

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA DENTAL BOARD
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING APPLICATION FOR MODERATE SEDATION PERMIT

Enclosed is an application for a permit to administer moderate sedation in the state of Iowa. When completing this application, please be advised of the following.

- Dentists licensed in the state of Iowa cannot administer deep sedation/general anesthesia or moderate sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Dental Board.
- **Moderate sedation** is defined in Board rules as “a drug-induced depression of consciousness, either by enteral or parenteral means, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Prior to January 1, 2010, moderate sedation was referred to as conscious sedation.” A moderate sedation permit is required to administer moderate sedation in Iowa.
- **Deep sedation/general anesthesia** is defined in Board rules as “a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.” A deep sedation/general anesthesia permit is required to administer deep sedation/general anesthesia in Iowa. A deep sedation permit also allows the permit holder to administer moderate sedation. [650 IAC 29.1(153)]
- Licensees are encouraged to seek pre-approval of any formal continuing education courses in moderate sedation prior to completing the course and applying for a permit. To apply for pre-approval, submit a copy of the course syllabus and related materials to the Board office.
- 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.
- Each facility in which an applicant plans to provide moderate sedation is subject to an on-site evaluation prior to issuance of a permit. The actual costs associated with the on-site evaluation of the facility are the responsibility of the applicant. The cost to the licensee shall not exceed \$500 per facility.
- Following review of a completed application and all required credentials by the Anesthesia Credentials Committee, a provisional permit may be issued pending final Board approval. A provisional permit may only be granted if the applicant will be practicing at a facility that has been inspected and approved by the Board.
- Based on its evaluation of credentials, facilities, equipment, personnel, and procedures, the Board may place restrictions on the permit.
- “ASA” refers to the American Society of Anesthesiologists Patient Physical Status Classification System. Category 1 means normal healthy patients, and category 2 means patients with mild systemic disease. Category 3 means patients with moderate systemic disease, and category 4 means patients with severe systemic disease that is a constant threat to life.
- A dentist who wishes to use moderate sedation in pediatric (patients age 12 or younger) or medically compromised patients (ASA patient classification 3 or higher) must be prepared to document additional training in an accredited residency program that includes training in sedating these patients. A dentist who does not have this additional training will be prohibited from using moderate sedation on pediatric or ASA category 3 or 4 patients.
- The application fee is non-refundable.
- Once issued, a permit must be renewed biennially at the time of license renewal. Permit holders are required to maintain current ACLS certification and document six hours of continuing education in the area of sedation for each renewal.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action.**

To assist you in completing the application, please utilize the checklist that follows and be sure that you have responded to each item.

- Type or legibly print the application.
- Complete each question on the application. If not applicable, answer N/A.
- Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your license or other documents.
- In section 3, basis for application, you must have completed a training program approved by the board that consists of a minimum of 60 hours of instruction and management of at least 20 patients or an ADA-accredited residency program AND one of the following: formal training in airway management or successful completion of an accredited residency program that includes formal training and clinical experience in moderate sedation approved by the board.
- Include evidence of possessing a valid, current certificate in Advanced Cardiac Life Support (ACLS) by copying the front and back of your card.
- Complete and mail the appropriate form to your program director 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.
 - Applicants who received their training in a formal moderate sedation continuing education program must have the program director complete Form B.
- Applicants who completed a postgraduate residency program must attach a copy of your certificate of completion of the postgraduate program.
- Copy and complete page 3 of the application for each facility in which you plan to provide moderate sedation. Each facility is subject to inspection.
- Prior to completing the questions in section 9, read the following definitions.

“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.
- For each “Yes” answer in section 9, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).
- If you have a license, permit, or registration to perform moderate sedation in any other state, request verification of your permit from each state. Please note that some states may require a processing fee.
- The application must be notarized.
- Enclose the non-refundable application fee of \$500, made payable to Iowa Dental Board.



IOWA DENTAL BOARD
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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)

Other Names Used: (e.g. Maiden)

Home E-mail:

Work E-mail:

Home Address:

City:

State:

Zip:

Home Phone:

License Number:

Issue Date:

Expiration Date:

Type of Practice:

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

Principal 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

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:

Location:

Date of Course:

Date Certification Expires:

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

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:

Type of Experience:

Length of Training:

Date(s) Completed:

Number of Patient Contact Hours:

Total Number of Supervised Sedation Cases:

- YES NO 1. Did you satisfactorily complete the above training program?
- YES NO 2. Does the program include at least sixty (60) hours of didactic training in pain and anxiety?
- YES NO 3. Does the program include management of at least 20 clinical patients?
- As part of the curriculum, are the following concepts and procedures taught:
- YES NO 4. Physical evaluation;
- YES NO 5. IV sedation;
- YES NO 6. Airway management;
- YES NO 7. Monitoring; and
- YES NO 8. Basic life support and emergency management.
- YES NO 9. Does the program include clinical experience in managing compromised airways?
- YES NO 10. Does the program provide training or experience in managing moderate sedation in pediatric patients?
- YES NO 11. Does the program provide training or experience in managing moderate sedation in ASA category 3 or 4 patients?

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

SECTION 6 – MODERATE SEDATION EXPERIENCE

- YES NO A. Do you have a license, permit, or registration to perform moderate sedation in any other state?
If yes, specify state(s) and permit number(s): _____
- YES NO B. Do you consider yourself engaged in the use of moderate sedation in your professional practice?
- YES NO C. Have you ever had any patient mortality or other incident that resulted in the temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, your use of antianxiety premedication, nitrous oxide inhalation analgesia, moderate sedation or deep sedation/general anesthesia?
- YES NO D. Do you plan to use moderate sedation in pediatric patients?
- YES NO E. Do you plan to use moderate sedation in medically compromised (ASA category 3 or 4) patients?
- YES NO F. Do you plan to engage in enteral moderate sedation?
- YES NO G. Do you plan to engage in parenteral moderate sedation?

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

SECTION 7 – AUXILIARY PERSONNEL

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

Name:	License/ Registration #:	BLS Certification Date:	Date BLS Certification Expires:

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:
<input type="checkbox"/>	<input type="checkbox"/>	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 type="checkbox"/>	<input type="checkbox"/>	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 type="checkbox"/>	<input type="checkbox"/>	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 type="checkbox"/>	<input type="checkbox"/>	4. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device?
<input type="checkbox"/>	<input type="checkbox"/>	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 type="checkbox"/>	<input type="checkbox"/>	6. A recovery area that has available oxygen, adequate lighting, suction, and electrical outlets? (The recovery area can be the operating room.)
<input type="checkbox"/>	<input type="checkbox"/>	7. Is the patient able to be observed by a member of the staff at all times during the recovery period?
<input type="checkbox"/>	<input type="checkbox"/>	8. Anesthesia or analgesia systems coded to prevent accidental administration of the wrong gas and equipped with a fail safe mechanism?
<input type="checkbox"/>	<input type="checkbox"/>	9. EKG monitor?
<input type="checkbox"/>	<input type="checkbox"/>	10. Laryngoscope and blades?
<input type="checkbox"/>	<input type="checkbox"/>	11. Endotracheal tubes?
<input type="checkbox"/>	<input type="checkbox"/>	12. Magill forceps?
<input type="checkbox"/>	<input type="checkbox"/>	13. Oral airways?
<input type="checkbox"/>	<input type="checkbox"/>	14. Stethoscope?
<input type="checkbox"/>	<input type="checkbox"/>	15. A blood pressure monitoring device?
<input type="checkbox"/>	<input type="checkbox"/>	16. A pulse oximeter?
<input type="checkbox"/>	<input type="checkbox"/>	17. Emergency drugs that are not expired?
<input type="checkbox"/>	<input type="checkbox"/>	18. A defibrillator (an automated defibrillator is recommended)?
<input type="checkbox"/>	<input type="checkbox"/>	19. Do you employ volatile liquid anesthetics and a vaporizer (i.e. Halothane, Enflurane, Isoflurane)?
<input type="checkbox"/>	<input type="checkbox"/>	20. In the space provided, list the number of nitrous oxide inhalation analgesia units in your facility.

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

SECTION 10 – AFFIDAVIT OF APPLICANT

STATE:	COUNTY:
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I, the below named applicant, hereby declare under penalty of perjury that I am the person described and identified in this application and that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license or permit to provide 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		
NOTARY SEAL	SUBSCRIBED AND SWORN BEFORE ME, THIS		DAY OF
			, YEAR
	NOTARY PUBLIC SIGNATURE		
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	MY COMMISSION EXPIRES:	



IOWA DENTAL BOARD
 400 S.W. 8th Street, Suite D, Des Moines, Iowa 50309-4687
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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):

MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE:

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

APPLICANT'S SIGNATURE:

DATE:

SECTION 2 – TO BE COMPLETED BY POSTGRADUATE PROGRAM DIRECTOR

NAME OF POSTGRADUATE PROGRAM DIRECTOR:

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:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/YR):

TO (MO/YR):

DATE PROGRAM COMPLETED:

- 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.*
 - 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:



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PLEASE TYPE OR PRINT LEGIBLY IN INK.

**FORM B: VERIFICATION OF MODERATE SEDATION TRAINING
 IN A CONTINUING EDUCATION PROGRAM**

SECTION 1 – APPLICANT INFORMATION

Instructions – Use this form if you obtained your training in moderate sedation from another program that must be approved by the Board (i.e. you did NOT obtain your training in moderate sedation while in a postgraduate residency program). Complete Section 1 and mail this form to the Program Director for verification of your having successfully completed this training.

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

MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE:

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

APPLICANT'S SIGNATURE:

DATE:

SECTION 2 – TO BE COMPLETED BY TRAINING PROGRAM DIRECTOR

NAME OF PROGRAM DIRECTOR:

NAME AND LOCATION OF PROGRAM:

PHONE:

FAX:

E-MAIL:

WEB ADDRESS:

DATES APPLICANT PARTICIPATED IN PROGRAM ▶

FROM (MO/DAY/YR):

TO (MO/DAY/YR):

DATE PROGRAM COMPLETED:

- YES NO 1. DID THE APPLICANT SATISFACTORILY COMPLETE THE ABOVE TRAINING PROGRAM?
 - YES NO 2. DOES THE PROGRAM COMPLY WITH THE AMERICAN DENTAL ASSOCIATION GUIDELINES FOR TEACHING PAIN CONTROL AND SEDATION TO DENTISTS OR DENTAL STUDENTS?
 - YES NO 3. DOES THE PROGRAM INCLUDE AT LEAST SIXTY (60) HOURS OF DIDACTIC TRAINING IN PAIN AND ANXIETY?
 - YES NO 4. DOES THE PROGRAM INCLUDE CLINICAL EXPERIENCE FOR PARTICIPANTS TO SUCCESSFULLY MANAGE MODERATE SEDATION IN AT LEAST TWENTY (20) PATIENTS?
- AS PART OF THE CURRICULUM, ARE THE FOLLOWING CONCEPTS AND PROCEDURES TAUGHT:
- YES NO 5. PHYSICAL EVALUATION;
 - YES NO 6. IV SEDATION;
 - YES NO 7. AIRWAY MANAGEMENT;
 - YES NO 8. MONITORING; AND
 - YES NO 9. BASIC LIFE SUPPORT AND EMERGENCY MANAGEMENT.

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

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

PROGRAM DIRECTOR SIGNATURE:

DATE: