

CERTIFICATION OF MODERATE SEDATION TRAINING

Instructions – Forward this form to the director of your moderate sedation training course.

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

City/State:

Email Address:

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

Applicant's Signature:

Date:

SECTION 2 – TO BE COMPLETED BY MODERATE SEDATION TRAINING DIRECTOR

Name of Moderate Sedation Training Program:

Phone:

Address:

Name of Training Director:

Email Address:

Type of Training Program:

Accredited postgraduate residency program (ADA, AMA, AOA)

- Did the residency program include training in the moderate sedation of pediatric patients? Yes No
- Did the residency program include training in the moderate sedation of medically-compromised patients? Yes No

Continuing education course.

- Did the course include training in the use of more than one drug in moderate sedation? Yes No
- If yes, please list drugs included in the training:

Dates Applicant Participated in Program:

From (Mo/Yr):

To (Mo/Yr):

Date Program Completed:

YES NO

1. Did the applicant satisfactorily complete the above training program?

YES NO

2. Did the program include at least sixty (60) hours of didactic training in pain and anxiety?

YES NO

3. Did the program comply with the guidelines of the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2016?

YES NO

4. Did the program include the management of a minimum of 20 patients?

YES NO

5. Did the program include training that addresses how to rescue patients from a deeper level of sedation than intended, including, but not limited to, intravascular or intraosseous access and reversal medications?

YES NO

6. Did the program include clinical experience in managing compromised airways? (If no, please provide a detailed explanation.)

YES NO

7. Did the applicant ever receive a warning, reprimand, or was the applicant placed on probation during the training program? (If yes, please explain.)

YES NO

8. Was the applicant ever requested to repeat a portion of the training program? (If yes, please explain).

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

Program Director Signature:

Date: