STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

January 21, 2016
12:00 P.M.

Location: The public can participate in the public session of the teleconference by speakerphone at the Board's office, 400 SW 8th St., Suite D, Des Moines, Iowa. The public can also participate by telephone using the call-in information below:

1. Dial the following number to join the conference call: 1-866-685-1580
2. When promoted, enter the following conference code: 0009990326#

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.; Jonathan DeJong, D.D.S. (alternate)*

I. CALL MEETING TO ORDER – ROLL CALL

II. COMMITTEE MINUTES

a. October 15, 2015 – Teleconference

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

a. Michael Zachar, D.D.S.

IV. APPLICATION FOR MODERATE SEDATION PERMIT

a. Annalee Fencl, D.D.S.
b. Adam Holton, D.D.S.

V. OTHER BUSINESS

a. Schedule In-Person Meeting

VI. OPPORTUNITY FOR PUBLIC COMMENT

VII. 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.

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES
October 15, 2015
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**October 15, 2015**
Kaaren Vargas, D.D.S.	Present
Richard Burton, D.D.S.	Absent
Steven Clark, D.D.S.	Absent
John Frank, D.D.S.	Present
Douglas Horton, D.D.S.	Absent
Gary Roth, D.D.S.	Present
Kurt Westlund, D.D.S.	Present
Jonathan DeJong, D.D.S. *(alternate)*	Present

Staff Member
Christel Braness

I. CALL MEETING TO ORDER – OCTOBER 15, 2015

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Thursday, October 15, 2015. This meeting was held by conference call to review committee minutes, applications for moderate sedation permits, and other committee business. It was impractical for the committee to meet in person with such a short agenda. A quorum was established with four (4) members present.

Roll Call:

Member	Burton	Clark	DeJong	Frank	Horton	Roth	Westlund	Vargas
Present			x	x		x		x
Absent	x	x			x		x	

II. COMMITTEE MEETING MINUTES

- *September 10, 2015 – Teleconference*

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

DRAFT

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

There weren't any general anesthesia applications received to date.

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

- *Julia A. Stanley, D.D.S.*

Ms. Braness provided an overview of the application.

➢ 12:08 p.m. Dr. Westlund joined the call.

❖ MOVED by ROTH, SECONDED by VARGAS, to APPROVE the application for moderate sedation permit.

Dr. Westlund asked about peer evaluations. Ms. Braness provided information about the protocol related to facility inspections. Dr. Westlund specified that his question related to peer evaluations. Ms. Braness indicated that this would need to be discussed further in the future, specifically, as it related to moderate sedation permit holders.

Dr. Frank is in favor of approving the application. Dr. Frank recommended that the committee meet in person to discuss some more of these issues in depth.

Dr. Westlund abstained from the vote as he lived in the area.

❖ Vote taken. Motion APPROVED unanimously.

V. OTHER BUSINESS

- *2016 Meeting Dates*

Ms. Braness provided an overview of the proposed dates. The committee members discussed which dates worked best. The dates were selected based on the availability for the committee members, who were present during the call.

❖ MOVED by ROTH, SECONDED by VARGAS, to set the meeting dates as discussed. Motion APPROVED unanimously.

Ms. Braness stated that she would email the committee members the final list of dates as selected.

VI. OPPORTUNITY FOR PUBLIC COMMENT

No comments were received.

DRAFT

VII. ADJOURN

- MOVED by WESTLUND, SECONDED by VARGAS, to adjourn. Motion APPROVED unanimously.

The Anesthesia Credentials Committee adjourned its meeting at 12:20 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for January 21, 2016. The meeting will be held at the Board office, and by teleconference.

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

DRAFT

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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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)				
ZACHAR, MICHAEL, R				
Other Names Used: (e.g. Maiden)	Home E-mail: KINNICK06@GMAIL.COM		Work E-mail: MICHAEL.ZACHAR.1@US.AF.MIL	
Home Address: 13849 WINDY OAKS RD	City: COLORADO SPRINGS	State: CO	Zip: 80921	Home Phone: 210-273-3628
License Number:	Issue Date:	Expiration Date:	Type of Practice:	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
2814 NORTHGATE DR #2	IOWA CITY	52245	319-499-4044	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	✓	JULY 2009
Formal training in airway management	✓	TO
Minimum of one year of advanced training in anesthesiology in a training program approved by the board	✓	JUNE 2013

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course:	Location:
ACLS INSTRUCTOR	UNITED STATES AIR FORCE ACADEMY
Date of Course:	**Date Certification Expires:**
DEC 2013	DEC 2015

Office Use				
	Lic. #	Sent to ACC:	Peer Eval:	Fee #1113 $500
	Permit #	Approved by ACC:	State Ver.:	ACLS
	Issue Date:	Temp #	Inspection:	Res. Ver Form
	Brd Approved:	T. Issue Date:	Inspection Fee:	Res. Cert

Name of Applicant MICHAEL ZACHAR

SECTION 5 – DENTAL EDUCATION, TRAINING & EXPERIENCE

Name of Dental School:	From (Mo/Yr):	To (Mo/Yr):
UNIVERSITY OF IOWA COLLEGE OF DENTISTRY	AUG 2003	MAY 2007
City, State:	Degree Received:	
	D.D.S.	

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

Name of Training Program:	Address:	City:	State:
LACKLAND AFB ORAL SURGERY RESIDENCY	2200 BERGQUIST DR.	LACKLAND AFB	TX
Phone:	**Specialty:**	**From (Mo/Yr):**	**To (Mo/Yr):**
210-292-7412	ORAL SURGERY	JULY 2009	JUNE 2013
Type of Training: ☐ Intern ☒ Resident ☐ Fellow ☐ Other (Be Specific): ORAL SURGERY			
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):
AF60 1 RESIDENCY, SHEPPARD AFB TX	AUG 2007	JULY 2008
GENERAL DENTIST, SHEPPARD AFB TX	JULY 2008	JUNE 2009
ORAL AND MAXILLOFACIAL SURGERY RESIDENCY, LACKLAND AFB, TX	JUNE 2009	JUNE 2013
STAFF ORAL SURGEON, UNITED STATES AIR FORCE ACADEMY	JUNE 2013	→ CURRENT
TRAINING DIRECTOR OF ORAL SURGERY, UNITED STATES AIR FORCE ACADEMY,	JUNE 2013	→ CURRENT

SECTION 6 – DEEP SEDATION/GENERAL ANESTHESIA EXPERIENCE

☒ YES ☐ NO A. Do you have a license, permit, or registration to perform sedation in any other state?
If yes, specify state(s) and permit number(s): COLORADO GEN. 02786093

☒ 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.

INHALATIONAL – N2O
ORAL – DIAZEPAM / ATIVAN

IV – MIDAZOLAM, FENTANYL, DECADRON, KETAMINE, PROPOFOL

Name of Applicant Michael Zachar. Facility Address page 1 of 2

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. continued

Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:
Rose Bachus	dental radiology QDA-05563	11/4/15	11-30-17
Stephanie Recke	dental radiology QDA-08210	11-4-15	11-30-17
see next page			

SECTION 8 – FACILITIES & EQUIPMENT

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

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

Page 2 of 2

Name of Applicant Michael Zachar. Facility Address

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 Rees	License/ LPN P15235 Registration #: dental XDA-03766	11-4-15	11-30-17
Janet Nicholson	License/ LPN P15344 Registration #: dental radiology XDA 02616	11-4-15	11-30-17
Anne Peterson	License/ RN 091238 Registration #: Dental Radiology XDA-09340	11-4-15	11-30-17
Desiree Vifian	License/ dental radiology Registration #: QDA 08924	11/4/15	11/30/17
Jamie Easton	License/ nurses 137342 Registration #: QDA 09664 Dental radiology	11/4/15	11-30-17
Jennifer Lebeda	License/ Dental Radiology Registration #: QDA- 105817	11-4-15	11-30-17
Kelly Speltz Snyder	License/ Dental Registration #: Radiography QDA-08924	11/4/15	11/30/17
Mary Kleopfer	License/ nurses 094615 Registration #: dental radiology XDA 00581	11/4/15	11/30/17

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.

See page 2

PALS INSTRUCTOR

American Heart Association. | American Academy of Pediatrics

PALS Instructor

Zachar Michael

This card certifies that the above individual is an American Heart Association Pediatric Advanced Life Support (PALS) Instructor.

March 2014
Issue Date

March 2016
Expiration Date

ACLS INSTRUCTOR

ACLS Instructor

American Heart Association.

Michael Zachar

This card certifies that the above individual is an American Heart Association Advanced Cardiovascular Life Support (ACLS) Instructor.

Dec 2013

Dec 2015

ACLS INSTRUCTOR

TC Alignment MTN

TC ID #

TC Address 10 MDG

TC City, State USAFA, CO

ZIP 80840

Instructor ID # L. Chiaramonte

Holder's Signature

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1803

PALS INSTRUCTOR

TC Alignment MTN

TC ID #

TC Address 10 MDG

TC City, State USAFA, CO.

ZIP 80840

Instructor ID #

Holder's Signature

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COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

Lookup Detail View

Licensee Information

This serves as primary source verification of the license.*

**Primary source verification: License information provided by the Colorado Division of Professions and Occupations, established by 24-34-102 C.R.S.*

Name	Public Address
Michael Robert Zachar	Monument, CO 80132

Credential Information

License Number	License Method	License Type	License Status	Original Issue Date	Effective Date	Expiration Date
DEN.00201973	Examination	Dentist	Active	05/07/2013	03/01/2014	02/29/2016

Authority Information

Authority Number	Authority Type	Original Issue Date	Effective Date	Expiration Date
TMPGEN.0000026	Temporary Deep Sedation/General Anesthesia Permit	09/24/2013	09/24/2013	12/23/2013
GEN.02786093	Deep Sedation/General Anesthesia	10/28/2013	10/28/2013	10/28/2018

Board/Program Actions

Discipline
There is no Discipline or Board Actions on file for this credential.

Generated on: 11/5/2015 1:54:03 PM

59th Medical Wing

This certifies that

Michael Robert Zachar , D.D.S.

Major, USAF, DC

Has successfully completed the

Oral and Maxillofacial Surgery Residency

1 July 2009 through 30 June 2013

In witness thereof, this certificate is awarded

At Joint Base San Antonio-Lackland Texas this 27th day of June 2013

Program Director

Commander, 59th Dental Group

Dean, Graduate Dental Education
59th Dental Group

Commander, 59th Medical Wing

The United States Air Force

CERTIFIES THAT

MICHAEL R. ZACHAR, MAJ, USAF, DC

HAS SUCCESSFULLY COMPLETED THE

NITROUS OXIDE-OXYGEN MINIMAL SEDATION TRAINING
(24 DIDACTIC HOURS + 250+ CASES)

AND IS HEREWITH AWARDED THIS

Certificate of Training

PAIN CONTROL COMMITTEE

PAIN CONTROL COMMITTEE

27 JUNE 2013

DATE

AF FORM 1256, NOV 86 Previous edition will be used.

The United States Air Force

CERTIFIES THAT

MICHAEL R. ZACHAR, MAJ, USAF, DC

HAS SUCCESSFULLY COMPLETED THE

INTRAVENOUS MODERATE SEDATION TRAINING
(60 DIDACTIC HOURS + 1,004 CASES)

AND IS HEREWITH AWARDED THIS

Certificate of Training

PAIN CONTROL COMMITTEE

PAIN CONTROL COMMITTEE

27 JUNE 2013

DATE

AF FORM 1256, NOV 86 Previous edition will be used.

The United States Air Force

CERTIFIES THAT

MICHAEL R. ZACHAR, MAJ, USAF, DC

HAS SUCCESSFULLY COMPLETED THE

ORAL ANXIOLYSIS/CONSCIOUS SEDATION TRAINING
(20 DIDACTIC HOURS + 15 CASES)

AND IS HEREWITH AWARDED THIS

Certificate of Training

PAIN CONTROL COMMITTEE

PAIN CONTROL COMMITTEE

27 JUNE 2013

DATE

AF FORM 1256, NOV 86 Previous edition will be used.

The United States Air Force

CERTIFIES THAT

MICHAEL R. ZACHAR, MAJ, USAF

HAS SUCCESSFULLY COMPLETED THE

Forensic Dentistry Course, L5OZO47G3-08AA

4 – 6 June 2013

AND IS HEREWITH AWARDED THIS

Certificate of Training

Dean, Graduate Dental Education

Course Director

6 June 2013

DATE

FORM 1256, NOV 86 Previous edition will be used.

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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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): MICHAEL ROBERT ZACHAR

MAILING ADDRESS: 13849 WINDY OAKS RD

CITY:	STATE:	ZIP CODE:	PHONE:
COLORADO SPRINGS	CO	80921	210-273-3628

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:
Michael Zachar, DDS, Maj, USAF, DC Oral and Maxillofacial Surgeon	14 ~~SEPT~~ OCT 2015

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Richard L. Johnson, MS, MD

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:
San Antonio Military Oral & Maxillofacial Surgery Residency Joint Base San Antonio, Lackland AFB TX	(210) 292-5215

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	07/09	06/13	30 June 2013

☒ 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:	DATE:
Richard L. Johnson, MS, MD	5 Nov 2015

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
OCT 29 2015
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) Fencl, Annalee Patricia				
Other Names Used: (e.g. Maiden) Reicks	Home E-mail: annaleefencl@gmail.com		Work E-mail: (same)	
Home Address: 2276 US Highway 52	City: Decorah	State: IA	Zip: 52101	Home Phone: 319-240-6500
License Number: DDS-09154	Issue Date: 11-7-14	Expiration Date: 8-31-2016	Type of Practice: Pediatric Dentistry	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
806 Commerce DR. Suite B	Decorah, IA	52101	563-382-6259	M-F 8-5pm
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.	Check if completed.	DATE(S):
Moderate Sedation Training Program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences	☐ Completed	
ADA-accredited Residency Program that includes moderate sedation training	☒ Completed	7-1-15 to 6-30-15
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☒ Completed	7-1-15 to 6-30-15
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: Pediatric Advanced Life Support (PALS)	Location: University of Iowa Hospitals & Clinics
Date of Course: 5-27-2015	Date Certification Expires: 05/2017

Office Use				
	Lic. #	Sent to ACC:	Inspection	Fee # 1034 $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 Annalee Fencl

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program: University of Iowa Pediatric Dentistry Residency	Address: 801 Newton Rd	City: Iowa City	State: IA

Type of Experience: Pediatric Dental Residency (Accredited)

Length of Training: 2 years	Date(s) Completed: 6-30-2015
Number of Patient Contact Hours: ~ 30 hrs / wk [All pt contact hours]	Total Number of Supervised Sedation Cases: 29 operator / 30+ monitoring

☒ 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? (not currently)

☐ 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.

Local anesthesia - orally for dental work

Sedatives - oral: Midazolam, diazepam, hydroxyzine, demerol

nasal: midazolam

Name of Applicant Annalee Fenci Facility Address 806 Commerce DR. Suite B Decorah, IA 52101

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:
Joyce Kucera	QDA-04335	May 20, 2015	May 2017
Shantel Perry	QDA-12051	march 18, 2014	March 2016
Emily Sullivan	QDA-12496	April 19, 2015	April 2017

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? Patient vitals monitor + AED which analyzes cardiac rhythms
☒	☐	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)?
2		20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Iowa

COUNTY: Winneshiek

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 Annalee Fencl DDS	
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS 30 DAY OF June , YEAR 2015	
NOTARIAL SEAL IOWA ANITA M. FORBES Commission Number 729650 My Commission Expires July 27, 2016	NOTARY PUBLIC SIGNATURE Anita M. Forbes	
	NOTARY PUBLIC NAME (TYPED OR PRINTED) Anita M. Forbes	MY COMMISSION EXPIRES: 7-27-2016

PEDIATRIC ADVANCED LIFE SUPPORT

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association | American Academy of Pediatrics

PEEL HERE

PALS Provider

Annalee Fencl

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

5/27/2015
Issue Date

05/2017
Recommended Renewal Date

Training Center Name: UIHC-EMSLRC

TC ID #: TCCIA05137

TC Info: 200 Hawkins Dr, Iowa City IA 52242

Course Location: 319-353-7495 EMSLRC

Instructor Name: Lori Hartley

Inst. ID #: 111100621143

Holder's Signature: Annalee Fencl

© 2011 American Heart Association *Tampering with this card will alter its appearance.* 90-1808

Annalee Fencl
249 Woolf Ave.
Iowa City IA 52246

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

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): Annalee Patricia Fencl

MAILING ADDRESS: 2276 US Highway 52

CITY:	STATE:	ZIP CODE:	PHONE:
Decorah	IA	52101	319-240-6500

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:
Annalee Fencl	6-30-2015

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Matthew Geneser, DDS

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:
University of Iowa College of Dentistry Pediatric Dental Residency	319-335-7480

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	07/2013	06/2015	6-30-2015

☒ 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. pediatric training program

☐ YES ☒ NO 9. DOES THE PROGRAM INCLUDE ADDITIONAL CLINICAL EXPERIENCE IN PROVIDING MODERATE SEDATION FOR MEDICALLY COMPROMISED (ASA CLASS 3 OR 4) PATIENTS? If yes, please provide details.

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

PROGRAM DIRECTOR SIGNATURE:	DATE:
[signature]	6-30-15

THE UNIVERSITY OF IOWA

College of Dentistry

THIS IS TO CERTIFY THAT

Annalee Patricia Fencl

HAS SUCCESSFULLY COMPLETED THE REQUIREMENTS FOR THE

Certificate in Pediatric Dentistry

TO THE SATISFACTION OF THE FACULTY

IN WITNESS WHEREOF, THIS CERTIFICATE IS AWARDED AT IOWA CITY

THIS THIRTIETH DAY OF JUNE, TWO THOUSAND AND FIFTEEN.

PRESIDENT OF THE UNIVERSITY

DEAN OF THE COLLEGE

THE UNIVERSITY OF IOWA ORGANIZED FEB. 25TH 1847.

HEAD OF DEPARTMENT

PROGRAM DIRECTOR

STATE OF IOWA
COUNTY OF JOHNSON

On this 23 day of June, 2015, I attest that the preceding or attached document is a true, exact, complete, and unaltered photocopy made by me of program certificate presented to me by the document's custodian, _____, and, to the best of my knowledge, that the photocopied document is neither a public record nor a publicly recordable document, certified copies of which are available from an official source other than a notary public.

Anita M. Forbes Notary Public My Comm. Exp. 7-27-2016

NOTARIAL SEAL IOWA
ANITA M. FORBES
Commission Number 729650
My Commission Expires
July 27, 2016

IOWA DENTAL BOARD

License Detail Report

First Name: Adam
Last Name: Holton
)ctober 29, 2015 7:43 am

Balance

License Basic Information

License Type	ANES-Moderate Sedation
License Number	
Status	Internet Wait
Orginal Issue Date	
Balance	$0.00

Facility Equipment

Operating room accommodates patient and 3 staff?	Yes
Operating table or chair sufficient to maintain airway and render emergency aid?	Yes
Lighting is sufficient to evaluate patient and has appropriate battery backup?	Yes
Suction equipment permits aspiration of oral / pharyngeal cavities & a backup?	Yes
Oxygen delivery system with adequate full face masks & adequate backup?	Yes
A recovery area that has oxygen, adequate lighting, suction, & electric outlets?	Yes
Is patient able to be observed by staff at all times during recovery?	Yes
Anesthesia / analgesia systems coded to prevent incorrect administration?	Yes
EKG Monitor?	Yes
Laryngoscope and blades?	Yes
Endotracheal tubes?	Yes
Magill forceps?	Yes
Oral airways?	Yes
Stethoscope	Yes
Blood pressure monitoring device?	Yes
A pulse oximeter?	Yes
Emergency drugs that are not expired?	Yes
A defibrillator (an automated defibrillator is recommended)?	Yes
Do you employ volatile liquid anesthetics and a vaporizer?	No
Number of nitrous oxide inhalation analgesia units in facility?	12

Facility Information

Joining previously inspected facility?	Yes
Equipment or exemption details	
Provide sedation at more than 1 facility?	No
Equipment requirements met?	Yes
Equipment exemptions?	No

IOWA DENTAL BOARD

License Detail Report

First Name: Adam
Last Name: Holton
)ctober 29, 2015 7:43 am

Balance

Final Acknowledgements

Application Signature	Yes
Application Signature Date	Oct 29, 2015 07:43:55
ACLS/PALS Certification Acknowledgement	Yes
ACLS/PALS Expiration (mm/yyyy)	07/2017

Initial Acknowledgements

Sedation / LA Permit Acknowledgement	Yes
Public Record Acknowledgement	Yes
Non-Refundable App Fee Acknowledgement	Yes
App Valid 180 Days Acknowledgement	Yes

MS Restrictions

Authorized to sedate pediatric patients?	Yes
Authorized to sedate ASA 3 or 4 patients?	Yes

Other State Licenses

Permitted In Other States?	No
State	
Permit Number	
Date Verified	
State 2	
Permit Number 2	
Date Verified 2	
State 3	
Permit Number 3	
Date Verified 3	

Peer Evaluation

Peer evaluation conducted?	Yes
If no, is one required?	
Date of peer evaluation	Aug 21, 2015

Printing

Number of Extra Certificates ($25 ea.)	0
Number of Extra Renewal Cards ($25 ea.)	0

Renewal Period Option

Joint New / Renewal Qualified	No
Joint New / Renewal Accepted	No

Sedation Experience

Any patient mortality or other incident?	No

Balance	
Details of incident	
Use enteral moderate sedation?	No
Use parenteral moderate sedation?	Yes

Sedation Training

Mod Sedation training program 60 hrs and 20 patients?	Yes
Airway management training?	Yes
Airway Training Date	Jul 27, 2015
ACLS Certified?	Yes
ADA accredited residency program?	Yes
Specialty 1	
Post Graduate Training Type 1	Intern
Post Graduate Training Institution 1	University of Iowa College of Dentistry and Denta
Institution 1 City & State	Iowa City, IA
Post Graduate Training 1 Start Date	Jun 26, 2015
Post Graduate Training 1 End Date	Jun 24, 2016
Continuing Education Course	
Continuing Education Course Location	
Continuing Education Course Date Completed	
Pediatric Training?	Yes
Pediatric Training Location	UIHC
Pediatric Training Date	Jul 27, 2015
Med. Comp. Training?	Yes
Med. Comp. Training Location	UIHC
Med. Comp. Training Date	Jul 27, 2015
Marriage/Divorce Decree Submission Method?	

Chronology

Out of State License Information

State/Country	Active	License No.	Date Issued	License Type	How Obtained

Question List and Details

Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?	No
Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	No
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?	No
Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical conditions or use of alcohol, drugs, or	No

	Balance
other chemical substances?	
Have you ever been requested to repeat a portion of any professional training program/school?	No
Have you ever received a warning, reprimand, or placed on probation or disciplined during a professional training program/school?	No
Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?	No
Was a license disciplinary action pending against you, or were you under investigation by a licensing agency at the time a voluntary surrender of license was tendered?	No
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?	No
Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?	No
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?	No
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 suspended, or revoked?	No

Attachments

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) Holton, Adam, Lee				
Other Names Used: (e.g. Maiden) N/A	Home E-mail: holton.uiowa@gmail.com		Work E-mail: adam-holton@uiowa.edu	
Home Address: 910 Westside Dr	City: Iowa City	State: IA	Zip: 52246	Home Phone: 712-299-4357
License Number: DDS-09188	Issue Date: 6/09/15	Expiration Date: 8/31/16	Type of Practice: Academic	

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

Principal Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Univ. of Iowa College of Dentistry 801 Newton Rd	Iowa City	52242	319-335-7457	8:00-5:00 M-F
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:
Other Office Address:	City:	Zip:	Phone:	Office Hours/Days:

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.	Check if completed.	DATE(S):
Moderate Sedation Training Program that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists of at least 60 hours and 20 patient experiences	☒ Completed	Aug 21, 2015
ADA-accredited Residency Program that includes moderate sedation training	☐ Completed	
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☒ Completed	Aug 21, 2015
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: ACLS	Location: University of Iowa Hospital and Clinics EMSLRC
Date of Course: 7/17/15	Date Certification Expires: 07/2017

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

Name of Applicant Adam L. Holton

SECTION 5 – MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program:	Address:	City:	State:
Univ. of Iowa Dept. of anesthesia	University of Iowa Hospital and Clinics	Iowa City	IA

Type of Experience: General Anesthesia in the OR and ASC, airway management, medical management

Length of Training:	Date(s) Completed:
1 month	8/21/15
Number of Patient Contact Hours:	**Total Number of Supervised Sedation Cases:**
1100	60

☑ YES ☐ NO 1. Did you satisfactorily complete the above training program?

☑ YES ☐ NO 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?

☑ YES ☐ NO 3. Does the program include management of at least 20 clinical patients?

As part of the curriculum, are the following concepts and procedures taught:

☑ YES ☐ NO 4. Physical evaluation;

☑ YES ☐ NO 5. IV sedation;

☑ YES ☐ NO 6. Airway management;

☑ YES ☐ NO 7. Monitoring; and

☑ YES ☐ NO 8. Basic life support and emergency management.

☑ YES ☐ NO 9. Does the program include clinical experience in managing compromised airways?

☑ YES ☐ NO 10. Does the program provide training or experience in managing moderate sedation in pediatric patients?

☑ YES ☐ NO 11. Does the program provide training or experience in managing moderate sedation in ASA category 3 or 4 patients?

Please attach the appropriate form to verify your moderate sedation training. Applicants who received their training in a postgraduate residency program must have their postgraduate program director complete Form A. In addition, attach a copy of your certificate of completion of the postgraduate program. Applicants who received their training in a formal moderate sedation continuing education program must have the program director complete Form B.

SECTION 6 – MODERATE SEDATION EXPERIENCE

☐ YES ☑ NO A. Do you have a license, permit, or registration to perform moderate sedation in any other state?

If yes, specify state(s) and permit number(s):_____

☑ YES ☐ NO B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?

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

☑ YES ☐ NO D. Do you plan to use moderate sedation in pediatric patients?

☑ YES ☐ NO E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients?

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

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

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

IV
Fentanyl
versed
valium
Decadron
Phenergan
Zofran
Inhalation
Nitrous oxide

Name of Applicant Adam L. Holton Facility Address 801 Newton Rd, Iowa City, IA 52242

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:
Kane, Kathleen	0640060	3/5/15	3/31/17
Kenney, Melanie	067348	12/24/14	12/31/16
Pardini, Margaret	078252	12/24/14	12/31/16
Smith, Cindy	QDA-00330	3/5/15	3/31/17
Kluesner, Anna	QDA-09354	3/5/15	3/31/17
Bolt, Holly	QDA-10156	12/24/14	12/31/16
Ernst, Ashley	QDA-10032	3/5/15	3/31/17

SECTION 8 – FACILITIES & EQUIPMENT

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

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

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

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE: Iowa	COUNTY: Johnson

I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide moderate sedation. I also declare that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

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

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

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

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

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

I further state that I have read the rules related to the use of sedation and nitrous oxide inhalation analgesia, as described in 650 Iowa Administrative Code Chapter 29. I hereby agree to abide by the laws and rules pertaining to the practice of dentistry and moderate sedation in the state of Iowa.

MUST BE SIGNED IN PRESENCE OF NOTARY ►	SIGNATURE OF APPLICANT Adam Hutton	
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS 2 DAY OF September, YEAR 2015	
	NOTARY PUBLIC SIGNATURE	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	MY COMMISSION EXPIRES:

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): Adam Lee Holton

MAILING ADDRESS: 910 Westside Dr

CITY:	STATE:	ZIP CODE:	PHONE:
Iowa City	IA	52246	712-299-4357

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:
Adam Holton	9/02/2015

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR: Kirk L. Fridrich

NAME AND LOCATION OF PROGRAM:	PHONE:
The University of Iowa Hospitals + Clinics College of Dentistry Iowa City IA 52242	319.335.7460

FAX: 319.335.7456	E-MAIL:	WEB ADDRESS:	
DATES APPLICANT PARTICIPATED IN PROGRAM ▶	FROM (MO/DAY/YR): 07/27/15	TO (MO/DAY/YR): 08/21/15	DATE PROGRAM COMPLETED: 08/21/15

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

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

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

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

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

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

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

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

PROGRAM DIRECTOR SIGNATURE:	DATE:
[signature]	10-26-2015

Report of Anesthesia Training

Prepared for

Anesthesia Credentials Committee
Iowa Dental Board

Prepared by
Adam Lee Holton DDS
October 15, 2015

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Anesthesia Rotation

Summary

The anesthesia rotation I completed was a competency based full time, four week rotation **(160 hours)** with The University of Iowa Department of Anesthesia. The four week rotation entailed didactic, simulation, and clinical experiences. The didactic component was completed with forth year medical students and second year anesthesia residents and included multiple topics of anesthesia, as detailed below. In addition, simulation exercises provided procedural training prior to beginning my advanced clinical experiences in anesthesia. The clinical component comprised the vast majority of the rotation. This included one-on-one patient experiences paired with anesthesiologists or an anesthesia team consisting of an anesthesiologist, and a fourth year anesthesia resident, or a certified nurse anesthetist. The clinical experience involved all aspects of anesthesia including pre-anesthesia evaluation, pre-induction protocol, management of surgical patients with co-existing medical problems, clinical experience in various forms of anesthesia including general and regional (spinal, epidural, peripheral nerve blocks), induction and airway management (via mask ventilation, endotracheal intubation, LMA placement, and other alternative airway techniques), maintenance, emergence, and postoperative care. A vast majority of my experiences included cases in which patients were undergoing general anesthesia with several surgical disciplines. Working closely with the anesthesiologist or anesthesia team I would participate in pre-anesthesia evaluations, premedication and pre-induction protocols, masking patients during induction (induction conducted by anesthesiologist), intubation of patients under direct supervision of the anesthesiologist, management of maintenance and emergence with the primary staff, extubating patients under the direct supervision of the anesthesiologist, and concluding the cases with postoperative care in conjunction with the anesthesia and surgical teams. In addition to general anesthesia cases I also worked with conscious sedation cases where my primary role was assisting in pre-anesthesia evaluations, maintenance, and emergence. Below is a detailed outline of the procedures I completed, medications I received training on and used during my rotation, and didactic course work completed during the

rotation. In addition, my time as a Fellow Associate in the Department of Oral and Maxillofacial Surgery at The University of Iowa has provided me with didactic course work and supervised sedations as outlined below.

Simulation Experiences

Intravenous catheter placement
Arterial line placement with the use of ultrasound
Central venous catheter placement with the use of ultrasound
Oropharyngeal airway placement
Endotracheal intubation
Emergency medical situation management with a multidisciplinary team

Clinical Experiences

30+ supervised cases demonstrating proper masking technique
20 supervised endotracheal and nasotracheal intubations via Direct (Macintosh and Miller blades) and Indirect Laryngoscopy (Video Laryngoscopes and Fiberoptics etc), including the use of laryngeal mask airways.
4 supervised conscious sedations
Intravenous catheter placement
Use of oropharyngeal airways

Pharmacological Training

Medications used under supervision during rotation:

Premedication: midazolam, ketamine
Induction: propofol, fentanyl, sevoflurane
Neuromuscular Blockade: succinylcholine, rocuronium
Reversal of Neuromuscular Blockade: neostigmine, atropine
Vasopressors: phenylephrine, ephedrine
Vasodilators: labetalol, vasopressin
Maintenance (intravenous): propofol, fentanyl, remifentanil, alfentanil
Maintenance (inhalational): sevoflurane, isoflurane, desflurane, and nitrous oxide

Didactic Coursework

Topics including but not limited to:

History of anesthesia
Preoperative evaluation
Premedication
Intubation and anesthesia complications
Intravenous anesthetics
Inhalational anesthetics
Intraoperative monitoring
Ventilation systems and modes
Extubation
Pediatric anesthesia
Obstetric anesthesia
Pain medicine
Regional anesthesia
Pharmacology of anesthetics
Clinical Case Conferences

Supplemental Anesthesia Training

Supervised Patient Procedures (Additional competency based instruction exceeding 60 hours)

45 supervised sedations in clinic setting
Intravenous catheter placement

Didactic Coursework

Topics including but not limited to:

Capnography use in OMFS
Review of anesthetic techniques and complications
Physical evaluation of patients
The use of conscious sedation in dentistry
Pediatric sedation considerations
Geriatric sedation considerations

Nitrous oxide
Emergency preparation and management
Monitoring for conscious sedation
Venipuncture anatomy and techniques
Intramuscular sedation (pharmacology and technique)
Intravenous sedation (pharmacology and technique)
Medically compromised patients

*The Department of Oral and Maxillofacial Surgery has arranged this individualized, competency based curriculum to benefit the education of our pre-doctoral students at the College of Dentistry. The individualized curriculum consisted of well over **220 hours** of training (didactic, clinical and simulation) and included live airway training and intubation experiences. It is not our intent (nor is it feasible) to offer such a comprehensive training program to others not associated with our Departmental or its mission(s).

ANESTHESIA CREDENTIALS COMMITTEE (ACC)

Meeting times would be scheduled for 12:00 p.m., noon, unless otherwise scheduled.

2016 Meeting Dates (Currently Scheduled)

January 21, 2016 (Thursday)

April 7, 2016 (Thursday)

June 2, 2016 (Thursday)

July 14, 2016 (Thursday)

August 25, 2016 (Thursday)

September 29, 2016 (Thursday)