



STATE OF IOWA

IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

September 19, 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.*

OPEN SESSION

- I. CALL MEETING TO ORDER – ROLL CALL** *Kaaren Vargas, D.D.S.*
- II. GENERAL ANESTHESIA PERMIT APPLICATION**
 - a. Reda Taleb, D.M.D.*
- III. OTHER BUSINESS**
- IV. OPPORTUNITY FOR PUBLIC COMMENT**
- V. ADJOURN**

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the office of the Board at 515/281-5157.

Please Note: At the discretion of the Committee Chair, agenda items may be taken out of order to accommodate scheduling requests of Committee members, presenters or attendees or to facilitate meeting efficiency.



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>

RECEIVED

SEP 03 2013

IOWA DENTAL BOARD

APPLICATION FOR DEEP SEDATION/GENERAL ANESTHESIA PERMIT

SECTION 1 – APPLICANT INFORMATION

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

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

Taleb, Reda

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

redataleb@yahoo.com

Work E-mail:

redataleb@yahoo.com

Home Address:

1530 South Monroe Ave

City:

Mason City

State:

IA

Zip:

50401

Home Phone:

7346444156

License Number:

DDS-09042

Issue Date:

August 29th 2013

Expiration Date:

August 31 2014

Type of Practice:

Oral & Maxillofacial Surgery

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

Principal Office Address:

1530 South Monroe Avenue

City:

Mason City

Zip:

IA

Phone:

641-424-1656

Office Hours/Days:

8-5 M-F

Other Office Address:

N/A

City:

Zip:

Phone:

Office Hours/Days:

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

Other Office Address:

City:

Zip:

Phone:

Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

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

Check all that apply.

DATE(S):

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

X

June 30th 2012

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:

American Heart Association ACLS

Location:

Hennepin County Medical Center

Date of Course:

03/2012

Date Certification Expires:

03/2014

Lic. #

DDS-09042

Sent to ACC:

Peer Eval:

Fee: \$161

\$500

Permit #

Approved by ACC:

State Ver.:

ACLS ✓

Issue Date:

Temp #

Inspection: MA

Res. Ver Form

Brd Approved:

T. Issue Date:

Inspection Fee: MA

Res. Cert

Office Use

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: Arizona School of Dentistry and Oral Health	From (Mo/Yr): 7/2004	To (Mo/Yr): 6/2008
---	-------------------------	-----------------------

City, State: Mesa , Arizona	Degree Received: DMD
--------------------------------	-------------------------

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

Name of Training Program: University of Minnesota	Address: 7-174 Moos Tower, 515 Delaware St Se	City: Minneapolis	State: MN
--	--	----------------------	--------------

Phone: 612-624-9959	Specialty: Oral & Maxillofacial Surgery	From (Mo/Yr): 7/1/2008	To (Mo/Yr): 6/30/2012
------------------------	--	---------------------------	--------------------------

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

Name of Training Program: N/A	Address:	City:	State:
----------------------------------	----------	-------	--------

Phone:	Specialty:	From (Mo/Yr):	To (Mo/Yr):
--------	------------	---------------	-------------

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

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
June 2008 Graduated from Dental School		
Oral and Maxillofacial Surgery Residency	7/2008	6/2012
Oral and Maxillofacial Surgery Private practice in Tucson Arizona	8/2012	8/2013

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): Anesthesia permit in Arizona. # 13011376
- 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 anesthesia using Midazolam, Fentanyl, Ketamine, Propofol. Alos will be administering Nitrous oxide anxiolysis

Name of Applicant Reda Taleb

Facility Address 1530 South Monroe Avenue, Mason City IA

SECTION 7 – AUXILIARY PERSONNEL

50401

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:
Dawn Hoss	Q06737	7/11/2012	7/31/2014
Lindsay Beavers	Q08763	7/11/2012	7/31/2014
Larae Rongey	QDA-08509	7/11/2012	7/31/2014
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

SECTION 8 – FACILITIES & EQUIPMENT

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

YES NO Is your dental office properly maintained and equipped with the following:

- 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least three individuals to move freely about the patient?
- 2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
- 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
- 4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
- 5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
- 6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
- 7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
- 8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
- 9. EKG monitor?
- 10. Laryngoscope and blades?
- 11. Endotracheal tubes?
- 12. Magill forceps?
- 13. Oral airways?
- 14. Stethoscope?
- 15. A blood pressure monitoring device?
- 16. A pulse oximeter?
- 17. Emergency drugs that are not expired?
- 18. A defibrillator (an automated defibrillator is recommended)?
- 19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?

5 20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Iowa	COUNTY: Cerro Gordo 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 deep sedation/general anesthesia. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

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

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

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

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

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

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

MUST BE SIGNED IN PRESENCE OF NOTARY	SIGNATURE OF APPLICANT
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>30</u> DAY OF <u>Aug</u> , YEAR <u>2013</u>
NOTARY SEAL	NOTARY PUBLIC SIGNATURE



NOTARY PUBLIC NAME (TYPED OR PRINTED) Julie Perrott	MY COMMISSION EXPIRES: 5/20/16
--	-----------------------------------

University of Minnesota School of Dentistry
Minneapolis, Minnesota

Be It Known That

Keda Taleb, D.M.D.

is granted this Certificate for having performed all duties faithfully and satisfactorily in this Academic Health Center in the capacity of

Resident in Oral and Maxillofacial Surgery
July 1, 2008 to June 30, 2011

Chief Resident in Oral and Maxillofacial Surgery
July 1, 2011 to June 30, 2012

This training meets the credentials for eligibility for specialty board examination.
In Witness Whereof We Have Affixed Our Hands This 30th Day of June, A.D. 2012.


Pamela J. Hughes, D.D.S., Associate Professor, U of MN
Director of OMS Advanced Training Program

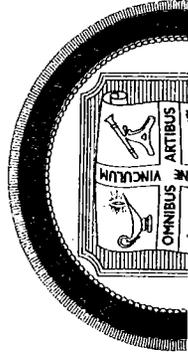

Lance W. Svoboda, D.D.S.
Affiliate Faculty, Hennepin County Medical Center


Deepak Kademan, D.M.D., M.D.
Associate Professor, U of MN


Bruce R. Templeton, D.M.D.
Affiliate Faculty, VA Medical Center


James Q. Swift, P.D.S.


Judith A. Buchanan, Ph.D., D.M.D.



ACLS Provider



Training Center Name **HCMC EMS Education** TC ID # **MN03782**

TC Info **Hennepin County Medical Center
Minneapolis, MN 55415 - 612-873-9147**

Course Location **Hennepin County Medical Center**

Instructor Name **Robert Treague** **02070284834**

Holder's
Signature

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

Reda Taleb

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.

03/2012

03/2014

Issue Date

Recommended Renewal Date

→
**PEEL
HERE**
→

This card contains unique security features to protect against forgery.

Healthcare Provider



→
PEEL
HERE
→

Reda Taleb

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.

03/2012

Issue Date

03/2014

Recommended Renewal Date

Training Center Name **HCMC EMS Education** TC ID # **MN03782**

TC Info **Hennepin County Medical Center
Minneapolis, MN 55415 - 612-873-9147**

Course Location **Hennepin County Medical Center**

Instructor Name **Susan Altmann** **0611469008**

Holder's
Signature

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

This card contains unique security features to protect against forgery.

Braness, Christel [IDB]

From: Braness, Christel [IDB]
Sent: Thursday, September 12, 2013 5:05 PM
To: 'Reda taleb'
Subject: RE: General Anesthesia Application

Thank you for confirming this. I suspected it was on its way; however, I did not want to make any assumptions, which might delay processing.

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

CONFIDENTIAL NOTICE: This email and the documents accompanying this electronic transmission may contain confidential information belonging to the sender, which is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reference to the contents of this electronic information is strictly prohibited. If you have received this email in error, please notify the sender and delete all copies of the email and all attachments. Thank you.

From: Rreda taleb [mailto:redataleb@yahoo.com]
Sent: Thursday, September 12, 2013 5:04 PM
To: Braness, Christel [IDB]
Subject: Re: General Anesthesia Application

Dear Crhistel:

I have already sent it to the program director about two weeks ago, I am sure you will receive it soon
Thank you
Reda

From: "Braness, Christel [IDB]" <Christel.Braness@iowa.gov>
To: Rreda taleb <redataleb@yahoo.com>
Sent: Thursday, September 12, 2013 5:01 PM
Subject: General Anesthesia Application

We are attempting to schedule a teleconference of the Anesthesia Credentials Committee in order to expedite the processing of your application.

In order to complete the paperwork for your application, please have your residency program complete the attached form and return it to this office. Please disregard this if you have already submitted this and are awaiting its completion.

Let me know if you have any questions.

Christel Braness, Program Planner
Iowa Dental Board | 400 SW 8th St., Suite D | Des Moines, IA 50309
Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

CONFIDENTIAL NOTICE: This email and the documents accompanying this electronic transmission may contain confidential information belonging to the sender, which is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reference to the contents of this electronic information is strictly prohibited. If you have received this email in error, please notify the sender and delete all copies of the email and all attachments. Thank you.

Braness, Christel [IDB]

From: Braness, Christel [IDB]
Sent: Thursday, September 12, 2013 5:02 PM
To: 'Reda taleb'
Subject: General Anesthesia Application
Attachments: GA_ResVerif.pdf

Importance: High

We are attempting to schedule a teleconference of the Anesthesia Credentials Committee in order to expedite the processing of your application.

In order to complete the paperwork for your application, please have your residency program complete the attached form and return it to this office. Please disregard this if you have already submitted this and are awaiting its completion.

Let me know if you have any questions.

Christel Braness, Program Planner

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

Phone: 515-242-6369 | Fax: 515-281-7969 | www.dentalboard.iowa.gov

CONFIDENTIAL NOTICE: This email and the documents accompanying this electronic transmission may contain confidential information belonging to the sender, which is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reference to the contents of this electronic information is strictly prohibited. If you have received this email in error, please notify the sender and delete all copies of the email and all attachments. Thank you.