# STATE OF IOWA

## IOWA DENTAL BOARD

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

MELANIE JOHNSON, J.D.
EXECUTIVE DIRECTOR

***TELEPHONIC MEETING***

**IOWA DENTAL BOARD**

***AGENDA***

September 20, 2013
1:00 p.m.

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

**Board Members:** *Steve Bradley, D.D.S., Board Chair; Steven Fuller, D.D.S., Board Vice Chair; Matthew McCullough, D.D.S., Board Secretary; Kaaren Vargas, D.D.S.; Tom Jeneary, D.D.S.; Mary Kelly, R.D.H.; Nancy Slach, R.D.H.; Diane Meier, Public Member; Lori Elmitt, Public Member*

**I. CALL MEETING TO ORDER – ROLL CALL**

**II. OPPORTUNITY FOR PUBLIC COMMENT**

**III. ANESTHESIA CREDENTIALS COMMITTEE RECOMMENDATION**

a. *Reda Taleb, D.M.D. – Application for General Anesthesia Permit*

**XIII. ADJOURN**

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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.

* These matters constitute a sufficient basis for the board to consider a closed session under the provisions of section 21.5(1), (a), (c), (d), (f), (g), and (h) of the 2013 Code of Iowa. These sections provide that a governmental body may hold a closed session only by affirmative public vote of either two-thirds of the members of the body or all of the members present at the meeting to review or discuss records which are required or authorized by state or federal law to be kept confidential, to discuss whether to initiate licensee disciplinary investigations or proceedings, and to discuss the decision to be rendered in a contested case conducted according to the provisions of Iowa Code chapter 17A.

**Pursuant to Iowa Code section 272C.6(1) a licensee may request that their disciplinary hearing be held in closed session.

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

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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 |

| Office Use | | | | |
|---|---|---|---|---|
| | 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 |

Name of Applicant Heda Taleb

## SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

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

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

**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: |
|---|---|---|---|
| University of Minnesota | 7-174 Moos Tower, 515 Delaware St Se | Minneapolis | MN |

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

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

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

| 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 50401

## 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: |
|---|---|---|---|
| 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 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION 8 – FACILITIES & EQUIPMENT

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

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

COPY FORM AND SUBMIT FOR EACH FACILITY.

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

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

**SECTION 10 – AFFIDAVIT OF APPLICANT**

| STATE: | COUNTY: |
|---|---|
| Iowa | 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 | |
|---|---|---|
| NOTARY SEAL | SUBSCRIBED AND SWORN BEFORE ME, THIS 30 DAY OF Aug , YEAR 2013 | |
| | NOTARY PUBLIC SIGNATURE | |
| JULIE PERROTT NOTARIAL SEAL - IOWA COMMISSION NO. 105078 MY COMMISSION EXPIRES 5/20/16 | 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

# Reda 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 Thereof 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

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

James Q. Swift, D.D.S.

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

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

Judith A. Buchanan, PhD., D.M.D.

# ACLS Provider

American Heart Association®

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 Advanced Cardiovascular Life Support (ACLS) 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<br>Minneapolis, MN 55415 - 612-873-9147 |
| Course Location | Hennepin County Medical Center |
| Instructor Name | Robert Treague Inst. ID # 02070264834 |
| Holder's Signature | |

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This card contains unique security features to protect against forgery.

90-1806 3/11

# 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** | **03/2014** |
| Issue Date | Recommended Renewal Date |

| | | |
|---|---|---|
| Training Center Name | HCMC EMS Education | TC ID # MN03782 |
| TC Info | Hennepin County Medical Center<br>Minneapolis, MN 55415 - 612-873-9147 | |
| Course Location | Hennepin County Medical Center | |
| Instructor Name | Susan Altmann | Inst. ID # 06114690008 |
| Holder's Signature | | |

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90-1801 3/11

## Braness, Christel [IDB]

**From:** Braness, Christel [IDB]
**Sent:** Thursday, September 12, 2013 5:05 PM
**To:** 'Rreda 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

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**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

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## Braness, Christel [IDB]

**From:** Braness, Christel [IDB]
**Sent:** Thursday, September 12, 2013 5:02 PM
**To:** 'Rreda 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

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