



STATE OF IOWA

IOWA DENTAL BOARD

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

PHIL MCCOLLUM
INTERIM DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

June 27, 2014, 12:30 P.M.

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

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

I. CALL MEETING TO ORDER – ROLL CALL

II. GENERAL ANESTHESIA PERMIT APPLICATIONS

- a. Ryan Borgwardt, D.D.S.*
- b. Erin Sheffield, D.D.S.*
- c. Ryan Toponce, D.M.D.*

III. MODERATE SEDATION PERMIT APPLICATIONS

- a. Michael Davidson, D.D.S.*
- b. Bernard Dudzinski, D.D.S.*
- c. Jordan Dudzinski, D.D.S.*
- d. Brian Prudent, D.D.S.*
- e. Brad Richstmeier, D.D.S.*

IV. OPPORTUNITY FOR PUBLIC COMMENT

V. ADJOURN

*Committee members may participate by telephone or in person.

If you require the assistance of auxiliary aids or services to participate in or attend the meeting because of a disability, please call the Board office 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

JUN 06 2014

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) BORGWARDT, RYAN NORMAN				
Other Names Used: (e.g. Maiden) N/A	Home E-mail: ryan.borgwardt@gmail.com		Work E-mail: ryan.borgwardt@gmail.com	
Home Address: 315 MAIN ST SUITE #200	City: CEDAR FALLS	State: IA	Zip: 50613	Home Phone: 563.357.2253
License Number: 08807	Issue Date: 04/26/2011	Expiration Date: 08/31/2014	Type of Practice: ORAL AND MAXILLOFACIAL SURGERY	
SECTION 2 – LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED				
Principal Office Address: 3640 CANTERBURY CT.	City: WATERLOO	Zip: 50702	Phone: 319.233.0851	Office Hours/Days: 8-5/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 & attach proof.			Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia			<input checked="" type="checkbox"/>	JULY 2010 → JULY 2014
Formal training in airway management			<input checked="" type="checkbox"/>	JULY 2010 → NOVEMBER 2010
Minimum of one year of advanced training in anesthesiology in a training program approved by the board			<input checked="" type="checkbox"/>	JULY 2010 → JULY 2014
SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION				
Name of Course: AMERICAN HEART ASSOCIATION ACLS PROVIDER		Location: CPR ASSOCIATES CHICAGO, IL		
Date of Course: 6.27.2012		Date Certification Expires: 6.27.2014 (RENEWAL COURSE SCHEDULED 6/14/14)		
Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee #1206 & 500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection: N/A	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee: N/A	Res. Cert

joining prev-existing facility/practice

Name of Applicant RYAN BORGWARDT

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>THE UNIVERSITY OF IOWA</u>	From (Mo/Yr): <u>JUNE 2006</u>	To (Mo/Yr): <u>2010</u> <u>JUNE</u>
City, State: <u>IOWA CITY IOWA</u>	Degree Received: <u>DDS</u>	

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

Name of Training Program: <u>LOYOLA UNIVERSITY MEDICAL CENTER</u>	Address: <u>2160 SOUTH 1ST AVE.</u>	City: <u>MAYWOOD</u>	State: <u>IL</u>
Phone: <u>708.216.9000</u>	Specialty: <u>ORAL & MAXILLOFACIAL SURGERY</u>	From (Mo/Yr): <u>JULY 2010</u>	To (Mo/Yr): <u>JULY 2014</u>

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

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

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

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>LOYOLA UNIVERSITY MEDICAL CENTER MAYWOOD, IL 60153</u> <u>ORAL & MAXILLOFACIAL SURGERY RESIDENCY</u>	<u>JULY 2010</u>	<u>JULY 2014</u>

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

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

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

INHALATION ANESTHESIA WILL NOT BE USED WITH THE EXCEPTION OF NITROUS OXIDE. IV ANESTHESIA WILL BE USED WITH THE MAJOR DRUGS BEING USED: VERSED, FENTANYL, KETAMINE, PROPOFOL

Name of Applicant **RYAN BORGWART**

Facility Address **3640 CANTERBURY CT.
WATERLOO IA, 50702**

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:
VALERIE L. HOY	QDA-05441	03/2014	03/2016
CHRISTINA BERNING	QDA-11361	8/13/2012	8/31/2014
ANGIE PEYTON	QDA-08347	03/2014	03/2014
EMILY FULLER	QDA-05421	03/2014	03/2016
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)?
- 20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

2

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 checked="" type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been requested to repeat a portion of any professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you ever voluntarily surrendered a license or permit issued to you by any professional licensing agency?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license or permit you held?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate or has your controlled substance registration ever been placed on probation, suspended, voluntarily surrendered or revoked?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Iowa COUNTY: BLACK HAWK 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 <i>Ryan Borgardt</i>	
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>2nd</u> DAY OF <u>June</u> , YEAR <u>2014</u>	
	NOTARY PUBLIC SIGNATURE <i>Lorena Gonzalez</i>	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) Lorena Gonzalez	MY COMMISSION EXPIRES: 4/25/2016

ACLS Provider



Ryan Borgwardt

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.

Issue Date 06-27-2012

Recommended Renewal Date 06-2014

Training Center Name CPR Associates, Inc. 15144
 (773) 973-6933

TC Info 2616 W. Peterson City, State Chicago, IL 60659 Zip USA TC Phone

Course Location CPR Associates, Inc. IL 15144

Instructor Name Mary Ann Gardner, CCRN Inst. ID # [Signature]

Holder's Signature Ryan Borgwardt

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Healthcare Provider



Ryan Borgwardt

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.

Issue Date 06-27-2012

Recommended Renewal Date 06-2014

Training Center Name CPR Associates, Inc. 15144
 (773) 973-6933

TC Info 2616 W. Peterson City, State Chicago, IL 60659 Zip USA TC Phone

Course Location CPR Associates, Inc. IL 15144

Instructor Name Mary Ann Gardner, CCRN Inst. ID # [Signature]

Holder's Signature Ryan B

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ATLS

Ryan N. Borgwardt, DDS

is recognized as having successfully completed the ATLS® Course for Doctors according to the standards established by the ACS Committee on Trauma.

[Signature]
 Karen Brussel, MD, FACS
 Chairperson,
 ATLS Subcommittee

[Signature]
 Kimberly Joseph, MD,
 FACS
 ACS Chairperson,
 State/Provincial
 Committee on Trauma

ATLS Course Director

Date of Issue: 02/04/2012

Date of Expiration: 02/04/2016





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.

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 – APPLICANT INFORMATION

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

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

RYAN NORMAN BOROWART

MAILING ADDRESS:

315 MAIN ST. UNIT #200

CITY:

CEPARD FALLS

STATE:

IA

ZIP CODE:

50613

PHONE:

563.357.2253

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

APPLICANT'S SIGNATURE:

Ryan Borowart

DATE:

5.22.2014

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

Stephen Macklin

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:

Loyola University Medical Center

PHONE:

708.216.9000

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

07/2010

TO (MO/YR):

06/2014

DATE PROGRAM COMPLETED:

06/19/2014

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain.
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

Schedule to graduate 06/19/2014

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

PROGRAM DIRECTOR SIGNATURE:

Stephen Macklin

DATE:

05/30/2014

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

Angela Marie Peyton
 Has renewed Registered Dental Assistant # QDA-08347.
 Registration Type: **Registered Dental Assistant**
 Added qualification in dental radiography
 Status: **Active**
 Effective: August 16, 2013 to August 31, 2015

Expires Aug 31, 2015

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

Christina Renee Berning
 Has renewed Registered Dental Assistant # QDA-11361.
 Registration Type: **Registered Dental Assistant**
 Added qualification in dental radiography
 Status: **Active**
 Effective: July 8, 2013 to August 31, 2015

Expires Aug 31, 2015

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

Emily Jo Fuller
 Has renewed Registered Dental Assistant # QDA-05421.
 Registration Type: **Registered Dental Assistant**
 Added qualification in dental radiography
 Status: **Active**
 Effective: August 14, 2013 to August 31, 2015

Expires Aug 31, 2015

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Holder's Signature

Instructor Name Eunice Kelly 11102103688

Inst. ID #

Course Location WFH-IA

TC Info West Allis WI 53214 414/389-4895

Training Center Name Wheaton Franciscan Healthcare SE WI WI15386

TC ID # WI15386

HEALTHCARE PROVIDER

Issue Date 03/2014

Recommended Renewal Date 03/2016

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.

Emily Fuller

Healthcare Provider

American Heart Association

HEALTHCARE PROVIDER

YOU MUST KEEP THIS CARD FOR FUTURE ENTRANCE INTO RENEWAL COURSES. PLEASE CONTACT MERRIAM LAKE 319/272-2284 FOR A REPLACEMENT CARD, A FEE OF \$6.00 WILL APPLY. WFH-IA #1413

HEALTHCARE PROVIDER **HEALTHCARE PROVIDER**

Healthcare Provider

Angie Peyton

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.

03/2014 03/2016

Issue Date Recommended Renewal Date

American Heart Association

Training Center Name Wheaton Franciscan Healthcare SE WI WI15386

TC Info West Allis WI 53214 414/389-4895

Course Location WFH-IA

Instructor Name Eunice Kelly 11102103688 Inst. ID #

Holder's Signature

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This card contains unique security features to protect against forgery.

HEALTHCARE PROVIDER

Healthcare
Provider



American
Heart
Association

Christina Berning

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

8/13/2012

Issue Date

8/31/2014

Recommended Renewal Date

HEALTHCARE PROVIDER

Training
Center Name

TC ID #

UIHC-EMSLRC

TC
Info

TCCIA05137

Course
Location

200 Hawkins Dr. Iowa City IA 52242

319-353-7495

Cedar Falls

Instructor
Name

Cindi Eastman 12070635788

Inst. ID #

Holder's
Signature

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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.

Valerie L Hoy

Has renewed Registered Dental Assistant # QDA-05441.

Registration Type: **Registered Dental Assistant**

Added qualification in dental radiography

Status: **Active**

Effective: August 16, 2013 to August 31, 2015

Expires Aug 31, 2015

HEALTHCARE PROVIDER

Healthcare
Provider



Valerie L. Hoy

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.

03/2014

03/2016

Issue Date

Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name Wheaton Franciscan Healthcare SE WI WI15386 TC ID #

TC Info West Allis WI 53214 414.389-4895

Course Location WFH-IA

Instructor Name Eunice Kelly 11102103688 Inst. ID #

Holder's Signature



IOWA DENTAL BOARD
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RECEIVED

APR 28 2014

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) SHEFFIELD, ERIN MERLINE JACKSON				
Other Names Used: (e.g. Maiden) JACKSON	Home E-mail: ERINMJSHEFFIELD@GMAIL.COM		Work E-mail: Ø	
Home Address: 266 MARIETTA AVE	City: IOWA CITY	State: IA	Zip: 52246	Home Phone: (319)541-6497
License Number: 08658	Issue Date: 6/29/09	Expiration Date: 08/31/14	Type of Practice: ORAL MAXILLOFACIAL SURGERY	
SECTION 2 – LOCATION(S) IN IOWA WHERE SEDATION SERVICES WILL BE PROVIDED				
Principal Office Address: 1225 S. Gear Ave mercy plaza sk156	City: W. BURLINGTON	Zip: 52655	Phone: (319)752-2659	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 & attach proof.			Check all that apply.	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia			<input checked="" type="checkbox"/>	06/2009-06/2010 06/2010-06/2014
Formal training in airway management			<input checked="" type="checkbox"/>	06/2010-06/2014
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: ADVANCED CARDIAC LIFE SUPPORT		Location: UIHC-EMSLRC		
Date of Course: 06/12/2013		Date Certification Expires: 6/30/2015		
Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee * 1080 & 500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection: N/A	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee: N/A	Res. Cert

(joining pre-inspected facility/practice)

Name of Applicant ERIN M.J SHEFFIELD Facility Address BURLINGTON IA

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:
NICOLE DAVIS	ODA-08975	2/19/14	2/19/16
ELLEN BRADLEY	112781	2/19/14	2/19/16
SANDY SMITH	045862	2/19/14	2/19/16
ERIKA PRICE	ODA-07445	2/19/14	2/19/16
JESSICA CURRY	ODA-06253	2/19/14	2/19/16
VIRGINIA LAYER	RDA 10849	2/19/14	2/19/16

SECTION 8 - FACILITIES & EQUIPMENT

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

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

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

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	<input type="checkbox"/>	<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: DES MOINES
-----------------------	------------------------------

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.

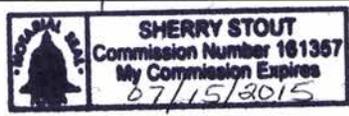
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation.

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 <i>[Signature]</i>	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>23rd</u> DAY OF <u>April</u> , YEAR <u>2014</u>	
NOTARY SEAL	NOTARY PUBLIC SIGNATURE <i>[Signature]</i>	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Sherry S. Stout</u>	MY COMMISSION EXPIRES: <u>July 15, 2015</u>



Name of Applicant ERIN MJ SHEFFIELD

SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>UNIVERSITY OF IOWA</u>	From (Mo/Yr): <u>08/2005</u>	To (Mo/Yr): <u>6/2009</u>
City, State: <u>IOWA CITY, IA</u>	Degree Received: <u>DDS</u>	

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

Name of Training Program: <u>UNIVERSITY OF IOWA - internship</u>	Address: <u>200 HAWKINS DR.</u>	City: <u>IOWA CITY</u>	State: <u>IA</u>
Phone: <u>319-356-7339</u>	Specialty: <u>OMS</u>	From (Mo/Yr): <u>06/2009</u>	To (Mo/Yr): <u>06/2010</u>
Type of Training: <input checked="" type="checkbox"/> Intern <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			

Name of Training Program: <u>UNIVERSITY OF IOWA</u>	Address: <u>200 HAWKINS DR.</u>	City: <u>IOWA CITY</u>	State: <u>IA</u>
Phone: <u>319-356-7339</u>	Specialty: <u>OMS</u>	From (Mo/Yr): <u>06/2010</u>	To (Mo/Yr): <u>06/2014</u>
Type of Training: <input type="checkbox"/> Intern <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Other (Be Specific):			

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>UNIVERSITY OF IOWA - INTERN OMS</u>	<u>06/2009</u>	<u>06/2010</u>
<u>UNIVERSITY OF IOWA - RESIDENCY OMS</u>	<u>06/2010</u>	<u>06/2014</u>

SECTION 6 - DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

YES NO A. Do you have a license, permit, or registration to perform sedation in any other state?
If yes, specify state(s) and permit number(s): _____

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

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

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

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

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

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

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

IV - versed, fentanyl, valium, ketamine, propofol
PO - versed
INHALATION - NITROUS OXIDE

ADVANCED CARDIOVASCULAR LIFE SUPPORT

**ACLS
Provider**



Erin Sheffield

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

6/12/2013

Issue Date

6/30/2015

Recommended Renewal Date

ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name UIHC-EMSLRC TC ID # _____

TC Info 200 Hawkins Dr, Iowa City IA 52242 TC 52242

Course Location EMSLRC 319-353-7495

Instructor Name Doug York Inst. ID # 05060084232

Holder's Signature _____



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

APR 28 2014

IOWA DENTAL BOARD

PLEASE TYPE OR PRINT LEGIBLY IN INK.

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 - APPLICANT INFORMATION

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

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

ERIN MERLINE JACKSON SHEFFIELD, (JACKSON)

MAILING ADDRESS:

266 MARIETTA AVE

CITY:

IOWA CITY

STATE:

IA

ZIP CODE:

52246

PHONE:

(319) 541-6497

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

APPLICANT'S SIGNATURE:

[Handwritten Signature]

DATE:

04/23/14

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

STEVEN FLETCHER

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:

UNIVERSITY OF IOWA - IOWA CITY, IA

PHONE:

(319) 356-7339

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

06/2009

TO (MO/YR):

06/2014

DATE PROGRAM COMPLETED:

06/30/2014

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain. *See Below.*
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

Dr. Sheffield will satisfactorily complete her training on June 30, 2014.

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

PROGRAM DIRECTOR SIGNATURE:

[Handwritten Signature]

DATE:

4-23-14



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) **TOPONCE, RYAN, MATTHEW**

Other Names Used: (e.g. Maiden)	Home E-mail: Ryantoponce@gmail.com	Work E-mail: Ryantoponce@gmail.com
Home Address: 359 Huntington St.	City: Iowa City	State: IA
	Zip: 52245	Home Phone: 801-807-9115
License Number: 08792	Issue Date: 1/5/11	Expiration Date: 8/31/14
	Type of Practice: Dental	

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

Principal Office Address: 2814 Northgate Dr. #2 IA City	City: IA City	Zip: 52245	Phone: 319-338-5484	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:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed & attach proof.	Check all that apply	DATE(S):
Advanced education program accredited by ADA that provides training in deep sedation and general anesthesia	<input checked="" type="checkbox"/>	6/2014
Formal training in airway management	<input checked="" type="checkbox"/>	6/2014
Minimum of one year of advanced training in anesthesiology in a training program approved by the board	<input checked="" type="checkbox"/>	6/2014

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS Renewal Course	Location: UNIVERSITY of Iowa EMS Learning Resources Center			
Date of Course: 4/9/14	Date Certification Expires: 4/30/16			
Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee #25468 \$500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection: N/A	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee: N/A	Res. Cert

joining pre-inspected facility/practice

Name of Applicant Ryan Toponce

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>University of Nevada Las Vegas School of Dental Medicine</u>	From (Mo/Yr): <u>9/2006</u>	To (Mo/Yr): <u>5/2010</u>
City, State: <u>Las Vegas, Nevada</u>	Degree Received: <u>DMD</u>	

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

Name of Training Program: <u>University of Iowa Hospitals & Clinics</u>	Address: <u>200 Hawkins Drive</u>	City: <u>Iowa City</u>	State: <u>Iowa</u>
Phone: <u>319-356-7339</u>	Specialty: <u>Oral & Maxillofacial Surgery</u>	From (Mo/Yr): <u>6/2010</u>	To (Mo/Yr): <u>6/2014</u>

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

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

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

CHRONOLOGY OF ACTIVITIES

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

Activity & Location	From (Mo/Yr):	To (Mo/Yr):
<u>Oral & Maxillofacial surgery residency University of Iowa</u>	<u>6/2010</u>	<u>6/2014</u>

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

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

Oral sedation including valium, versed, triazolam
Nitrous oxide use (inhalation)
IV sedation with drugs including valium, versed, fentanyl, ketamine, propofol, morphine, dilaudid

Name of Applicant Ryan M Toponce

Facility Address 2814 Northgate Dr STE 2

IA 014 IA52245

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:
Janet Nicholson	P15344	11-5-13	11-30-15
Janet Rees	P15235	11-5-13	11-30-15
Mary Kleopfer	094615	11-5-13	11-30-15
Jennifer LeBeda	Q10587	11-5-13	11-30-15
Stephanie Ricke	QDA 08210	11-5-13	11-30-15
Tara Krause	Q11215	11-5-13	11-30-15
Angela Reistroffer	QDA-10167	11-5-13	11-30-15
Rose Bachus name: Unne Peterson	QDA-05563 0191258	11-5-13	11-30-15

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

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: <u>IOWA</u>	COUNTY: <u>JOHNSON</u>
--------------------	------------------------

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.

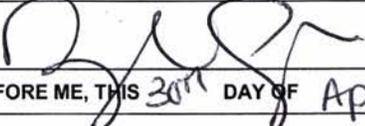
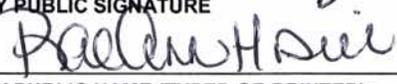
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under deep sedation/general anesthesia. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency 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.

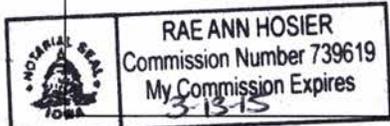
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of sedation.

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>30th</u> DAY OF <u>April</u> , YEAR <u>2014</u>
NOTARY SEAL	NOTARY PUBLIC SIGNATURE 
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>RAE ANN Hosier</u>
MY COMMISSION EXPIRES: <u>3-13-15</u>	



ADVANCED CARDIOVASCULAR LIFE SUPPORT

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider



→
PEEL
HERE
→

Ryan Toponce

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.

4/9/2014

4/30/2016

Issue Date

Recommended Renewal Date

Training Center Name	UIHC-EMSLRC	TC ID #
TC Info	TCCIA05137	TC
City	200 Hawkins Dr, Iowa City, IA	ZIP
Course Location	319-353-7495	Inst. ID #
Instructor Name	Lee Ridge 03060026618	

Holder's
Signature

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1805

Ryan Toponce
359 Huntington St
Iowa City Iowa 52245

Peel the wallet card off the sheet and fold it over.



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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MAY 05 2014

IOWA DENTAL BOARD

PLEASE TYPE OR PRINT LEGIBLY IN INK.

VERIFICATION OF POSTGRADUATE RESIDENCY PROGRAM

SECTION 1 – APPLICANT INFORMATION

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

NAME (First, Middle, Last, Suffix, Former/Maiden): *Ryan, Matthew, Toponce*

MAILING ADDRESS: *359 Huntington St.*

CITY: <i>Iowa City</i>	STATE: <i>Iowa</i>	ZIP CODE: <i>52245</i>	PHONE: <i>801-807-9115</i>
------------------------	--------------------	------------------------	----------------------------

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

APPLICANT'S SIGNATURE:	DATE: <i>4/30/14</i>
------------------------	----------------------

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: *Steven L. Fletcher*

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: <i>University of Iowa, Iowa City, IA</i>	PHONE: <i>319-356-7339</i>
-------------------------------------------------------------------------------------	----------------------------

DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/YR): <i>7/10</i>	TO (MO/YR): <i>6/14</i>	DATE PROGRAM COMPLETED: <i>6/30/14</i>
-------------------------------------------	---------------------------	-------------------------	----------------------------------------

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain. *See below*
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

Dr. Toponce will complete his OMFS residency on 6-30-14. He is on track to satisfactorily complete all training

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

PROGRAM DIRECTOR SIGNATURE:	DATE: <i>4-30-14</i>
-----------------------------	----------------------



ORAL SURGERY
ASSOCIATES
OF IOWA CITY, P.C.
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5/5/14

Iowa Dental Board
State of Iowa
400 SW 8th St. Suite D
Des Moines IA 50309

RE: new applicant Ryan M Toponce- Anesthesia Permit

To Whom It May Concern:

I am submitting the completed application for Ryan Toponce to apply for his general anesthesia license. Ryan is graduating from the University of Iowa Oral Surgery Residency program on 6/20/14. He will be starting as an associate at Oral Surgery Associates on June 30, 2014.

Per Dr. Toponce **the postgraduate verification of residency program** will be coming from the University of Iowa – Dr. Steven Fletcher under separate cover.

Thank you for processing Ryan's application.

Sincerely

Janet Major
Office Manager
Oral Surgery Associates of Iowa City PC
2814 Northgate Dr Suite 2
Iowa City IA 52245

Andrew C. Hartwig D.D.S., Ph.D.* • Chad M. Pfohl D.D.S.* • Deborah L. Zeitler D.D.S., M.S.*
2814 Northgate Dr., Suite 2, Iowa City, IA 52245-9568 • ph. 319.338.5484 • fax. 319.338.9413



*Diplomates, American Board of Oral & Maxillofacial Surgery



*Fellows, American Association of Oral & Maxillofacial Surgeons



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MAY 30 2014

IOWA DENTAL BOARD

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)

Davidson, Michael, James

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

michael.james.davidson@gmail.com

Work E-mail:

Same

Home Address:

8106 N Walnut Creek Dr.

City:

Urbandale

State:

IA

Zip:

50322

Home Phone:

(515) 401-5040

License Number:

08635

Issue Date:

June 12, 2009

Expiration Date:

Aug 31, 2014

Type of Practice:

Private

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

Principal Office Address:

8573 Urbandale Ave

City:

Urbandale

Zip:

50322

Phone:

(515) 279-3848

Office Hours/Days:

M-R 7-5 F7-12

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

JAN - APRIL 2014

ADA-accredited Residency Program that includes moderate sedation training

Completed

N/A

You must have training in moderate sedation AND one of the following:

Formal training in airway management; OR

Completed

FEB 2014

Moderate sedation experience at graduate level, approved by the Board

Completed

N/A

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

Heartcode ACLS

Location:

Unity Point Health - Des Moines

Date of Course:

1/14/2014

Date Certification/Expires:

01/2016

Office Use	Lic. #	Sent to ACC:	Inspection	Fee #31831 \$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 Michael Davidson

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:
 Postgraduate Residency Program Continuing Education Program Other Board-approved program, specify:

Name of Training Program: <u>Oregon AGD</u>	Address: <u>1730 SW Harbor Way #502</u>	City: <u>Portland</u>	State: <u>OR</u>
------------------------------------------------	--------------------------------------------	--------------------------	---------------------

Type of Experience:
didactic + clinical + simulation

Length of Training: <u>103 HR</u>	Date(s) Completed: <u>JAN - APR 2014</u>
--------------------------------------	---------------------------------------------

Number of Patient Contact Hours: <u>43</u>	Total Number of Supervised Sedation Cases: <u>20</u>
-----------------------------------------------	---------------------------------------------------------

- 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 anti-anxiety 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
Midazolam
~~Fentanyl~~
Hydromorphone

benzodiazepines
opioids

Name of Applicant Michael Davidson Facility Address 8573 Urbandale Ave Urbandale IA 50302

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:
<u>Donna Deppe</u>	<u>QDA-01675</u>	<u>1-9-13</u>	<u>1-9-15</u>
<u>Stemmeyer, Beverly</u>	<u>QDA-03165</u>	<u>8-15-13</u>	<u>8-15-15</u>
<u>Nimmo, Traci</u>	<u>QDA-05432</u>	<u>1-17-14</u>	<u>1-17-16</u>
<u>Wilder, Lisbeth</u>	<u>QDA-11745</u>	<u>8-16-13</u>	<u>8-16-15</u>
<u>Wood, Jan</u>	<u>QDA-02580</u>	<u>1-9-13</u>	<u>1-9-15</u>
<u>Wright, Tracy</u>	<u>QDA-07338</u>	<u>8-16-13</u>	<u>8-16-15</u>
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:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<u>11</u>		20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

	YES	NO
1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. If YES to any of the above, are you receiving ongoing treatment or participation in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	<input type="checkbox"/>	<input checked="" type="checkbox"/> N/A
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"/> N/A
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: 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.

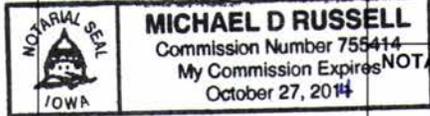
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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 <u>19th</u> DAY OF <u>April</u> , YEAR <u>2014</u>
	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Michael Russell</u>	MY COMMISSION EXPIRES: <u>10/27/2014</u>



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): Michael James Davidson

MAILING ADDRESS: 8573 Urbandale Ave

CITY: Urbandale **STATE:** IA **ZIP CODE:** 50322 **PHONE:** (515) 279-3844

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:** 4/13/14

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR: Kenneth L. Reed DMD

NAME AND LOCATION OF PROGRAM: Oregon AGD
 616 SW Campus Drive
 Portland OR 97201 **PHONE:** 503 228 6266

FAX: 503 228 4838 **E-MAIL:** KLR@KLRDMD.com **WEB ADDRESS:** WWW.learninseparation.com

DATES APPLICANT PARTICIPATED IN PROGRAM ▶ FROM (MO/DAY/YR): 01/16/14 TO (MO/DAY/YR): 04/13/14 **DATE PROGRAM COMPLETED:** 04/13/2014

- 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:** 4/13/14



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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):

MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE:

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:

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:

**DATES APPLICANT
PARTICIPATED IN PROGRAM ▶**

FROM (MO/YR):

TO (MO/YR):

**DATE PROGRAM
COMPLETED:**

- 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:



Kenneth L. Reed, DMD

Doctor of Dental Medicine

P.O. Box 85883
Tucson, AZ 85754-5883
Cell: 520.370.3693
FAX: 877.522.0480
<http://www.klrmd.com>

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APR 21 2014
IOWA DENTAL BOARD

Melanie Johnson, J.D.
Executive Director
Iowa Dental Board
400 SW 8th St. Suite D
Des Moines, IA. 50309-4687

April 13, 2014

Dr. Michael Davidson recently completed a parenteral moderate sedation course that I taught, sponsored by the Oregon Academy of General Dentistry, held at the Oregon Health and Sciences University, School of Dentistry in Portland, OR. This course meets the requirements of **IAC 650—29.4 (1)(a, b)**. The didactic component was sixty clock hours in duration and consisted of the following broad topics:

- Airway management
- History of anesthesia
- Physical evaluation
- Definitions
- Respiratory anatomy and physiology
- Monitoring
- Pharmacology of utilized agents
- Oral sedation
- Local anesthesia
- Medical emergencies
- IV sedation techniques
- Records and record keeping
- Recognition and management of complications and emergencies
- Venipuncture techniques
- High Fidelity Human Simulation (Sim-Man)

Additionally, Dr. Davidson completed parenteral moderate sedation on 20 patients under my direct supervision. The clinical component was 43 hours in duration and required Michael to provide both the sedation and the dentistry. I certify that Michael is competent in both airway management as well as parenteral moderate sedation.

Kenneth L. Reed DMD



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>

updated Application

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)

Dudzinski, Bernard, Paul

Other Names Used: (e.g. Maiden)	Home E-mail: bdudzy@cox.net	Work E-mail:		
Home Address: 16735 Harney St	City: Omaha	State: NE	Zip: 68118	Home Phone: 402-333-2181
License Number: 07224	Issue Date: 6/15/1987	Expiration Date: 8/31/14	Type of Practice: General Practice Dental	

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

Principal Office Address: 3331 Marketplace Drive	City: Council Bluffs	Zip: 55123 51501	Phone: 712-366-7077	Office Hours/Days: 7-4 MTWR 7-12 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	<input checked="" type="checkbox"/> Completed	5/4/14
ADA-accredited Residency Program that includes moderate sedation training	<input checked="" type="checkbox"/> Completed	5/4/14
You must have training in moderate sedation AND one of the following:		
Formal training in airway management; OR	<input checked="" type="checkbox"/> Completed	4/25/14
Moderate sedation experience at graduate level, approved by the Board	<input type="checkbox"/> Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Conscious Sedation Consulting		Location: Philadelphia, PA	
Date of Course: 4/14/14-5/4/14 4/25/14		Date Certification Expires: 4/25/16	
Office Use	Lic. #	Sent to ACC:	Inspection <input checked="" type="checkbox"/> Fee <input checked="" type="checkbox"/>
	Permit #	Approved by ACC:	Inspection Fee Pd: <input checked="" type="checkbox"/> ACLS <input checked="" type="checkbox"/>
	Issue Date:	Temp #	ASA 3/4? NO Form A/B
	Brd Approved:	T. Issue Date:	Pediatric? NO Peer Eval

Name of Applicant

Bernard
Jordan Dudzinski

SECTION 5 - MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program:

Conscious Sedation Consulting

Address:

79 Hubble Drive

City:

O'Fallon

State:

MO

Type of Experience:

IV Sedation

Length of Training:

100 CEU

4/11/13 - 5/4/14

Date(s) Completed:

5/4/14

Number of Patient Contact Hours:

30

Total Number of Supervised Sedation Cases:

21

- 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.

I. V. moderate sedation using: Versed
Fentanyl

Name of Applicant Bernard Dudzinski

Facility Address 3331 Marketplace Dr. C.B. IA57501

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:
<u>BSN ICU Nurse Samantha Snyder RN</u>	<u>77304</u>	<u>9/7/12 ACLS 3/20/14</u>	<u>9/7/14 ACLS 3/20/16</u>
<u>Dana White RDA</u>	<u>IARDA 03928</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Amanda Holub RDA</u>	<u>IARDA 04220</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Becky Petty RDA</u>	<u>pending</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Mercedes Shure RDA</u>	<u>CDA 102054 IA RDA 0473</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Raina McAuliffe</u>	<u>IA RDA 10695</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Heather Peppers RDA</u>	<u>IA RDA 08977</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Kim Fitzgerald RDA</u>	<u>IARDA 04209</u>	<u>11/12</u>	<u>11/14</u>

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:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility. <u>6</u>

Course Completion Statement

This notice confirms that **Bernie Dudzinski**

has successfully completed the program requirements for the following American Heart Association training course:(Circle One).

ACLS

The course was administrated by Advance CE LLC on:

April 25, 2014

The training course curriculum is in compliance with American Heart Association ECC training course guidelines, and all lead instructors are certified by the AHA Regional Training Center at the time of the course.

Course completion cards are currently being processed. It can take up to six weeks for completion cards to be issued once the rosters are submitted.

If your completion card has not been received within six weeks of the course completion date above, please contact Advance CE.

Thank you.

Steven Halaway

Authorized Provider
of CPR and ECC Courses



Director of ECC training programs for

Advance CE, LLC

Email: shalaway@advancece.com



RECEIVED

MAY 09 2013

www.SedationConsulting.com IOWA DENTAL BOARD

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

May 6, 2014

Dear Board Members,

This letter is to confirm that Bernard Dudzinski, DDS License # DDS-07224 recently successfully completed 100 hours of continuing education while participating in a comprehensive post doctoral training program in the administration of parenteral conscious (moderate) sedation, which is consistent to *The Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. As adopted by the October 2007 American Dental Association (ADA) House of Delegates.

This program was presented April 11 - 27, 2014 in Philadelphia, Pennsylvania.

Documented competency has been demonstrated with successful completion of at least 60 hours of didactic education and the personal administration of parenteral sedation to at least 20 dental patients while being supervised by an anesthesia provider. In addition, a hands on skills lab in airway management was completed utilizing simulation with multiple airway devices including advanced airway devices.

If you have any questions or need any additional information please do not hesitate to contact me.

Thank you,

Randy Pigg, BSN
CEO, Conscious Sedation Consulting
888-581-4448
randy@sedationconsulting.com

79 Hubble, Suite 102
O'Fallon, MO 63368
888.581.4448

"Creating a culture of safety through education"



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): Bernard Paul Dudzinski

MAILING ADDRESS: 3331 MARKET PLACE DRIVE

CITY: COUNCIL BLUFFS STATE: IA ZIP CODE: 51501 PHONE: 72-366-7077

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: [Signature] DATE: 5/6/14

SECTION 2 - TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR: Randy Pigg

NAME AND LOCATION OF PROGRAM: Philadelphia PA PHONE: 888-581-4448

IV Sedation Training for Dentists

FAX: _____ E-MAIL: _____ WEB ADDRESS: _____

DATES APPLICANT PARTICIPATED IN PROGRAM ▶ FROM (MO/DAY/YR): _____ TO (MO/DAY/YR): _____ DATE PROGRAM COMPLETED: _____

- 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: [Signature] DATE: 5/6/2014

Department of Health and Human Services
 Division of Public Health

Lic. Type: Registered Nurse
 Multi-State

License No. 77304

Samantha Christine Snyder
 210 S 16 ST, APT 409
 Omaha NE 68102

Expires: 10/31/2014

Jake L. Meeks
 Administrator, Licensure Unit

Signature

ACLS Provider



American Heart Association

SAMANTHA SNYDER

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.

Issue Date: 03/20/2014 Recommended Renewal Date: 03/2016

Please do not lose this card. A replacement fee of \$15 will be charged.

© 2011 American Heart Association. Copying with this card will alter its appearance. 90-1906

Training Center Name: CLARKSON COLLEGE TC ID # NE 02080 (402)
TC Info: OMAHA NE 68131 552-3100
Course Location: CLARKSON COLLEGE
Instructor Name: CHRIS HATCHER Inst. # 003337
Holder's Signature: *Samantha Snyder*

This card contains unique security features to protect against forgery.

90-18

Healthcare Provider



American Heart Association

SAMANTHA SNYDER

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.

Issue Date: 09/07/2012 Recommended Renewal Date: 09/2014



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>

Original Application

RECEIVED

APR 21 2014

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)

Dudzinski, Bernard, Paul

Other Names Used: (e.g. Maiden)	Home E-mail: bdudzy@cox.net	Work E-mail:		
Home Address: 16735 Harney St	City: Omaha	State: NE	Zip: 68118	Home Phone: 402-333-2181
License Number: 07224	Issue Date: 6/15/1987	Expiration Date: 8/31/14	Type of Practice: General Practice Dental	

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

Principal Office Address: 3331 Marketplace Drive	City: Council Bluffs	Zip: 55123	Phone: 712-366-7077	Office Hours/Days: 7-4 MTWR 7-12 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	<input type="checkbox"/> Completed	
ADA-accredited Residency Program that includes moderate sedation training	<input type="checkbox"/> Completed	
You must have training in moderate sedation AND one of the following:		
Formal training in airway management; OR	<input type="checkbox"/> Completed	
Moderate sedation experience at graduate level, approved by the Board	<input type="checkbox"/> Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Conscious Sedation Consulting		Location: Philadelphia, PA		
Date of Course: 4/11/14-5/4/14		Date Certification Expires:		
Office Use	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

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION			
Type of Program: <input type="checkbox"/> Postgraduate Residency Program <input checked="" type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-approved program, specify:			
Name of Training Program: Conscious Sedation Consulting	Address: 79 Hubble Drive	City: O'Fallon	State: MO
Type of Experience: IV Sedation			
Length of Training:		Date(s) Completed:	
Number of Patient Contact Hours:		Total Number of Supervised Sedation Cases:	
<input type="checkbox"/> YES <input type="checkbox"/> NO 1. Did you satisfactorily complete the above training program? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety? <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> NO 4. Physical evaluation; <input type="checkbox"/> YES <input type="checkbox"/> NO 5. IV sedation; <input type="checkbox"/> YES <input type="checkbox"/> NO 6. Airway management; <input type="checkbox"/> YES <input type="checkbox"/> NO 7. Monitoring; and <input type="checkbox"/> YES <input type="checkbox"/> NO 8. Basic life support and emergency management. <input type="checkbox"/> YES <input type="checkbox"/> NO 9. Does the program include clinical experience in managing compromised airways? <input type="checkbox"/> YES <input type="checkbox"/> NO 10. Does the program provide training or experience in managing moderate sedation in pediatric patients? <input type="checkbox"/> YES <input type="checkbox"/> 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			
<input type="checkbox"/> YES <input type="checkbox"/> 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): _____ <input type="checkbox"/> YES <input type="checkbox"/> NO B. Do you consider yourself engaged in the use of moderate sedation in your professional practice? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO D. Do you plan to use moderate sedation in pediatric patients? <input type="checkbox"/> YES <input type="checkbox"/> NO E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients? <input type="checkbox"/> YES <input type="checkbox"/> NO F. Do you plan to engage in enteral moderate sedation? <input type="checkbox"/> YES <input type="checkbox"/> 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 Jordan Dudzinski

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:

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.

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department TC ID #

Address: 1516 Jackson St, Omaha

Course Location: 3331 Marketplace Dr., CB

Instructor Name: JOE ALLGIRE Inst. ID #

Holder's Signature

AMBER ALLISON

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.

Issue Date: 03-12-14

Recommended Renewal Date: MARCH 2016

Issue Date

Recommended Renewal Date

American Heart Association | Training with this card will take its appearance | 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department TC ID #

Address: 1516 Jackson St, Omaha

Course Location: 3331 Marketplace Dr., CB

Instructor Name: JOE ALLGIRE Inst. ID #

Holder's Signature

DENA WHITE

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.

Issue Date: 03-12-14

Recommended Renewal Date: MARCH 2016

Issue Date

Recommended Renewal Date

American Heart Association | Training with this card will take its appearance | 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department TC ID #

Address: 1516 Jackson St, Omaha

Course Location: 3331 Marketplace Dr., CB

Instructor Name: JOE ALLGIRE Inst. ID #

Holder's Signature

AMANDA HOLUB

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.

Issue Date: 03-12-14

Recommended Renewal Date: MARCH 2016

Issue Date

Recommended Renewal Date

American Heart Association | Training with this card will take its appearance | 90-1801

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90-1801 3/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



RAINA McAULIFFE

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.

Issue Date: **03-12-14**

Recommended Renewal Date: **MARCH 2016**

Training Center Name: **Omaha Fire Department** TC ID #

TC Info: **1516 Jackson St, Omaha**

Course Location: **3331 Marketplace Dr., CB**

Instructor Name: **JOE ALLGIRE** Inst. ID #

Provider's Signature

© 2014 American Heart Association. Copying or using this card without its appearance is illegal. 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



HEATHER PEPPERS

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.

Issue Date: **03-12-14**

Recommended Renewal Date: **MARCH 2016**

Training Center Name: **Omaha Fire Department** TC ID #

TC Info: **1516 Jackson St, Omaha**

Course Location: **3331 Marketplace Dr., CB**

Instructor Name: **JOE ALLGIRE** Inst. ID #

Provider's Signature

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This card contains unique security features to protect against forgery.

90-1801 3/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



BECKY PETTY

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.

Issue Date: **03-12-14**

Recommended Renewal Date: **MARCH 2016**

Training Center Name: **Omaha Fire Department** TC ID #

TC Info: **1516 Jackson St, Omaha**

Course Location: **3331 Marketplace Dr., CB**

Instructor Name: **JOE ALLGIRE** Inst. ID #

Provider's Signature

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90-1801 3/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Omaha Fire Department

1516 Jackson St, Omaha

KENT E McARDLE, DDS

3331 Marketplace Dr, CB

JOE ALLGIRE

03-12-14

MARCH 2016

Healthcare Provider Information: This card is provided to you by the Omaha Fire Department. It is not intended to be used as a medical record. It is provided for informational purposes only.

Healthcare Provider Information: This card is provided to you by the Omaha Fire Department. It is not intended to be used as a medical record. It is provided for informational purposes only.

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Omaha Fire Department

1516 Jackson St, Omaha

JORDAN P DUDZINSKI, DDS

3331 Marketplace Dr., CB

JOE ALLGIRE

03-12-14

MARCH 2016

Healthcare Provider Information: This card is provided to you by the Omaha Fire Department. It is not intended to be used as a medical record. It is provided for informational purposes only.

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Omaha Fire Department

1516 Jackson St, Omaha

BERNARD P DUDZINSKI, DDS

3331 Marketplace Dr., CB

JOE ALLGIRE

03-12-14

MARCH 2016

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #: [blank]
TC: 1516 Jackson St, Omaha
TC State: [blank]
TC Zip: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE
Instructor ID #: [blank]
Provider's Signature: [blank]

MERCEDES SHIRE

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.

Issue Date: 03-12-14 Expiration Date: MARCH 2016

This card contains unique security features to protect against forgery.

90 1801 1/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #: [blank]
TC: 1516 Jackson St, Omaha
TC State: [blank]
TC Zip: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE
Instructor ID #: [blank]
Provider's Signature: [blank]

PEGGY SORENSON

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.

Issue Date: 03-12-14 Expiration Date: MARCH 2016

This card contains unique security features to protect against forgery.

90 1801 1/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #: [blank]
TC: 1516 Jackson St, Omaha
TC State: [blank]
TC Zip: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE
Instructor ID #: [blank]
Provider's Signature: [blank]

MARIBEL CAUDILLO DDS

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.

Issue Date: 03-12-14 Expiration Date: MARCH 2016

This card contains unique security features to protect against forgery.

90 1801 1/11

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: 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 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.

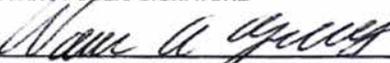
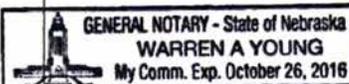
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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 <u>16</u> DAY OF <u>April</u> , YEAR <u>2014</u>
NOTARY PUBLIC SIGNATURE 		NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Warren A Young</u>
		MY COMMISSION EXPIRES: <u>10/26/16</u>



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):

Bernard, Paul, Dudzinski

MAILING ADDRESS:

3331 Marketplace Drive

CITY:

Council Bluffs

STATE:

IA

ZIP CODE:

51501

PHONE:

712-366-7077

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:

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

NAME AND LOCATION OF PROGRAM:

PHONE:

FAX:

E-MAIL:

WEB ADDRESS:

**DATES APPLICANT
PARTICIPATED IN PROGRAM ▶**

FROM (MO/DAY/YR):

TO (MO/DAY/YR):

**DATE PROGRAM
COMPLETED:**

- 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:

RECEIVED

MAY 09 2013

IOWA DENTAL BOARD

From: "Braness, Christel [IDB]" <Christel.Braness@iowa.gov>
Subject: Application for Moderate Sedation Permit
Date: April 25, 2014 11:31:50 AM CDT
To: Bernie Dudzinski <bdudzzy@cox.net>

2 Attachments, 1.4 MB

After reviewing your application for moderate sedation permit, the following items will need to be submitted to complete the documentation with your application:

- 1. Application fee - \$500.00 made payable to the Iowa Dental Board. Please forward a check or money order to the Board office with a copy of this email.
2. Complete the highlighted portions of the attached copy of the application and return to this office.
3. Proof of current certification in ACLS. Certification course must include a "hands-on" component; courses, which were completed by self-study alone are not acceptable.
4. Verification of Moderate Sedation Training (continuing education course).

Upon receipt of these items, your application will be forwarded to the Anesthesia Credentials Committee for review.

Let me know if you have any other 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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PLEASE TYPE OR PRINT LEGIBLY IN INK.

FORM B: VERIFICATION OF MODERATE SEDATION TRAINING IN A CONTINUING EDUCATION PROGRAM. Includes sections for applicant information, mailing address, program director details, and a list of 9 questions regarding program completion and curriculum.

Bernard P Dudzinski
3331 Marketplace Dr.
CB IA 51501

10726
\$500.

DudzinskiB ...pdf (1.3 MB)



IOWA DENTAL BOARD
 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
 Phone (515) 281-5157 Fax (515) 281-7969
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updated Application

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)
 Dudzinski, Jordan, Paul

Other Names Used: (e.g. Maiden)	Home E-mail: jdudzy@gmail.com	Work E-mail:		
Home Address: 12433 Read Street	City: Omaha	State: NE	Zip: 68118 68142	Home Phone: 402-981-2182
License Number: 08996	Issue Date:	Expiration Date:	Type of Practice: General Practice	

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

Principal Office Address: 3331 Marketplace Drive	City: Council Bluffs	Zip: 55123 51501	Phone: 712-366-7077	Office Hours/Days: 7-4 MTWR 7-12 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	<input checked="" type="checkbox"/> Completed	<i>see email</i>
ADA-accredited Residency Program that includes moderate sedation training	<input checked="" type="checkbox"/> Completed	<i>dated 5/6/14</i>
You must have training in moderate sedation AND one of the following:		
Formal training in airway management; OR	<input checked="" type="checkbox"/> Completed	
Moderate sedation experience at graduate level, approved by the Board	<input type="checkbox"/> Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Conscious Sedation Consulting		Location: Philadelphia, PA	
Date of Course: <i>4/25/14</i>		Date Certification Expires: <i>4/25/16</i>	
Office Use	Lic. #	Sent to ACC:	Inspection <i>5/29/14</i> Fee <input checked="" type="checkbox"/>
	Permit #	Approved by ACC:	Inspection Fee Pd: <input checked="" type="checkbox"/> ACLS
	Issue Date:	Temp #	ASA 3/4? <i>NO</i> Form A/B
	Brd Approved:	T. Issue Date:	Pediatric? <i>NO</i> Peer Eval

Braness, Christel [IDB]

From: Jordan Dudzinski <jdudzy@gmail.com>
Sent: Tuesday, May 06, 2014 8:28 PM
To: Braness, Christel [IDB]
Subject: Fwd: Application for Moderate Sedation Permit

Christel,

I found one more correction on my application. Page 1 where we were to check boxes. I forgot to include dates of completion. They are, going down the column: 5/4/14, @ 5/4/14, 4/25/14, blank.

Please let me know if you need further information,

Jordan Dudzinski

Begin forwarded message:

From: Jordan Dudzinski <jdudzy@gmail.com>
Date: May 6, 2014 at 7:32:42 PM CDT
To: "Braness, Christel [IDB]" <Christel.Braness@iowa.gov>
Subject: Re: Application for Moderate Sedation Permit

Christel,

Also I forgot to provide details on the bottom of page two in the scanned document I sent to you.

We will be primarily using iv versed and fentanyl in our practice for sedation.

Sorry for forgetting to include that on my application.

Thanks again,

Jordan

On Apr 25, 2014, at 11:18 AM, "Braness, Christel [IDB]" <Christel.Braness@iowa.gov> wrote:

After reviewing your application for moderate sedation permit, the following items will need to be submitted to complete the documentation with your application:

1. Complete the highlighted portions of the attached copy of the application and return to this office.
2. Proof of current certification in ACLS. Certification course must include a "hands-on" component; courses, which were completed by self-study alone are not acceptable.
3. Verification of Moderate Sedation Training (continuing education course).

Upon receipt of these items, your application will be forwarded to the Anesthesia Credentials Committee for further review.

Let me know if you have any other questions.

Christel Braness, Program Planner

Name of Applicant Jordan Dudzinski

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION			
Type of Program: <input type="checkbox"/> Postgraduate Residency Program <input checked="" type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-approved program, specify:			
Name of Training Program: Conscious Sedation Consulting	Address: 79 Hubble Drive	City: O'Fallon	State: MO
Type of Experience: IV Sedation			
Length of Training: <i>100 CEU 4/11/13-5/4/14</i>		Date(s) Completed: <i>5/4/14</i>	
Number of Patient Contact Hours: <i>30</i>		Total Number of Supervised Sedation Cases: <i>23</i>	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 1. Did you satisfactorily complete the above training program?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> 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:			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 4. Physical evaluation;			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 5. IV sedation;			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 6. Airway management;			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 7. Monitoring; and			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 8. Basic life support and emergency management.			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 9. Does the program include clinical experience in managing compromised airways?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10. Does the program provide training or experience in managing moderate sedation in pediatric patients?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) _____			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO D. Do you plan to use moderate sedation in pediatric patients?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients?			
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO F. Do you plan to engage in enteral moderate sedation?			
<input checked="" type="checkbox"/> YES <input type="checkbox"/> 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. <i>see email dated 5/6/14</i>			

Braness, Christel [IDB]

From: Jordan Dudzinski <jdudzy@gmail.com>
Sent: Tuesday, May 06, 2014 7:33 PM
To: Braness, Christel [IDB]
Subject: Re: Application for Moderate Sedation Permit

Christel,
Also I forgot to provide details on the bottom of page two in the scanned document I sent to you.

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Jordan

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Let me know if you have any other questions.

Christel Braness, Program Planner
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<MS_TrainingVerif_ConEd.pdf>

<DudzinskiJ_MS_App.pdf>

Name of Applicant Jordan Dudzinski

Facility Address 3331 Marketplace Dr. CB, IA 52001

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:
<u>Mercedes Shire</u> CDA RDA	<u>CDA 100004</u> <u>IA RDA 0413</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Peggy Sorenson</u> RDA	<u>IA RDA 00044</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Raina McAuliffe</u> RDA	<u>IA RDA 10695</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Heather Peppers</u> RDA	<u>IA RDA 03977</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Becky Petty</u> RDA	<u>pending</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Dena White</u> RDH	<u>IA RDH 03428</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Amanda Holub</u> RDH	<u>IA RDH 04220</u>	<u>3/12/14</u>	<u>3/12/16</u>
<u>Kim Fitzgerald</u> RDA	<u>IA RDA 04209</u>	<u>11/12</u>	<u>11/14</u>

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.

Course Completion Statement

This notice confirms that **Jordan Dudzinski**

has successfully completed the program requirements for the following American Heart Association training course:(Circle One).

ACLS

The course was administrated by Advance CE LLC on:

April 25, 2014

The training course curriculum is in compliance with American Heart Association ECC training course guidelines, and all lead instructors are certified by the AHA Regional Training Center at the time of the course.

Course completion cards are currently being processed. It can take up to six weeks for completion cards to be issued once the rosters are submitted.

If your completion card has not been received within six weeks of the course completion date above, please contact Advance CE.

Thank you.

Steven Halaway

Authorized Provider
of CPR and ECC Courses

American Heart
Association 

Director of ECC training programs for

Advance CE, LLC

Email: shalaway@advancece.com



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MAY 09 2013

www.SedationConsulting.com IOWA DENTAL BOARD

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

May 6, 2014

Dear Board Members,

This letter is to confirm that Jordan Dudzinski, DDS License # DDS-08996 recently successfully completed 100 hours of continuing education while participating in a comprehensive post doctoral training program in the administration of parenteral conscious (moderate) sedation, which is consistent to *The Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. As adopted by the October 2007 American Dental Association (ADA) House of Delegates.

This program was presented April 11 - 27, 2014 in Philadelphia, Pennsylvania.

Documented competency has been demonstrated with successful completion of at least 60 hours of didactic education and the personal administration of parenteral sedation to at least 20 dental patients while being supervised by an anesthesia provider. In addition, a hands on skills lab in airway management was completed utilizing simulation with multiple airway devices including advanced airway devices.

If you have any questions or need any additional information please do not hesitate to contact me.

Thank you,

Randy Pigg, BSN
CEO, Conscious Sedation Consulting
888-581-4448
randy@sedationconsulting.com

79 Hubble, Suite 102
O'Fallon, MO 63368
888.581.4448

"Creating a culture of safety through education"



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):

JORDAN PAUL DUDZINSKI

MAILING ADDRESS:

3331 MARKETPLACE DRIVE

CITY:

COUNCIL BLUFFS

STATE:

IA

ZIP CODE:

51501

PHONE:

712-366-7077

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:

[Handwritten Signature]

DATE:

5/5/14

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

Randy Pigg

NAME AND LOCATION OF PROGRAM:

Philadelphia, PA
 IV Sedative Training Program for Dentists

PHONE:

888-581-4448

FAX:

E-MAIL:

WEB ADDRESS:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/DAY/YR):

TO (MO/DAY/YR):

DATE PROGRAM COMPLETED:

- 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:

[Handwritten Signature]

DATE:

5/6/2014

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #
TC Info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

MERCEDES SHIRE

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.

Issue Date 03-12-14

Recommended Renewal Date MARCH 2016

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90-1801 3/11

HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #
TC Info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

PEGGY SORENSON

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.

Issue Date 03-12-14

Recommended Renewal Date MARCH 2016

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department
TC ID #
TC Info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

MARIBEL CAUDILLO, DDS

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.

Issue Date 03-12-14

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department TC ID #
TC info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

KENT E McARDLE, DDS

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.

03-12-14

MARCH 2016

Issue Date

Recommended Renewal Date

American Heart Association | Training with the American Heart Association | 99-1801

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department TC ID #
TC info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

JORDAN P DUDZINSKI, DDS

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03-12-14

MARCH 2016

Issue Date

Recommended Renewal Date

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name: Omaha Fire Department #
TC info: 1516 Jackson St, Omaha
Course Location: 3331 Marketplace Dr., CB
Instructor Name: JOE ALLGIRE Inst. ID #
Holder's Signature

BERNARD P DUDZINSKI, DDS

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.

03-12-14

MARCH 2016

Issue Date

Recommended Renewal Date

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name **Omaha Fire Department** TC ID #

TC Info **1516 Jackson St, Omaha**

Course Location **3331 Marketplace Dr., CB**

Instructor Name **JOE ALLGIRE** Inst. ID #

Holder's Signature

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RAINA McAULIFFE

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Issue Date **03-12-14**

Recommended Renewal Date **MARCH 2016**

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name **Omaha Fire Department** TC ID #

TC Info **1516 Jackson St, Omaha**

Course Location **3331 Marketplace Dr., CB**

Instructor Name **JOE ALLGIRE** Inst. ID #

Holder's Signature

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HEATHER PEPPERS

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Issue Date **03-12-14**

Recommended Renewal Date **MARCH 2016**

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name **Omaha Fire Department** TC ID #

TC Info **1516 Jackson St, Omaha**

Course Location **3331 Marketplace Dr., CB**

Instructor Name **JOE ALLGIRE** Inst. ID #

Holder's Signature

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BECKY PETTY

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.

Issue Date **03-12-14**

Recommended Renewal Date **MARCH 2016**

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name Omaha Fire Department TC ID #

TC Info 1516 Jackson St, Omaha

Course Location 3331 Marketplace Dr., CB

Instructor Name JOE ALLGIRE Inst. ID #

Holder's Signature

AMBER ALLISON

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.

Issue Date 03-12-14

Recommended Renewal Date MARCH 2016

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name Omaha Fire Department TC ID #

TC Info 1516 Jackson St, Omaha

Course Location 3331 Marketplace Dr., CB

Instructor Name JOE ALLGIRE Inst. ID #

Holder's Signature

DENA WHITE

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.

Issue Date 03-12-14

Recommended Renewal Date MARCH 2016

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HEALTHCARE PROVIDER HEALTHCARE PROVIDER

Healthcare Provider



Training Center Name Omaha Fire Department TC ID #

TC Info 1516 Jackson St, Omaha

Course Location 3331 Marketplace Dr., CB

Instructor Name JOE ALLGIRE Inst. ID #

Holder's Signature

AMANDA HOLUB

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.

Issue Date 03-12-14

Recommended Renewal Date MARCH 2016

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Braness, Christel [IDB]

From: Jordan Dudzinski <jdudzy@gmail.com>
Sent: Tuesday, May 06, 2014 12:11 PM
To: Iowa Dental Board [IDB]
Subject: Fwd: Jordan Dudzinski - Application Update
Attachments: scan05062014_0013.pdf

----- Forwarded message -----

From: **Jordan Dudzinski** <jdudzy@gmail.com>
Date: Tue, May 6, 2014 at 12:01 PM
Subject: Jordan Dudzinski - Application Update
To: "Braness, Christel [IDB]" <Christel.Braness@iowa.gov>

Christel,

Here is the application that I just updated. The instructor, Randy Pigg, should be sending in the forms soon. My father, Dr. Bernard Dudzinski, is sending in his application fee and changes today or tomorrow.

Thank you for speaking with me today-- I appreciate your help and efforts to expedite this process. Obviously, after investing in and completing this course, and seeing the day to day needs of my patients, the sooner my application is reviewed and approved, the better.

Please let me know if you need anything else, and thank you again.

Yours Truly,
Jordan Dudzinski



IOWA DENTAL BOARD
 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
 Phone (515) 281-5157 Fax (515) 281-7969
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 MAR 01

MAR 01 2014

IOWA DENTAL BOARD

Original Application

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)
 Dudzinski, Jordan, Paul

Other Names Used: (e.g. Maiden)	Home E-mail: jdudzy@gmail.com	Work E-mail:		
Home Address: 12433 Read Street	City: Omaha	State: NE	Zip: 68118	Home Phone: 402-981-2182
License Number: 08996	Issue Date: 5/29/13	Expiration Date: 8/31/14	Type of Practice: General Practice Dental	

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

Principal Office Address: 3331 Marketplace Drive	City: Council Bluffs	Zip: 55123	Phone: 712-366-7077	Office Hours/Days: 7-4 MTWR 7-12 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	<input type="checkbox"/> Completed	
ADA-accredited Residency Program that includes moderate sedation training	<input type="checkbox"/> Completed	
You must have training in moderate sedation AND one of the following: Formal training in airway management; OR	<input type="checkbox"/> Completed	
Moderate sedation experience at graduate level, approved by the Board	<input type="checkbox"/> Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Conscious Sedation Consulting	Location: Philadelphia, PA
Date of Course: 4/11/14-5/4/14	Date Certification Expires:

X

Office Use	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

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:			
<input type="checkbox"/> Postgraduate Residency Program <input checked="" type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-approved program, specify:			
Name of Training Program: Conscious Sedation Consulting	Address: 79 Hubble Drive	City: O'Fallon	State: MO
Type of Experience: IV Sedation			
Length of Training:		Date(s) Completed:	
Number of Patient Contact Hours:		Total Number of Supervised Sedation Cases:	

- 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 Jordan Dudzinski

Facility Address 3331 Marketplace Dr. CB, IA 51501

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:

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.

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: 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 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.

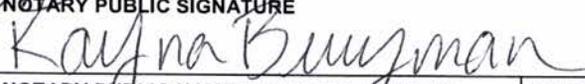
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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.

<p>MUST BE SIGNED IN PRESENCE OF NOTARY ▶</p>	SIGNATURE OF APPLICANT	
		
<p>NOTARY SEAL</p>	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>27th</u> DAY OF <u>FEBRUARY</u> , YEAR <u>2014</u>	
	<p>NOTARY PUBLIC SIGNATURE</p> 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	MY COMMISSION EXPIRES:
	<u>Rayna BERRYMAN</u>	<u>Oct. 25, 2017</u>



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):
Jordan, Paul, Dudzinski

MAILING ADDRESS:
3331 Marketplace Drive

CITY: Council Bluffs	STATE: IA	ZIP CODE: 55123	PHONE: 712-366-7077
--------------------------------	---------------------	---------------------------	-------------------------------

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: 2/27/14
-----------------------------------	-------------------------

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

NAME AND LOCATION OF PROGRAM:	PHONE:
--------------------------------------	---------------

FAX:	E-MAIL:	WEB ADDRESS:	
DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/DAY/YR):	TO (MO/DAY/YR):	DATE PROGRAM COMPLETED:

- 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:
------------------------------------	--------------

(ins course)

Will be complete

5/4/14

BLS for
all staff
at that location
expires soon.
BLS training is
in march for renewal

Will be

complete

5/4/14



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

APR 25 2014

IOWA DENTAL BOARD

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) <i>Prudent, Brian Anthony</i>				
Other Names Used: (e.g. Maiden)	Home E-mail: <i>bprudent@hotmail.com</i>		Work E-mail: <i>info@myotechdental.com</i>	
Home Address: <i>3030 13th Avenue</i>	City: <i>Moline</i>	State: <i>IL</i>	Zip: <i>61265</i>	Home Phone: <i>309-335-6465</i>
License Number: <i>08990</i>	Issue Date: <i>4-9-2013</i>	Expiration Date: <i>8/31/2014</i>	Type of Practice: <i>General Practice</i>	
SECTION 2 – LOCATION(S) IN IOWA WHERE MODERATE SEDATION SERVICES ARE PROVIDED				
Principal Office Address: <i>666 LORAS BLVD.</i>	City: <i>Dubuque</i>	Zip: <i>52001</i>	Phone: <i>563-582-0117</i>	Office Hours/Days: <i>M,T,Th,F 8-6</i>
Other Office Address: <i>1631 Avenue of the Cities</i>	City: <i>Moline</i>	Zip: <i>61265</i>	Phone: <i>309-764-0008</i>	Office Hours/Days: <i>M-F 7-6</i>
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
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			<input checked="" type="checkbox"/> Completed	<i>June 5, 2010</i>
ADA-accredited Residency Program that includes moderate sedation training			<input checked="" type="checkbox"/> Completed	<i>June 5, 2010</i>
You must have training in moderate sedation AND one of the following:				
Formal training in airway management; OR			<input checked="" type="checkbox"/> Completed	<i>June 5, 2010</i>
Moderate sedation experience at graduate level, approved by the Board			<input type="checkbox"/> Completed	
SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION				
Name of Course: <i>Advanced Cardiovascular Life Support</i>		Location: <i>GMC-Illini Davenport Campus</i>		
Date of Course: <i>2/14/2013</i>		Date Certification Expires: <i>Feb. 2015</i>		
Office Use	Lic. # <i>DS-08990</i>	Sent to ACC:	Inspection <i>NA</i>	Fee 4310 <i>9500</i>
	Permit #	Approved by ACC:	Inspection Fee Pd: <i>NA</i>	ACLS <input checked="" type="checkbox"/>
	Issue Date:	Temp # <i>NA</i>	ASA 3/4? <i>NO</i>	Form A/B
	Brd Approved:	T. Issue Date: <i>NA</i>	Pediatric? <i>NO</i>	Peer Eval

* joining previously-inspected facility

Name of Applicant Brian A. Prudent

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:
 Postgraduate Residency Program Continuing Education Program Other Board-approved program, specify:

Name of Training Program: <u>University of Puerto Rico</u>	Address: <u>Medical Science Campus</u>	City: <u>San Juan</u>	State: <u>PR</u>
Type of Experience: <u>Oral maxillofacial Residency course (TATUM Institute - international)</u>			
Length of Training: <u>10 month</u>	Date(s) Completed: <u>June 5, 2010</u>		
Number of Patient Contact Hours: <u>+100</u>	Total Number of Supervised Sedation Cases: <u>48</u>		

- 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): IL 137.000803
- 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 anti-anxiety 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- Benadryl
IV- Fentanyl
IV- Versed
Nitrous oxide

Name of Applicant Brian A. Prudent Facility Address 666 Coras Blvd. Dubuque

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:
Alecia OKey	Q 11022	2/14	2/16
Megan Timmerman	Q 10498	2/14	2/16
Jami Roth	Q 11511	2/14	2/16
Stephanie Ingles	03119	2/14	2/16
Sarah Leslein	02941	2/14	2/16
Tamara Miller-Schultz	04137	2/14	2/16
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:
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

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

N/A
N/A

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Illinois COUNTY: Rock Island

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.

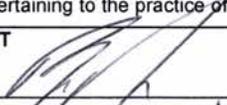
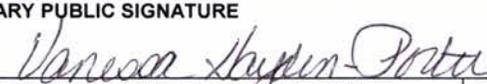
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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 OFFICIAL SEAL VANESSA HAYDEN-PORTER NOTARY PUBLIC - STATE OF ILLINOIS MY COMMISSION EXPIRES: 10/14/16	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>16th</u> DAY OF <u>April</u> , YEAR <u>2014</u>	
	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Vanessa Hayden-Porter</u>	MY COMMISSION EXPIRES: <u>10/14/2016</u>

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS
Provider



Brian Prudent

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.

02/14/2013

Issue Date

February 2015

Recommended Renewal Date

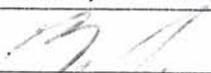
ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name **GMC - Illini** TC ID# **IL 01821**

TC Info **Silvis, IL 61282** 309-281-5092

Course Location **Davenport**

Instructor Name **Beth Cetanyan** Inst ID# **05060081985**

Holder's Signature 

Search DDS/DMD Programs

Search DDS/DMD Programs

Search Advanced Programs

Search Dental Assisting, Hygiene and Lab Technology Programs

Accreditation Notices

Accreditation Status Definitions

DDS/DMD Programs - U.S.

[Canadian Programs](#)

Below is a listing of all accredited dental education programs in the United States. Graduates receive either a DDS or DMD degree. Questions related to admission's criteria and application process should be directed to the dental school. The information includes web and mailing address, on-site evaluation years and current accreditation status.

AL

University of Alabama School of Dentistry at UAB

1530 3rd Avenue S.

SDB 406

Birmingham 35294-0007

Dean: Dr. Michael S. Reddy

Phone: (205) 934-4720

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2014

Last Accreditation Visit: 2007

www.dental.uab.edu

AZ

Midwestern University College of Dental Medicine- Arizona

19555 North 59th Avenue

Glendale 85308

Dean: Dr. Russell O. Gilpatrick

Phone: 623.572.3800

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2019

Last Accreditation Visit: 2012

www.midwestern.edu/Programs_and_Admission/AZ_Dental_Medicine.html

AZ

A.T. Still University Arizona School of Dentistry and Oral Health

5850 East Still Circle

Mesa 85206

Dean: Dr. Jack Dillenberg

Phone: 480-219-6081 dean

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2014

Last Accreditation Visit: 2007

www.atsu.edu/asdoh

CA

Loma Linda University School of Dentistry

11092 Anderson St.

Loma Linda 92350

Dean: Dr. Ronald J. Dailey

Phone: 909.558.4683

Next Accreditation Visit: 2020

Last Accreditation Visit: 2013

www.dent.ohio-state.edu

OK

University of Oklahoma College of Dentistry

1201 N. Stonewall Avenue

Oklahoma City 73117

Dean: Dr. Stephen Kent Young

Phone: (405) 271-5444

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2015

Last Accreditation Visit: 2008

dentistry.ouhsc.edu

OR

Oregon Health and Science University School of Dentistry

611 SW Campus Drive

Portland 97239

Dean: Dr. Phillip T. Marucha

Phone: 503-494-8801

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2016

Last Accreditation Visit: 2009

www.ohsu.edu/sod/admissions

PA

Temple University The Maurice H. Kornberg School of Dentistry

3223 North Broad Street

Philadelphia 19140

Dean: Dr. Amid I. Ismail

Phone: 215-707-2799

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2018

Last Accreditation Visit: 2011

www.temple.edu/dentistry

PA

University of Pennsylvania School of Dental Medicine

240 South 40th Street;

Robert Shattner Center

Philadelphia 19104-6030

Dean: Dr. Denis F. Kinane

Phone: (215) 898-1038

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2014

Last Accreditation Visit: 2007

www.dental.upenn.edu

PA

University of Pittsburgh School of Dental Medicine

3501 Terrace Street

Pittsburgh 15261

Dean: Dr. Thomas W. Braun

Phone: (412) 648-1938

Accreditation Status: Approval without Reporting Requirements

Next Accreditation Visit: 2017

Last Accreditation Visit: 2010

www.dental.pitt.edu

PR

University of Puerto Rico School of Dental Medicine

Medical Sciences Campus

University Of Puerto Rico

Medical Sciences Campus
School Of Dental Medicine
Office Of The Assistant Dean Of Research

Certifies That

Brian Anthony Prudent, DMD

*Has Successfully Completed The 400 Hour
Continuing Education Course*

*A Comprehensive Training Program On Oral
Rehabilitation And Implant Dentistry*

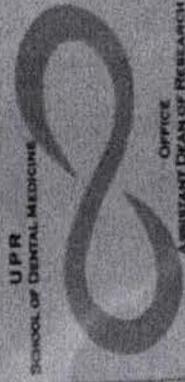
Issued in San Juan, Puerto Rico, June 5, 2010



*The Advanced Dental Implant Institute
Tatum Institute-International
Puerto Rico | England*

J. E. P.

*José E. Peboza, D.M.D., M.Sc.
Program Director*



*School of Dental Medicine,
Medical Sciences Campus,
University of Puerto Rico*

Augusto R. Elias

*Augusto Elias, D.M.D., M.D.
Assistant Dean of Research*



IOWA DENTAL BOARD
 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
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RECEIVED

JUN 17 2014

PLEASE TYPE OR PRINT LEGIBLY IN INK.

IOWA DENTAL BOARD

**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):

BRIAN Anthony Prudent DMD

MAILING ADDRESS:

666 LOHAS BLVD.

CITY: Dubuque **STATE:** Ia **ZIP CODE:** 52001 **PHONE:** 563-582-0117

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:

[Signature]

DATE:

4-16-14

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

Jose E. Pedroza DMD, MSc.

NAME AND LOCATION OF PROGRAM:

The Puerto Rico Maxicourse Program and Clinical Residency in Implant Dentistry

PHONE:

787-781-1831
Guaynabo, P.R.

FAX: 787-781-5030

E-MAIL: miriam.montes

WEB ADDRESS: www.theadii.com

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/DAY/YR): Sep 24, 2009

TO (MO/DAY/YR): June 5, 2010

DATE PROGRAM COMPLETED: June 4, 2010

- 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:

[Signature]

DATE:

APRIL 22, 2014

Course Venue

- Anatomic sessions will take place in the facilities of the School of Medicine of the University of Puerto Rico, San Juan PR.
- Most Didactic Sessions will be held at the conference room of The Advanced Dental Implant Institute, San Juan PR.
- Live patients surgeries will be held at the Centro de Reconstrucción Oral e Implantes, San Juan PR.

Fees and Funding

The total cost of tuition and training is \$19,950.00. This includes \$2,000 for required supplies, instruments and equipment, and an extensive CD and videotaped surgeries.

A non-refundable deposit of \$2,000 (due in or before August 19, 2014) will secure your place for the year-long course. For the participants' convenience, we are offering a five equal installment option for the balance of the Course fees. The first installment is due at the commencement of the training on September. The remainder installment payments are due by October and November 2014, and January and March, 2015.

Refunds and Cancellations Policies

Deposits and Tuition payments are non-refundable and non-transferable.

Continuing Education Units

This Program provides over 400 hours of continuing education credits. The Academy of General Dentistry is a Recognized Provider.



Registration

*For more information and registration,
please call, write or visit us at*

www.theadii.com

Mrs. Miriam Montes
Program Coordinator

(787) 642-2708

miriam.montes59@yahoo.com

Puerto Rico Maxicourse®

THE
ADVANCED DENTAL IMPLANT
INSTITUTE

Presents:

The Puerto Rico Maxicourse® Program and Clinical Residency in Implant Dentistry

San Juan • Puerto Rico
Sept 2014 to June 2015

mentorship

Get a condensed and robust "fellowship" program under the leading team in Implant Dentistry. Dr. Tatum and Dr. Pedroza.



training

Experience advanced concepts on oral implantology first hand, and participate in live surgeries which will increase your surgical acumen in leaps and bounds.



research

Improve your understanding and knowledge of the current literature in implant dentistry.



Co-sponsor

AAID
AMERICAN ACADEMY
OF IMPLANT DENTISTRY

Testimonials

"I can say that this 400 hour course effectively provides the skills and knowledge necessary in this multidisciplinary field of Dentistry. The Faculty's intensive mentorship is a very important aspect of this Course. I recommend it very highly".

Rafael I. Aponte, DDS • San Juan, PR

"This Course for myself as an intermediate level implantologist gives me 'pearls by the minute' and a paradigm shift in my clinical application immediately. The discussion of treatment planning gives you a vast jump in utilizing the traditional and advanced concepts that Dr. Tatum provides in his treatment armamentarium".

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Christopher H. Hughes, DDS • Herrin, Ill

"The Puerto Rico MaxiCourse with Dr. Tatum and Dr. Pedroza is an excellent experience that I highly recommend. It has expanded my surgical skills and improved my ability to treat complex situations. The course is distinguished by the practical surgical orientation. Participants see many different surgical procedures and management of complications. Thanks to the course I feel comfortable doing bone grafting procedures and posterior mandibular bone manipulation in my office that I had not done before. I appreciate the camaraderie with all involved in the course."

Dr. Greg Cyra • WS

About our Sponsors



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The mission of the FILIUS Institute is to improve the quality of life of Hispanic individuals with very special life conditions within communities in Puerto Rico, the United States and Latin America. This will be accomplished through research projects, faculty and

student education, training of professionals, intramural practice, policy analysis, service system changes, and science based knowledge and technology transfer and community interventions towards better health, education, rehabilitation and community strengthening.

THE PUERTO RICO MAXICOURSE® PROGRAM AND CLINICAL RESIDENCY IN IMPLANT DENTISTRY

Course Outline

with New Schedule Sept 2014 up to June 2015

Session 1: Sept. 11-14, 2014 (Thursday to Sunday)

• Laying the Foundations

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis,

Session 2: Oct. 11-15, 2014 (Saturday to Wednesday)

• Intravenous Conscious Sedation, Soft Tissue Management, Sinus Graft Surgeries - Dr. V. Cardona, Dr. H. Tatum, Dr. Pedroza, Dr. R. Pérez, Dr. R. Giacosis

Session 3: Nov. 10-15, 2014 (Monday to Saturday)

• Sedation (Part II) and Basic Surgical Techniques

Dr. Daniel Becker, Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis

Session 4: Dec. 3-7, 2014 (Wednesday to Sunday)

• Principles of Bone Grafting and Segmental Osteotomies

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Pérez, Dr. R. Giacosis,

Session 5: Jan. 10-14, 2015 (Wednesday to Sunday)

• Orofacial Applied Anatomy Related to Oral Implant Dentistry - Dr. W. Shankland, Dr. J. Pedroza, Dr. R. Giacosis

Session 6: Feb. 4-8, 2015 (Wednesday to Sunday)

• Maxillary Sinus Augmentation Techniques

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis

Session 7: Mar. 4-8, 2015 (Wednesday to Sunday)

• Non Root Form Implants

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis

Session 8: Apr. 8-12, 2015 (Wednesday to Sunday)

• Occlusal Considerations and Advanced Restorative Techniques - Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis,

Session 9: May. 6-10, 2015 (Wednesday to Sunday)

• Advanced Surgical and Prosthetic Cases

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Giacosis

Session 10: Jun. 3-7, 2015 (Wednesday to Saturday)

• Bringing It All Together

Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Aponte

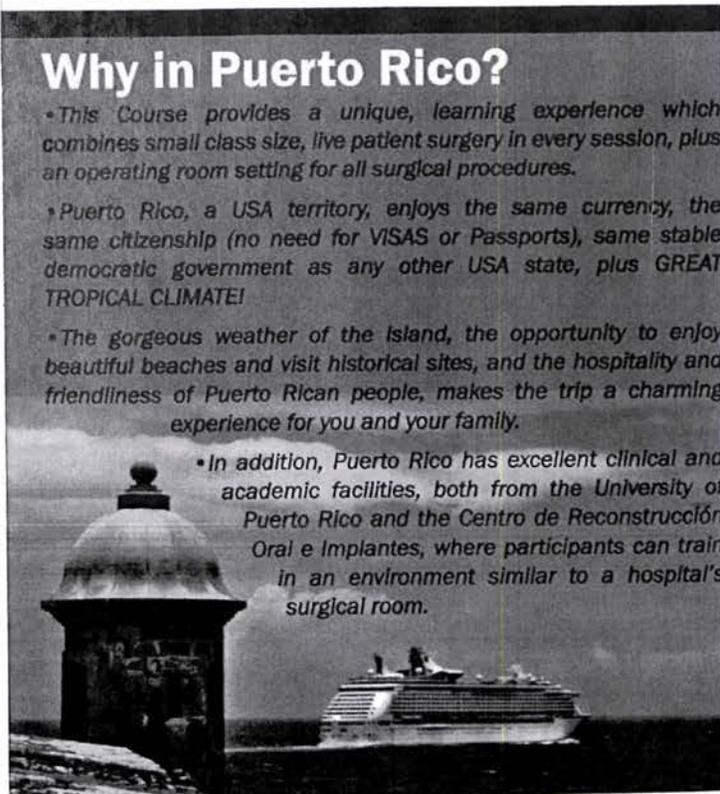
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• The gorgeous weather of the Island, the opportunity to enjoy beautiful beaches and visit historical sites, and the hospitality and friendliness of Puerto Rican people, makes the trip a charming experience for you and your family.

• In addition, Puerto Rico has excellent clinical and academic facilities, both from the University of Puerto Rico and the Centro de Reconstrucción Oral e Implantes, where participants can train in an environment similar to a hospital's surgical room.



The Advanced Dental Implant Institute and Tatum Institute International have the pleasure of announcing the **The Puerto Rico MaxiCourse® Program and Clinical Residency in Implant Dentistry**, which will consist in over 400 hours of continuing education, and will span from September 2014 up to June 2015. The course is presented in 10 sessions; however, due to the nature of the program, space availability is limited. Sessions will combine lectures with lab exercises and surgical demonstrations.

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Review of his complete curriculum vitae requires considerable time. In summary he is the former President of both the American Academy of Implant Dentistry as well as the American Board of Oral Implantology, and has been a member and leader of many professional organizations. Dr. Tatum is also a recipient of the Aaron Gershkoff and Isiah Lew research awards, and in recognition of his important contributions to the healing sciences, in 2004 he was awarded the Chevalier of the French Legion of Honor by the former French President Jacques Chirac. However, Dr. Tatum's most important contributions have been the gifts graciously given to the profession and his students as he devoted an entire career to advancing the discipline of implant dentistry and teaching others the techniques he developed and perfected. The lives of many patients and dentists throughout the world have been significantly enriched as a result of Dr. Hilt Tatum's devoted efforts to improve the art and science of Implant Dentistry.

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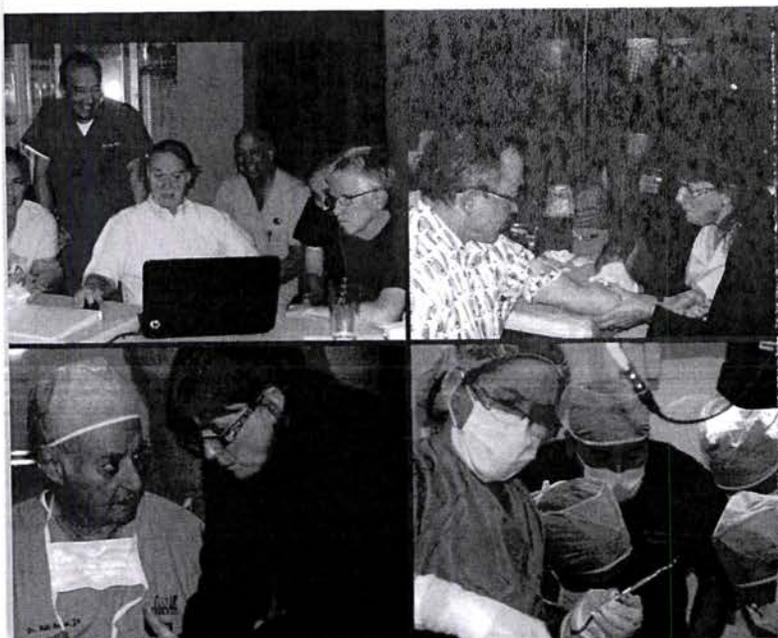
"Twenty one years after I placed my first implant, I am thrilled to pass on the knowledge and experience that granted me the opportunity of a specialized practice, and the amazing responsibility of offering my patients revolutionary and life changing dental choices".

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And Our Team of Oral Surgeons, Restorative Dentists and Clinical Researchers

Hilt Tatum, Jr., DDS	Augusto Elías, DMD; MSD
José E. Pedroza, DMD; MSc	Ramón Pérez, DMD (Maxillofacial Surgeon)
Robert Giacole, PhD	Rafael Aponte, DDS (Maxillofacial Surgeon)
Daniel Becker, DDS (Pharmacology & IV Sedation)	Wesley Shankland, DDS; PhD
Victor Cardona, MD (Anesthesiologist & Internal Medicine)	Albert Bläsius, DMD (Assistant Professor)
Aleida Burés, DMD (Graduate Assistant)	José A. Román, DMD (Graduate Assistant)



Course Outline

- The scope of Implantology
- Apply basic science to Implant Dentistry
- Medical considerations and patient selection
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- Basic surgical and restorative concepts
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- Root form implant techniques and bone expansion techniques
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- Principles of clinical governance in implantology
- Restorative and aesthetic enhancement techniques
- Maintenance in Implantology
- Management of surgical and prosthetic complications
- Research applied to Implant Dentistry

Participants will be able to experience...

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training

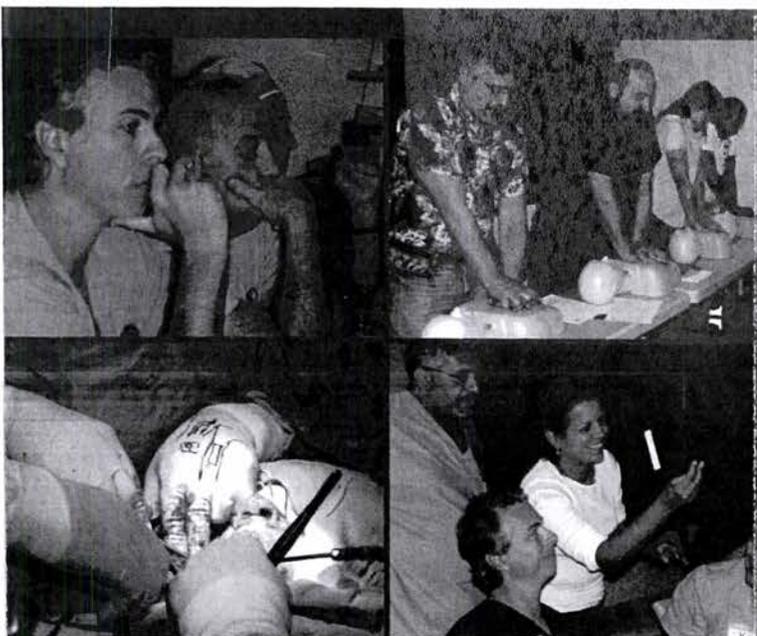
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research

Techniques taught at The Advanced Dental Implant Institute are based on research and scientific principles. Students are trained to interpret and evaluate research literature, which helps them to clearly understand and analyze new information once they have completed the Course.

Sessions will include:

- An applied head and neck anatomy dissection related to Implant Dentistry
- Training in oral and intravenous sedation techniques
- Opportunity to develop clinical research skills and write a scientific paper.
- Opportunity to bring your own patients and perform surgical procedures under the mentor's close supervision.
- An intensive learning experience with repetitive training concepts similar to a hospital training program
- Lectures, laboratory exercises, surgical demonstrations and supervised hands-on surgical sessions used to develop skills for each procedure
- Closed circuit T.V. coverage of live procedures relayed into the main lecture room to enable all participants to observe surgical sessions close-up



Course Venue

• *Anatomic sessions will take place in the facilities of the School of Dental Medicine of the University of Puerto Rico, San Juan, PR.*

• *Most Didactic Sessions will be held at the conference room of The Advanced Dental Implant Institute, San Juan PR.*

• *Live patients surgeries will be held at the Centro de Reconstrucción Oral e Implantes, San Juan, PR.*

Fees and Funding

The total cost of tuition and training is \$19,950.00. This includes \$2,000 for required supplies, instruments and equipment, and an extensive CD.

A Non-Refundable deposit of \$750.00 (due in or before September 3, 2009) will secure your place for the year-long course. For the participants' convenience, we are offering a five equal installment option for the balance of the Course fees. The first installment is due at the commencement of the training on September. The remainder installment payments are due by October and November 2009, and January and March, 2010.

Refunds and Cancellations Policies

Deposits and Tuition payments are Non-Refundable.

Continuing Education Units

This course provides over 360 hours of continuing education credit. The University of Puerto Rico is an ADA CERP Recognized Provider.

ADA CERP® | Continuing Education Recognition Program

Registration

For more information and registration, please call or write us at:

Dr. José E. Pedroza

(787) 644-3890 • jose.pedroza@upr.edu

Tatum Surgical

(888) 360-5550 • tatumimplants@verizon.net,

www.tatumsurgical.com

Mrs. Miriam Montes

(787) 642-2708 • mimontesmock@yahoo.com

The AAID MaxiCourse®

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IOWA DENTAL BOARD

A COMPREHENSIVE
TRAINING PROGRAM ON
ORAL REHABILITATION AND
IMPLANT DENTISTRY

San Juan • Puerto Rico • 2009 - 2010

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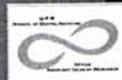


research

Improve your understanding and knowledge of the current literature in Implant dentistry.



Presented by:



MENTORSHIP • TRAINING • RESEARCH

Testimonials

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Office of the Assistant Dean of Research
School of Dental Medicine
Medical Sciences Campus
University of Puerto Rico

Co-Sponsors



Founded in 1951, the American Academy of Implant Dentistry is the oldest dental implant organization in the world. Its mission is to advance the practice of implant dentistry through education, credentialing, and advocacy on behalf of patients and practitioners. The AAID promotes both the individual and team approaches to implant dentistry.

A Comprehensive Training Program on Oral Rehabilitation and Implant Dentistry

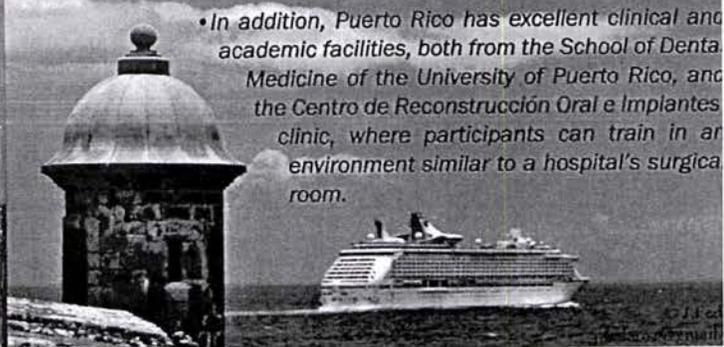
Course Outline with New Schedule

- Session 1: Sept. 24-27, 2009** (Thursday through Sunday)
• Laying the Foundations - Dr. H. Tatum, Dr. J. Pedroza
- Session 2: Oct. 19-24, 2009** (Monday through Saturday)
• Intravenous Conscious Sedation, Soft Tissue Management, Sinus Graft Surgeries - Dr. Víctor Cardona, Dr. R. Pérez, Dr. H. Tatum, Dr. J. Pedroza
- Session 3: Nov. 4-8, 2009** (Wednesday through Sunday)
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Dr. D. Becker, Dr. H. Tatum, Dr. J. Pedroza
- Session 4: Dec. 2-6, 2009** (Wednesday through Sunday)
• Principles of Bone Grafting and Segmental Osteotomy
Dr. H. Tatum, Dr. J. Pedroza, Dr. R. Pérez
- Session 5: Jan. 13-17, 2010** (Wednesday through Sunday)
• Orofacial Applied Anatomy Related to Oral Implant Dentistry - Anatomy Department, UPR, Dr. J. Pedroza
- Session 6: Feb. 3-7, 2010** (Wednesday through Sunday)
• Maxillary Sinus Augmentation Techniques
Dr. H. Tatum, Dr. J. Pedroza
- Session 7: Mar. 3-7, 2010** (Wednesday through Sunday)
• Non Root Form Implants - Dr. H. Tatum, Dr. J. Pedroza
- Session 8: Apr. 7-11, 2010** (Wednesday through Sunday)
• Occlusal Considerations and Advanced Restorative Techniques - Dr. H. Tatum, Dr. J. Pedroza, Dr. A. Blanco
- Session 9: May 5-9, 2010** (Wednesday through Sunday)
• Advanced Surgical and Prosthetic Cases
Dr. H. Tatum, Dr. J. Pedroza
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José E. Pedroza, DMD; MSc	Richard Borgner, DDS
Arturo Blanco Plaud, DMD (Prosthodontist)	Ramón Pérez, DMD (Maxillofacial Surgeon)
Daniel Becker, DDS (Pharmacology & IV Sedation)	Javier Arbona, DMD (Periodontist)
Victor Cardona, MD (Anesthesiologist & Internal Medicine)	Rafael Aponte, DDS (Oral Surgeon)
Ben Aghabelgi, DDS; MSc; PhD (Maxillofacial Surgeon)	

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Search DDS/DMD Programs - American Dental Association - ADA.org
 Sciences Campus
 Main Building-Office #A103B, 1st Floor
 San Juan 00936-5067
 Dean: Dr. Noel J. Aymat
 Phone: 787-758-2525
 Accreditation Status: Approval with Reporting Requirements
 Next Accreditation Visit: 2020
 Last Accreditation Visit: 2013
dental.rcm.upr.edu/

SC**Medical University of South Carolina James B. Edwards College of Dental Medicine**

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 PO Box 250507
 Charleston 29425-5070
 Dean: Dr. John J. Sanders
 Phone: (843) 792-3811
 Accreditation Status: Approval without Reporting Requirements
 Next Accreditation Visit: 2017
 Last Accreditation Visit: 2010
www.musc.edu/dentistry/

TN**University of Tennessee College of Dentistry**

University of Tennessee Health Science Ctr;
 875 Union Avenue
 Memphis 38163
 Dean: Dr. Timothy L. Hottel
 Phone: (901) 448-6202
 Accreditation Status: Approval without Reporting Requirements
 Next Accreditation Visit: 2017
 Last Accreditation Visit: 2010
www.uthsc.edu/dentistry/

TN**Meharry Medical College School of Dentistry**

1005 D.B. Todd Blvd.
 Nashville 37208
 Dean: Dr. Cherae Farmer-Dixon
 Phone: 615.327.6784
 Accreditation Status: Approval with Reporting Requirements
 Next Accreditation Visit: 2014
 Last Accreditation Visit: 2013
www.mmc.edu/education/dentistry/

TX**Texas A&M University Baylor College of Dentistry**

3302 Gaston Avenue
 Dallas 75246
 Dean: Dr. Lawrence E Wolinsky
 Phone: (214) 828-8201
 Accreditation Status: Approval without Reporting Requirements
 Next Accreditation Visit: 2018
 Last Accreditation Visit: 2011
www.tambcd.edu

TX**The University of Texas School of Dentistry at Houston**

7500 Cambridge Street
 Houston 77054
 Dean: Dr. John A. Valenza
 Phone: (713) 486-4021
 Accreditation Status: Approval without Reporting Requirements

HEALTHCARE PROVIDER

Healthcare
Provider



JAMI ROTH

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.

FEBRUARY 2014

Issue Date

FEBRUARY 2016

Recommended Renewal Date

PEEL
HERE

HEALTHCARE PROVIDER

Training Center Name NORTHEAST IOWA TC ID # IA05133

TC Info Dubuque, IA 52001 563.557.8271

Course Location DR MURRAY'S OFFICE

Instructor Name ARENSDORF Inst ID # 10110055307

Holder's Signature

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90-1801 3/11

90-1801 3/11

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Holder's Signature

Instructor Name ARENSDORF

Inst ID # 10110055307

Course Location DR MURRAY'S OFFICE

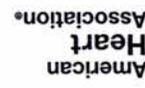
TC Info Dubuque, IA 52001 563.557.8271

Training Center Name NORTHEAST IOWA TC ID # IA05133

Issue Date FEBRUARY 2014

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.

AIMEE EIGENBERGER



Healthcare
Provider

PEEL
HERE

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

HEALTHCARE PROVIDER

Healthcare
Provider



Training Center Name **NORTHEAST IOWA** TC ID # **IA05133**

TC Info **Dubuque, IA** **52001** **563.557.8271**

Course Location **DR MURRAY'S OFFICE**

Instructor Name **ARENSDORF** Inst ID # **10110055307**

Holder's Signature

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HERE

ALICIA OKEY

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.

FEBRUARY 2014

FEBRUARY 2016

Issue Date

Recommended Renewal Date

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90-1801 3/11

HEALTHCARE PROVIDER

Training Center Name **NORTHEAST IOWA** TC ID # **IA05133**

TC Info **Dubuque, IA** **52001** **563.557.8271**

Course Location **DR MURRAY'S OFFICE**

Instructor Name **ARENSDORF** Inst ID # **10110055307**

Holder's Signature

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HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association

MEGAN TIMMERMAN

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.

Issue Date **FEBRUARY 2014**

Recommended Renewal Date **FEBRUARY 2016**

HEALTHCARE PROVIDER

Healthcare Provider



HEALTHCARE PROVIDER

Training Center Name NORTHEAST IOWA TC ID # IA05133

TC Info City: Dubuque, IA 52001 TC 563.557.8271

Course Location DR MURRAY'S OFFICE

Instructor Name ARENSDORF Inst ID # 10110055307

Holder's Signature

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PEEL HERE

SARAH LESLEIN

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.

FEBRUARY 2014

FEBRUARY 2016

Issue Date

Recommended Renewal Date

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90-1801 3/11

HEALTHCARE PROVIDER

Healthcare Provider



HEALTHCARE PROVIDER

Training Center Name NORTHEAST IOWA TC ID # IA05133

TC Info City: Dubuque, IA 52001 TC 563.557.8271

Course Location DR MURRAY'S OFFICE

Instructor Name ARENSDORF Inst ID # 10110055307

Holder's Signature

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PEEL HERE

MARY BETH SMITH

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.

FEBRUARY 2014

FEBRUARY 2016

Issue Date

Recommended Renewal Date

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90-1801 3/11

HEALTHCARE PROVIDER

Healthcare
Provider



TAMARA MILLER-SCHULTZ

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.

FEBRUARY 2014

FEBRUARY 2016

Issue Date

Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name NORTHEAST IOWA TC ID # IA05133

TC Info ^{City}Dubuque, IA 52001 ^{TC}563.557.8271

Course Location DR MURRAY'S OFFICE

Instructor Name ARENSDORF Inst ID # 10110055307

Holder's Signature

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90-1801 3/11

HEALTHCARE PROVIDER

Healthcare
Provider



STEPHANIE INGLES

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.

FEBRUARY 2014

FEBRUARY 2016

Issue Date

Recommended Renewal Date

HEALTHCARE PROVIDER

Training Center Name NORTHEAST IOWA TC ID # IA05133

TC Info ^{City}Dubuque, IA 52001 ^{TC}563.557.8271

Course Location DR MURRAY'S OFFICE

Instructor Name ARENSDORF Inst ID # 10110055307

Holder's Signature

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90-1801 3/11



Illinois Department of Financial and Professional Regulation
Division of Professional Regulation

Pat Quinn
 Governor

RECEIVED

JUN 05 2014

Manuel Flores
 Acting Secretary

IOWA DENTAL BOARD

Jay Stewart
 Director
 Division of Professional Regulation

CERTIFICATION OF LICENSURE

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

Licensee: BRIAN ANTHONY PRUDENT DMD
 License Number: 137.000803
 Profession: DENTAL SEDATION PERMIT
 Date of Issuance: 11/17/2010
 Expiration Date: 09/30/2015
 License Status: ACTIVE
 License Method: NON-EXAM
 Disciplinary History: Has not been disciplined

This document is a certified copy of the records maintained and kept by this Department in the regular course of business as of today's date.



[Handwritten Signature]
 #0

Jay Stewart
 Director

Division of Professional Regulation

May 30, 2014
 Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

State of Illinois
Department of Financial and Professional Regulation
Division of Professional Regulation
320 W. Washington St., 3rd Floor, Springfield, IL 62786

ATTENTION

The attached document is an official
State of Illinois
Licensure certification/verification, prepared by the
Illinois Department of Financial and Professional Regulation.

This certifies that the named individual has met all of the
education/examination requirements by law in order to
receive the credential that is being verified.

The Department has eliminated specific
examination status from certifications/verifications
of licensure, as passage of an examination is a
requirement for licensure.

This information is the **ONLY** certification
information provided by this Department. If other information is
needed, it **MUST** be obtained from the applicant.

THANK YOU



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)

Richtsmeier, Brad, Ernst

Other Names Used: (e.g. Maiden)

Home E-mail:

brad.richtsmeier@gmail.com

Work E-mail:

bradr@lifepointdental.com

Home Address:

1409 Valleyview Ct

City:

Cumming

State:

IA

Zip:

50061

Home Phone:

515-783-6822

License Number:

08472

Issue Date:

6/25/07

Expiration Date:

8/31/14

Type of Practice:

General Dentistry

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

Principal Office Address:

1903 EP True Pkwy #301

City:

West Des Moines

Zip:

50265

Phone:

515.224.1618

Office Hours/Days:

M-Th
7:30 - 5:00

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

3/7 - 3/23 2014

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

3/7 - 3/23 2014

Moderate sedation experience at graduate level, approved by the Board

Completed

SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

ACLS - Timpanogas Regional Hospital

Location:

Salt Lake City, Utah

Date of Course:

3/14/14

Date Certification Expires:

3/2016

Office Use	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

↓ 1250
 \$ 500
 Lifepoint.

Name of Applicant

Brad Richtsmeier

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program:

Conscious Sedation Consulting

Address:

6360 South 3000 East

City:

Salt Lake City

State:

UT

Type of Experience:

Didactic and Clinical

Length of Training:

9 Days

Date(s) Completed: 2014

3/7, 3/8, 3/9, 3/14, 3/15, 3/16, 3/21, 3/22, 3/23

Number of Patient Contact Hours:

30

Total Number of Supervised Sedation Cases:

23

- 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.

I plan to use midazolam and fentanyl to achieve moderate sedation. I also may use N₂O during the insertion of the IV for anxious patients. I will also utilize local anesthetics in the routine manner for dentistry. Nitrous oxide and local anesthetics aside, I plan to administer all sedatives or opioid analgesics via IV. No oral sedation is planned.

Name of Applicant

Brad Richtsmeier

Facility Address

1903 EP Trne Pkwy WDM, IA

50265

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:
Lacey Gehringer	Q09418	2/7/13	2/15
Stacy Cook	Q09968	5/11/12	5/14
Aubrey McDougal	Q12033	8/12	8/14
Jessica McCoId	R11413	4/13	4/15
Jennifer Pierce	RDH-02682	5/11/12	5/14
Ida Welsch	RDH-02087	5/11/12	5/14
Samantha Webb	RDH-03985	8/24/12	8/14
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)?
 - 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: Madison

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.

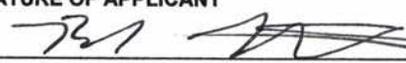
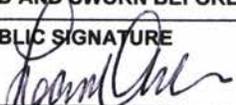
I certify that I am trained and capable of administering Advanced Cardiac Life Support and that I employ sufficient auxiliary personnel to assist in monitoring a patient under moderate sedation. Such personnel are trained in and capable of monitoring vital signs, assisting in emergency procedures, and 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 	
	SUBSCRIBED AND SWORN BEFORE ME, THIS <u>15TH</u> DAY OF <u>APRIL</u> , YEAR <u>2014</u>	
NOTARY SEAL <u>SEE CERTIFICATE w/ SEAL</u>	NOTARY PUBLIC SIGNATURE 	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>LEANN SOU</u>	MY COMMISSION EXPIRES: <u>4-11-2017</u>

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS
Provider



Brad Richtsmeier

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.

14 Mar 2014
Issue Date

Mar 2016
Recommended Renewal Date

Training Center Name Timpanogas Regional Hospital TC ID # UT05647

TC Info Orem, UT 84058

Course Location UEMTC 801-562-2663

Instructor Name Arik Campbell 02120080437st. ID #

Holder's Signature *BR* *MA*

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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>

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):

Brad Ernst Richtsmeier, DDS

MAILING ADDRESS:

1903 E.P. Trone Pkwy # 301

CITY:

West Des Moines

STATE:

Iowa

ZIP CODE:

50265

PHONE:

515-224-1618

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:

[Handwritten Signature]

DATE:

3/25/14

SECTION 2 - TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

Randy Pigg

Conscious Sedation Consulting

NAME AND LOCATION OF PROGRAM:

IV Sedation Training Program for Dentists
SALT LAKE CITY, UT

PHONE:

888-581-4448

FAX:

E-MAIL: bee@thornd.com

WEB ADDRESS:

www.SedationConsulting.com

DATES APPLICANT PARTICIPATED IN PROGRAM >

FROM (MO/DAY/YR):

03/07/2014

TO (MO/DAY/YR):

03/23/14

DATE PROGRAM COMPLETED:

03/23/14

- 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:

[Handwritten Signature]

DATE:

3/25/2014



RECEIVED

MAR 28 2014
www.SedationConsulting.com

IOWA DENTAL BOARD

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

March 25, 2014

Dear Board Members,

This letter is to confirm that **Brad E. Richtsmeier**, DDS License # DDS-08472 recently successfully completed 100 hours of continuing education while participating in a comprehensive post doctoral training program in the administration of parenteral conscious (moderate) sedation, which is consistent to *The Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*. As adopted by the October 2007 American Dental Association (ADA) House of Delegates.

This program was presented March 7 - 23, 2014 in Salt Lake City, UT.

Documented competency has been demonstrated with successful completion of at least 60 hours of didactic education and the personal administration of parenteral sedation to at least 20 dental patients while being supervised by an anesthesia provider. In addition, a hands on skills lab in airway management was completed utilizing simulation with multiple airway devices including advanced airway devices.

If you have any questions or need any additional information please do not hesitate to contact me.

Thank you,

Randy Pigg, BSN
CEO, Conscious Sedation Consulting
888-581-4448
randy@sedationconsulting.com

79 Hubble, Suite 102
O'Fallon, MO 63368
888.581.4448

"Creating a culture of safety through education"

**Conscious Sedation Consulting, LLC verifies that
Brad Richtsmeier, DDS**

Has successfully completed 100 hours of continuing education and formal training, including 60 hours of didactic instruction as well as personal administration, utilizing single or multiple agents of parenteral sedation to at least 20 patients while supervised, for a variety of dental procedures.

There has been documented understanding and demonstrated competency of:

- 1) Principles ensuring patient safety**
- 2) Goals and risks of sedation**
- 3) The continuum of sedation**
- 4) Patient pre-sedation assessment**
- 5) Pertinent pharmacology and physiology of sedative agents**
- 6) Intra-procedure patient management and monitoring**
- 7) Titration to effect techniques**
- 8) Administration of sedative agent combinations**
- 9) Advanced techniques of airway management**
- 10) Preparedness and management of adverse events / emergencies**
- 11) Patient recovery and discharge**
- 12) State Regulations & Facility Requirements**

**March 7 - March 23, 2014 during the IV Sedation for Dentistry Training Program
Salt Lake City, UT**

This program is presented in compliance with the Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students by the American Dental Association.

ADA CERP® | Continuing Education
Recognition Program

Conscious Sedation Consulting is an approved provider of continuing education by the ADA CERP. *ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.*



Conscious Sedation Consulting LLC is designated as an Approved PACE Program Provider by the Academy of General Dentistry. *The formal continuing dental education programs of this program provider are accepted by the AGD for Fellowship, Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from January 1, 2013 to December 31, 2015*



**Randy Pigg, CEO
Conscious Sedation Consulting**

RECEIVED

APR 18 2014

IOWA DENTAL BOARD

4/16/14

Anesthesia Credentials Committee,

I have enclosed my application for a moderate sedation permit. My program director for the continuing education course sent a letter to the board verifying my completion of the program and its content. If you are not in receipt of this letter, or if additional information is needed, please let me know.

Thank you for your consideration,



Brad Richtsmeier, DDS