



STATE OF IOWA

IOWA DENTAL BOARD

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

PHIL MCCOLLUM
INTERIM DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

September 18, 2014, 12:00 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. APPLICATION FOR GENERAL ANESTHESIA PERMIT**
 - a. Justin Nagel, D.D.S.
- III. OPPORTUNITY FOR PUBLIC COMMENT**
- IV. 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>

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AUG 21 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)

Nagel, Justin Wayne

Other Names Used: (e.g. Maiden)

N/A

Home E-mail:

jwnagel29@gmail.com

Work E-mail:

jnagel@greatriveroms.com

Home Address:

5706 Grosseto Dr

City:

Frisco

State:

TX

Zip:

75034

Home Phone:

319-331-9556

License Number:

Issue Date:

Expiration Date:

Type of Practice:

Oral Surgery

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

Principal Office Address:

100 Bryant St.

City:

Dubuque

Zip:

52003

Phone:

563-557-1440

Office Hours/Days:

8-12 sat. 8-5 M-F

Other Office Address:

511 S. 4th St.

City:

Clinton

Zip:

52732

Phone:

563-259-4349

Office Hours/Days:

9-3 M, T, Th, Fr.

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

✓

7/2008 - 6/2012

Formal training in airway management

✓

7/2008 - 6/2012

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

✓

7/2008 - 6/2012

SECTION 4 - ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:

ACLS Provider Course

Location:

AMT Carrollton, TX

Date of Course:

02/2014

Date Certification Expires:

02/2016

Office Use	Lic. #	Sent to ACC:	Peer Eval:	Fee \$700 & 500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

* 1250 Arrowhead Drive Dubuque IA 52003 319-331-9556
 (Sept. 2014)

Name of Applicant Justin Wayne Nagel

SECTION 5 - DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School: <u>University of Iowa</u>	From (Mo/Yr): <u>8/2003</u>	To (Mo/Yr): <u>6/2007</u>
City, State: <u>Iowa City, Iowa</u>	Degree Received: <u>D.D.S.</u>	

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

Name of Training Program: <u>UT Southwestern Parkland Hospital</u>	Address: <u>5223 Harry Hines Blvd</u>	City: <u>Dallas</u>	State: <u>TX</u>
Phone: <u>214-645-3979</u>	Specialty: <u>Oral & Maxillofacial Surg.</u>	From (Mo/Yr): <u>7/2007</u>	To (Mo/Yr): <u>6/2008</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 Minnesota</u>	Address: <u>7-174 Moos Tower 515 Delaware St. SE</u>	City: <u>Minneapolis</u>	State: <u>MN</u>
Phone: <u>612-624-4435</u>	Specialty: <u>Oral & Maxillofacial Surgery</u>	From (Mo/Yr): <u>7/2008</u>	To (Mo/Yr): <u>6/2012</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>Oral Surgery Intern UT Southwestern Parkland Memorial Hospital Dallas, TX</u>	<u>07/2007</u>	<u>06/2008</u>
<u>Oral & Maxillofacial Surgery Resident University of Minnesota Minneapolis, MN</u>	<u>07/2008</u>	<u>06/2012</u>
<u>Center for Facial & Oral Surgery Private Practice Carrollton, TX</u>	<u>07/2012</u>	<u>08/2014</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): Texas Number 27866
- 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 deep sedation/general anesthesia (Midazolam, Fentanyl, Ketamine Propofol)
Inhalational anesthesia (Nitrous oxide)

GREAT RIVER OMS**Auxillary Personnel**

	<u>RN License</u>	<u>Dental Assistant #</u>	<u>BLS Cert</u>	<u>BLS Expires</u>
Kelly Bergfeld, Surgical Assisant		Q04453	Oct-13	Oct-15
Julie Betz, RN	134977	XDA-11302	Oct-13	Oct-15
Mary Beth Bowden, RN	092708	X10104	Oct-13	Oct-15
Sharon Braem, Dental Assistant		Q00443	Oct-13	Oct-15
Kristy (Breiner) DuPont, Dental Assistant		Q09197	Oct-13	Oct-15
Susan Curwen, Dental Assistant		Q02492	Oct-13	Oct-15
Mary Jo Dalen, Dental Assistant		Q00441	Oct-13	Oct-15
Alyssa Ann Danner, Dental Asst.		Q10749	Oct-13	Oct-15
Heidi (Huseman) Duehr, RN	112671	X03040	Oct-13	Oct-15
Cindy Evans, RN	089765	X06126	Oct-13	Oct-15
Susan Baskerville Gerhard, Dental Asst.		Q04357	Oct-13	Oct-15
Tanya (Harwell) Carner, Dental Assistant		Q09995	Oct-13	Oct-15
Kathy Haverland, Dental Asst		Q02604	Oct-13	Oct-15
Tanya Kluesner, RN	103610	X09448	Oct-13	Oct-15
Trisha (Losh) Reck, Dental Assistant		Q07587	Oct-13	Oct-15
Mohr. Beth, Dental Asst.		Q02389	Oct-13	Oct-15
Holly Ann O'Connell, Dental Asst.		Q10275	Oct-13	Oct-15
Kate Rahe, RN	122856	XDA-05359	Oct-13	Oct-15
Judy Zahren-Kalb, Dental Asst.		Q00676	Oct-13	Oct-15

Name of Applicant Justin Wayne Nagel Facility Address 511 S. 4th St. Clinton, 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. Attached list

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)?

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

GREAT RIVER OMS**Auxillary Personnel**

	<u>RN License</u>	<u>Dental Assistant #</u>	<u>BLS Cert</u>	<u>BLS Expires</u>
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Holly Ann O'Connell, Dental Asst.		Q10275	Oct-13	Oct-15
Kate Rahe, RN	122856	XDA-05359	Oct-13	Oct-15
Judy Zahren-Kalb, Dental Asst.		Q00676	Oct-13	Oct-15

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>Texas</u>	COUNTY: <u>Denton</u>
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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 <u>Justin Noyel, D.D.S.</u>
		SUBSCRIBED AND SWORN BEFORE ME, THIS <u>8th</u> DAY OF <u>August</u> , YEAR <u>2014</u>
		NOTARY PUBLIC SIGNATURE <u>Donna D. Robertson</u>
	NOTARY PUBLIC NAME (TYPED OR PRINTED) <u>Donna D Robertson</u>	MY COMMISSION EXPIRES: <u>April 25, 2015</u>

Training Center Name **Training Division** TC ID # **TX20766**

TC Info **Crowley, Texas 76036 817-297-4500**

Course Location **AMT**

Instructor Name **Mike Merritt** 01112240156

Holder's Signature *Justin Nagel*

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

**ACLS
Provider**



**American
Heart
Association**

Justin Nagel

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.

02/2014

Issue Date

02/2016

Recommended Renewal Date

THE UNIVERSITY OF TEXAS



SOUTHWESTERN MEDICAL CENTER AT DALLAS

This is to certify that

Justin Wayne Nagel, DDS

Has Successfully Completed an Internship in
ORAL AND MAXILLOFACIAL SURGERY

July 1, 2007 – June 30, 2008

Director
Resident Education

Chairman
Division of Oral and Maxillofacial
Surgery

University of Minnesota

The Regents of the University of Minnesota
on the recommendation of the faculty
have conferred upon

Justin Wayne Nagel

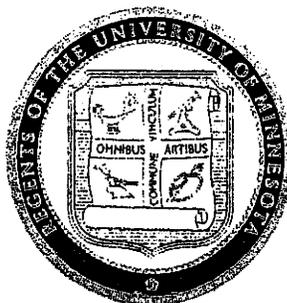
∞ the certificate of ∞

Oral & Maxillofacial Surgery

with all its privileges and obligations.

Given at Minneapolis, in the State of Minnesota,
this twenty-ninth day of June two thousand twelve.

Ann D. Carlson
Secretary, Board of Regents



Judith A. Buchanan
Interim Dean, School of Dentistry

UNIVERSITY OF MINNESOTA

Staler
President

A. 2 Fred
Vice President for Health Sciences

Minneapolis, Minnesota

Be It Known That

Justin Wayne Nagel, D.D.S.

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

Resident in Oral and Maxillofacial Surgery

July 1, 2008 to June 30, 2011

Chief Resident in Oral and Maxillofacial Surgery

July 1, 2011 to June 30, 2012

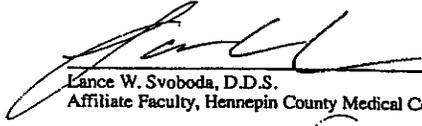
This training meets the credentials for eligibility for specialty board examination.

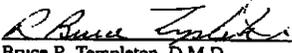
In Witness Whereof We Have Affixed Our Hands This 30th Day of June, A.D. 2012.


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

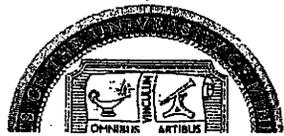

Deepak Kademani, D.M.D., M.D.
Associate Professor, U of MN


James O. Swift, D.D.S.


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


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


Judith Buchanan





TEXAS STATE BOARD OF DENTAL EXAMINERS

333 Guadalupe, Tower 3, Suite 800, Austin, Texas 78701-3942
Phone (512) 463-6400 Fax (512) 463-7452

November 20, 2012

Dr Justin Nagel
1813 Golden Trail Course
Suite 100
Carrollton TX 75010

Dear Dr. Nagel,

The State Board of Dental Examiners (SBDE) has evaluated your sedation/anesthesia permit application. Based on the information furnished regarding your training (and practice to noted standards of care), you have been formally approved for the following permit(s):

NITROUS OXIDE
LEVEL 1 – MINIMAL SEDATION
LEVEL 2 – MODERATE ENTERAL SEDATION
LEVEL 3 – MODERATE PARENTERAL SEDATION
LEVEL 4 – DEEP SEDATION / GENERAL ANESTHESIA

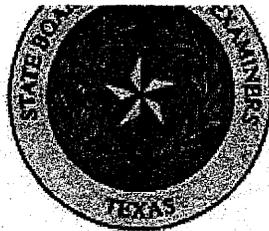
Approved procedures may be performed by a dentist only as an adjunct to the treatment of conditions and diseases that are within the scope of practice of dentistry or its recognized specialties.

You are required to display the enclosed annual registration certificate where services are provided in accordance with SBDE Rule 108.11 (Display of Registration). Also, please retain a copy of this letter in your files. Both of these documents serve as your authority to administer the above-listed sedation/anesthesia.

If you have any questions, please contact this office by e-mail at information@tsbde.texas.gov or by phone at (512) 463-6400.

Sincerely,

Vicki J. Shoemith
Director of Licensing
Texas State Board of Dental Examiners



TEXAS LICENSED DENTIST

Justin Wayne Nagel

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

EXPIRATION DATE

October 31, 2014

LICENSE NUMBER 27866

Anesthesia Permits:
Level 1
Level 4
Level 3
Level 2
Nitrous Oxide
Anesthesia Portability

A handwritten signature in black ink, reading "Rodolfo G. Ramos Jr DDS", is written over a horizontal line.

Rodolfo G. Ramos Jr DDS
Presiding Officer



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

AUG 14 2014

PLEASE TYPE OR PRINT LEGIBLY IN INK.

IOWA DENTAL BOARD

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):

Justin Wayne Nagel

MAILING ADDRESS:

5706 Grosseto Drive

CITY: Frisco	STATE: Texas	ZIP CODE: 75034	PHONE: 319-331-9556
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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:

Justin Nagel, D.D.S.

DATE:

7-30-2014

SECTION 2 - TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

PAM HUGHES

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

- American Dental Association; CODA
- Accreditation Council for Graduate Medical Education of the American Medical Association (AMA); or
- Education Committee of the American Osteopathic Association (AOA).

NAME AND LOCATION OF POSTGRADUATE PROGRAM:

UNIVERSITY OF MINNESOTA, ADVANCED ED PROGRAM DMS

PHONE:

6126247937

DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/YR): 7/2008	TO (MO/YR): 6/2012	DATE PROGRAM COMPLETED:
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- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE POSTGRADUATE TRAINING PROGRAM? If no, please explain.
- YES NO 2. DID THE APPLICANT EVER RECEIVE A WARNING OR REPRIMAND, OR BEEN PLACED ON PROBATION DURING THE TRAINING PROGRAM? If yes, please explain.
- YES NO 3. WAS THE APPLICANT EVER REQUESTED TO REPEAT A PORTION OF THE TRAINING PROGRAM? If yes, please explain.
- YES NO 4. DOES THE PROGRAM PROVIDE FORMAL TRAINING IN AIRWAY MANAGEMENT? If no, please explain.
- YES NO 5. DOES THE PROGRAM PROVIDE A MINIMUM OF ONE YEAR OF ADVANCED TRAINING IN ANESTHESIOLOGY AND RELATED ACADEMIC SUBJECTS BEYOND THE UNDERGRADUATE DENTAL LEVEL? If no, please explain.

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

PROGRAM DIRECTOR SIGNATURE:

JQ SWIFT

DATE:

8/6/2014