STATE OF IOWA

IOWA DENTAL BOARD

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

JILL STUECKER
EXECUTIVE DIRECTOR

ANESTHESIA CREDENTIALS COMMITTEE

AGENDA

July 16, 2015
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.*

I. CALL MEETING TO ORDER – ROLL CALL

II. COMMITTEE MINUTES

a. January 15, 2015 – Teleconference
b. March 10, 2015 – Teleconference
c. June 11, 2015 – Teleconference

III. APPLICATION FOR GENERAL ANESTHESIA PERMIT

a. Douglas E. Kendrick, D.D.S.

IV. APPLICATION FOR MODERATE SEDATION PERMIT

a. Kecia S. Leary, D.D.S.
b. Arwa I. Owais, D.D.S.

V. OPPORTUNITY FOR PUBLIC COMMENT

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

Committee Members	**January 15, 2015**
Kaaren Vargas, D.D.S.	Present
Richard Burton, D.D.S.	Absent
Steven Clark, D.D.S.	Present
John Frank, D.D.S.	Present
Douglas Horton, D.D.S.	Present
Gary Roth, D.D.S.	Present
Kurt Westlund, D.D.S.	Present

Staff Member
Jill Stuecker, Christel Braness

Other Attendees
Judd Larson, D.D.S.

I. CALL MEETING TO ORDER – JANUARY 15, 2015

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:05 p.m. on Thursday, January 15, 2015. This meeting was held by conference call to review meeting 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 members present.

Roll Call:

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

- Dr. Larson joined the call 12:07 p.m.

II. COMMITTEE MEETING MINUTES

DRAFT

- *October 2, 2014 – Teleconference Meeting*

❖ MOVED by ROTH, SECONDED by FRANK, to APPROVE the minutes as submitted.

Dr. Horton asked to comment. Dr. Horton stated that he was aware that Dr. Burton who had asked about the person who requested the survey of permit holders. Dr. Horton stated that the request came from an oral surgeon in Iowa. Dr. Horton stated that anyone with questions could be in contact with him.

❖ Vote taken. Motion approved unanimously.

III. APPLICATION FOR MODERATE SEDATION PERMIT

- *Ashley Sunstrum, D.D.S.*

Ms. Braness provided an overview of this application. It appears that Dr. Sunstrum did not complete a residency program at the University of Iowa College of Dentistry. Rather, it appears that the University of Iowa College of Dentistry put together a continuing education program for her. To date, a formal request for review by the University of Iowa College of Dentistry for review of a continuing education program in moderate sedation program has not been received.

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

Dr. Westlund asked where Dr. Sunstrum would be practicing. Ms. Braness indicated that Dr. Sunstrum is at the University of Iowa College of Dentistry.

Dr. Vargas stated that she would like to see the curriculum, and information about how the course was constructed.

Ms. Braness stated that she would request additional information. Ms. Braness stated that the committee may need to schedule a brief meeting in the near future to address this application to avoid further delays.

Dr. Westlund asked where she was working in the University of Iowa College of Dentistry. Ms. Braness was not certain where Dr. Sunstrum is practicing specifically. Ms. Braness believed that Dr. Sunstrum was a general practitioner. Dr. Westlund was in favor of requesting additional information. Dr. Westlund was reluctant to set a precedent of approving a course without sufficient information.

➢ Dr. Clark joined the call at 12:11 p.m.

Dr. Frank agreed with the request for additional information. Dr. Frank wanted to be sure that all applicants are treated the same.

Ms. Braness asked Dr. Clark if he had some information about Dr. Sunstrum's role at the University of Iowa College of Dentistry. Dr. Clark stated that she is interning in oral surgery. Dr.

DRAFT

Clark reported that she applied for the oral and maxillofacial surgery residency; however, she is currently completing an internship in advance of that residency. The internship includes teaching responsibilities. Dr. Sunstrum will likely enter the oral and maxillofacial surgery upon completion of the internship.

- MOVED by Horton to APPROVE the application as submitted.

Dr. Vargas stated that she would prefer to have more detailed information since an intern status is not sufficient. Dr. Vargas stated that if there is not a precedent, Dr. Vargas would like to see additional information. Ms. Braness was not aware of a precedent.

Dr. Westlund asked if a permit was necessary. Ms. Braness stated that Dr. Sunstrum is also teaching; therefore, she is not strictly in student status. For that reason, it would appear that a permit is necessary. Dr. Clark stated that he was not certain of the specifics of Dr. Sunstrum's internship, and was not able to comment further.

- Dr. HORTON withdrew his motion.

- MOVED by ROTH, SECONDED by WESTLUND to request additional information. Motion approved unanimously.

  - *Mitch Driscoll, D.D.S.*

Ms. Braness provided an overview of this application. Dr. Driscoll completed a continuing education program through Georgia Regents University College of Dental Medicine.

Dr. Frank asked about the course content. Ms. Braness stated that the only information available was that which was submitted as part of the application.

Dr. Frank asked about the historical basis for approving courses. Dr. Frank believed that other courses required additional information prior to approving.

Ms. Braness stated that in most cases, these applications have been submitted on the basis of training completed in an accredited residency program, which would have established standards; whereas, continuing education programs may not be required to adhere to the same standards.

Dr. Roth recommended asking for additional information regarding the curriculum. Dr. Roth recommended documenting compliance with the rule.

- MOVED by ROTH, SECONDED by WESTLUND, to APPROVE the application for moderate sedation permit. Motion approved unanimously.

IV. OTHER BUSINESS

- *2015 Committee Meeting Dates*

DRAFT

Ms. Braness stated that the 2015 meeting dates were established. Additional dates may be added as necessary.

- *Request for Consideration of Prior Training and Experience*
  - *Judd Larson, D.D.S.*

Ms. Braness provided an overview of the request. Dr. Larson requested that his previous training and experience be considered when determining whether he would be eligible for a moderate sedation permit in Iowa.

Dr. Horton stated that the DOCS program does not meet the requirements to get a permit in Iowa. Dr. Horton and Dr. Clark attended a DOCS course in the past and did not feel that the training was adequate.

Dr. Roth believed that the training was inadequate, and encouraged Dr. Larson to attend an approved course. Other states may have differing requirements; however, Iowa requires training to meet the ADA guidelines. Dr. Roth did not consider video as adequate training.

- MOVED by ROTH, SECONDED by HORTON, to deny the request and remain consistent with the determination that DOCS training is insufficient. Motion approved unanimously.

V. OPPORTUNITY FOR PUBLIC COMMENT

Dr. Larson asked to speak. Dr. Larson was the past president Oregon Dental Association. Dr. Larson reported having completed approximately 400 cases with positive outcomes. Dr. Larson asked why past experience is not sufficient.

Dr. Roth asked what a negative outcome would be. Dr. Larson stated that hospital visits and things of that nature would be a negative outcome. Dr. Larson stated that he has not had to use a reversal drug.

Dr. Frank asked if the approved moderate sedation courses are worthwhile to attend. Dr. Larson did not intend to suggest that they were not worthwhile; however, he felt that it was impacting his ability to practice dentistry. When the requirements in Oregon changed, he was grandfathered in. Dr. Larson believed that there was an effect on his livelihood and ability to practice.

VI. ADJOURN

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

The Anesthesia Credentials Committee adjourned its meeting at 12:28 p.m.

<u>NEXT MEETING OF THE COMMITTEE</u>

DRAFT

The next meeting of the Anesthesia Credentials Committee is scheduled for April 16, 2015. The meeting will be held at the Board offices and by teleconference.

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

DRAFT

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES
March 10, 2015
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**March 10, 2015**
Kaaren Vargas, D.D.S.	Absent
Richard Burton, D.D.S.	Present
Steven Clark, D.D.S.	Absent
John Frank, D.D.S.	Absent
Douglas Horton, D.D.S.	Present
Gary Roth, D.D.S.	Present
Kurt Westlund, D.D.S.	Present

Staff Member
Christel Braness

I. CALL MEETING TO ORDER – MARCH 10, 2015

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:14 p.m. on Tuesday, March 10, 2015. This meeting was held by conference call to review applications for moderate sedation permits. It was impractical for the committee to meet in person with such a short agenda. A quorum was established with four members present.

Roll Call:

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

II. APPLICATION FOR MODERATE SEDATION PERMIT

- *Ashley Sunstrum, D.D.S.*

Ms. Braness provided an overview of the application.

DRAFT

- ❖ MOVED by ROTH, SECONDED by WESTLUND, to APPROVE the application for moderate sedation permit. Motion approved unanimously.

  - *Mitch Driscoll, D.D.S.*

Ms. Braness provided an overview of the application.

- ❖ MOVED by ROTH, SECONDED by BURTON, to APPROVE the application for moderate sedation permit. Motion approved unanimously.

III. OPPORTUNITY FOR PUBLIC COMMENT

No comments were received.

IV. ADJOURN

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

The Anesthesia Credentials Committee adjourned its meeting at 12:17 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for April 16, 2015. The meeting will be held at the Board offices and by teleconference.

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

DRAFT

ANESTHESIA CREDENTIALS COMMITTEE

MINUTES
June 11, 2015
Conference Room
400 S.W. 8th St., Suite D
Des Moines, Iowa

Committee Members	**June 11, 2015**
Kaaren Vargas, D.D.S.	Absent
Richard Burton, D.D.S.	Present
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

Staff Members
Jill Stuecker
Christel Braness

I. CALL MEETING TO ORDER – JUNE 11, 2015

Ms. Braness called the meeting of the Anesthesia Credentials Committee to order at 12:02 p.m. on Thursday, June 11, 2015. This meeting was held by conference call to review applications for general anesthesia and moderate sedation permits, which require committee review and approval prior to issuance. It was impractical for the committee to meet in person with such a short agenda. A quorum was established with four members present.

Roll Call:

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

II. APPLICATION FOR GENERAL ANESTHESIA PERMIT

- *Jared Dye, D.M.D.*
- *Jarom Maurer, D.M.D.*

Ms. Braness provided an overview of the applications.

DRAFT

- ❖ MOVED by WESTLUND, SECONDED by ROTH, to APPROVE the applications for general anesthesia permit. Motion approved unanimously.

III. APPLICATION FOR MODERATE SEDATION PERMIT

- *Brandon Peterson, D.D.S.*

Ms. Braness provided an overview of the application. Ms. Braness reported that Dr. Peterson completed his training while in residency at the Medical University of South Carolina. Ms. Braness reported that Dr. Peterson has been serving in the military, and intends to return to private practice in the near future.

Dr. Roth made note of his periodontal residency, and recommended approval.

Dr. Burton also recommended approval of the application. Dr. Burton stated that he was former Navy, and previously served at the same command where Dr. Peterson is currently stationed. Sedation privaleges would have been allowed in his current position.

Dr. Roth asked about sedating patients who are ASA 3-4. Ms. Braness reviewed Dr. Peterson's application, and indicated that Dr. Peterson did not intend to sedate pediatric patients nor medically-compromised patients. Dr. Burton noted that the letter from the residency program made reference to having provided training in the sedation of ASA 3 patients.

- ❖ MOVED by ROTH, SECONDED by BURTON, to APPROVE the application for moderate sedation permit as requested.

Dr. Westlund asked about peer evaluations. Ms. Braness reported that this was a matter for the committee to discuss further. Upon a past review, it appeared that peer review evaluations had not been completed in some time. The committee will need to discuss this further and set a policy about how to handle this.

Dr. Roth asked about the facility inspection. Ms. Braness believed that Dr. Peterson may be joining a previously-inspected facility. If not, Ms. Braness will ensure that this is completed in advance of issuance of the permit.

Dr. Frank asked about an in-person meeting. Ms. Braness indicated that the intent was still to do that; however, there has been some difficulty in scheduling a meeting with a quorum. The committee may want to look into this further after the Board addresses the issue of committee composition at its upcoming meeting.

- ❖ Vote taken. Motion approved unanimously.

IV. OPPORTUNITY FOR PUBLIC COMMENT

DRAFT

Ms. Braness noted the board will be meeting in July. As a standard procedure, committee composition will be reviewed. The committee will be apprised of any changes.

V. ADJOURN

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

The Anesthesia Credentials Committee adjourned its meeting at 12:11 p.m.

NEXT MEETING OF THE COMMITTEE

The next meeting of the Anesthesia Credentials Committee is scheduled for July 16, 2015. The meeting will be held at the Board offices and by teleconference.

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

DRAFT

IOWA DENTAL BOARD

License Detail Report

First Name: Douglas
Last Name: Kendrick

July 07, 2015 10:52 am

Balance

License Basic Information

License Type	ANES-General Anesthesia
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?	4

Facility Information

Joining previously inspected facility?	Yes
Equipment or exemption details	
Provide sedation at more than 1 facility?	Yes
Equipment requirements met?	Yes
Equipment exemptions?	Yes

IOWA DENTAL BOARD

License Detail Report

First Name: Douglas
Last Name: Kendrick

July 07, 2015 10:52 am

Balance

Final Acknowledgements

Application Signature	Yes
Application Signature Date	Jul 07, 2015 10:52:13
ACLS/PALS Certification Acknowledgement	Yes
ACLS/PALS Expiration (mm/yyyy)	02/2016

Initial Acknowledgements

Sedation / LA Permit Acknowledgement	Yes
Public Record Acknowledgement	Yes
Non-Refundable App Fee Acknowledgement	Yes
App Valid 180 Days Acknowledgement	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?	No
If no, is one required?	
Date of peer evaluation	

Printing

Number of Extra Certificates ($25 ea.)	2
Number of Extra Renewal Cards ($25 ea.)	2

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 deep sedation/GA in pediatric?	Yes
Use deep sedation/GA in med comp?	Yes
Use enteral moderate sedation?	Yes

License Detail Report

First Name: Douglas
Last Name: Kendrick

July 07, 2015 10:52 am

	Balance
Use parenteral moderate sedation?	Yes

Sedation Training

Completed accredited ADA training in deep sedation?	Yes
Completed formal training in airway managemt?	Yes
Min. 1yr training in anesthesiology?	Yes
ACLS Certified?	Yes
Specialty 1	Oral & Max. Surgery
Post Graduate Training Type 1	Intern
Post Graduate Training Institution 1	University of Iowa Hospitals and Clinics
Institution 1 City & State	Iowa City, Iowa
Post Graduate Training 1 Start Date	Jul 01, 2010
Post Graduate Training 1 End Date	Jun 30, 2011
Post Graduate Training Type 2	Resident
Post Graduate Training Institution 2	University of Pacific/Highland Hospital
Specialty 2	Oral & Max. Surgery
Institution 2 City & State	Oakland, California
Post Graduate Training 2 Start Date	Jun 30, 2011
Post Graduate Training 2 End Date	Jun 30, 2015
Marriage/Divorce Decree Submission Method?	

Chronology

Internship: Oral & Maxillofacial Surgery, Hospital Dentistry, University of Iowa Hospitals and Clinics, Iowa City IA 52242	07/2010	06/2011
Resident: Department of Oral and Maxillofacial Surgery, University of Pacific/Highland Hospital, Oakland CA	06/2011	06/2015

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 other chemical substances?	No
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

License Detail Report

First Name: Douglas

Last Name: Kendrick

July 07, 2015 10:52 am

	Balance
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

Facilities: Douglas E. Kendrick, D.D.S.

Douglas Edward Kendrick > GA > Initial[ANES]

List View

1 row retrieved Show counts

Query View

Folder Name	In Date	Status	Issued
Douglas Edward Kendrick > GA >	07/07/2015	New	

Folder | People(1) | Info(102) | Fee(4) | Process(1) | Document | Comment | Attachment(1) | Out-of-State Licens... | Chronology of Activities | Faciliti...

Add Delete Save Refresh

Office Address	City	State	ZIP	Telephone	Primary Location?
Hospital Dentistry 200 Hawkins Drive	Iowa City	Iowa	52242	3193567340	Yes No
College of Dentistry Oral Surgery 801 Newton R	Iowa City	Iowa	52242	3193567340	Yes No
Hawkeye Oral Surgery 2401 Coral Ct Suite 5	Coralville	Iowa	52241	3193354517	Yes No

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) Leary, Kecia, Suzanne				
Other Names Used: (e.g. Maiden)	**Home E-mail:** Ksleary@gmail.com		**Work E-mail:** Kecia-Leary@uiowa.edu	
Home Address: 609 N. Jerico (Current Address)	**City:** Nixa	**State:** MO	**Zip:** 65714	**Home Phone:** 319-631-0368
License Number: IA, DDS-08346	**Issue Date:** 08/11/2014	**Expiration Date:** 08/31/2016	**Type of Practice:** Dentistry	

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

Principal Office Address: Centers for Disability and Development 330 Hawkins Dr.	**City:** Iowa City, IA	**Zip:** 52242	**Phone:** 319-353-6711	**Office Hours/Days:** M-F 8-5
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.	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	2004-2007
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☐ Completed	
Moderate sedation experience at graduate level, approved by the Board	☐ Completed	

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: PALS/ACLS/BLS	**Location:** Springfield, MO
Date of Course: 09/19/2014	**Date Certification Expires:** 09/19/2016

Office Use				
	Lic. #	Sent to ACC:	Inspection	Fee
	Permit #	Approved by ACC:	Inspection Fee Pd:	ACLS
	Issue Date:	Temp #	ASA 3/4?	Form A/B
	Brd Approved:	T. Issue Date:	Pediatric?	Peer Eval

02942925
$500.00

Name of Applicant Kecia Leary, DDS, MS

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:
University of Iowa, Pediatric Dentistry	801 Newton Road, DSB	Iowa City	IA

Type of Experience: Pediatric Dental Residency Program

Length of Training:	Date(s) Completed:
3 years	2007
Number of Patient Contact Hours:	**Total Number of Supervised Sedation Cases:** 20

☒ 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): MO

☒ YES ☐ NO **B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?** Have been providing sedations since 2007 at my current location in Missouri

☐ 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.

Oral conscious sedation with nitrous oxide. Using hydroxyzine, meperidine, midazolam, chloral hydrate, valium, alone or in combination with each other based on patient's weight and treatment needs.

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: Missouri **COUNTY:** Christian

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 DDS, MS

NOTARY SEAL

JENNIE L HARRISON
Notary Public – Notary Seal
STATE OF MISSOURI
Christian County
My Commission Expires Oct. 26, 2017
Commission #13887066

SUBSCRIBED AND SWORN BEFORE ME, THIS 20th **DAY OF** May **, YEAR** 2015

NOTARY PUBLIC SIGNATURE Jennie L Harrison

NOTARY PUBLIC NAME (TYPED OR PRINTED) Jennie L Harrison

MY COMMISSION EXPIRES: 10-26-2017

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): Kecia Suzanne Leary

MAILING ADDRESS: 609 N. Jerico

CITY:	STATE:	ZIP CODE:	PHONE:
Nixa	MO	65714	319-631-0368

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:
[signature] DDS MS	05/18/2015

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Matthew K. Geneser

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:
Advanced Program in Pediatric Dentistry, University of Iowa, Iowa City IA	319-335-7480

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	07/2004	06/2007	06/2007

☒ 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 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]	5/28/08

#02942975
$500.00

State of Missouri

Department of Insurance, Financial Institutions and Professional Registration
Division of Professional Registration
Missouri Dental Board

Enteral Conscious Sedation Permit

VALID THROUGH JUNE 01, 2017
ORIGINAL CERTIFICATE/LICENSE NO. 2007027134

KECIA SUZANNE LEARY, DDS

EXECUTIVE DIRECTOR

DIVISION DIRECTOR

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association. | American Academy of Pediatrics

PEEL HERE

PALS Provider

Kecia Leary

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.

SEP 19 2014
Issue Date

SEP 19 2016
Recommended Renewal Date

Training Center Name: Babcock Healthcare Ed. Svc. TC ID #: FL05264

TC Info: Critical Intervention Educators
St. Petersburg, Fl 33713 727-321-8002

Course Location: For Class Information: WWW.CIEUSA.ORG 954-663-4919

Instructor Name: Brian Cowin, RN, BSN #05060097416 Inst. ID #:

Holder's Signature: DDS MS

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1818

This card contains unique security features to protect against forgery.

90-1818 3/11

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

American Heart Association.

PEEL HERE

Kecia Leary

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

SEP 19 2014
Issue Date

SEP 19 2016
Recommended Renewal Date

Training Center Name: Babcock Healthcare Ed. Svc. TC ID #: FL05264
Critical Intervention Educators

TC Info: St. Petersburg, Fl 33713 727-321-8002

Course Location: For Class Information: WWW.CIEUSA.ORG 954-663-4919

Instructor Name: Brian Cowin, RN, BSN #05060097416

Holder's Signature:

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90-1806 3/11

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association.

PEEL HERE

Kecia Leary

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

SEP 19 2014
Issue Date

SEP 19 2016
Recommended Renewal Date

Training Center Name: Babcock Healthcare Ed. Svc. TC ID #: FL05264

TC Info: Critical Intervention Educators
St. Petersburg, Fl 33713 727-321-8002

Course Location: For Class Information: WWW.CIEUSA.ORG 954-663-4919

Instructor Name: Brian Cowin, RN, BSN #05060097416 Inst. ID #:

Holder's Signature:

© 2011 American Heart Association Tampering with this card will alter its appearance. 90-1801

This card contains unique security features to protect against forgery.

90-1801 3/11

THE UNIVERSITY OF IOWA

COLLEGE OF DENTISTRY

THIS IS TO CERTIFY THAT

Kecia Suzanne Leary, D.D.S.

HAS SUCCESSFULLY COMPLETED THE REQUIREMENTS FOR THE

Certificate in Pediatric Dentistry

FROM

July 1, 2004 to June 30, 2007

Gary C. Fiddle
INTERIM PRESIDENT OF THE UNIVERSITY

David C. Johnsen
DEAN OF THE COLLEGE

THE UNIVERSITY OF IOWA ORGANIZED FEB. 25TH 1847

James S. Wefel
HEAD OF DEPARTMENT

Michael Vanuelis
PROGRAM DIRECTOR

Section 7 – AUXILIARY PERSONNEL (page 3)

Dental Assistant Name	State Registration #	BLS Certification Date	Date BLS Certification Expires
Mary Akers	QDA-03838	1/2/2014	1/31/2016
Bridget Barba	QDA-06156	7/14/2014	7/31/2016
Lindsay Baumgart	QDA-08919	11/14/2013	11/31/2015
Lisa Brenneman	QDA-07696	7/16/2014	7/31/2016
Andrea Davidson	QDA-00605	11/12/2014	11/30/2016
Heather Hill	QDA-09590	7/16/2014	7/31/2016
Jaimie Kleppe	QDA-06212	6/24/2013	6/30/2015
Shanna Kolar	QDA-10078	4/9/2014	4/30/2016
Michele Murphy	QDA-08838	7/14/2014	7/31/2016
Mechelle Porter	QDA-11638	1/29/2015	1/31/2017
Sarah Strabala	QDA-11196	1/29/2015	1/31/2017

IOWA DENTAL BOARD
400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
Phone (515) 281-5157 Fax (515) 281-7969
http://www.dentalboard.iowa.gov

RECEIVED
JUN 19 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) Owais, Arwa, Issa				
Other Names Used: (e.g. Maiden) —	**Home E-mail:** arwa_owais@yahoo.com		**Work E-mail:** arwa-owais@uiowa.edu	
Home Address: 9 Kearney Court	**City:** Iowa City	**State:** IA	**Zip:** 52246	**Home Phone:** (319) 359-1617
License Number: FAC-40143	**Issue Date:** 7/1/2014	**Expiration Date:** 8/31/2016	**Type of Practice:**	

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

Principal Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Center For Diseases & Development	Iowa	52242	(319) 353-6711	Mon-Fri 8-5
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**
Other Office Address:	**City:**	**Zip:**	**Phone:**	**Office Hours/Days:**

SECTION 3 – BASIS FOR APPLICATION

Check each box to indicate the type of training you have completed.	**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	1998-2000
ADA-accredited Residency Program that includes moderate sedation training	☒ Completed	1998-2000
You must have training in moderate sedation AND one of the following: **Formal training in airway management; OR**	☒ Completed	
Moderate sedation experience at graduate level, approved by the Board	☒ Completed	2015

SECTION 4 – ADVANCED CARDIAC LIFE SUPPORT (ACLS) CERTIFICATION

Name of Course: PALS Provider	**Location:** UIHC-EMSLRC
Date of Course: 6/2/2015	**Date Certification Expires:** 06/2017

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

02945755 $500.00

Name of Applicant _____

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:
Pediatric Sedation Review Course	Las Vegas (attached)	Las Vegas	NV

Type of Experience:
16 CE Credit hours

Length of Training:	Date(s) Completed:
2 days	Feb 20-21, 2015

Number of Patient Contact Hours:	Total Number of Supervised Sedation Cases:
≈ 70 hours (Plus clinical experience for 13 years)	95

All questions except 5 applies to training in the US.

☒ 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;** – In my practice for 10 years with anesthesiologists in Jordan.

☒ 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?** in the future

☐ 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.

- Midazolam
- Hydroxizine
  mainly oral, nasal & inhalation
- I.V. sedation with anesthesiologist

Name of Applicant _____ Facility Address _____

SECTION 7 – AUXILIARY PERSONNEL

A dentist administering moderate sedation in Iowa must document and ensure that all auxiliary personnel have certification in basic life support (BLS) and are capable of administering basic life support. Please list below the name(s), license/registration number, and BLS certification status of all auxiliary personnel.

Name: (attached)	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
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Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**
Name:	**License/ Registration #:**	**BLS Certification Date:**	**Date BLS Certification Expires:**

SECTION 8 – FACILITIES & EQUIPMENT

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

YES	NO	Is your dental office properly maintained and equipped with the following:
☑	☐	**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)?**
5		**20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.**

Section 7 – AUXILIARY PERSONNEL

Dental Assistant Name	State Registration #	BLS Certification Date	Date BLS Certification Expires
Mary Akers	QDA-03838	1/2/2014	1/31/2016
Bridget Barba	QDA-06156	7/14/2014	7/31/2016
Lindsay Baumgart	QDA-08919	11/14/2013	11/31/2015
Lisa Brenneman	QDA-07696	7/16/2014	7/31/2016
Andrea Davidson	QDA-00605	11/12/2014	11/30/2016
Heather Hill	QDA-09590	7/16/2014	7/31/2016
Jaimie Kleppe	QDA-06212	6/24/2013	6/30/2015
Shanna Kolar	QDA-10078	4/9/2014	4/30/2016
Michele Murphy	QDA-08838	7/14/2014	7/31/2016
Mechelle Porter	QDA-11638	1/29/2015	1/31/2017
Sarah Strabala	QDA-11196	1/29/2015	1/31/2017

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** Anwa Owais	
NOTARY SEAL	**SUBSCRIBED AND SWORN BEFORE ME, THIS** 4th **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

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): Arwa Issa Owais

MAILING ADDRESS: S 201 DSB (Dental Science Building) 801 Newton Road

CITY:	STATE:	ZIP CODE:	PHONE:
Iowa City	IA	52242	(319)335-7478

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:
Arwa Owais	6/3/2015

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR: Dr. Matt Geneser

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 Advanced Program in Pediatric Dentistry Iowa City, IA	319-335-7480

DATES APPLICANT PARTICIPATED IN PROGRAM ►	FROM (MO/YR):	TO (MO/YR):	DATE PROGRAM COMPLETED:
	7/1998	6/2000	6/2000

☒ 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 Dentistry Residency

☐ 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:
	6/4/15

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association. | American Academy of Pediatrics

PEEL HERE

PALS Provider

Arwa Owais

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.

6/2/2015
Issue Date

06/2017
Recommended Renewal Date

PEDIATRIC ADVANCED LIFE SUPPORT

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 #: 11110062153
Holder's Signature

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Arwa Owais
5201 DSB
Iowa City IA 52242

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

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association.

PEEL HERE

Arwa Owais

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

6/2/2015
Issue Date

06/2017
Recommended Renewal Date

HEALTHCARE PROVIDER

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
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Holder's Signature

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Arwa Owais
5201 DSB
Iowa City IA 52242

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

American Dental Society of Anesthesiology

verifies that

Arwa Owais BDS, M.S.

has attended the

Continuing Education Lecture Course:

Pediatric Sedation Review Course
Las Vegas, NV
February 20 – 21, 2015

For **16** CE Credit Hours

President, ADSA

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