Skinner participated in a clinical day at SOLIS Surgical Arts in Sherman Oaks, California where he was introduced to out-patient day surgery and general anesthesia. This was a 6-hour session.

Module 1, PREREQUISITES
At the conclusion of the prerequisite programs, enrollees were required to successfully pass a multiple choice question examination covering these materials. Dr. William Skinner received a 92% grade.

The Basic Life Support training program (7 hours) is mandatory for all persons enrolled in the intravenous sedation program at the Ostrow School of Dentistry of U.S.C. Dr. William Skinner successfully completed this course.

Module 2, CLINICAL INTRAVENOUS MODERATE SEDATION
The thrust of Module 2 is Intravenous Moderate Sedation, pure and simple. Seven days devoted to the art and science of IV drug administration. The course, though on paper for 7 hours each day, runs to about 10 to 12 hours on each of the four clinical days (Saturday & Sundays). Our state dental board in California does not allow us to provide a doctor with more than 7 hours CDE units per day, but the fact is that these four days are much more intensive and extensive.

During module #2 Dr. Skinner administered intravenous sedation and completed dental treatment for at least 20 patients. Records of patient treatments are available should you desire to review them.

A word about the supervision of the doctors participating in the clinical sessions (there were twenty-one enrollees in the clinical portion of the course in which Dr. Skinner participated): Besides myself and Dr. Kenneth Reed, the co-director of the program, both of whom are Dentist Anesthesiologists, our faculty included Drs. H. William Gottschalk, Kenneth Lee, Jason Brady and Amanda Okundaye, all of whom are Dentist Anesthesiologists. Drs. Paul Weyman and Charles Tozzer, both experienced 'sedationists' were also members of the faculty. Dr. Tozzer is a parenteral sedation examiner for the Dental Board of California. Additionally there were 12 teaching assistants in the clinical sessions. The enrolled doctors were very closely scrutinized during the program and each was evaluated by multiple faculty over the course of their four clinical days.

This course has existed for thirty-six years (established in 1977) and has provided approximately 700 dentists with training in this invaluable technique of patient management. Successful completion of the program has been recognized, thus far, by all state and provincial boards as eligibility for a permit in intravenous moderate sedation.

Should the Iowa Dental Board have any questions or desire any additional information regarding the parenteral sedation training of Dr. William Skinner please do not hesitate to contact me. My email address is: malamed@usc.edu

Yours truly,

Dr. Stanley F. Malamed
Professor of Anesthesia & Medicine (Retired)
Director, Intravenous Moderate Sedation program

SFM/pt

13 May 2013	9.5 hours
Physical evaluation	9.5 hours
14 May 2013	9.5 hours
Emergency Medicine	9.5 hours
15 May 2013	9.5 hours
Pharmacology	9.5 hours
16 May 2013	9.5 hours
Simulated medical emergencies (SIM-MAN)	9.5 hours
9 August 2013	11 hours
Introduction to Sedation	2.0 hours
Venipuncture	1.0 hour
Complications of Venipuncture	1.5 hours
CLINIC - Venipuncture	1.5 hours
Basic concepts of Sedation	1.0 hour
Techniques of Intravenous Sedation	1.5 hour
Benzodiazepine Sedation Technique	1.5 hours
Monitoring & Record Keeping	1.0 hour
10 August 2013	12 hours
Review of Venipuncture Technique	0.5 hour
Clinical Session	11.5 hours
11 August 2013	12 hours
Review of Patient Evaluation	0.5 hour
Clinical Session	11.5 hours
15 August 2013	6 hours
CLINICAL - SOLIS Surgical Arts Center	6.0 hours
16 August 2013	9.5 hours
Review of Clinical Sessions	1.0 hour

Advanced Airway Management	2.0 hours
Pediatrics – Geriatrics	2.0 hours
Post-Operative Analgesics	2.0 hours
Practical Aspects of IV Sedation	1.0 hour
Preparation for State Board Evaluation	1.5 hours
17 August 2013	**12 hours**
Review of Emergency Management	0.5 hour
Clinical Session	11.5 hours
18 August 2013	**13 hours**
Review of Pharmacology	0.5 hour
Clinical Session	11.5 hours
Review of Clinical Session and Sign-out	1.0 hour
Total hours – DIDACTIC	60.0 hours
Total hours – CLINICAL	53.5 hours
Total hours	[illegible] hours

Healthcare Provider

PEEL HERE

Bill E. Skinner

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.

08-15-2012 — Issue Date

08-2014 — Recommended Renewal Date

Training Center Name: Mercy College TC — TC ID #

TC Info: Des Moines, IA 50309

Course Location: Plum Drive Dental

Instructor Name: Bud Hartsell — Inst. ID #

Holder's Signature

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This card contains unique security features to protect against forgery.

90-1801 3/11

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

William Eugene Skinner, DDS

Has renewed license # **07913**
License Type: Dentist
Status: Active
Effective: 9/1/2012 to 8/31/2014

Expires **2014**

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

Cathy Christine Templeman Nelson
Has renewed Registered Dental Assistant # QDA-01107.
Registration Type: **Registered Dental Assistant**
Added qualification in dental radiography
Status: **Active**
Effective: August 6, 2013 to August 31, 2015

Expires Aug 31, 2015

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association®

Cathy C. Nelson

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.

08-15-2012	08-2014
Issue Date	Recommended Renewal Date

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

Steven P Bradley, D.D.S.
Board Chair

Melanie Johnson, J.D.
Executive Director

This is to certify renewal of Registration # QDA-07652.
This card shall be displayed with the original certificate.

Registration Type: **Registered Dental Assistant**
Added qualification in dental radiography
Status: **Active**
Effective: July 28, 2013, to August 31, 2015

Susan Mary Crawmer
6612 ARNOLD Ln.
PANORA, IA 50216-8716

Expires Aug 31, 2015

Healthcare Provider

Susan M. Crawmer

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.

08-15-2012	08-2014
Issue Date	Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name: Mercy College TC — TC ID #

TC Info: Des Moines, IA 50309
City, State — ZIP — Phone

Course Location: Plum Drive Dental

Instructor Name: Bud Hartsell — Inst. ID #

Holder's Signature

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HEALTHCARE PROVIDER

Training Center Name: Mercy College TC — TC ID #

TC Info: Des Moines, IA 50309
City, State — ZIP — Phone

Course Location: Plum Drive Dental

Instructor Name: Bud Hartsell — Inst. ID #

Holder's Signature

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RECEIVED

OCT 16 2013

IOWA DENTAL BOARD

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

APPLICATION FOR 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)				
Syme Brandon, Michael				
Other Names Used: (e.g. Maiden)	**Home E-mail:**		**Work E-mail:**	
N/A	brandon-syme@gmail.com		brandon-syme@	
Home Address:	**City:**	**State:**	**Zip:**	**Home Phone:**
405 Grandview CT	Iowa City	IA	52246	801-710-0379
License Number:	**Issue Date:**	**Expiration Date:**	**Type of Practice:**	
FAC-40140	7/2/13	8/31/14	Academic	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Univ. of IA College of Dentistry 801 Newton Road	Iowa City	52242	319-335-7457	8:00-5:00 M-F
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.	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	Aug 23, 2013
ADA-accredited Residency Program that includes moderate sedation training	☐ Completed	
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☒ Completed	Aug 23, 2013
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:	Location:
ACLS	Medical College of Wisconsin
Date of Course:	**Date Certification Expires:**
6/13/2013	06/2015

Office Use				
	Lic. #	Sent to ACC:	Inspection	Fee #0278 1114 $500
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

Name of Applicant Brandon Symp

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:
Univ. of Iowa Dept. of Anesthesia	Univ. of Iowa Hospitals	Iowa city	IA

Type of Experience:

General Anesthesia in the OR and ASC

Length of Training:	Date(s) Completed:
1 month	8/23/13
Number of Patient Contact Hours: 160	**Total Number of Supervised Sedation Cases:** 60

☑ 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.

Fentanyl
Versed
Decadron
Phenergan
Valium
Nitrous Oxide

Name of Applicant Brandon Symp Facility Address 801 Newton Rd, Iowa City 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:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Kathleen Kane RN	0640060	4/2013	4/2015
Melanie Kenney, RN	067348	4/2013	4/2015
Margaret Pardini, RN	078252	1/2013	1/2015
Teresa Hahn	Q05014	4/2013	4/2015
Cindy Smith	Q00330	4/2013	4/2015
Ashley Ernst	Q10032	4/2013	4/2015

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)?
12		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?	☐	☒
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:	COUNTY:
Iowa	Johnson

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.

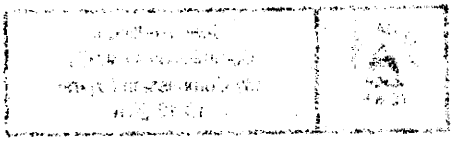
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation. I also understand that if moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

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	SUBSCRIBED AND SWORN BEFORE ME, THIS 1 DAY OF October, YEAR 2013	
	NOTARY PUBLIC SIGNATURE Jan Redlinger	
Jean Redlinger Commission #730971 My Commission Expires 10-12-2016	NOTARY PUBLIC NAME (TYPED OR PRINTED) Jean Redlinger	MY COMMISSION EXPIRES: 10-12-2016



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

PLEASE TYPE OR PRINT LEGIBLY IN INK.

FORM B: VERIFICATION OF MODERATE SEDATION TRAINING IN A CONTINUING EDUCATION PROGRAM

SECTION 1 – APPLICANT INFORMATION

Instructions – Use this form if you obtained your training in moderate sedation from another program that must be approved by the Board (i.e. you did NOT obtain your training in moderate sedation while in a postgraduate residency program). Complete Section 1 and mail this form to the Program Director for verification of your having successfully completed this training.

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

MAILING ADDRESS: 405 Grandview CT

CITY:	STATE:	ZIP CODE:	PHONE:
Iowa City	IA	52246	801-710-0379

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:
[signature]	7/9/13

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR: KIRK L FRIORICH

NAME AND LOCATION OF PROGRAM:	PHONE:
University of Iowa College of Dentistry & Dental Clinics 801 Newton Rd OMFS	319-335-7460

FAX: 319-335-7458	E-MAIL: kirk-friorich@uiowa.edu	WEB ADDRESS:	
DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/DAY/YR): 07/29/13	TO (MO/DAY/YR): 08/23/13	DATE PROGRAM COMPLETED: 8/23/13

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

☒ YES ☐ NO 2. DOES THE PROGRAM COMPLY WITH THE AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS OR DENTAL STUDENTS?

☒ YES ☐ NO 3. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?

☒ YES ☐ NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE FOR PARTICIPANTS TO SUCCESSFULLY MANAGE MODERATE SEDATION IN AT LEAST TWENTY (20) PATIENTS?

AS PART OF THE CURRICULUM, ARE THE FOLLOWING CONCEPTS AND PROCEDURES TAUGHT:

☒ YES ☐ NO 5. PHYSICAL EVALUATION;
☒ YES ☐ NO 6. IV SEDATION;
☒ YES ☐ NO 7. AIRWAY MANAGEMENT;
☒ YES ☐ NO 8. MONITORING; AND
☒ YES ☐ NO 9. BASIC LIFE SUPPORT AND EMERGENCY MANAGEMENT.

(If no to any of above, please attach a detailed explanation.)

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

PROGRAM DIRECTOR SIGNATURE:	DATE:
[signature]	10-2-13

ACLS Provider

Brandon Syme

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.

06/13/2013	06/2015
Issue Date	Recommended Renewal Date

Training Center Name	Bellin Health System	TC ID # WI04638
TC Info	PO Box 180062 Delafield, WI 53018	(414) 791-5018 www.aphcd.com
Course Location	Froedtert OBGYN	
Instructor Name	Mary Braun	Inst. ID # 10120126801
Holder's Signature		

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REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE

ACTION

MEETING DATE: October 24, 2013
SUBMITTED BY: Melanie Johnson, Executive Director; Christel Braness, Program Planner
ACTION REQUESTED: Establish the 2014 Committee Meeting Schedule

Anesthesia Credentials Committee – Proposed 2014 Meeting Schedule

January 16	OR	January 23
March 27	OR	April 3
July 17	OR	July 24
September 18	OR	September 25
October 2	OR	October 9

Proposed start time: 12:00 P.M.

Iowa Dental Board 2014 Meeting Schedule

January 30-31	(Thursday, Friday)	
April 10-11		
*May 9	(Friday)	* Organizational mtg. to elect officers, appoint committees
July 31- August 1	(Thursday, Friday)	
October 16-17	(Thursday, Friday)	

2014 Board Calendar

Dates shaded in Yellow = Board Quarterly Meetings

* May 9th = annual election of officers and committee appointments

January						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
29	30	31	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	*9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31	1	

August						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

December						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

State Holidays 2014

New Year's Day	Wednesday, January 1
Martin Luther King, Jr.'s Birthday	Monday, January 20
Memorial Day	Monday, May 26
Independence Day	Friday, July 4
Labor Day	Monday, September 1
Veterans Day	Tuesday, November 11
Thanksgiving Day	Thursday, November 27
Friday after Thanksgiving	Friday, November 28
Christmas Day	Thursday, December 25

Other Federal Holidays

Presidents' Day	Monday, February 17
Columbus Day	Monday, October 13

(FINAL - approved at May 10, 2013 meeting)

REPORT TO THE ANESTHESIA CREDENTIALS COMMITTEE

ACTION

MEETING DATE: October 24, 2013

SUBMITTED BY: Melanie Johnson, Executive Director; Christel Braness, Program Planner

ACTION REQUESTED: Discussion Regarding Application Review Process and Deadlines

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Role of ACC

The Anesthesia Credentials Committee (ACC) is responsible for reviewing all moderate sedation and general anesthesia/deep sedation permit applications and providing recommendations to the Dental Board.

ACC Procedures

The Committee conducts its business at meetings open to the public. Prior to each scheduled meeting, Board staff distributes to Committee members copies of the applications to be reviewed at that meeting. At the meeting the Committee discusses the pending applications and prepares recommendations the Iowa Dental Board. The Board meets quarterly and takes action on the Committee's recommendations.

For Discussion

Does the ACC want to consider establishing due dates for applications to be considered at the regularly scheduled ACC meetings? If yes, how much time is needed at each step of the process?

Attached for Review

- Draft for review - Application Deadlines

SEDATION/ANESTHESIA PERMIT APPLICATION DEADLINES 2013-2014

Deadlines for:

- **Moderate sedation permit applications**
- **General anesthesia/deep sedation permit applications**
- **All other requests for the ACC**

ANESTHESIA CREDENTIALS COMMITTEE (ACC)

Role of ACC
The Anesthesia Credentials Committee is responsible for reviewing all moderate sedation and general anesthesia/deep sedation permit applications and providing recommendations to the Dental Board.

ACC Procedures
The Committee conducts its business at meetings open to the public. Prior to each scheduled meeting, Board staff distributes to Committee members copies of the applications to be reviewed at that meeting. At the meeting the Committee discusses the pending applications and prepares recommendations the Iowa Dental Board. The Board meets quarterly and takes action on the Committee's recommendations.

Application Deadlines
In order to be considered at a regularly scheduled quarterly Board meeting, applications need to be submitted to the Board office three (3) weeks before the scheduled Committee meeting. Meeting materials are distributed to Committee members two (2) weeks before the Committee meeting. There is one (1) week period of time between the Committee meeting and the quarterly Board meeting to prepare the Committee's recommendations

The following table outlines the deadlines for submitting applications and requests to the Committee in time for consideration at the regularly scheduled quarterly Board meetings.

(3 wks. before mtg) **Submit application to IDB office by:**	(2 wks. before mtg) **Scheduled distribution to Committee:**	**Committee Meeting**	**Board Meeting**
October 3, 2013	October 10, 2013	October 24, 2013	Oct. 31- Nov. 1, 2013

DRAFT