



STATE OF IOWA

IOWA DENTAL BOARD

KIM REYNOLDS, GOVERNOR
ADAM GREGG, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

MARCH 5, 2020

12:00 P.M.

Location: Iowa Dental Board, 400 SW 8th St., Suite D, Des Moines, Iowa. The public can also participate by telephone using the call-in information below:

- | |
|---|
| <ol style="list-style-type: none">1. Dial the following number to join the conference call: 1-866-685-15802. When prompted, enter the following conference code: 0009990326# |
|---|

Members: *Gregory Ceraso, D.D.S., Chair; Steven Clark, D.D.S.; Jonathan DeJong, D.D.S.; John Frank, D.D.S.; Karen Potaczek, D.D.S.; Gary Roth, D.D.S.; Kurt Westlund, D.D.S.*

I. CALL MEETING TO ORDER – ROLL CALL

II. COMMITTEE MINUTES

- a. October 24, 2019 – Teleconference
- b. December 12, 2019 – Teleconference

III. APPLICATIONS FOR GENERAL ANESTHESIA PERMIT

<No applications received to date.>

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

- a. Sandra Fox, D.D.S.
- b. Gregory Ceraso, D.D.S.
- c. Zach Dannenbring, D.D.S. (Reinstatement)

V. OTHER BUSINESS

- a. For Discussion: Requirements for Postoperative Aftercare, Iowa Administrative Code 650—29.5(7)

VI. OPPORTUNITY FOR PUBLIC COMMENT

VII. ADJOURN

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.



STATE OF IOWA

IOWA DENTAL BOARD

KIM REYNOLDS, GOVERNOR
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JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES

October 24, 2019
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members

Michael Davidson, D.D.S., Chairperson
Gregory Ceraso, D.D.S.
Steven Clark, D.D.S.
Jonathan DeJong, D.D.S.
John Frank, D.D.S.
Karen Potaczek, D.D.S.
Gary Roth, D.D.S.
Kaaren Vargas, D.D.S.
Kurt Westlund, D.D.S.

October 24, 2019

Present
Present
Present
Present
Present
Absent
Absent
Absent
Absent

Staff Members

Christel Braness, Jill Stuecker, David Schultz

I. CALL MEETING TO ORDER – OCTOBER 24, 2019

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Thursday, October 24, 2019. The meeting was held by electronic means in compliance with Iowa Code section 21.8. The purpose of the meeting was to review meeting minutes, applications for sedation permits, and other committee-related business. It was impractical to meet in person with such a short agenda.

Roll Call:

<u>Member</u>	<u>Davidson</u>	<u>Ceraso</u>	<u>Clark</u>	<u>DeJong</u>	<u>Frank</u>	<u>Potaczek</u>	<u>Roth</u>	<u>Vargas</u>	<u>Westlund</u>
Present	x	x	x	x	x				
Absent						x	x	x	x

A quorum was established with five (5) members present.

II. COMMITTEE MINUTES

- *August 29, 2019 – Teleconference*

- ❖ MOVED by DAVIDSON, SECONDED by CERASO, to APPROVE the minutes from the August 29, 2019 meeting as submitted. Motion APPROVED unanimously.

III. APPLICATIONS FOR GENERAL ANESTHESIA PERMIT

Ms. Braness reported that were not any applications for general anesthesia permit received to date.

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

- *James Shealy, Jr., D.D.S.*

Ms. Braness provided an update on Dr. Shealy's application. Dr. Shealy completed a pediatric dentistry residency at the Children's Hospital of Wisconsin in 1995. Dr. Shealy also requested approval to sedate pediatric and medically-compromised patients. Dr. Shealy provided the additional information as requested by the committee.

Dr. Frank asked to confirm some information about the application as he was not in attendance at the previous meeting. Dr. Shealy is a pediatric dentist with specialty practice in another state. Dr. Shealy uses the services of another anesthesia provider and has not administered sedation himself in recent years. Dr. Frank recommended that a set number of cases be supervised

Dr. Clark stated that the primary reason for requiring a permit to use another sedation provider was based on the difference of treating sedated patients. Dr. Clark stated that Dr. Shealy appeared to meet this criteria. It appeared that the committee could be overly restrictive in the application of the rule. Dr. Ceraso agreed with Dr. Clark's comments. Dr. Ceraso believed that Dr. Shealy met the requirements and intent of the rule.

The committee members further discussed Dr. Shealy's experience and training. Dr. Clark believed that Dr. Shealy's experience exceeds that of a practitioner who only recently completed training in sedation. Dr. Frank agreed.

Dr. Ceraso noted that Dr. Shealy intended to continue using a separate anesthesia provider. Dr. DeJong agreed with the recent comments and agreed that Dr. Shealy met the requirements for a permit.

- ❖ MOVED by DEJONG, SECONDED by DAVIDSON, to APPROVE the application pending completion of the facility inspection. Motion APPROVED unanimously.

- *Dean Hussong, D.D.S.*

Ms. Braness provided an overview of Dr. Hussong's application. Dr. Hussong completed his training in moderate sedation through a continuing education course at the University of Minnesota College of Dentistry in 2005. Dr. Hussong does not intend to sedate pediatric or ASA III-IV patients.

- ❖ MOVED by CLARK, SECONDED by CERASO, to APPROVE the application pending completion of the facility inspection. Motion APPROVED unanimously.

- *Chase Wicker, D.D.S.*

Ms. Braness provided an overview of Dr. Wicker's application. Dr. Wicker completed his training in moderate sedation at a continuing education course through Conscious Sedation Consulting in 2019. Dr. Wicker does not intend to sedate pediatric or ASA III-IV patients.

- ❖ MOVED by FRANK, SECONDED by CERASO, to APPROVE the application pending completion of the facility inspection. Motion APPROVED unanimously.

V. OTHER BUSINESS

- *Facility Inspections & Emergency Drugs: Narcan/Naloxone*

Recently, Mr. Schultz has received questions as to whether facilities are required to stock Narcan/naloxone for emergencies even in cases where opioids are not being utilized at the facility. Mr. Schultz requested guidance from the committee.

Dr. Ceraso stated that a permit holder could change sedation protocols, including the addition of narcotics, without committee review or approval. It would be good practice to keep an opioid antagonist on hand should the types of drugs for sedation change.

Dr. Frank agreed and referenced the opioid epidemic as a basis for maintaining this. Even if the patient did not overdose on drugs taken before an appointment, different medications can interact and result in adverse occurrences. Dr. Frank stated that increasingly fire departments and EMTs regularly carry this as well.

Dr. Clark noted that these medications are relatively inexpensive and would not pose a financial burden. The committee members were in favor of continuing to require facilities to stock Narcan/naloxone or an equivalent.

Mr. Schultz also asked whether pediatric facilities should stock sublingual nitrostat tablets. Dr. Ceraso believed that this would be useful in emergencies since pediatric patients are often accompanied by adults.

VI. OPPORTUNITY FOR PUBLIC COMMENT

Ms. Braness allowed the opportunity for public comment.

There were not any comments received.

VII. ADJOURN

- ❖ MOVED by CERASO, SECONDED by FRANK, to ADJOURN. Motion APPROVED unanimously.

The Anesthesia Credentials Committee adjourned its meeting at 12:26 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for December 12, 2019. 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



STATE OF IOWA IOWA DENTAL BOARD

KIM REYNOLDS, GOVERNOR
ADAM GREGG, LT. GOVERNOR

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES

December 12, 2019
Conference Room
400 SW 8th St. Suite D
Des Moines, Iowa

Committee Members

Michael Davidson, D.D.S., Chairperson
Gregory Ceraso, D.D.S.
Steven Clark, D.D.S.
Jonathan DeJong, D.D.S.
John Frank, D.D.S.
Karen Potaczek, D.D.S.
Gary Roth, D.D.S.
Kaaren Vargas, D.D.S.
Kurt Westlund, D.D.S.

December, 2019

Present
Present
Absent
Absent
Absent
Present
Absent
Absent
Present

Staff Members

Christel Braness

I. CALL MEETING TO ORDER – DECEMBER 12, 2019

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:14 p.m. on Thursday, December 12, 2019. The meeting was held by electronic means in compliance with Iowa Code section 21.8. The purpose of the meeting was to review meeting minutes, applications for sedation permit, and other committee-related business. It was impractical to meet in person with such a short agenda.

Roll Call:

<u>Member</u>	<u>Davidson</u>	<u>Ceraso</u>	<u>Clark</u>	<u>DeJong</u>	<u>Frank</u>	<u>Potaczek</u>	<u>Roth</u>	<u>Vargas</u>	<u>Westlund</u>
Present	x	x				x			x
Absent			x	x	x		x	x	

A quorum was not established with four (4) members present.

The committee members in attendance decided to meet and discuss the agenda items in order to make a formal recommendation to the full Board for approval. Due to the upcoming holidays and normally busy schedules, there were concerns about substantial delays involved with trying to

reschedule the committee meeting. The recommendations from this meeting will be forwarded to the January 24, 2020 Iowa Dental Board meeting for ratification.

II. COMMITTEE MINUTES

- *October 24, 2019 – Teleconference*

- ❖ MOVED by WESTLUND, SECONDED by CERASO, to APPROVE the minutes as drafted. Motion APPROVED unanimously.

Due to a lack of quorum, the October 2019 meeting minutes will be brought back to the March 5, 2020 meeting for formal committee approval.

III. APPLICATIONS FOR GENERAL ANESTHESIA PERMIT

- *Brock Radich, D.D.S.*

Dr. Radich completed his oral and maxillofacial residency at the University of Iowa College of Dentistry in June 2018. Dr. Radich will be joining Oral Surgeons, P.C. and a facility inspection will not be required.

- ❖ MOVED by DAVIDSON, SECONDED by CERASO, to RECOMMEND APPROVAL of the application as submitted. Motion APPROVED unanimously.

IV. APPLICATIONS FOR MODERATE SEDATION PERMIT

- *Jared Bitner, D.D.S.*

Dr. Bitner completed a continuing education course in moderate sedation at the University of Iowa College of Dentistry in August 2019. Dr. Bitner will be practicing at the University of Iowa College of Dentistry and a facility inspection would not be required.

Dr. Bitner listed Propofol and Ketamine as drugs intended in the use of sedation. Ms. Braness has informed Dr. Bitner that Iowa Administrative Code 650—29.7 prohibits the use of these drugs in the administration of moderate sedation. Dr. Ceraso recommended that Ms. Braness inform Dr. Bitner that a rule waiver would be required to use those drugs in the administration of moderate sedation.

- ❖ MOVED by DAVIDSON, SECONDED by WESTLUND, to RECOMMEND APPROVAL of the application. Motion APPROVED unanimously.

V. OPPORTUNITY FOR PUBLIC COMMENT

Ms. Braness provided the opportunity for public comment. No comments were received.

VI. ADJOURN

❖ MOVED by CERASO, SECONDED by DAVIDSON, to ADJOURN. Motion APPROVED unanimously.

The meeting of the Anesthesia Credentials Committee adjourned at 12:18 p.m. on December 12, 2019.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for March 5, 2020, in Des Moines, Iowa.

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

DRAFT



IOWA DENTAL BOARD

License Detail Report

First Name: Sandra

Last Name: Fox

January 29, 2020 7:21 pm

Balance

License Basic Information

License Type	ANES-Moderate Sedation
License Number	
Status	Internet Wait
Original 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?	1

Facility Information

Joining previously inspected facility?	No
Equipment or exemption details	
Provide sedation at more than 1 facility?	No
Have the equipment requirements listed above been met?	Yes
Equipment exemptions?	Yes



IOWA DENTAL BOARD

License Detail Report

First Name: Sandra

Last Name: Fox

January 29, 2020 7:21 pm

Balance

Final Acknowledgements

Application Signature	Yes
Application Signature Date	Jan 29, 2020 19:21:42
ACLS/PALS Certification Acknowledgement	Yes
ACLS/PALS Expiration (mm/yyyy)	01/2022

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?	Yes
State	Texas
Permit Number	30623
Date Verified	Mar 15, 2015
State 2	
Permit Number 2	
Date Verified 2	
State 3	
Permit Number 3	
Date Verified 3	

Peer Evaluation

Peer evaluation conducted?	No
If no, is one required?	
Date of peer evaluation	

Renewal Period Option

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

Sedation Experience

Any patient mortality or other incident?	No
Details of incident	
Use enteral moderate sedation?	Yes
Use parenteral moderate sedation?	No



IOWA DENTAL BOARD

License Detail Report

First Name: Sandra

Last Name: Fox

January 29, 2020 7:21 pm

Balance

Sedation Training

Mod Sedation training program 60 hrs and 20 patients? Yes
 Airway management training? Yes
 Airway Training Date Jul 01, 2012
 ACLS Certified? No
 ADA accredited residency program? Yes
 Specialty 1 Pediatrics
 Post Graduate Training Type 1
 Post Graduate Training Institution 1 University of Iowa
 Institution 1 City & State Iowa City, IA
 Post Graduate Training 1 Start Date 07/01/2012
 Post Graduate Training 1 End Date 06/30/2014
 Continuing Education Course
 Continuing Education Course Location
 Continuing Education Course Date Completed
 Pediatric Training? Yes
 Pediatric Training Location University of Iowa
 Pediatric Training Date
 Med. Comp. Training? Yes
 Med. Comp. Training Location University of Iowa
 Med. Comp. Training Date
 Marriage/Divorce Decree Submission Method?

Chronology

Private practice in West Des Moines, IA	07/2014	05/2015
Private practice in Dallas, TX	05/2015	07/2018
Private practice in Cleveland, OH	07/2018	06/2019
Private practice in Dallas, TX	07/2019	12/2019

Out of State License Information

State/Country	Active	License No.	Date Issued	License Type	How Obtained
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Question List and Details

Do you currently have a medical condition that in any way impairs or No
limits your ability to practice dentistry with reasonable skill and
safety?

Are you currently engaged in the illegal or improper use of drugs or No
other chemical substances?

Do you currently use alcohol, drugs, or other chemical substances No
that would in any way impair or limit your ability to practice
dentistry with reasonable skill and safety?

Are you receiving ongoing treatment or participating in a monitoring No
program that reduces or eliminates the limitations or impairments
caused by either your medical conditions or use of alcohol, drugs, or
other chemical substances?



IOWA DENTAL BOARD

License Detail Report

First Name: Sandra

Last Name: Fox

January 29, 2020 7:21 pm

	<u>Balance</u>
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

Board Certification.pdf

Pediatric Dentistry Certificate.pdf

Texas Dental License.jpg

ABPD Certification

Pediatric Dentistry Certificate

Texas Dental License - shows sedation endorsement



APPLICATION FOR MODERATE SEDATION PERMIT

IOWA DENTAL BOARD

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

Ph. (515) 281-5157 <http://www.dentalboard.iowa.gov>

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee \$500. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) Sandra Fox				
Other Names Used: (e.g. Maiden Name)				
Home Address:				
City:	County:	State:	Zip:	
Iowa License #: DDS-09709	Issue Date: 5/8/2014	Expiration Date: 8/31/2020	Type of Practice:	

LOCATIONS IN IOWA WHERE MODERATE SEDATION SERVICES WILL BE PROVIDED

Office Address	City	Zip Code	Phone	Office Hours/Days
2001 N 6th St.	Indianola	50125	515-808-7000	

BASIS FOR APPLICATION

Type of Training Completed	Check if completed	Date(s) completed:
A minimum of 60 hours instruction that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2016. <i>(e.g. ADA-accredited residency or continuing education program.)</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Management of a minimum of 20 patients.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Formal training in airway management:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	07/01/2012
Residency training, which included training in pediatric sedation:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	06/30/2014
Residency training, which included training in medically-compromised patients:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	06/30/2014
ACLS/PALS certification: (Date of expiration: <u>01/2022</u>)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

For Office Use Only	Permit. #		Approved by ACC:	ACLS/PALS:	Fees:
	Issue Date:	License #	Inspection:	Training:	Ped/MC:

MODERATE SEDATION TRAINING INFORMATION			
Type of Program: <input checked="" type="checkbox"/> Postgraduate residency <input type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-approved program, specify: _____			
Name of Training Program: University of Iowa College of De	Street Address: _____	City: Iowa City	State: Iowa
Type of Experience: Pediatric residency			
Length of Training: 2 years			Dates Completed: _____
Number of Patient Contact Hours: _____		Total Number of Supervised Sedation Cases: _____	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<ol style="list-style-type: none"> 1. Did you satisfactorily complete the above training program? 2. Did the curriculum include training in physical evaluation? 3. Did the curriculum include training in IV sedation? 4. Did the curriculum include training in airway management? 5. Did the curriculum include training in monitoring? 6. Did the curriculum include training in basic life support and emergency management? 7. Did the program include the clinical experience in managing compromised airways? 8. Did the program include rescuing patients from a deeper level of sedation than intended, including, but not limited to, intravascular or intraosseous access and reversal medications? 9. Did the program provide training or experience in managing moderate sedation in pediatric patients? 10. Did the program provide training or experience in managing moderate sedation in medically-compromised patients? 		

MODERATE SEDATION EXPERIENCE	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<ol style="list-style-type: none"> 1. Do you have a license, permit or registration to perform moderate sedation in any other state? If yes, specify state(s) and permit numbers: <u>Iexas</u> 2. Do you consider yourself engaged in the use of moderate sedation in your professional practice? 3. Have you ever had any patient mortality, or other incident, which 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?

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. **Is your dental office properly maintained and equipped with the following?**

<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail-safe mechanism?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. EKG monitor?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	10. Laryngoscope and blades?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	11. Endotracheal tubes?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	12. Magill forceps?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13. Oral airways?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	14. Stethoscope?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	15. Blood pressure monitoring device?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	16. Pulse oximeter?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	18. A defibrillator (an automated defibrillator is recommended)?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	19. Capnography machine?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20. Pretracheal or precordial stethoscope?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	21. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	22. How many nitrous oxide inhalation analgesia units are in your facility? _____

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):

Sandra Renae Fox

City/State:
Indianola, Iowa

Email Address:
sandra.fox.dds@gmail.com

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: *Sandra Fox*

Date:
01/30/2020

SECTION 2 – TO BE COMPLETED BY MODERATE SEDATION TRAINING DIRECTOR

Name of Moderate Sedation Training Program:

Univ. of Iowa College of Dentistry Advanced Education in Pediatric Dentistry

Phone:

319-335-7480

Address:

202 Dental Science S. Iowa City IA 52241

Name of Training Director:

Matthew K. Geneser DDS

Email Address:

matt-geneser@uiowa.edu

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):
07/2012

To (Mo/Yr):
07/2014

Date Program Completed:
7-1-2014

- | | |
|--|---|
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 1. Did the applicant satisfactorily complete the above training program?
2. Did the program include at least sixty (60) hours of didactic training in pain and anxiety?
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?
4. Did the program include the management of a minimum of 20 patients?
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?
6. Did the program include clinical experience in managing compromised airways? (If no, please provide a detailed explanation.)
7. Did the applicant ever receive a warning, reprimand, or was the applicant placed on probation during the training program? (If yes, please explain.)
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:

[Signature]

Date:

2-3-20



AMERICAN BOARD OF PEDIATRIC DENTISTRY

As of: 01/29/2020

Dr. Sandra Fox

This document does not serve as a primary source verification.

The above referenced pediatric dentist is an Active Diplomate of the American Board of Pediatric Dentistry.

A Diplomate of the American Board of Pediatric Dentistry is a pediatric dentist whose credentials have been verified, who has successfully completed voluntary examinations, and who demonstrates specialized knowledge and skill. A Diplomate is dedicated to providing patient care through a voluntary commitment to lifelong learning.

An active Diplomate must comply with the Annual Diplomate Renewal fee, have an active license to practice dentistry and submit the annual Credentials. Active Diplomates with time-limited certificates are required to fulfill all requirements of the Renewal of Certification Process.

If you need further assistance, do not hesitate to contact our office.

Status: Active

Original Certification Date: 09/28/2015

Current Certification Expiration Date: 12/31/2020

Sincerely,

A handwritten signature in blue ink that reads "Christine Sharp". The signature is written in a cursive style.

Christine Sharp, Chief Operations Officer



THE UNIVERSITY OF IOWA

College of Dentistry

THIS IS TO CERTIFY THAT

Sandra Renee Fox

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 FOURTEEN.

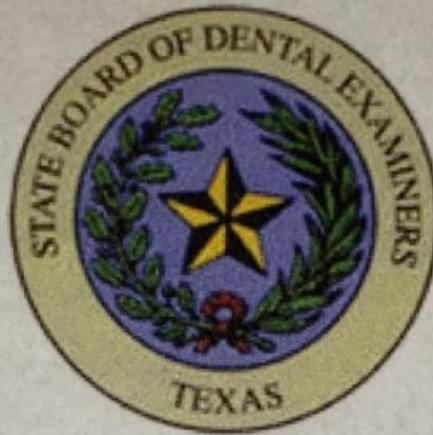
Sally Mues
PRESIDENT OF THE UNIVERSITY

Kevin Weber - Gray
HEAD OF DEPARTMENT

David C. Hansen
DEAN OF THE COLLEGE

Mark [unclear]
PROGRAM DIRECTOR





TEXAS LICENSED DENTIST

SANDRA RENAE FOX

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

EXPIRATION DATE

April 30, 2020

LICENSE NUMBER 30623

ements:

- Moderate Enteral
- Minimal Sedation
- Oxide

David Tillman DDS
Presiding Officer



TEXAS STATE BOARD OF DENTAL EXAMINERS

TSBDE Dentist: FOX, SANDRA RENAE # 30623

License Number 30623
 License Status Active
 License Issue Date 12/03/2014
 License Expiration Date 04/30/2020

Last Name FOX
 Former Last Name
 First Name SANDRA
 Middle Name RENAE
 Gender Female
 City LEWISVILLE
 State TX
 Zip Code 75067
 County DENTON

Nitrous Certification Date 03/13/2015
 Anesthesia Level 1 Permit Issue Date 03/13/2015
 Anesthesia Level 2 Permit Issue Date 03/13/2015
 Anesthesia Level 3 Permit Issue Date No Permit
 Anesthesia Level 4 Permit Issue Date No Permit
 Sedation of Pediatric Patients Yes
 Sedation of High-Risk Patients No

Type of Practice
 Year Graduated 2012
 Dental School University of Iowa
 Year of Birth 1986

Public Actions

Disciplinary Action No
 Disciplinary Action PDFs
 Remedial Plans No
 Remedial Plan PDFs

CERTIFICATION OF INFORMATION: The Texas State Board of Dental Examiners certifies that it maintains the information for the license verification functions of this website, performs daily updates to the website and considers the website to be a secure, primary source for license verification.

Codes for Type of Practice

DPH=Dental Public Health

END=Endodontics

GEN=General Dentistry

OMP=Oral&Maxillofacial Pathology

OMR=Oral&Maxillofacial Radiology

OMS=Oral&Maxillofacial Surgery

ORTH=Orthodontics

PEDO=Pediatric Dentistry

PERI=Periodontics

PROS=Prosthodontics

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RECEIVED

FEB 05 2020

IOWA DENTAL BOARD

Sandra Fox, DDS
Indianola Pediatric Dentistry
2001 North Sixth Street
Indianola, IA 50125-4873

Anesthesia Credentials Committee
400 SW 8th Street, Suite D
Des Moines, IA 50309-4687

Committee members:

I am writing to clarify some points on my application that you may have questions about. When applying online, the first page asked if I had current ACLS, but did not state that PALS was an alternative option. I checked "no" as I do not have ACLS and did not want to mislead anyone. As a pediatric sedation provider, I have been certified continuously in PALS since 07/2012 along with BLS.

My work history also tends to present some questions. My husband is a physician, so my frequent moves around the county mirror his medical training. I practiced in West Des Moines during his intern year, in Dallas, TX during his 3-year residency, and in Cleveland, OH during his 1-year fellowship. My new office is under construction and I anticipate opening in April. Now that his training is done, I will be practicing in Indianola for the foreseeable future.

Only in Texas was I licensed to provide sedation. It is added as an endorsement on your dental license. I was endorsed for nitrous oxide, level 1 (minimal) and level 2 (moderate enteral). I typically sedated 2 children per week. I did not obtain sedation permits in other states because the offices I worked at were not offering this service and did not want to go through purchasing the necessary equipment knowing I would only be employed a short time.

My drug regimen for pediatric patients is one of the following depending on the child's age, weight, medical history, demeanor and type of dental treatment to be completed:

- 0.5 mg/kg of PO midazolam with a maximum dose of 15 mg
- 2.0 mg/kg of PO meperidine with a maximum dose of 50 mg + 1.0 mg/kg of PO hydroxyzine with a maximum dose of 25 mg
- 0.5 mg/kg of PO diazepam with a maximum dose of 15 mg

With any of these combinations I also utilize nitrous oxide up to a maximum level of 50% during treatment.

If there is anything else regarding my application that needs clarification please let me know.

Sincerely,



Sandra Fox, DDS

PEDIATRIC ADVANCED LIFE SUPPORT

**PALS
Provider**



American Academy
of Pediatrics



Sandra Fox

**has successfully completed the cognitive and skills evaluations
in accordance with the curriculum of the American Heart Association
Pediatric Advanced Life Support (PALS) Program.**

Issue Date

1/29/2020

Recommended Renewal Date

01/2022

Training Center Name

Central Iowa Hospital Corporation d/b/a UnityPoint
Health - Des Moines

Instructor Name

Katie Dumermuth

Training Center ID

IA05121

Instructor ID

02120082340

Training Center Address

1200 Pleasant St
Des Moines IA 50309-1406 USA

eCard Code

207001074643

**Training Center Phone
Number**

(515) 241-6811

QR Code



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

© 2016 American Heart Association. All rights reserved. 15-3006 10/16



THE UNIVERSITY OF IOWA
College of Dentistry

THIS IS TO CERTIFY THAT

Sandra Renae Fox

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 FOURTEEN.

Sally Mason

PRESIDENT OF THE UNIVERSITY



Karin Weber-Gay

HEAD OF DEPARTMENT

David C. Johnson

DEAN OF THE COLLEGE

Mark [Signature]

PROGRAM DIRECTOR



APPLICATION FOR MODERATE SEDATION PERMIT

RECEIVED

FEB 12 2020

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

IOWA DENTAL BOARD

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee \$500. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle) CERASO, GREGORY FRANK				
Other Names Used: (e.g. Maiden Name)				
Home Address: 7030 FOREST DR				
City: JOHNSTON	County: POLK	State: IOWA	Zip: 50131	
Iowa License #:	Issue Date: July 18 1994	Expiration Date: Aug 31, 2020	Type of Practice: GENERAL	
LOCATIONS IN IOWA WHERE MODERATE SEDATION SERVICES WILL BE PROVIDED				
Office Address	City	Zip Code	Phone	Office Hours/Days
4201 WESTOWN PKY Suite 118	W. DES MOINES	50266	515-282-1213	8:00 AM - M-Tu 4:00 PM
BASIS FOR APPLICATION				
Type of Training Completed	Check if completed	Date(s) completed:		
A minimum of 60 hours instruction that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2016. <i>(e.g. ADA-accredited residency or continuing education program.)</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5/78		
Management of a minimum of 20 patients.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5/78		
Formal training in airway management:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5/78		
Residency training, which included training in pediatric sedation:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Residency training, which included training in medically-compromised patients:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5/78		
ACLS/PALS certification: (Date of expiration: 2-4-2022)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2-4-2020		

For Office Use Only	Permit. #	Approved by ACC:	ACLS/PALS:	Fees: CR# 4507 / \$500
	Issue Date:	License #	Inspection:	Training: Ped/MC:

Name of Applicant: GREGORY F. CERASO

DEFINITIONS

Important! Read these definitions before completing the following questions.

“Ability to practice dentistry with reasonable skill and safety” means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

“Medical condition” means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

“Chemical substances” means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

“Improper use of drugs or other chemical substances” means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

“Illegal use of drugs or other chemical substances” means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

PERSONAL & CONFIDENTIAL

If you answer “yes” to any questions 1-11 below, attach a written, signed explanation. Attach additional pages, if needed.	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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"/> YES <input checked="" type="checkbox"/> NO	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	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 checked="" type="checkbox"/> YES <input type="checkbox"/> NO	4. If YES to any of the above, are you receiving ongoing treatment or participating 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?

Name of Applicant: GREGORY F. CERASO

MODERATE SEDATION TRAINING INFORMATION

Type of Program:

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

Name of Training Program: <u>University of Pittsburgh School of Dental Medicine - Anesthesia Elective</u>	Street Address:	City: <u>Pittsburgh</u>	State: <u>PA</u>
--	-----------------	----------------------------	---------------------

Type of Experience:
Didactic + Hands on Clinical

Length of Training: <u>1 yr</u>	Dates Completed: <u>5/77 - 5/78</u>
---	---

Number of Patient Contact Hours: <u>100+</u>	Total Number of Supervised Sedation Cases: <u>50+</u>
--	---

- | | |
|---|---|
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 1. Did you satisfactorily complete the above training program? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 2. Did the curriculum include training in physical evaluation? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 3. Did the curriculum include training in IV sedation? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 4. Did the curriculum include training in airway management? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 5. Did the curriculum include training in monitoring? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 6. Did the curriculum include training in basic life support and emergency management? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 7. Did the program include the clinical experience in managing compromised airways? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 8. Did the program include rescuing patients from a deeper level of sedation than intended, including, but not limited to, intravascular or intraosseous access and reversal medications? |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 9. Did the program provide training or experience in managing moderate sedation in pediatric patients? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 10. Did the program provide training or experience in managing moderate sedation in medically-compromised patients? |

MODERATE SEDATION EXPERIENCE

- | | |
|---|---|
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 1. Do you have a license, permit or registration to perform moderate sedation in any other state? If yes, specify state(s) and permit numbers: _____ |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 2. Do you consider yourself engaged in the use of moderate sedation in your professional practice? |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 3. Have you ever had any patient mortality, or other incident, which 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? |

Name of Applicant: GREGORY F. CARASO

MODERATE SEDATION EXPERIENCE

<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	4. Do you plan to use moderate sedation in pediatric patients?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	5. Do you plan to use moderate sedation in medically-compromised (ASA 3-4) patients?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	6. Do you plan to engage in enteral moderate sedation?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	7. Do you plan to engage in parenteral moderate sedation?

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

I will continue to use minimal sedation on my own (ie. valium / N₂O₂) as an anxiety/lysis protocol

* All IV cases are + will be performed by MD anesthesiologist / CRNA utilizing their drug protocol

* I do not wish to pursue providing IV sed. as a single provider

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. Attached another sheet if necessary.

Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Melanie Trusty RN	DA- RN 105009 / R07261	1/2020	01-2022
Vicki Thomas RN	RN 062292	1/2020	01-2022
DESIREA Austin	Q 11266	1/2020	01-2022
Kendall Corbett	13088	1/2020	01-2022
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:
Name:	License/Registration #:	CPR Certification Date:	CPR Certification Expiration Date:

Name of Applicant: GREGORY F. GEMSO

AFFIDAVIT OF APPLICANT

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.

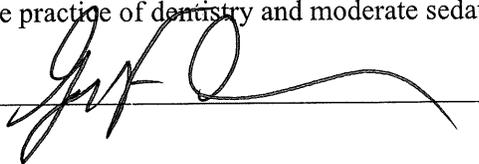
I am aware that pursuant to Iowa Administrative Code 650—29.9(153) I must report any adverse occurrences related to the use of moderate sedation. I also understand that if moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

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 moderate sedation, deep sedation/general anesthesia 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.

Signature of Applicant: _____



Date: 02-24-2020

Name of Applicant: GREGORY F. CERASO

APPLICATION ACKNOWLEDGEMENTS

FEES

Pursuant to Iowa Administrative Code 650—Chapter 15, application fees are non-refundable.

MODERATE SEDATION AND/OR GENERAL ANESTHESIA

Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry until an active permit has been issued to you. For additional information, please refer to the Board's rules at Iowa Administrative Code 650-Chapter 29.

PUBLIC RECORDS

All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650-Chapter 6. Information on misconduct and examination results is not subject to disclosure. Criminal history may be subject to disclosure.

APPLICATIONS

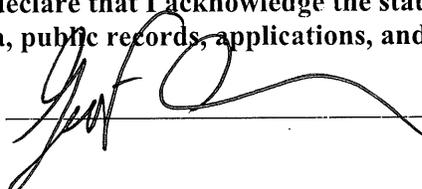
Permits are issued administratively following review and approval of a completed application and all required documentation by the Anesthesia Credentials Committee. Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, restrictions may be placed on the permit.

Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain a license in Iowa.

ACLS/PALS CERTIFICATION

I hereby declare that I possess a valid certificate from a nationally-recognized course in ACLS/PALS that includes a “hands-on” clinical component. I acknowledge that proof of certification will be maintained and made available to the Board upon request.

I hereby declare that I acknowledge the statements above concerning fees, moderate sedation and/or general anesthesia, public records, applications, and ACLS/PALS certification.

Signature: 

Date: 02-04-2020

Name of Applicant: GREGORY F. CERASO

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. **Is your dental office properly maintained and equipped with the following?**

- | | |
|---|--|
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.) |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 7. Is the patient able to be observed by a member of the staff at all times during the recovery period? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail-safe mechanism? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 9. EKG monitor? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 10. Laryngoscope and blades? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 11. Endotracheal tubes? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 12. Magill forceps? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13. Oral airways? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 14. Stethoscope? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 15. Blood pressure monitoring device? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 16. Pulse oximeter? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 17. Emergency drugs that are not expired? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 18. A defibrillator (an automated defibrillator is recommended)? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 19. Capnography machine? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 20. Pretracheal or precordial stethoscope? |
| <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 21. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)? |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 22. How many nitrous oxide inhalation analgesia units are in your facility? <u>8</u> |

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):
 Gregory Ceraso, D.M.D.

City/State:
 West Des Moines, IA

Email Address:
 gceraso276@gmail.com

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: 6-17-19

SECTION 2 – TO BE COMPLETED BY MODERATE SEDATION TRAINING DIRECTOR

Name of Moderate Sedation Training Program:
 University of Pittsburgh School of Dental Medicine-Anesthesia Elective

Phone:
 412-648-8609

Address:
 Pittsburgh, PA

Name of Training Director:
 C. Richard Bennett, DDS (Retired)

Email Address:
 lrl12@pitt.edu

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: Valium, Demerol, Brevital

Dates Applicant Participated in Program:	From (Mo/Yr): 5/77	To (Mo/Yr): 5/78	Date Program Completed: 5/78
--	--------------------	------------------	------------------------------

- | | |
|--|---|
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 1. Did the applicant satisfactorily complete the above training program?
2. Did the program include at least sixty (60) hours of didactic training in pain and anxiety?
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?
4. Did the program include the management of a minimum of 20 patients?
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?
6. Did the program include clinical experience in managing compromised airways? (If no, please provide a detailed explanation.)
7. Did the applicant ever receive a warning, reprimand, or was the applicant placed on probation during the training program? (If yes, please explain.)
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: *[Signature]*

Date: 6-13-19

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ADVANCED CARDIOVASCULAR LIFE SUPPORT

**ACLS
Provider**



Gregory Ceraso

This card certifies that the above individual has successfully completed the Advanced Cardiovascular Life Support (ACLS) course requirements and cognitive evaluation in accordance with the curriculum of ACLS Medical Training and American Heart Association guidelines.

Feb 04, 2020

Issue Date

Feb 04, 2022

Recommended Renewal Date

Training Center Name ACLS Medical Training

Training Center ID NDS225

TC Phone (866) 540-8212

Instructor ID 0522001125

Holder's Signature *Gregory Ceraso*

© ACLS Medical Training

V01120

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ADVANCED CARDIOVASCULAR LIFE SUPPORT

**ACLS
Provider**



Gregory Ceraso

This card certifies that the above individual has successfully completed the Advanced Cardiovascular Life Support (ACLS) course requirements and cognitive evaluation in accordance with the curriculum of ACLS Medical Training and American Heart Association guidelines.

Feb 04, 2020

Issue Date

Feb 04, 2022

Recommended Renewal Date

Training Center Name ACLS Medical Training

Training Center ID ND5225

TC Phone (866) 540-8212

Instructor ID 0522001125

Holder's Signature _____

© ACLS Medical Training

V01120

BASIC LIFE SUPPORT

BASIC LIFE SUPPORT

**BLS
Provider**



Greg Ceraso

The above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.

Issue Date **Recommended Renewal Date**
1/22/2020 01/2022



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

Training Center Name Mercy College of Health Sciences

Training Center ID IA15182

TC Address 921 6th
Des Moines IA 50309 USA

TC Phone (515) 643-6671

Instructor Name Nancy Lacy

Instructor ID 03130162033



APPLICATION FOR MODERATE SEDATION PERMIT

RECEIVED

FEB 07 2020

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

IOWA DENTAL BOARD

This form must be completed and returned to the Iowa Dental Board. Include the *non-refundable* application fee \$500. Do not submit payment in cash. Complete each question on the application. If not applicable, mark "N/A."

Full Legal Name: (Last, First, Middle)
 Dannenbring, Zach

Other Names Used: (e.g. Maiden Name)

Home Address:
 6851 Cypress Pt.

City: Sioux City	County: Woodbury	State: Ia	Zip: 51106
Iowa License #: 08499	Issue Date: Aug 28, 2018	Expiration Date: Aug 31, 2020	Type of Practice: General Dentistry

LOCATIONS IN IOWA WHERE MODERATE SEDATION SERVICES WILL BE PROVIDED

Office Address	City	Zip Code	Phone	Office Hours/Days
2114 Pierce St.	Sioux City	51104	712-252-3440	M-F/7-4

BASIS FOR APPLICATION

Type of Training Completed	Check if completed	Date(s) completed:
A minimum of 60 hours instruction that meets ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2016. (e.g. ADA-accredited residency or continuing education program.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6-18-2012 1 6-30-2012
Management of a minimum of 20 patients.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6-18-2012 6-30-2012
Formal training in airway management:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6-18-2012 6-30-2012
Residency training, which included training in pediatric sedation:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Residency training, which included training in medically-compromised patients:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ACLS/PALS certification: (Date of expiration: <u>03/2021</u>)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

Previously issued MS-0099. Expired 8/31/2018.

For Office Use Only	Permit. #	Approved by ACC:	ACLS/PALS:	Fees:
	Issue Date:	License #	Inspection:	Ped/MC:

Fees: \$500 #1005224
 Ped/MC: N
 Training:

Name of Applicant: Zach Dannenberg

MODERATE SEDATION TRAINING INFORMATION			
Type of Program: <input type="checkbox"/> Postgraduate residency <input checked="" type="checkbox"/> Continuing Education Program <input type="checkbox"/> Other Board-approved program, specify: _____			
Name of Training Program: <u>Amini Residency in Parenteral Conscious Sedation</u>	Street Address: <u>13333 68th Parkway #1010</u>	City: <u>Tigard</u>	State: <u>Or</u>
Type of Experience: <u>Continuing ED Course. Using Midazolam, Fentanyl, Ketorolac</u>			
Length of Training: <u>6-18-2012 → 6-30-2012</u>		Dates Completed: <u>6/30/2012</u>	
Number of Patient Contact Hours: <u>32</u>		Total Number of Supervised Sedation Cases: <u>20</u>	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<ol style="list-style-type: none"> 1. Did you satisfactorily complete the above training program? 2. Did the curriculum include training in physical evaluation? 3. Did the curriculum include training in IV sedation? 4. Did the curriculum include training in airway management? 5. Did the curriculum include training in monitoring? 6. Did the curriculum include training in basic life support and emergency management? 7. Did the program include the clinical experience in managing compromised airways? 8. Did the program include rescuing patients from a deeper level of sedation than intended, including, but not limited to, intravascular or intraosseous access and reversal medications? 9. Did the program provide training or experience in managing moderate sedation in pediatric patients? 10. Did the program provide training or experience in managing moderate sedation in medically-compromised patients? 		

MODERATE SEDATION EXPERIENCE	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<ol style="list-style-type: none"> 1. Do you have a license, permit or registration to perform moderate sedation in any other state? If yes, specify state(s) and permit numbers: <u>Nebraska</u> 2. Do you consider yourself engaged in the use of moderate sedation in your professional practice? 3. Have you ever had any patient mortality, or other incident, which 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?

Name of Applicant: Zach Dannenbring

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. **Is your dental office properly maintained and equipped with the following?**

<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	1. An operating room large enough to adequately accommodate the patient on a table or in an operating chair and permit an operating team consisting of at least two individuals to move freely about the patient?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. An operating table or chair that permits the patient to be positioned so the operating team can maintain the airway, quickly alter the patient position in an emergency, and provide a firm platform for the management of cardiopulmonary resuscitation?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	3. A lighting system that is adequate to permit evaluation of the patient's skin and mucosal color and a backup lighting system that is battery powered and of sufficient intensity to permit completion of any operation underway at the time of general power failure?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	5. An oxygen delivery system with adequate full face masks and appropriate connectors that is capable of delivering oxygen to the patient under positive pressure, together with an adequate backup system?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail-safe mechanism?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	9. EKG monitor?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	10. Laryngoscope and blades?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	11. Endotracheal tubes?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	12. Magill forceps?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13. Oral airways?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	14. Stethoscope?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	15. Blood pressure monitoring device?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	16. Pulse oximeter?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	17. Emergency drugs that are not expired?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	18. A defibrillator (an automated defibrillator is recommended)?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	19. Capnography machine?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20. Pretracheal or precordial stethoscope?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	21. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	22. How many nitrous oxide inhalation analgesia units are in your facility? <u>5</u>

Name of Applicant: Zach Dannenbring

DEFINITIONS

Important! Read these definitions before completing the following questions.

“Ability to practice dentistry with reasonable skill and safety” means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

“Medical condition” means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

“Chemical substances” means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

“Currently” does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

“Improper use of drugs or other chemical substances” means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

“Illegal use of drugs or other chemical substances” means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

PERSONAL & CONFIDENTIAL

If you answer “yes” to any questions 1-11 below, attach a written, signed explanation. Attach additional pages, if needed.

<input type="checkbox"/> YES <input checked="" type="checkbox"/> 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"/> YES <input checked="" type="checkbox"/> NO	2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	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"/> YES <input checked="" type="checkbox"/> NO	4. If YES to any of the above, are you receiving ongoing treatment or participating 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?

Name of Applicant: Zach Dannenbring

AFFIDAVIT OF APPLICANT

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 moderate 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 moderate sedation, deep sedation/general anesthesia 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.

Signature of Applicant: Zach Dannenbring

Date: 1/24/2020

Name of Applicant: Zach Dannenbring

APPLICATION ACKNOWLEDGEMENTS

FEES

Pursuant to Iowa Administrative Code 650—Chapter 15, application fees are non-refundable.

MODERATE SEDATION AND/OR GENERAL ANESTHESIA

Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry until an active permit has been issued to you. For additional information, please refer to the Board's rules at Iowa Administrative Code 650-Chapter 29.

PUBLIC RECORDS

All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650-Chapter 6. Information on misconduct and examination results is not subject to disclosure. Criminal history may be subject to disclosure.

APPLICATIONS

Permits are issued administratively following review and approval of a completed application and all required documentation by the Anesthesia Credentials Committee. Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, restrictions may be placed on the permit.

Applications are valid for only 180 days from the date of receipt. If the application has not been completed within 180 days, a new application and fee will have to be submitted if you wish to obtain a license in Iowa.

ACLS/PALS CERTIFICATION

I hereby declare that I possess a valid certificate from a nationally-recognized course in ACLS/PALS that includes a “hands-on” clinical component. I acknowledge that proof of certification will be maintained and made available to the Board upon request.

I hereby declare that I acknowledge the statements above concerning fees, moderate sedation and/or general anesthesia, public records, applications, and ACLS/PALS certification.

Signature: Zach Dannenbring

Date: 1/24/2020

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):

Zach Dannenbring

City/State:

Sioux City, Ia

Email Address:

Zachdannenbring@live.com

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:

Zach Dannenbring

Date:

10-1-19

SECTION 2 – TO BE COMPLETED BY MODERATE SEDATION TRAINING DIRECTOR

Name of Moderate Sedation Training Program:

A MINI RESIDENCY IN PARENTERAL CONSCIOUS SEDATION

Phone:

(503) 228-6214

Address:

13333 WBTM PARKWAY #10 TIGARD, OR 97223

Name of Training Director:

DR. KEN REED

Email Address:

UNFD@ORADO.ORG

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: *MIDAZOLAM, MORPERIDINE, FENTANYL, KETOROLAC*

Dates Applicant Participated in Program:

From (Mo/Yr):

6/18/2012

To (Mo/Yr):

6/30/2012

Date Program Completed:

6/30/2012

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:

Wahy Hester

Date:

10/1/2019

ADVANCED CARDIOVASCULAR LIFE SUPPORT

**ACLS
Provider**



**American
Heart
Association®**

Zach Dannenbring

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

Issue Date

3/26/2019

Recommended Renewal Date

03/2021

Training Center Name

Western Iowa Tech Community College

Instructor Name

Terry Ragaller

Training Center ID

IA05138

Instructor ID

08110038980

Training Center Address

4647 Stone Ave
Sioux City IA 51106-3815 USA

eCard Code

196502415843

**Training Center Phone
Number**

(712) 274-8733

QR Code



To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to www.heart.org/cpr/mycards.

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IOWA DENTAL BOARD
MEMORANDUM

DATE: February 18, 2020

TO: Anesthesia Credentialing Committee

FROM: David Schultz, Investigator *ds*

REFERENCE: Rule 29.5(7)

I am seeking clarification on Board rule 29.5(7) which states "*The dentist or another designated permit holder or licensed sedation provider must be available for postoperative aftercare for a minimum of 48 hours following the administration of sedation.*"

This means the permit holder or licensed sedation provider must be physically available but questions have been raised as to how much distance would render the permit holder or licensed sedation provider as "unavailable"? What is an acceptable distance or time frame for the permit holder or licensed sedation provider to be within, and meet the requirement of this rule?

This is brought to you as during the past several months when conducting facility inspections for sedation permit holders, I have noticed an increase in the number of sedation permit holders who are performing sedation procedures at offices other than their regular practice location. The facility is properly equipped and in some of these cases the permit holder brings in a licensed sedation provider.

In the cases I am referencing, after the surgical procedures for the day are done, the permit holder and licensed sedation provider leave the city of that practice and are returning to the location of their full-time practices. The practice does not have another sedation permit holder in their office, and the licensed sedation provider is not from the city where the surgery takes place.

In some of the cases the permit holder and licensed sedation provider are flying or driving to home offices located out of state. In one instance the permit holder performs surgery at 12 different offices in the state. He completes his procedures at one location and then travels to the next office. He does not have a permanent practice location and resides out of state. In a third case, the permit holder and licensed sedation provider would return to their primary practice location that are almost a three hour drive from where they will be performing the dental surgery.

This is being presented to you for review and to offer guidance for addressing this when I am conducting sedation inspections or when the Committee receives initial sedation permit applications.