OREGON BOARD OF DENTISTRY

BOARD MEETING
FEBRUARY 10, 2012
APPROVAL OF MINUTES
This Page

Left Blank
OREGON BOARD OF DENTISTRY  
MINUTES  
December 16, 2011

MEMBERS PRESENT:  
Mary Davidson, M.P.H., R.D.H., L.A.P., President  
Patricia Parker, D.M.D., Vice-President  
Julie Ann Smith, D.D.S., M.D.  
David Smyth, B.S., M.S.  
Jill Mason, M.P.H., R.D.H., L.A.P.  
Norman Magnuson, D.D.S.  
Jonna E. Hongo, D.M.D.  
Brandon Schwindt, D.M.D.  
Alton Harvey, Sr.

STAFF PRESENT:  
Patrick D. Braatz, Executive Director  
Paul Kleinstub, D.D.S., M.S., Dental Director/Chief Investigator  
Daryll Ross, Investigator (portion of meeting)  
Harvey Wayson, Investigator (portion of meeting)  
Michelle Lawrence, D.M.D., Consultant (portion of meeting)  
Lisa Warwick, Office Specialist (portion of meeting)

ALSO PRESENT:  
Lori Lindley, Sr. Assistant Attorney General

VISITORS PRESENT:  

Call to Order:  
The meeting was called to order by the President at 7:30 a.m. at the Board office; 1600 SW 4th Ave., Suite 770, Portland, Oregon.

NEW BUSINESS

MINUTES  
Ms. Mason moved and Dr. Magnuson seconded that the minutes of the October 28, 2011 Board meeting be approved as amended. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

ASSOCIATION REPORTS

Oregon Dental Association  
Dr. Larson stated that ODA had nothing to report.

Oregon Dental Hygienists’ Association  
Ms. Ironside stated that the ODHA had nothing to report.
The ODAA had nothing to report.

COMMITTEE AND LIAISON REPORTS

WREB Liaison Report
Dr. Magnuson stated that WREB would hold the first board meeting of the newly reorganized board in January.

AADB Liaison Report
Dr. Parker stated that the AADB was getting ready for the Mid-year Meeting. Mr. Braatz added that more information would follow in the Executive Director’s report.

ADEX Liaison Report
Dr. Parker stated that she, as well as several other Board members attended the ADEX meeting. Brian Kennedy spoke about the elimination of live patients from Board exams and the movement towards a portfolio exam, arguing that there should be more confidence in the college system.

She also mentioned that the Quality Assurance Committee recommended some changes to the exam. Dr. Parker stated that ADEX recognized Patrick as the ADEX Executive Director for doing an excellent job.

NERB
Dr. Hongo had nothing new to report but added that there was an upcoming meeting.

Dental Hygiene Committee Meeting Report
Ms. Mason stated that the Dental Hygiene Committee met December 1, 2011. Several items were discussed. The Board will continue to take Limited Access Permit (LAP) applications until December 21 and then switch all Limited Access Permits over to the new Expanded Practice Permits (EPP) in January. The ODHA had requested that the OBD review its policy defining underserved areas and dental HIPSA definitions, as well as a few other documents. She stated that there is a new statute that describes what an underserved area is. She stated that the Hygiene Committee reviewed that, but what came out of the discussion was that the new SB738 from the last legislative session added a new category of patients for EPP hygienists as those under the federal poverty level and those “populations” designated by the Oregon Board of Dentistry; so there is now no geographic reference, instead there is a “population” reference. She stated that the Committee made a recommendation to the Board to change its policy from approval of geographic locations to approving populations. She added that in doing so, Expanded Practice Permit hygienists would need to submit approval to the Board for those populations not already provided for in the Dental Practice Act.

Licensing, Standards and Competency Committee Meeting Report
Dr. Parker stated that everything discussed was as shown in the minutes and that she’d be happy to answer any questions.

Anesthesia Committee Meeting Report
Dr. Smith said the Committee met on December 7 at the Board office. She stated that most of the issues had to do with wording, and clarifying wording to make it easier to understand and that the changes that are being proposed reflect that. She added that they also discussed the possibility

December 16, 2011
Board Meeting
Page 2 of 10
of office inspections for General Anesthesia Permit holders in the future, but nothing definitive had
been decided.

Rules Oversight Committee Meeting Report
Dr. Schwindt stated that the Rules Oversight Committee met on December 13 to review the
proposed rule changes submitted by the various committees and proposed the following:

OAR 818-012-0005 – Scope of Practice
Ms. Mason moved and Dr. Schwindt seconded that the Board send OAR 818-012-0005 Scope of
Practice to a Rulemaking Hearing as published. The motion passed with Dr. Smith, Mr. Smyth,
Ms. Mason, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye. Dr. Parker and Dr. Magnuson
were opposed.

OAR 818-035-0065 – Expanded Practice Dental Hygiene Permit
Dr. Parker moved and Dr. Magnuson seconded that the Board send OAR 818-035-0065
Expanded Practice Dental Hygiene Permit to a Rulemaking Hearing as published. The motion
passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr.
Schwindt and Mr. Harvey voting aye.

OAR 818-026-0055 – Dental Hygiene and Dental Assistant Procedures Performed Under
Minimal Sedation
Ms. Mason moved and Dr. Hongo seconded that the Board send OAR 818-026-0055 Dental
Hygiene and Dental Assistant Procedures Performed Under Minimal Sedation to a Rulemaking
Hearing as published. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr.
Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

OAR 818-026-0030 – Requirement for Anesthesia Permit, Standards and Qualifications of
an Anesthesia Monitor
Ms. Mason moved and Dr. Smith seconded that the Board send OAR 818-026-0030 Requirement
for Anesthesia Permit, Standards and Qualifications of an Anesthesia Monitor to a Rulemaking
Hearing as amended. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr.
Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

OAR 818-042-0040 – Prohibited Acts
Ms. Mason moved and Dr. Magnuson seconded that the Board send OAR 818-042-0040
Prohibited Acts to a Rulemaking Hearing as published. The motion passed with Dr. Parker, Dr.
Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting
aye.

OAR 818-042-0100 – Expanded Functions – Orthodontic Assistant (EFODA)
Ms. Mason moved and Dr. Hongo seconded that the Board send OAR 818-042-0100 Expanded
Functions – Orthodontic Assistant (EFODA) to a Rulemaking Hearing as amended. The motion
passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr.
Schwindt and Mr. Harvey voting aye.

Committee Meeting Dates
Mr. Braatz stated that no committee meeting dates have been scheduled, but he would notify the
Board and public as needed.
EXECUTIVE DIRECTOR’S REPORT

Budget Status Report
Mr. Braatz stated that the budget is performing as expected and that attached were the latest budget reports for the 2011-2013 Biennium.

Customer Service Survey Report
Mr. Braatz attached the most recent chart showing the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2011 through November 30, 2011. The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys.

Board and Staff Speaking Engagements
December 8 – Mr. Braatz made a presentation, in place of Dr. Kleinstub, at Carrington College for their dental hygiene students.

Staff Changes
Mr. Braatz stated that the Board’s Executive Assistant, Sharon Ingram, has retired. He added that she would be returning as a temporary employee to finish a few projects for the Board in the months following her official retirement. Mr. Braatz stated the Governor has issued a state hiring freeze that affects all agencies, except Other Fund agencies, which we are. Mr. Braatz continued by stating that we should be able to eventually hire for that position, it just may take a bit longer than usual.

ADA Workgroup on Portfolio Style Exams
Mr. Braatz stated that he does not believe that a national association should be in the business of testing. Dr. Magnuson moved and Dr. Hongo seconded that Mr. Braatz send his letter as drafted to the ADA. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2012 Legislative Session
Mr. Braatz stated that he had not seen any specific bills that would deal with the OBD at this point, but that he had heard of one possible piece of legislation that may allow the OBD to grant temporary licenses to dentists and dental hygienists that would be working at various charitable dental programs. The OBD does not have that statutory authority at this time.

Implementation of SB 738
Mr. Braatz stated that the new Expanded Practice Dental Hygiene Permit becomes law on January 1, 2012. All LAPs will be sent a letter, a copy of the bill, the collaborative agreement, as well as a copy of their new license. They will fill out and return the collaborative agreement so we can make the collaborative agreement a public record.

Mr. Braatz reminded the Board that they are responsible for approving the Expanded Practice CE course providers once we start receiving those requests. He added that the form has been created and is on the Web site. He wanted to remind the Board that this is new for the Board as we’ve never approved CE courses before. Mr. Braatz stated that he believed that staff has done everything that was needed to be in compliance with SB738.
Mr. Braatz asked the Board to review the new section of SB738 that discusses when and how Expanded Practice Permit Dental Hygienists can work on people without supervision. The new subs (E)(F) are the areas that have been changed. Mr. Braatz wanted to know what population was left that EPP Dental Hygienists could not work on. He added that if the issue was that dental hygienists wanted an independent practice status, that should be stated and discussed so appropriate steps could be taken. Ms. Lindley, Sr. Assistant Attorney General, stated that it was a simple process to add populations that needed the services of Expanded Practice Permit holders. The people requiring service would need to be designated into populations, those populations need to be presented to the Board for approval, and upon that approval those populations could be treated.

**AADB /AADA Mid-Year Meeting**

Mr. Braatz stated that the AADB/AADA Mid-year Meeting would be held April 22-23. He asked the Board for permission to attend the meeting. Dr. Parker moved and Dr. Schwindt seconded that the Board send Mr. Braatz to the AADB/AADA Mid-year meeting. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye. Ms. Mason, Dr. Parker and Ms. Lindley will be attending.

**Newsletter**

Mr. Braatz stated that the newsletter is ready to go but just needs final formatting which will be one of the projects that Ms. Ingram will be finishing when she returns in January.

**UNFINISHED BUSINESS**

**CORRESPONDENCE**

**The Board received a letter from April Love, D.D.S.**

Dr. Love sent a letter to the Board asking them to consider changing the restorative rules dental hygienists and dental assistants to allow for posterior composite restorations. Ms. Mason moved and Dr. Parker seconded that the Board send the proposal to the Licensing, Standards and Competency Committee for review. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Hongo, and Mr. Harvey voting aye. Dr. Schwindt and Dr. Magnuson were opposed.

**The Board received a letter from Bill Osmunson, D.D.S.**

Dr. Osmunson sent a letter regarding consideration of a possible rule change regarding maintaining records and diagnosis. Dr. Magnuson moved and Dr. Smith seconded that we send a letter to Dr. Osmunson stating that the current rules provide sufficient direction. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

**OTHER BUSINESS**

**EXECUTIVE SESSION:** The Board entered into Executive Session pursuant to ORS 192.606 (1)(f), (h) and (k); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review records exempt from public disclosure, to review confidential investigatory materials and investigatory information, and to consult with counsel.
PERSONAL APPEARANCES AND COMPLIANCE ISSUES
Licensee appeared pursuant to their Consent Order in case number 2007-0071.

LICENSING ISSUES

OPEN SESSION: The Board returned to Open Session.

CONSENT AGENDA

2012-0059 Dr. Parker moved and Mr. Smyth seconded that the above referenced cases be closed with No Further Action per the staff recommendations. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

COMPLETED CASES

2011-0130, 2010-0077, 2011-0011, 2011-0137, 2010-0029, 2011-0144, 2011-0141, 2011-0209, 2011-0139, 2011-0145, 2012-0047, 2011-0069, 2012-0055, 2011-0040 and 2011-0153 Dr. Parker moved and Ms. Mason seconded that the above referenced cases be closed with a finding of No Violation of the Dental Practice Act or No Further Action per the Board recommendations. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0154 Dr. Smith moved and Dr. Schwindt seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that treatment notes provide thorough documentation of vital signs as well as full soft tissue examination findings in patients with active infections. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, and Dr. Schwindt voting aye. Dr. Magnuson, Dr. Hongo and Mr. Harvey were opposed.

2012-0049 Mr. Smyth moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of fee splitting and ensuring that the Licensee does not accept or offer rebates, split fees, or commissions for services rendered to a patient or to any person other than a partner, employee, or employer. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0163 Mr. Harvey moved and Dr. Schwindt seconded that the Board close the matter with a strongly worded Letter of Concern addressing the issue of ensuring that every effort is made to diagnose pathology clearly evident on dental radiographs. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2012-0038 Dr. Hongo moved and Mr. Harvey seconded that the Board close the matter with a Letter of Concern addressing the issue of fee splitting and ensuring that the Licensee does not accept or offer rebates, split fees, or commissions for services rendered to a patient or to any person other than a partner, employee, or employer. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

December 16, 2011
Board Meeting
Page 6 of 10
2010-0059 Dr. Schwindt moved and Dr. Hongo seconded that the Board issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded and the Licensee shall pay a civil penalty of $8,000.00 within 90 days of the effective date of the Order. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2012-0050 Dr. Smith moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that the Licensee does not accept or offer rebates, split fees, or commissions for services rendered to a patient or to any person other than a partner, employee, or employer. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0147 Ms. Mason moved and Dr. Magnuson seconded that the Board issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand and a civil penalty in the amount of $3,000.00. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2012-0056 Dr. Magnuson moved and Mr. Harvey seconded that the Board with regard to Respondent #1 and Respondent #3, issue each a Notice of Proposed Disciplinary Action and offer each a Consent Order incorporating a reprimand and a civil penalty in the amount of $5,000.00 each; with regard to Respondent #2, issue a Notice of Proposed Disciplinary Action and offer a Consent Order incorporating a reprimand, and a civil penalty in the amount of $2,500.00. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0161 Dr. Hongo moved and Dr. Parker seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when informed consent is obtained prior to providing treatment, PARQ or its equivalent is documented in the patient records and that diagnostic radiographs should be taken immediately after the placement of implants. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0095 Mr. Smyth moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of ensuring that when nitrous oxide is administered the appropriate documentation is entered in the patient records and that a dental justification is documented when medication is prescribed. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2011-0142 Dr. Parker moved and Mr. Smyth seconded that the Board close the matter with a finding of No Violation of the Dental Practice Act. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2012-0051 Mr. Harvey moved and Dr. Hongo seconded that the Board close the matter with a Letter of Concern addressing the issue of fee splitting and ensuring that the Licensee does not accept or offer rebates, split fees, or commissions for services rendered to a patient or to any person other than a partner, employee, or employer. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.
2012-0048 Dr. Hongo moved and Dr. Magnuson seconded that the Board close the matter with a Letter of Concern addressing the issue of fee splitting and ensuring that the Licensee does not accept or offer rebates, split fees, or commissions for services rendered to a patient or to any person other than a partner, employee, or employer. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

PREVIOUS CASES REQUIRING BOARD ACTION
2011-0050 Dr. Schwindt moved and Dr. Smith seconded the Board move to issue Orders of Dismissal dismissing the Notices of Proposed Disciplinary Action for Licensee #1 and Licensee #2, and close the case with a Letter of Concern to each Licensee reminding them to assure adherence to the Dental Practice Act. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2010-0132 Dr. Magnuson moved and Dr. Smyth seconded that the Board move to reject the Licensee’s proposed Consent Order and affirm the Board’s action on 10/28/11, which remains open until 1/16/12. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2010-0029 Dr. Smith moved and Dr. Magnuson seconded that the Board move to deny the Licensee’s request and offer the Licensee a re-worded Consent Order incorporating a $1,000 civil penalty. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2010-0019 Ms. Mason moved and Dr. Parker seconded the Board move to issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action for the Licensee, and close the case with a Letter of Concern reminding the Licensee to assure adherence to the Dental Practice Act. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo and Mr. Harvey voting aye. Dr. Schwindt recused himself.

2007-0150 Dr. Magnuson moved and Mr. Smyth seconded that the Board move to accept the Licensee’s proposal of a Consent Order incorporating a reprimand. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo and Mr. Harvey voting aye. Dr. Schwindt recused himself.

2011-0188 Mr. Smyth moved and Dr. Parker seconded the Board grant the Applicant’s request, permit the Licensee to withdraw their application for an Oregon dental license, and issue an Order of Dismissal withdrawing the Notice of Proposed Denial of Application for Licensure, issued 9/18/07. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2009-0074 Mr. Harvey moved and Dr. Hongo seconded that the Board move to require the Licensee to remit the reimbursement by 1/31/12. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

2010-0229 Dr. Hongo moved and Mr. Harvey seconded the Board move to issue an Order of Dismissal dismissing the Notice of Proposed Disciplinary Action for the Licensee, and close the case with a Letter of Concern reminding the Licensee to assure adherence to the Dental Practice
Act. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

**2010-0177** Dr. Schwindt moved and Dr. Hongo seconded that the Board accept the Licensee’s proposal for resolution of cases 2010-0177 and 2011-0057 with a single Consent Order calling for a $10,000 civil penalty and those provisions proposed by the Board in both cases. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

**2011-0057** Dr. Schwindt moved and Dr. Hongo seconded that the Board accept the Licensee’s proposal for resolution of cases 2010-0177 and 2011-0057 within a single Consent Order calling for a $10,000 civil penalty and those provisions proposed by the Board in both cases. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

**2010-0008** Dr. Smith moved and Mr. Smyth seconded that the Board accept the offer proposed by the Licensee. The motion passed with Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye. Dr. Parker recused herself.

**2010-0014** Dr. Smith moved and Mr. Smyth seconded that the Board accept the offer proposed by the Licensee. The motion passed with Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye. Dr. Parker recused herself.

**LICENSURE AND EXAMINATION**

**Ratification of Licenses Issued**
Dr. Magnuson moved and Dr. Parker seconded that licenses issued be ratified as published. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

**Dental Hygiene**

<table>
<thead>
<tr>
<th>License Number</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6163</td>
<td>ASHLEY N STEAD, R.D.H.</td>
<td>10/10/2011</td>
</tr>
<tr>
<td>H6170</td>
<td>BRITTANI JEAN HUNSAKER, R.D.H.</td>
<td>10/25/2011</td>
</tr>
<tr>
<td>H6171</td>
<td>DANIELLE S APKEN, R.D.H.</td>
<td>10/31/2011</td>
</tr>
<tr>
<td>H6172</td>
<td>DARLA J HOPKINS, R.D.H.</td>
<td>10/31/2011</td>
</tr>
<tr>
<td>H6173</td>
<td>ERIN ELIZABETH ERICKSON, R.D.H.</td>
<td>10/31/2011</td>
</tr>
<tr>
<td>H6174</td>
<td>SARA MAY SPEIR, R.D.H.</td>
<td>10/31/2011</td>
</tr>
</tbody>
</table>
Ms. Mason moved and Mr. Smyth seconded that the Board move to reinstate Dr. Bailey’s dental license. The motion passed with Dr. Parker, Dr. Smith, Mr. Smyth, Ms. Mason, Dr. Magnuson, Dr. Hongo, Dr. Schwindt and Mr. Harvey voting aye.

Announcement
No announcements.

ADJOURNMENT

The meeting was adjourned at 12:52 p.m. Ms. Davidson stated that the next Board meeting would take place February 10, 2012.

Approved by the Board February 10, 2012.

Mary Davidson, M.P.H., R.D.H., E.P.P.
President

December 16, 2011
Board Meeting
Page 10 of 10
ASSOCIATION REPORTS
Nothing to report under this tab
COMMITTEE REPORTS
American Association of Dental Boards

Guidelines on Advertising

The Report of the AADB Board Attorneys Roundtable Committee to Develop Guidelines on Advertising

Copyright 2012 American Association of Dental Boards
All rights reserved. Reproduced and distributed by permission.
American Association of Dental Boards Guidelines on Advertising

The Report of the AADB Board Attorneys Roundtable Committee to Develop Guidelines on Advertising

Approved by the 128th AADB Annual Meeting, October 10, 2011.

Copyright 2011 American Association of Dental Boards
All rights reserved. Reproduced and distributed by permission.
SECTION 1. INTRODUCTION, PURPOSE AND DISCLAIMER.

A. INTRODUCTION AND PURPOSE: These provisions are intended to provide guidance to regulatory bodies in order to protect the health and general welfare of patient consumers from advertising that is false, or materially deceptive or misleading.

B. DISCLAIMER: The following guidelines are deliberately generalized and intended for educational purposes only. The statutory and regulatory authority of each state dental board of examiners to regulate advertising and take action on infractions differs significantly as does each state's burden of proof in substantiating an infraction (i.e.... “preponderance of evidence” versus “clear and convincing evidence” of an infraction.) Therefore, each state board should confer with assigned counsel to determine how to appropriately incorporate or modify these provisions in order to effectively protect patients from false or deceptive advertising in any material respect. In addition, the substance contained herein, except where otherwise specifically cited, consists of a compilation of individual state statutory and regulatory provisions as well as Section 5 of the 2011 edition of the American Dental Association Principle of Ethics and Code of Professional Conduct.

Approved by the 128th AADB Annual Meeting General Assembly, October 10, 2011.
SECTION 2. DEFINITIONS.

A. **False or misleading.** Statements which a) contain a material misrepresentation of fact; b) omit a fact necessary to make the statement considered as a whole not materially misleading, c) intend or create an unjustified expectation about results the dentist can achieve, d) contain a material, objective representation, whether express or implied, that the advertised services are superior in quality to those of other dentists, if that representation is not subject to reasonable substantiation.

B. **"Material" Misrepresentation or Practice.** A misrepresentation or practice which is likely to affect a consumer's choice of or conduct regarding a product or service.²

C. **Commercial Speech.** Communication (such as advertising and marketing) that involves only the commercial interests of the speaker and the audience, and is therefore afforded lesser First Amendment protection than social, political, or religious speech.³

SECTION 3. SAMPLE REGULATORY PROVISIONS.

A. **ADVERTISING IN SPECIALITIES AND INTEREST AREAS:**

1. **Recognized Specialties.** A dentist may advertise as a specialist or use the terms "specialty" or "specialist" to describe professional services in recognized specialty areas only if the dentist limits the dentist's practice exclusively to one or more specialty areas that satisfy both of the following criteria:

---

¹ See American Dental Association Principle of Ethics and Code of Professional Conduct, Section 5, Advisory Opinion 5.f.2. (2011)


³ Black's Law Dictionary – 9th Edition
a. Recognized by a board that certifies specialists for the area of specialty. Board certification means that the dentist who has met the requirements of a specialty board and who has received a certificate from the recognized specialty board, indicating the dentist has achieved diplomate status;

b. Completed an education program accredited by the Commission on Dental Accreditation of the American Dental Association in a recognized specialty as set forth in Section 3(A)(3) below. A dentist is educationally qualified if he has successfully completed an educational program of two or more years in a specialty area accredited by the Commission on Dental Accreditation of the American Dental Association, as specified by the Council on Dental Education of the American Dental Association;

2. **Interest Areas.** Any dentist who advertises as a specialist or uses the terms “specialty” or “specialist” to describe professional services provided within his practice, which do not meet each of the criteria of Section 3(A)(1)(a) and (b) above, and therefore, technically, are not recognized specialty areas, shall ensure the advertisement reasonably discloses to the public the type of training the dentist completed and the dentist’s experience in the interest area. To determine if a dentist’s advertising disclosure for an interest area comports with this provision and is not misleading, the Board may consider the following factors:

a. Whether the disclosure indicates that the dentist’s practice is limited to the asserted interest area;

b. Whether the disclosure reasonably informs the public of the educational curriculum the dentist obtained in the asserted interest area including the duration of the program. Full disclosure of education content may further include a statement by the dentist which indicates whether the curriculum is:

(i) Formal or Informal;

(ii) Full-time or Part-time;
(iii) Graduate or Post-Graduate Level;
(iv) Recognized by any board which certifies specialists for an asserted interest area;
(v) Accredited by the Commission on Dental Accreditation of American Dental Association;
c. Whether the disclosure identifies the institution which conferred completion of the curriculum in the interest area; and
d. Whether the disclosure sets forth the number of clinical and didactic classroom hours the dentist has successfully completed in the asserted interest area.

3. The following are recognized specialty areas and meet the requirements of Section 3A(1)(a) and (b) above:

   a. Endodontics,
   b. Oral and maxillofacial surgery,
   c. Orthodontics and dentofacial orthopedics,
   d. Pediatric dentistry,
   e. Periodontics,
   f. Prosthodontics,
   g. Dental Public Health,
   h. Oral and Maxillofacial Pathology, and
   i. Oral and Maxillofacial Radiology.

4. A dentist whose license is not limited to the practice of a recognized specialty identified under Section 3(A)(3)(a)-(i) above may advertise that the dentist performs or limits practice to the aforementioned recognized specialty services even if the dentist is not a specialist in the advertised area of practice so long as the dentist clearly discloses that the dentist is a general dentist or a specialist in a different specialty. For example, the following disclosures would be in compliance with this rule for dentists: "Jane Doe, DDS, General Dentist, practice limited to pediatric dentistry." "John Doe, DMD, Endodontist, practice includes prosthodontics."

   a. In addition to this provision, if a dentist advertises he is a specialist in an interest area [an area not specifically recognized and set forth in Section 3(A)(3)(a)-(i) above],
the dentist should reasonably disclose the type of training he has obtained, and its duration, in the asserted interest area. Factors in determining whether the dentist has reasonably disclosed this information include an assessment of each of the aforementioned criteria set forth in Section 3(A)(2)(a)-(d) above.

b. For example, the following disclosures would comply with this rule for dentists: "John Doe, DDS, General Dentist, services including dental anesthesia. Certification as a Dental Anesthesiologist from the Dental Anesthetist Institute, after successfully completing an oral examination, not based on psychometric principles and following his successful completion of an informal, part-time, graduate level program lasting 2 days and consisting of 2 clinical hours of training and 2 didactic classroom hours of instruction. Dental Anesthesia is not recognized by a board which certifies specialists and is not accredited by the Commission on Dental Accreditation of the American Dental Association.

5. Dentists who choose to advertise specialization in a recognized specialty area as set forth in Section 3(A)(2)(a)-(i) above should use "specialist in" or "practice limited to" and shall limit their practice exclusively to the announced special area(s) of dental practice, provided at the time of the advertisement such dentists have met in each approved specialty for which they advertise the existing educational requirements and standards set forth by the American Dental Association. Dentists who use their eligibility to advertise as specialists to make the public believe that specialty services rendered in the dental office are being rendered by qualified specialists when such is not the case are engaged in unethical conduct. The burden of responsibility is on specialists, within recognized specialty areas, to avoid any inference that general practitioners who are associated with specialists are qualified to advertise themselves as specialists in said recognized specialty areas.
6. Standards For Multiple-Specialty Advertisements in Recognized Specialty Areas. The educational criterion for announcement of limitation of practice in additional specialty areas is the successful completion of an advanced educational program accredited by the Commission on Dental Accreditation (or its equivalent if completed prior to 1967) in each area for which the dentist wishes to advertise. Dentists who are presently ethically advertising limitation of practice in a specialty area and who wish to advertise in an additional recognized specialty area must submit to the appropriate constituent society documentation of successful completion of the requisite education in specialty programs listed by the Council on Dental Education and Licensure or certification as a diplomate in each area for which they wish to announce.

7. Specialist Advertisement of Credentials in Non-Specialty Interest Areas. A dentist who is qualified to advertise specialization under this section may not advertise to the public that he or she is certified or a diplomate or otherwise similarly credentialed in an area of dentistry not recognized as a specialty area by the American Dental Association unless the advertisement contains a disclosure which reasonably informs the public of the dentist’s training and experience in the non-recognized area. To determine whether the dentist’s disclosure comports with this provision, the Board may consider the factors identified in Section 3(A)(2)(a)-(d) above.

B. ADVERTISING CREDENTIALS AND CERTIFICATIONS:

1. Unearned, Non-health Degrees. A dentist may use the title Doctor or Dentist, DDS, DMD or any additional earned, advanced academic degrees in health service areas in an announcement to the public. The announcement of an unearned academic degree may be misleading because of the likelihood that it will indicate to the public the attainment of specialty or diplomate status. An unearned academic degree is one which is awarded by an educational institution not
accredited by a generally recognized accrediting body or is an honorary degree.

a. The use of a non-health degree in an announcement to the public may be a representation which is misleading because the public is likely to assume that any degree announced is related to the qualifications of the dentist as a practitioner.

b. Some organizations grant dentists fellowship status as a token of membership in the organization or some other form of voluntary association. The use of such fellowships in advertising to the general public may be misleading because of the likelihood that it will indicate to the public attainment of education or skill in the field of dentistry.

c. Generally, unearned or non-health degrees and fellowships that designate association, rather than attainment, should be limited to scientific papers and curriculum vitae. In all instances, state law should be consulted.

d. Recognizing the potential of the public being misled or deceived by advertisement in these circumstances where a degree or status has not actually been conferred, the practitioner must include a disclosure in the advertisement which sets forth each of the following criteria:

(i) The institution the practitioner enrolled in educational program as well as the date of initial enrollment;

(ii) The fact the degree or status has not yet been earned or conferred;
2. Credentials in General Dentistry. General dentists may advertise fellowships or other credentials earned in the area of general dentistry so long as they avoid any communications that express or imply specialization in a recognized specialty and the advertisement includes the disclaimer that the dentist is a general dentist. In order to prevent a reasonable person from concluding that abbreviations indicate a designation of an academic degree, any use of abbreviations to designate credentials in interest area areas in an advertisement shall be accompanied by reasonable disclosure of the dentist’s training and experience in the interest area. To determine whether the disclaimer reasonably discloses this information to the public, the Board may use the factors set forth in Section 3(A)(2)(a)-(d) above.

C. NAMES AND RESPONSIBILITIES:

1. Practice under name of licensee; full disclosure required.

   a. No person shall:

      (i) Practice dentistry under the name of a corporation, company, association, limited liability company, or trade name without full and outward disclosure of his full name, which shall be the name used in his license or renewal certificate as issued by the board, or his commonly used name.

      (ii) Conduct, maintain, operate, own, or provide a dental office in the state of licensure, either directly or indirectly, under the name of a corporation, company, association, limited liability company, or trade name without full and outward disclosure of his full name as it appears on the license or renewal
certificate as issued by the board or his commonly used name.

(iii) Hold himself out to the public, directly or indirectly, as soliciting patronage or as being qualified to practice dentistry in the state of licensure under the name of a corporation, company, association, limited liability company, or trade name without full and outward disclosure of his full name as it appears on the license or renewal certificate as issued by the board or his commonly used name.

(iv) Operate, manage, or be employed in any room or office where dental service is rendered or conducted under the name of a corporation, company, association, limited liability company, or trade name without full and outward disclosure of his full name as it appears on the license or renewal certificate as issued by the board or his commonly used name.

(v) Practice dentistry without displaying his full name or his commonly used name as it appears on the license or renewal certificate as issued by the board in front of each dental office location if the office is in a single-story and/or single-occupancy building, or without displaying his full name or his commonly used name as it appears on the license or renewal certificate as issued by the board on the outside of the entrance door of each dental office if the office is in a multi-occupancy and/or multi-story building.

b. Name of Practice. Since the name under which a dentist conducts his or her practice may be a factor in the selection process of the patient, the use of a trade name or an assumed name that is false or misleading in any material respect is unethical. Use of the name of a dentist no longer actively
associated with the practice may be continued for a period not

to exceed one year.

c. Dentist Leaving Practice. Dentists leaving a practice who
authorize continued use of their names should receive
competent advice on the legal implications of this action. With
permission of a departing dentist, his or her name may be used
for more than one year, if, after the one year grace period has
expired, prominent notice is provided to the public through such
mediums as a sign at the office and a short statement on
stationery and business cards that the departing dentist has
retired from the practice.

2. Responsibility. The responsibility for the form and content of an
advertisement offering services or goods by a dentist shall be
jointly and severally that of each licensed professional who is a
principal, partner, officer, or associate of the firm or entity
identified in the advertisement regardless whether the
advertising has been generated by them personally, by their
employees, or a third-party contractor.

D. FEES.

1. General: Dentists shall not represent the fees they charge in a
false or misleading manner when advertising. Dentists shall state
availability and price of goods, appliances or services in a clear
and non-deceptive manner and include all material information to
fully inform members of the general public about the nature of the
goods, appliances or services offered at the announced price.

2. Disclosures: An advertisement which includes the price of dental
services shall disclose:

a. The professional service being offered in the advertisement.

b. Any related services which are usually required in conjunction
with the advertised services and for which additional fees may
be charged.
c. A disclaimer statement that the fee is a minimum fee and that the charges may increase depending on the treatment required.

d. The dates upon which the advertised service will be available at the advertised price.

e. When a service is advertised at a discount, the standard fee of the service and whether the discount is limited to a cash payment.

f. When a service is advertised at less than market value, how the market value was determined.

g. If the advertisement quotes a range of fees for a service, the advertisement shall contain all the basic factors upon which the actual fee shall be determined.

E. RECORD KEEPING OF ADVERTISEMENTS.

1. Retention of broadcast, print and electronic advertising. A prerecorded copy of all broadcast advertisements, a copy of print advertisements and a copy of electronic advertisements shall be retained for a reasonable period of time following the final appearance or communication of the advertisement. In addition, the dentist shall document the date the dentist discovered a false or misleading advertisement, as well as the date and substance of all corrective measures the dentist took to rectify false or misleading advertisements. The dentist shall maintain documentation of all corrective measures for a reasonable period of time following the most recent appearance or communication of the advertisement which the dentist discovered was in inaccurate.

2. The advertising dentist shall be responsible for making copies of the advertisement available to the board if requested.
F. FALSE AND MISLEADING ADVERTISING:

1. The dentist has a duty to communicate truthfully. Professionals have a duty to be honest and trustworthy in their dealings with people. The dentist's primary obligations include respecting the position of trust inherent in the dentist-patient relationship, communicating truthfully and without deception, and maintaining intellectual integrity. In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the profession. Dentists should not misrepresent their training and competence in any way that would be false or misleading in any material respect. No dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect.

2. Published Communications. If a dental health article, message or newsletter is published in print or electronic media under a dentist's byline, to the public without making truthful disclosure of the source and authorship or is designed to give rise to questionable expectations for the purpose of inducing the public to utilize the services of the sponsoring dentist, the dentist is engaged in making a false or misleading representation to the public in a material respect.

3. Examples. In addition to the plain and ordinary meaning of the provisions set forth throughout these guidelines, additional examples of false or misleading advertising include but are not limited to:

a. Claims to provide or perform painless dentistry.
b. A statement which implies or suggests a procedure is guaranteed to be successful or creates false or unjustified expectation of favorable results.
c. A statement which implies or suggests superiority of services or materials that cannot be reasonably substantiated. In this regard, the Board may request the licensee submit his or her evidence to sustain his claim to the licensing board before using the advertisement that includes the claim of superiority.
d. A statement which implies or suggests any guarantee of satisfaction except the guarantee to return a fee if the patient is not satisfied with the treatment rendered.

e. A statement which implies or suggests that a service is free or discounted when the fee is built into a companion procedure provide to the patient and charged to the patient.

f. A statement which contains a testimonial from a person who was not a patient of record.

g. A statement which misrepresents or misnames any dental method or system.

SECTION 4. LEGAL REQUIREMENTS FOR ADVERTISING REGULATIONS:

A. FOUR PART TEST: In commercial speech cases, the court will use a four-part analysis to determine whether a regulatory provision violates the First Amendment of the U.S. Constitution (see Central Hudson Gas & Electric Corp. v. Public Service Commission of New York, 447 U.S. 557 at 566, 100 S.CT 2343, 65 L.Ed.2d 341 (1980). The provision must meet each of the following criteria:

1. An expression which is protected by the First Amendment is one which concerns a lawful activity and is not misleading.

2. If the expression concerns a lawful activity and is not misleading, the governmental interest in regulating the expression must be substantial.

3. The regulation directly advances the (substantial) governmental interest asserted in that the regulation addresses actual harm (not a hypothetical harm); "[M]ere speculation or conjecture" (that the regulation will advance the substantial government interest) will not suffice; rather the State "must demonstrate that the harms it recites are real and that its restriction will in fact
alleviate them to a material degree." Id at 143 citing *Edenfield v. Fane*, 507 U.S. 761, 767 (1993).

a. Public surveys are an acceptable means for a State Board to demonstrate the actual harm and to demonstrate that the proposed regulation will remedy the harm (See *Borgner v Brooks*, 284 F.3d 1204 at 1213 (11th Cir. 2002).

4. The regulation cannot be more extensive than is necessary to serve the government’s (substantial) interest.


**SECTION 5. GROUNDS AND PROCEDURES FOR DISCIPLINARY ACTION FOR ADVERTISING VIOLATIONS.**

A. In accordance with the Board’s statutory and regulatory authority for disciplinary action and denial of licensure for advertising violations as set forth below, the Board may refuse to issue or renew a license, may suspend or revoke a license, may reprimand, restrict or impose conditions on the practice of a licensee or applicant for licensure.

1. “Advertising violations” consist of expressions explicitly or implicitly authorized by a licensee, or applicant for licensure, which are false or misleading as otherwise referenced in these guidelines;

B. A licensee or applicant for licensure explicitly or implicitly authorizes advertising when the individual permits or fails to correct statements that are false or misleading. Failure to attempt to retract or otherwise correct advertising violations as directed by the Board may constitute a willful violation of these provisions and may be a separate and
distinct independent violation of the Board's statutory or regulatory authority. A willful violation of the Board's directive may subject the licensee or applicant to disciplinary action, non-renewal or denial of licensure.

C. When determining whether an "advertising violation" has occurred, the Board shall proceed in accordance with due process and its statutory and regulatory provisions which govern investigations and contested case proceedings.
January 16, 2012

TO: ADEX Member States

FROM: Bruce Barrette, D.D.S., ADEX President

SUBJECT: ADEX 7th Annual Meeting

Enclosed is a copy of the Highlights of the ADEX House of Representatives Meeting, November 6, 2011, Rosemont, IL as well as a draft of the Proceedings of the HOR and the 2010-2011 ADEX Annual Report

The success and achievements of ADEX over the past seven years is due to the commitment of the member state dental boards.
Highlights of the American Board of Dental Examiners, Inc. (ADEX)
7th House of Representatives
November 6, 2011
Rosemont, IL

The following are highlights of the 7th ADEX House of Representatives:

**Officers were elected:** Dr. Bruce Barrett, WI, President; Dr. Stanwood Kanna, HI, Vice-President; Dr. William Pappas, NV, Secretary and Dr. H. M. "Bo" Smith, AR, Treasurer.

Representatives from 42 out of 45 State Board, District Hygiene and Consumer Representatives were present.

Presentations were made by:

- Dr. Brian Kennedy, Chairman – ADA’s Council on Dental Education and Licensure.
- Mysiha Stokes, Program Manager—Alpime Testing.
- E.W. Looney, CEO-Brightlink.

A Post Dental and Dental Hygiene Exam Analysis report was reviewed by Dr. Stephen Klein, Psychometrician.

District 6 elected, Dr. Michelle Bedell, SC, for a three year term on the Board of Directors.

District 10 re-elected Dr. Richard Dickinson, VT, for another three year term on the Board of Directors.

District 12 elected Dr. Wade Winker, FL, for a term a three year term on the Board of Directors.

**Dental and Hygiene Exams:** The House approved a motion to approve the dental and hygiene examinations for 2012.

It was announced that the ADEX Board of Directors has elected Dr. Scott Houfek of Wyoming as the Dental Examination Chair for the next three years.

**2012 ADEX House of Representatives:** The 8th ADEX House of Representatives was scheduled for Sunday, November 11, 2012, Doubletree Hotel, Rosemont, IL.

2011 ADEX HOR Highlights
Call to Order and Introductions: President Bruce Barrette called to order the 7th meeting of the ADEX House of Representatives at 8:05 a.m. on Sunday, November 6, 2011 in the Signature 2 Room, Doubletree Hotel, Rosemont, IL.

Roll Call: President Barrette introduced the members of the House of Representatives: Dentist/Administrator Representatives: Dr. Robert Ray, DC; Dr. David Perkins, CT; Dr. Mark Baird, HI; Maulid Miskell, CO; Dr. Dennis Manning, IL; Dr. Matthew Miller, IN; Dr. Rockwell Davis, ME; Dr. Peter DeSciscio, NJ; Dr. Harold “Bo” Smith, KY; Dr. David Averill, VT; Dr. Maurice Miles, MD; Dr. William Wright, MI; Dr. Patrica Parker, OR; Dr. William Pappas, NV; Dr. Neil Hiltunen, NH; Dr. John Reitz, PA; Dr. Phillip Beckwith, OH; Dr. Scott Houfek, WY; Dr. Wade Winker, FL; Dr. Craig Meadows, WV; Dr. Keith Clemence, WI; Dr. Warren Whitis, AR; Dr. Michael Tabor, TN; Dr. Michelle Bedell, SC; Dr. Henry Levin, RI; Dr. Mina Paul, MA; Dental Hygiene Representatives: Mary Davidson, RDH, OR, District 2; Nan Dreves, RDH, WI, District 4; Mary Johnston, RDH, MI, District 5; Mary Ann Burch, RDH, KY District 6; Cheryl Bruce, RDH, MD, District 7; Sibyl Gant, RDH, DC, District 8; Nancy St. Pierre, RDH, NH, District 9; Karen Dunn RDH, MA, District 10; Irene Stavros, RDH, FL, District 12; Consumer Representatives: Ms. Marian Grey, HI, District 2; Ms. Clance LaTurner, IN, District 5; Mr. Allan Francis, KY, District 6; Mr. Allan Horwitz, PA, District 7; Ms Lynn Joslyn, NH, District 9; Ms. Diane Denk, ME District 10; Ms. Vicki Campbell, FL, District 12. There were 42 out of 45 State Board, District Hygiene and Consumer Representatives present.

President Barrette introduced ADEX officers, Dr. Stan Kanna, HI, Vice-President and Dr. William Pappas, NV, Treasurer, Dr. Guy Shampaine, MD, Immediate Past President and District 7 Director.

President Barrette also introduced representatives from Associate Member organizations: Dr. Peter Robinson, American Dental Education Association (ADEA); Mr. Ken Randall, American Student Dental Association (ASDA); and Dr. Samuel Low, ADA Trustee.

Presentations from Associate Members

ADEA - Dr. Robinson ADEA had no report.

ASDA - Mr. Ken Randal thanked the House for allowing him to attend on behalf of ASDA.
With the help of EW Looney and the folks at Brightlight, we have adopted a computer program that is not only collects data from our exam but also is a program that manages time. To our knowledge, no other program has these two capabilities. By utilizing our program, the time in the grading area has been reduced by 1 ½ hours, which gives our candidates that much additional working time. A little later in the program EW will talk about the current program and enhancements in the future.

On the hygiene exam, our dental hygiene exam committee continues to refine and improve the exam. During the past year they have worked especially diligently updating the candidate and examiner’s manuals.

We have begun to undertaken a major project in redoing the calibration for both the dental exam and the dental hygiene examinations. I have appointed Dr. Bill Pappas and together we have selected a committee of experienced examiners that includes all facets of our membership to begin addressing this huge undertaking. I know they are working feverishly to make improvements in our calibration instruments and we patiently are waiting for their results. We anticipate that some of their work will be incorporated in the current exam cycle.

Our communication committee has designed and gone live this past year with our website and have been busy exploring ways to explain who we are and get our message out. Later in the program some members of the committee will be talking to you about those efforts.

Another major project that we have initiated is the joint task analysis we’ve undertaken in conjunction with the Southern Regional Testing Agency (SRTA). Along with Bob Jolly and Kathleen White from SRTA we have spent a lot of effort in laying the foundation for the analysis, which culminated in a joint meeting of 12 of our members and 12 members of SRTA in June in Atlanta to formulate the questions to be asked on the task analysis. The task analysis surveys the entire country inquiring of both new and experienced practitioners on what procedures they are doing in their offices. With the emphasis on the new practitioner it gives us data on what procedures we should be testing for on our examinations. You will hear an update later from Myisha Stokes regarding the task analysis.

During the past year, the Florida board voted to join ADEX and administer the ADEX exams both in dental and dental hygiene and we welcome Florida’s decision. Florida has had a long relationship with NERB through NERB’s administration of the Florida Exam and to a lesser extent with ADEX. Many people both in Florida and ADEX have worked to achieve this goal and we are grateful for all of their efforts. We look forward to working together with the representatives from Florida as they begin utilizing the ADEX exam.

We also have opened a dialogue with representatives from SRTA. During the past year, Dr. Shampaine and myself have meet with the SRTA Board of directors twice in person, twice on teleconference calls and have attended and addressed their Annual meeting in Portland Maine. We have had frank and open conversations. During those conversations, we both have learned a lot about
Dr. Kennedy discussed the January 2005 birth of ADEX and the potential we all saw in 2005. He reviewed the WREBs movement away from ADEX and the number of decreasing states accepting ADEX and then the recent turnaround now with the SRTA and states that make up SRTA and FL, NV, HI being most positive developments. Dr. Kennedy emphasized the recurring history of the ADA House of Delegates adopting positions of eliminating live patient’s from the examination process.

Dr. Kennedy related the history of the S21 and 42H workgroups and the intent of the portfolio process to develop a “true” Clinic Integrated Format type of process.

Dr. Kennedy discussed the rise of the patient brokering services and the need to eliminate them from the process as well as the opportunity for a portfolio process to impact dental education. The portfolio product would function with the state boards as being the final decision maker in the licensing process.

Dr. Kennedy also stated categorically, the ADA House of Delegates policy mandates an ”independent” evaluation process and the final product would comply with that principle. He emphasized the portfolio will not advocate graduation being licensure being the same as graduation, and the process will be gradual as the process continues and there will never be a system all can agree to simultaneously.

Dr. Kennedy concluded that it is time for collaboration between all parties to move this process forward. We all want the best process that meets the needs of the state boards and the profession.

Myisha Stokes, Program Manager – Alpine Testing Solutions

“Using Job Analysis to inform Test Development”

Myisha Stokes’ presented an overview of the Test Development Cycle and Validation process with emphasis on the importance of the Program Design and Job Task Analysis steps recently undertaken by ADEX and SRTA. It was pointed out that these steps were of the more crucial sources of validity evidence. Specifically, after walking through Alpine’s Test Development graphic beginning with “Design Program” and ending with “Maintain Test”, Myisha refocused on recent steps undertaken by ADEX and SRTA such as Test Design with a discussion centered on intended and unintended use of test scores.

This was followed by a more focused look at validation framework, core elements of defensibility, and domain representation. The presentation progressed into a summary of the job analysis procedure used for ADEX’s clinical examinations, inclusive of a description of the committee meetings in Atlanta, the survey process and chosen stratification methods, communication tools used, and concluded with a sample report from the surveys’ empirical results. Supporting literature was provided at the conclusion of the presentation.
• That the Captain be allowed to counsel and discuss with examiners who misapply objective measurable criteria of a critical deficiency.

• That retakes for the restorative examination be limited to 6 hours.

• That if a lesion on the Class III composite was assigned without a contact it can be restored without a contact and examiners should be informed of this change.

• That a second lesion can be assigned anytime during the exam, but the first restoration would have to be graded before the second preparation can be started.

Dr. Scott Houfek moved to accept the Dental Examination Committee Report. Motion approved by general consent.

The next Dental Examination Committee Meeting will be Friday and Saturday November, 9-10, 2012.

Dr. Barrette presented an award to Dr. Yaman thanking him for serving as the Chair of the Dental Exam Committee for the past 3 years.

Nancy St. Pierre - Chair ADEX Dental Hygiene Exam Committee - Dental Hygiene Examination Overview

2012 CHANGES:

1. To allow the candidates to bring the candidate manual, ADEX Forms, and notes written in the manual to the treatment area on the clinic floor.

2. The Candidate may not bring into the clinical examination any paperwork other than ADEX forms, the manual and notes written in the manual

3. To decrease the point value deduction for the pocket qualifying teeth to: -10 points for missing one tooth/surface and -20 missing two or more tooth/surfaces.

4. To allow local Injectable anesthesia during the clinic ADEX DH exam in compliance with the Examination Hosting Sites State statue.

5. The primary quadrant will have at least 6 permanent teeth.
The Candidate must select a Primary Quadrant with at least 6 permanent teeth for Complete Treatment that satisfies the minimum criteria described below:

1. The Primary Quadrant must present 12 surfaces of subgingival calculus on a minimum of 6 teeth.

2. The 12 surfaces of subgingival calculus must be distributed as follows:
   - 8 of these surfaces must be on approximating posterior teeth (premolars and molars). These posterior teeth must be within 2mm of each other.
   - 5 of these posterior (premolars/molars) surfaces must be on mesial or distal proximal surfaces.
   - 3 of these mesial or distal proximal surfaces must be on molars, in particular.
   - One distal surface of a 2nd or 3rd terminal molar may be used.

3. The 4 remaining surfaces are at the choice of the candidate. The Candidate may select an Alternative Selection for Complete Treatment, should the above criteria not be met in the Primary Quadrant.

3. An alternative selection of up to 4 approximating posterior teeth (premolar and molar) in one additional quadrant may be used to satisfy the tooth and surface selection criteria. These posterior teeth must be within 2mm of each other. For Complete Treatment, each tooth in the Alternative Selection must be free of all supra and subgingival calculus as well as coronal plaque and stain.

4. To establish two sections in the ADEX DH exam to demonstrate calculus detection and calculus removal.

5. The detection exercise will consist of 3 consecutive teeth, two of which being posterior teeth in the primary quadrant.

6. Add four additional teeth and surface for the 12 subgingival calculus removal. The 1, 2, 3, or 4 surfaces will only be used for grading purposes if the candidates first 12 selections do NOT meet criteria.

7. To eliminate the 6 plaque, stain, and supra calculus removal area on the grade form and add the 6 points to the Hard Tissue Management “SUB” point value now equally 8 pts. To eliminate the 6 plaque, stain, and supra calculus removal area on the grade form and add the 6 points to the Hard Tissue Management “SUB” point value now equally 8 pts.
District 5: Mary Johnston, RDH, MI, Dental Hygiene Representative  
Ms. Clance LaTurner, IN, Consumer Representative  
Dr. George Willis, MI, Educator Dental Exam Committee

District 6: Michelle Bedell, DDS, SC, Board of Directors  
Mary Ann Burch, RDH, WV, Dental Hygiene Representative  
Allan Francis, KY, Consumer Representative  
TBD Educator, Dental Exam Committee Member

District 7: Cheryl Bruce, R.D.H., MD, Dental Hygiene Representative  
Allan Horwitz, Esq., PA, Consumer Representative  
Mariellen Brickley-Raab, RDH, Dental Hygiene Exam Committee  
Uri Hangorsky, DDS, PA, Educator Dental Exam Committee

District 8: Sibyl Gant, RDH, DC, Dental Hygiene Representative  
Consumer Representative: TBD  
Dr. John Bailey, DC, Educator, Dental Exam Committee

District 9: Nancy St. Pierre, RDH, NH, Dental Hygiene Representative  
Ms. Lynn Joslyn, NH Consumer Representative  
Dr. Marc Rosenblum, NJ, Educator, Dental Exam Committee

District 10: Richard Dickinson, DDS, VT, Board of Directors  
Diane Denk, ME, Consumer Representative  
Steven DuLong, MA, Educator, Dental Exam Committee

District 12: Wade Winker, DDS, FL Board of Directors  
Irene Stavros, RDH, FL, Dental Hygiene Representative  
Vicki Campbell, FL, Consumer Representative  
Dr. Boyd Robinson, FL Educator, Dental Exam Committee  
Dr. Wiliam Kuchenour, FL, Dental Exam Committee

Dr. Scott Houfek moved and Dr. Peter DeSciscio seconded a motion to accept the dental exam. The motion passed by general consent.

Nan Kosydar Dreves, RDH moved and Dr. Scott Houfek seconded a motion to accept the dental hygiene exam.

Dr. Wade Winker moved and Dr. Dennis Manning seconded to amend the motion for the approval of the dental hygiene examination, that ADEX develop a Local Anesthesia component for the Dental Hygiene Examination.

The motion as amended passed by general consent.
This Page

Left Blank
American Board of Dental Examiners, Inc.
a test development agency for the member state dental boards

2010-2011 Annual Report
ADEX
American Board of Dental Examiners, Inc.
a test development agency for the member state dental boards

2010-2011 Annual Report
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Message from the President</td>
<td>1</td>
</tr>
<tr>
<td>ADEX Membership</td>
<td>2</td>
</tr>
<tr>
<td>ADEX Governance</td>
<td>4</td>
</tr>
<tr>
<td>ADEX Committees</td>
<td>10</td>
</tr>
<tr>
<td>ADEX Dental Licensing Examination</td>
<td>16</td>
</tr>
<tr>
<td>ADEX Dental Hygiene Licensing Examination</td>
<td>22</td>
</tr>
</tbody>
</table>
Message from the President

Welcome to the Seventh Annual ADEX House of Representatives. The American board of Dental Examiners (ADEX) has just finished its fifth full year of initial licensure examinations in dentistry and dental hygiene. This has been an especially busy year with much accomplished. Three new states (Arkansas, Florida and Tennessee) have become members. A regional testing agency (SRTA) has voted to administer the ADEX dental examination in 2013. At the same time, we continue to strengthen our examinations with a special emphasis this year on improving our calibration exercises.

ADEX still remains the largest licensure test development entity for dentistry in the United States with 27 state dental boards as members and with approximately 42 states accepting the examinations for licensure. This progress is due to the support and commitment of the member state boards and the volunteers chosen by those state dental boards toward developing the most valid, reliable and defensible examinations possible for the dental profession.

Thank you for your dedication and participation in the 2011 ADEX House of Representatives.

Bruce Barrette, DDS
President, ADEX
ADEX Membership

Membership gives a recognizing state dental board direct involvement in the development and evolution of the examinations through committee appointments; and approval of the final form of the examinations in dentistry and dental hygiene through their appointments to the House of Representatives.

Consumer members of state dental boards are full active voting members of ADEX directly involved in the evolution and participation of the examinations.

Member States

Arkansas
Colorado
Connecticut
District of Columbia
Florida
Hawaii
Illinois
Indiana
Iowa
Kentucky
Maine
Maryland
Massachusetts
Michigan
Nevada
New Hampshire
New Jersey
Ohio
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Wyoming
Vermont
West Virginia
Wisconsin
ADEX Districts

ADEX initial districts were drawn to try to equalize the number of dental students, dentists licensed each year, and to some degree practicing dentist numbers.

District 1: California


District 3: Kansas, Missouri, Nebraska, Oklahoma, Texas

District 4: *Iowa*, Minnesota, North Dakota, South Dakota, *Wisconsin*

District 5: *Illinois, Indiana, Michigan, Ohio*

District 6: *Arkansas*, Georgia, *Kentucky, South Carolina, Tennessee*, Virginia, *West Virginia*

District 7: *Maryland, Pennsylvania*

District 8: *Connecticut*, Delaware, *District of Columbia*, U.S. Virgin Islands

District 9: *New Hampshire, New Jersey*, New York, *Rhode Island*

District 10: *Maine, Massachusetts, Vermont*

 District 11: Alabama, Louisiana, Mississippi, North Carolina, Puerto Rico

District 12: *Florida*

States highlighted in *bold italics* are Member States
ADEX Governance

Governance Principle

ADEX’s governing principle is that the governing authority is vested with the active member state boards of dentistry. Representatives are directly appointed by the active state dental board and the directors elected by state board representatives.

Important committee appointments are directly made through the representatives of the active state dental boards.

House of Representatives

Governance is from the Member State Dental Boards in the House of Representatives.

- The House of Representatives consists of dentist or executive director representatives from the member state dental boards. They hold final approval of major examination changes.

- Each state board will designate one representative.

- Representatives are required to have been active voting board members of the member state at some time.

- A Dental Hygiene representative from each ADEX district is required to be or have been an active board member from a member state.

- A Consumer representative from each ADEX district is required to be or have been an active board member from a member state.

- Each state will determine the qualifications of their representative.

- Members from American Dental Association (ADA), American Student Dental Association (ASDA), American Dental Education Association (ADEA), American Dental Hygienists’ Association (ADHA), The National Dental Examining Board of Canada (NDEB), Canadian Dental Association (CDA), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) are chosen by their respective organizations.
2010 ADEX House of Representatives

Dentist or Executive Director Representatives

Colorado – Mr. Maulid Miskell, Nevada – William Pappas, DDS
Connecticut – David Perkins, DDS New Hampshire – Neil Hiltunen, DMD
District of Columbia – Robert Ray, DMD New Jersey – Peter DeSciscio, DDS
Florida – Hal Hearing, DDS Ohio – Phil Beckwith, DDS
Hawaii – Ms. Sandra Matushima Oregon – Patricia Parker, DMD
Indiana – Steve Pritchard, DDS Rhode Island – Craig VanDongen, DDS
Iowa – No Representative South Carolina – No Representative
Kentucky – Mr. Brian Bishop Vermont – Richard Dickinson, DDS
Maine – Rockwell Davis, DDS West Virginia – George “Buck” Conard, DDS
Maryland – Maurice Miles, DDS Wisconsin – Dr. Keith Clemmence, DDS
Massachusetts – Mina Paul, DDS Wyoming – Scott Houfek, DDS
Michigan – William Wright, DDS
2010 ADEX House of Representatives (con’t.)

Dental Hygiene Representatives

Mary Davidson, RDH, OR                District 2
Nan Dreves, RDH, WI                   District 4
Mary Johnston, RDH, MI                District 5
Dina Vaughn, BSDH, MS, WV             District 6
Mariellen Brickley-Raab, RDH, MD      District 7
Sibyl Gant, RDH, DC                   District 8
Nancy St. Pierre, RDH, NH             District 9
Karen Dunn, RDH, MA                   District 10
Irene Stavros, RDH, FL                District 12

Consumer Representatives

Marian Grey, HI                       District 2
Ms. Judith Ficks, WI                  District 4
Ms. Clance LaTurner, IN               District 5
Mr. Allan D. Francis, KY              District 6
Allan Horwitz, Esq., PA               District 7
No Representative                     District 8
No Representative                     District 9
Ms. Diane Denk, ME                    District 10
Mr. Ben Poitevent, FL                 District 12
2010 ADEX House of Representatives (con’t.)

Associate Members

American Dental Association – Charles Norman, DDS, ADA Trustee
American Student Dental Association – Mr. Corwyn Hopke, President
American Dental Education Association – Peter Robinson, DDS
American Dental Hygienists’ Association – No Representative
National Dental Examining Board of Canada – No Representative
Canadian Dental Association – No Representative
Federation of State Medical Boards – No Representative
National Board of Medical Examiners – No Representative
ADEX Board of Directors

ADEX Officers

Bruce Barrette, DDS  Wisconsin  President
Stanwood Kanna, DDS  Hawaii  Vice-President
Vacant
William Pappas, DDS  Nevada  Treasurer
Guy Shampaine, DDS  Maryland  Immediate Past President

ADEX Board of Directors – Up to 17 Members

12 Districts, Examination Committee Chairs, Dental Hygiene Representatives
Directors elected by state board representatives in House of Representatives

Board of Directors

Stan Kanna, DDS  Hawaii  District 2
Bruce Barrette, DDS  Wisconsin  District 4
M.H VanderVeen, DDS  Michigan  District 5
David Narramore, DMD  Kentucky  District 6
Guy Shampaine, DDS  Maryland  District 7
Robert Ray, DMD  DC  District 8
Peter DeSciscio, DMD  New Jersey  District 9
Richard Dickinson, DDS  Maine  District 10
Hal Haering, DDS  Florida  District 12
Ms. Judith Ficks  Wisconsin  Consumer Member
Mr. Zeno St. Cyr, II  Maryland  Consumer Member
Cathy Turbyne, EdD, MS, RDH  Maine  Hygiene Member
James “Tuko” McKernan, RDH,  Nevada  Hygiene Member
Nancy St. Pierre, RDH,  New Hampshire  Chair, Dental Hygiene Examination Committee
Peter Yaman, DDS  Michigan  Chair, Dental Examination Committee
Terms for Current ADEX Board of Directors*

<table>
<thead>
<tr>
<th>District</th>
<th>Incumbent</th>
<th>Remaining Tenure</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 2</td>
<td>Stan Kanna, DDS</td>
<td>1 Year</td>
</tr>
<tr>
<td>District 4</td>
<td>Bruce Barrette, DDS</td>
<td>1 Year</td>
</tr>
<tr>
<td>District 5</td>
<td>M. H. VanderVeen, DDS</td>
<td>2 Years</td>
</tr>
<tr>
<td>District 6</td>
<td>David Narramore, DMD</td>
<td>0 Years</td>
</tr>
<tr>
<td>District 7</td>
<td>Guy Shampaine, DDS</td>
<td>1 Year</td>
</tr>
<tr>
<td>District 8</td>
<td>Robert Ray, DMD</td>
<td>2 Years</td>
</tr>
<tr>
<td>District 9</td>
<td>Peter DeScisco, DMD</td>
<td>2 Years</td>
</tr>
<tr>
<td>District 10</td>
<td>Richard Dickinson, DDS</td>
<td>0 Years</td>
</tr>
<tr>
<td>District 12</td>
<td>Hal Haering, DDS</td>
<td>0 Years</td>
</tr>
<tr>
<td>Consumer Member</td>
<td>Ms. Judith Ficks</td>
<td>2 Years</td>
</tr>
<tr>
<td>Consumer Member</td>
<td>Mr. Zeno St. Cyr, II</td>
<td>1 Year</td>
</tr>
<tr>
<td>Hygiene Member</td>
<td>Cathy Turbyne, EdD, MS, RDH</td>
<td>1 Year</td>
</tr>
<tr>
<td>Hygiene Member</td>
<td>James &quot;Tuko&quot; McKernan, RDH</td>
<td>2 Years</td>
</tr>
</tbody>
</table>

* All members of the Board of Directors are eligible to serve a second three-year term if elected by their district.
ADEX Committees

Dental Examination Committee

- One (1) dentist from each Member Board.
- One (1) Member Board consumer representative
- 1 Consumer
- The Chair of the Dental Examination Committee
- All appointments are nominated by the representatives of the member state dental boards.

Dental Examination Committee Members

Peter Yaman, DDS, MI – Chair

District 2: (CO, HI, NV, OR, WY)
   Peter Carlesimo, DDS, CO
   Stan Kanna, DDS, HI
   William Pappas, DDS, NV
   Jonna Hongo, DMD, OR
   Scott Houfek, DDS, WY
   Rick Thiriot, DDS, NV Educator

District 4: (IA, WI)
   Gary Roth, DDS, IA
   Keith Clemmence, DDS, WI
   Karen Jahimiak, DDS, WI Educator

District 5: (IL, IN, MI, OH)
   Dennis Manning, DDS, IL
   Matt Miller, DDS, IN
   Chuck Marinelli, DDS, MI
   Eleanore Awadalla, DDS, OH
   George Willis, DDS, IN, Educator
Dental Examination Committee Members (con’t.)

District 6: (AK, KY, SC, TN, WV)
  George Martin, DDS, AR
  Robert Zena, DDS, KY
  Michelle Bedell, DDS, SC
  John M. Douglas, Jr. DDS, TN
  John Dixon, DDS, WV
  Educator Rep

District 7: (MD, PA)
  Guy Shampaine, DDS, MD
  Susan Calderbank, DMD, PA
  Ronald Chenette, DMD, MD, Educator

District 8: (CT, DC)
  Lance Banwell, DDS, CT
  Rahele Rezai, DMD, DC
  John Bailey, DDS, DC, Educator

District 9: (NH, NJ, RI)
  Barbara Rich, DMD, NJ
  Neil S. Hiltunen, DMD, NH
  Henry Levin, DMD, RI
  Marc Rosenblum, DMD, NJ, Educator

District 10: (ME, MA, VT)
  Robert DeFrancesco, DMD, MA
  LeeAnn Podruch, DDS, VT
  Rockwell Davis, DDS, ME
  Stephen DuLong, DMD, MA, Educator

District 12: (FL)
  Wade Winker, DDS, FL
  Boyd Robinson, DDS, FL, Educator
Dental Examination Committee Members (con't.)

Consumer:
Alan Horwitz, Esq., PA

Consultants:
Ogden Munroe, DDS, IL
Terry Rees, DDS, TX

Testing Specialist:
Steven Klein, Ph.D, CA

NERB Administrative Liaison:
Ellis Hall, DDS, MD

Nevada Administrative Liaison:
Kathleen Kelly, NV
ADEX Committees (con’t.)

Dental Hygiene Examination Committee

- 1 Dental Hygienist from each district
- 1 Dental Hygiene Educator
- 1 Dentist
- 1 Consumer
- All appointments are nominated by the active member state dental boards.

Dental Hygiene Examination Committee Members

Nancy St. Pierre, RDH, NH – Chair
District 2: Jill Mason, RDH, OR
District 4: Nanette Kosydar Dreves, RDH, WI
District 5: Lynda Sabat, RDH, OH
District 6: Diana Vaughan, RDH WV
District 7: Angie Riccelli, RDH, MS, PA
District 8: Judith Neely, RDH, BS, DC
District 9: Shirley Birenz, RDH, BS, NJ
District 10: Karen Dunn, RDH, MA
Dentist: Maxine Feinberg, DDS, NJ
Educator: Donna Homenko, RDH, PhD, OH
Consumer: Zeno St. Cyr II, MPH, MD
Testing Specialist: Steven Klein, Ph.D, CA
ADEX Committees (con’t.)

Budget Committee
William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Neil Hiltunen, DDS, NH
Tony Guillen, DDS, NV
Guy Shampaine, DDS, MD

Bylaws Committee
Robert Ray, DDS, WI - Chair
Garo Chaian, DDS, CO
James “Tuko” McKernan, NV
Alan Horowitz, Esq. PA

Calibration Committee
William Pappas, DDS, NV - Chair
Scott Houfek, DDS, WY
Tony Guillen, DDS, NV
Rick Thiriot, DDS, NV
Neil Hiltunen, DDS, NH
Ogden Munroe, DDS, IL
Ken Van Meter, DDS, VT
Rick Kewlowitz, DDS, FL
Peter Yaman, DDS, MI
Ronald Chenette, DMD MD
Wendell Garrett, DDS, AK

Quality Assurance Committee
Hal Haering, DDS, AZ - Chair
Stanwood Kanna, DDS, HI
Patricia Parker, DMD OR
Scott Houfek, DDS, WY
Robert Sherman, DDS, HI
J. George Kinnard, DDS NV
Barbara Rich, DMD NJ
Nan Kosydar Dreves, RDH, WI
Ronald Chenette, DMD MD
James Haddix, DMD, FL
Guy Shampaine, DDS, MD
Peter Yaman, DDS, MI
Nancy St. Pierre, RDH,NH
Stephen Klein, PhD., CA, Testing Specialist
Communications Committee

Mary Johnston, RDH, MI - Chair
Stanwood Kanna, DDS HI
David Narramore, DMD, KY
Geri Ann DiFranco, DDS, IL
Mary Davidson, RDH, OR
Clance LaTurner, IN
Margo Rheinberger, PhD, MN
ADEX Dental Examination

Content

- Five stand alone examinations
  - Critical skill sets identified by criticality in the Occupational Analysis

- Computerized Examination in Applied Diagnosis and Treatment Planning

- Endodontic Clinical Examination
  - Manikin-based

- Fixed Prosthodontic Clinical Examination
  - Manikin-based

- Restorative Clinical Examination
  - Patient-based

- Periodontal Clinical Examination
  - Patient-based

Scoring

- Criterion based scoring system

- Three (3) independent raters without cross-validation

Rating Levels

- Satisfactory

- Minimally Acceptable

- Marginally Substandard

- Critically Deficient
ADEX Dental Exam Scoring

Criterion-Based Analytical Scoring Rubric:

- More detailed feedback.
- More consistent scoring.
- Allows for the separate evaluation of factors.
- Evaluation of all gradable criteria.
- Scoring methodologies were developed with consultation from the Buros Institute, University of Nebraska and the Rand Institute with input from studies completed by testing specialists from the University of Chicago.
- Three (3) independent raters evaluate all measurable criteria.
- Median score is utilized when there are no matching scores; all zeros must be independently corroborated to be utilized as a critical deficiency.
- Performance criteria-based scoring will be provided to both the candidate and the dental school so that appropriate remediation can be completed prior to a retake when required.
- Clinical sections utilize compensatory grading with critical errors within a skill set.
- No grading across skills.
- Critical errors are those performance deficiencies that would cause treatment to fail. A critical error forces a failure on that skill set examination. Not all criteria have critical errors.

Evaluation Criteria

Objective measurable criteria developed by a panel of experts consisting of examiners, practitioners, and educators.
Amalgam Prep External Outline Criteria (Example)

SATISFACTORY
1. Contact is visibly open proximally and gingivally up to 0.5 mm.
2. The proximal gingival point angles may be rounded or sharp.
3. The isthmus must be 1-2 mm wide, but not more than ¼ the intercuspal width of the tooth.
4. The external cavosurface margin meets the enamel at 90°. There are no gingival bevels. The gingival floor is flat, smooth and perpendicular to the long axis of the tooth.
5. The outline form includes all cavosurfaces and non-coalesced fissures, and is smooth, rounded and flowing.
6. The cavosurface margin terminates in sound natural tooth surface. There is no previous restorative material, including sealants, at the cavosurface margin. There is no degree of decalcification on the gingival margin.

MINIMALLY ACCEPTABLE
1. Contact is visibly open proximally, and proximal clearance at the height of the contour extends beyond 0.5 mm but not more than 1.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 0.5 mm but not greater than 2 mm.
3. The isthmus is more than ¼ and not more than 1/3 the intercuspal width.
4. The proximal cavosurface margin deviates from 90°, but is unlikely to jeopardize the longevity of the tooth or restoration; this would include small areas of unsupported enamel.

MARGINALLY SUBSTANDARD
1. The gingival floor and/or proximal contact is not visually open; or proximal clearance at the height of contour extends beyond 1.5 mm but not more than 2.5 mm on either one or both proximal walls.
2. The gingival clearance is greater than 2 mm but not more than 3 mm.
3. The outline form is inappropriately overextended so that it compromises the remaining marginal ridge and/or cusp(s).
4. The isthmus is less than 1 mm or greater than 1/3 the intercuspal width.
5. The proximal cavosurface margin deviates from 90° and is likely to jeopardize the longevity of the tooth or restoration. This would include unsupported enamel and/or excessive bevel(s).
6. The cavosurface margin does not terminate in sound natural tooth structure; or, there is explorer penetrable decalcification remaining on the cavosurface margin, or the cavosurface margin terminates in previous restorative material. (See glossary under Previous Restorative Material).
7. There is explorer-penetrable decalcification remaining on the gingival floor.
8. Non-coalesced fissure(s) remain which extend to the DEJ and are contiguous with the outline form.

CRITICAL DEFICIENCY
1. The proximal clearance at the height of contour extends beyond 3 mm on either one or both proximal walls.
2. The gingival clearance is greater than 3 mm.
3. The isthmus is greater than ½ the intercuspal width.
4. The outline form is overextended so that it compromises, undermines and leaves unsupported the remaining marginal ridge to the extent that the pulpal-occlusal wall is unsupported by dentin or the width of the marginal ridge is 1 mm or less.
Endodontic Clinical Examination on a Simulated Patient (Manikin)

Part II: Endodontics – 18 Scorable Items
- Anterior Endodontic Procedures 12 Criteria
  Access Opening
  Canal Instrumentation
  Root Canal Obturation
- Posterior Access Opening 6 Criteria

Fixed Prosthodontic Examination on a Simulated Patient (Manikin)

Part III: Fixed Prosthodontics – 43 Scorable Items
- Cast Gold Crown 15 Criteria
- Porcelain-Fused-to-Metal Crown 14 Criteria
- Ceramic Crown Preparation 14 Criteria
- Preparations 1 & 2 evaluated as a mandibular posterior 3-unit bridge

Part V: Restorative – 47 Scorable Items
- Class II Amalgam Preparation 16 Criteria
- Amalgam Finished Restoration 9 Criteria
- Class III Composite Preparation 12 Criteria
- Composite Finished Restoration 10 Criteria

Periodontal Clinical Examination

Treatment Selection (Procedural)
- Patient Selection severity of periodontal disease.

Treatment
1. Subgingival Calculus Detection
2. Subgingival Calculus Removal
3. Plaque/Stain Removal
4. Pocket Depth Measurement
5. Treatment Management
ADEX Dental Post-Exam Analysis

- Technical Report Developed
- Demographic Data/Analysis
  - Conducted by respective administering agencies
  - Synopsis of data provided for Restorative and Periodontal Procedures with several years of history:
Demographic Data on the Candidate Pool
Failure Rate Summaries
Analysis of Candidate Performance by Test Section
Analysis of Failure Rates by Group Assignment
Analysis of Mean Scores by Procedure/Examination Part
Examiners’ Score Agreement Summary
Frequency of Rating Assignments
Correlation of Treatment Selection with Restorative Results
Frequency of Penalty Assignments
Annual Schools Report
  - Schools are provided with data regarding their performance annually
  - Schools are provided individual candidate performance after each examination series.
  - School identities are coded so that each school may compare their performance confidentially
  - Performance data for each area of examination content is analyzed and presented
  - By procedure
  - By individual criterion
Examiner Profiles
  - Data is collected for each examiner and compiled into profiles providing information to the examiners regarding their evaluations.
Summary of Total Number of Evaluations per Dental Examiner
Summary of Examiner Agreements for each Examination/Procedure
Percentage Rating Level Assigned per Procedure
Summary of Examiner Agreements & Disagreements across all Procedures
Peer Evaluations
  - This information is utilized to monitor examiner performance
ADEX Dental Post-Exam Analysis (con’t.)

Candidate Results:

- Total CIF Candidates, Class of 2011: 1448

Initial and eventual passing rates by examination

<table>
<thead>
<tr>
<th>Test</th>
<th>% Pass on 1st Attempt</th>
<th>% Pass by last Attempt</th>
<th>% Did Not Repeat after Initial Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSCE</td>
<td>97</td>
<td>100</td>
<td>2.5</td>
</tr>
<tr>
<td>Endodontics</td>
<td>96</td>
<td>100</td>
<td>0.13</td>
</tr>
<tr>
<td>Fixed Prosthodontics</td>
<td>88</td>
<td>99</td>
<td>0.53</td>
</tr>
<tr>
<td>Periodontics</td>
<td>98</td>
<td>97</td>
<td>1.26</td>
</tr>
<tr>
<td>Restorative Dentistry</td>
<td>87</td>
<td>99</td>
<td>1.8</td>
</tr>
<tr>
<td>Mean</td>
<td>?</td>
<td>?</td>
<td>?</td>
</tr>
</tbody>
</table>

97% of candidates who took advantage of all opportunities passed all 5 sections by the time they graduated from Dental School.

Inter-Examiner Agreement

Failing the Endodontic, Prosthodontic, or Restorative Dentistry exams was driven by whether or not the candidate committed a “critical” error or had a critical deficiency. Specifically, almost no one failed one of these exams without committing a corroborated critical error or deficiency and no one passed who did. A candidate also can fail by not earning enough points, but that only really occurred on the Periodontal exam.

Given this situation, the analysis of examiner agreement on the Endodontic, Prosthodontic, and Restorative Dentistry exams focused on whether the examiners reached the same conclusion as to whether or not a candidate had a critical deficiency or made a critical error. Examiners achieved consensus (i.e., all three agreed with each other) 98 to 99 percent of the time on whether a critical error or deficiency was present.
ADEX Dental Hygiene Examination
Candidate Results:

Tested as of December 31, 2010: 2374

<table>
<thead>
<tr>
<th>Test</th>
<th>% Pass on 1st Attempt</th>
<th>% Pass by last Attempt</th>
<th>% Did Not Repeat after Initial Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSE</td>
<td>96</td>
<td>100</td>
<td>2.03</td>
</tr>
<tr>
<td>Patient Based Examination</td>
<td>92</td>
<td>100</td>
<td>2.03</td>
</tr>
</tbody>
</table>

For 2010: 100% of candidates who took advantage of all opportunities had passed the examination by the end of 2010.

For 2011: 95% of candidates passed the CSCE on the first attempt, 93% of candidates passed the Patient Based Examination on their first attempt which occurred by the time the graduated Dental Hygiene School.

STATISTICAL ANALYSIS THE 2010 DENTAL HYGIENE EXAM

Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
September 28, 2011

This report provides summary data on ADEX’s Clinical Hygiene Examination and on its Computer Simulated Clinical Examination (CSCE) for dental hygienists.¹ Results are for the 2,430 candidates who took both tests for the first time between April 2010 and March 2011. All but 22 of these candidates took these exams by December 2010.

A total score of 75 or higher is needed for passing each test. The percent passing the clinical exam, the CSCE, and both tests on the first try were: 92.2, 94.9, and 87.8 percent, respectively.

¹ Technical reports for the 2007 examinations describe the occupational analyses on which these tests are based and the procedures used to select and train examiners.
Clinical Exam Scoring Rules

Table 1 shows the number of points candidates could receive on each part of the clinical exam. A candidate’s score on a part is the median of the scores assigned by three independent examiners. The first two scores are for the “Pre-treatment” portion of the exam and the last three are for the “Post-treatment” portion. The total score is the sum of the five part scores minus any penalty points. Appendix A describes the penalty point deductions that could be assigned.

<table>
<thead>
<tr>
<th>Section</th>
<th>Number of judgments</th>
<th>Points per judgment</th>
<th>Total points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pocket Depth Measurement</td>
<td>12</td>
<td>1.5</td>
<td>18</td>
</tr>
<tr>
<td>Calculus Detection</td>
<td>12</td>
<td>3.0</td>
<td>36</td>
</tr>
<tr>
<td>Calculus Removal</td>
<td>12</td>
<td>3.0</td>
<td>36</td>
</tr>
<tr>
<td>Plaque/Stain Removal</td>
<td>6</td>
<td>1.0</td>
<td>6</td>
</tr>
<tr>
<td>Hard/Soft Tissue</td>
<td>2</td>
<td>2.0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2 shows the mean score and standard deviation on each part. A comparison of these means with the corresponding maximum possible scores indicates that most candidates had perfect or near perfect scores on each part. Nevertheless, the reliability (coefficient alpha) of the total score was 0.78, which is high given that (a) candidates usually had different examiners for the pre- and post-treatment sections and (b) there was a significant restriction in the range of scores assigned.

<table>
<thead>
<tr>
<th>Exam Section</th>
<th>Maximum Score</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
<th>Score Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pocket Depth Measurement</td>
<td>18</td>
<td>17.60</td>
<td>1.02</td>
<td>0.51</td>
</tr>
<tr>
<td>Calculus Detection</td>
<td>36</td>
<td>34.81</td>
<td>3.31</td>
<td>0.75</td>
</tr>
<tr>
<td>Calculus Removal</td>
<td>36</td>
<td>32.76</td>
<td>4.88</td>
<td>0.69</td>
</tr>
<tr>
<td>Plaque/Stain Removal</td>
<td>6</td>
<td>5.98</td>
<td>0.16</td>
<td>0.29</td>
</tr>
<tr>
<td>Hard/Soft Tissue</td>
<td>4</td>
<td>3.83</td>
<td>0.38</td>
<td>0.07</td>
</tr>
<tr>
<td>Total Score</td>
<td>100</td>
<td>94.98</td>
<td>7.47</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Penalty points were not considered for these calculations, and a candidate’s final score on an item corresponded to the score that at least two of the three examiners assigned.
**Effect of Penalties**

Table 3 shows the number and percentage of candidates that lost points for the reasons noted in Appendix A, such as making a pocket depth qualification error. It also shows the number and percent that failed the exam because of these errors; i.e., these candidates would have passed were it not for the penalties they received. The policy of imposing only the largest applicable penalty (rather than the sum of all the separate ones assigned to the candidate) had no effect on the passing rate. Only two candidates received a deficient (def) score for hard or soft tissue, but neither def was corroborated. There were no pocket depth measurement penalties (and no one failed the exam because of making a pocket depth measurement error). The mean total clinical score before and after penalty points were awarded were 95.0 and 93.5, respectively.

<table>
<thead>
<tr>
<th>Exam Section</th>
<th>Received a penalty for:</th>
<th>Failed because of penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>Case Acceptance</td>
<td>102</td>
<td>4.2</td>
</tr>
<tr>
<td>Pocket Depth</td>
<td>31</td>
<td>0.1</td>
</tr>
<tr>
<td>Qualification</td>
<td>63</td>
<td>2.6</td>
</tr>
<tr>
<td>Calculus Detection</td>
<td>107</td>
<td>4.4</td>
</tr>
<tr>
<td>Calculus Removal</td>
<td>288</td>
<td>11.9</td>
</tr>
</tbody>
</table>

**Inter-Examiner Agreement**

Each candidate's work on the Clinical Examination was evaluated by three independent examiners (i.e., the examiners made their judgments without consultation with each other or knowing the scores assigned by other examiners). Table 4 shows that despite the extreme restriction in range noted in Table 2, there was still an adequate overall correlation between examiners in the scores they assigned.²

<table>
<thead>
<tr>
<th>Exam Section</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pocket Depth Measurement</td>
<td>0.335</td>
</tr>
<tr>
<td>Calculus Detection</td>
<td>0.429</td>
</tr>
<tr>
<td>Calculus Removal</td>
<td>0.338</td>
</tr>
<tr>
<td>Plaque/Stain Removal</td>
<td>0.076</td>
</tr>
<tr>
<td>Hard/Soft Tissue</td>
<td>0.147</td>
</tr>
<tr>
<td>Total</td>
<td>0.353</td>
</tr>
</tbody>
</table>

² Correlation coefficients can range from -1.00 to 1.00. The stronger the relationship between the two variables (such as the scores assigned by examiner #1 and examiner #2), the higher the coefficient (regardless of its algebraic sign). For example, a high positive correlation between two examiners indicates that they generally agreed with each other in how they rank ordered the candidates.
Another way to look at examiner agreement is to see how often different examiners would make the same pass/fail decision about an applicant. This analysis (which did not consider penalty points) found that 86.3% of the applicants received a passing grade from all three examiners and 0.5% percent received a failing grade from all three. The total perfect agreement rate was therefore 86.8% (see Table 5). However, an 86.8% agreement rate is only 3.2 percentage points higher than the 83.6% rate that would occur by chance alone.3

Table 5
Percent Agreement in Overall Pass/Fail Decisions Among the First, Second, and Third Examiners

<table>
<thead>
<tr>
<th>3/3 Agree Pass</th>
<th>2/3 Agree Pass</th>
<th>3/3 Agree Fail</th>
<th>2/3 Agree Fail</th>
<th>% All agree</th>
<th>% All Agree by Chance</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.3</td>
<td>10.6</td>
<td>0.5</td>
<td>2.6</td>
<td>86.8</td>
<td>83.6</td>
</tr>
</tbody>
</table>

**Comparison of Clinical and CSCE Statistics**

Table 6 shows that 87.8% of the candidates passed both tests and 0.7% failed both for an overall agreement rate of 88.5%. However, given the marginal totals, this is very close to the agreement rate that would occur by chance.4

Table 6
Correspondence in the Percentage of Pass/Fail Decisions Between the Clinical and CSCE Exams

<table>
<thead>
<tr>
<th></th>
<th>Fail Clinical</th>
<th>Pass Clinical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fail CSCE</td>
<td>0.7</td>
<td>4.4</td>
<td>5.1</td>
</tr>
<tr>
<td>Pass CSCE</td>
<td>7.1</td>
<td>87.8</td>
<td>94.9</td>
</tr>
<tr>
<td>Total</td>
<td>7.8</td>
<td>92.2</td>
<td>100.0</td>
</tr>
</tbody>
</table>

There was a very low correlation between CSCE and Clinical Examination scores \((r = 0.11)\). If the 0.11 is corrected for the less than perfect reliability of the measures, the correlation between them would still be only 0.14. In short, the degree of agreement in pass/fail

---

3 The chance rate is the product of the average of the three examiners' individual passing rates. Specifically, the first, second, and third examiners had passing rates of 94.65%, 94.03%, and 93.91%, respectively. The product of these three rates was 83.65%. Analyses were not conducted of the degree to which different examiners and Hygiene Coordinators would make the same decisions regarding case acceptance, the assignment of penalty points, or tooth selection for pocket depth measurements.

4 Data on repeaters were not analyzed for this report.
decisions and scores between these two tests was not much higher than what would occur by chance alone.

Table 7 shows that the almost zero correlation between the Clinical and CSCE was not the result of their scores being unreliable. They both had adequate reliabilities (coefficient alphas) for making pass/fail decisions, especially given their high passing rates. Taken together, these findings support ADEX’s use of a “conjunctive” rule (i.e., a rule that requires candidates to pass both tests in order to pass overall) rather than a “compensatory” rule (that would allow candidates to offset a low score on one test with a high score on the other).

<table>
<thead>
<tr>
<th>Test</th>
<th>Mean</th>
<th>Median</th>
<th>Standard Deviation</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>93.5</td>
<td>97.0</td>
<td>10.6</td>
<td>0.78</td>
</tr>
<tr>
<td>CSCE</td>
<td>86.2</td>
<td>87.0</td>
<td>6.7</td>
<td>0.77</td>
</tr>
</tbody>
</table>

Clinical scores are after penalty points were imposed.

Appendix A
Clinical Exam Penalty Point And Disqualification Rules

Case Acceptance

There are five case acceptance criteria, the first four of which are initially evaluated by a single examiner and have 2 to 4 scoring levels. The fifth criterion, Pocket Depth Qualification, is evaluated by three examiners. The five criteria are:

- Required Forms (SAT, ACC, SUB, or DEF)
- Blood Pressure (SAT, ACC, or DEF)
- Radiographs (SAT, ACC, SUB, or DEF)
- Teeth Deposit Requirements (SAT or ACC)
- Pocket Depth Qualification

No penalty points are deducted if the first examiner assigns a SAT to all of the first four of these criteria. However, if the examiner assigns a non-SAT score to one or more of them, then a second examiner is called in to evaluate all four criteria. If the two examiners agree on a non-SAT call, then that call stands. The point deductions for a corroborated ACC, SUB, and DEF call are 5, 15, and 30, respectively.

If the two examiners disagree as to the seriousness of a problem, then the penalty for the least serious call is used. For instance, if the first and second examiners made calls of DEF and ACC for Blood Pressure, then the 5-point penalty for the ACC call stands.
Pocket Depth Qualification is evaluated by three independent examiners. Candidates select 3 teeth they believe satisfy the requirements. Three examiners independently make their calls as to whether these teeth are satisfactory. There is a 15-point deduction off the candidate’s total score if two or three examiners agree that one of the teeth the candidate nominated does not satisfy the requirements; and 30 points are deducted if two or three examiners agree that two or three of the nominated teeth do not satisfy the requirements.

Penalty points do not accumulate across the five case acceptance criteria. Only the largest deduction for any of the five criteria is applied. For example, there is a total deduction of 15 points even if a candidate would otherwise lose 10 points for Blood Pressure, 5 points for Radiographs, and 15 points for Pocket Depth Qualification.

**Other Point Deductions and Disqualifications**

Candidates lose 3 points for each corroborated calculation detection or removal error, such as by saying a surface is calculus free when two or three examiners say it is not free of calculus. Candidates fail the exam if they make: (a) 4 or more corroborated calculus detection errors, (b) 4 or more corroborated calculus removal errors, or (c) a corroborated hard or soft tissue critical error. Candidates lose 1.5 points for each corroborated pocket depth measurement error and 1 point for each plaque and stain removal error.

*Updated 10.15.11*

For additional info on ADEX contact:

ADEXOFFICE@aol.com

(503) 724-1104
This Page

Left Blank
EXECUTIVE DIRECTORS REPORT
OBD Budget Status Report

Attached are the latest budget reports for the 2011-2013 Biennium. This report, which is from July 1, 2011 through December 31, 2011, shows revenue of $476,673.24 and expenditures of $546,554.68. The Board has just begun the first dental renewal cycle for the 2011-2013 Biennium. The Budget is performing as expected.

If Board members have questions on this budget report format, please feel free to ask me.

Attachment #1

Customer Service Survey

Attached is a chart which shows the OBD State Legislatively Mandated Customer Service Survey Results from July 1, 2011 through January 31, 2012.

The results of the survey show that the OBD continues to receive positive comments from the majority of those that return the surveys. The booklet containing the written comments that are on the survey forms, which staff has reviewed, are available on the table for Board members to review. Attachment #2

Board and Staff Speaking Engagements

Dental Director/Chief Investigator Dr. Paul Kleinstub made a presentation to the senior Dental students at OHSU on Wednesday, January 18, 2012.

Dental Director/Chief Investigator Dr. Paul Kleinstub and I made a presentation to the senior Dental students at OHSU on Wednesday, January 25, 2012.

I made a presentation to the Lane County Dental Society at the Downtown Athletic Club in Eugene on Friday, January 27, 2012.

Licensing Manager Teresa Haynes and I made a presentation to the Dental Hygiene students at OIT in Klamath Falls on Monday, February 6, 2012.

ADA Workshop on Development of RFP for Portfolio-Style Examination

Attached are letters from other state boards joining the OBD in their opposition to the ADA becoming involved in clinical licensing examinations, as well as a response from the ADA to those letters. Attachment #3

Dental Renewal 2012

On January 20, 2012 the OBD mailed 1,919 postcards informing dentists whose Oregon License will expire March 31, 2012 that the on-line renewal was available. As of 2/1/12, 394 dentists have renewed their license.
2012 Legislative Session

The 2012 Session will be in full swing as the Board meets. Attached is a copy of HB 4009 which is the only legislation that I am aware of that will have any impact on the OBD at this time. This legislation would remove the special monitoring entity from the HPSP program, thus saving approximately $180,000 during the 2011 – 2013 Biennium. Attachment #4

ORS 676.405 Release of personal information

The Board needs to have a discussion and make a motion to allow the OBD to not release personal information regarding licensees unless licensees have informed the OBD that they do not have any issues with releasing personal information as defined by Oregon Law. Attachment #5

Newsletter

The Newsletter should be at the printers as of the February Board meeting.
# BOARD OF DENTISTRY

**Fund 3400  BOARD OF DENTISTRY**  
*For the Month of DECEMBER 2011*

## REVENUES

<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>0205</td>
<td>OTHER BUSINESS LICENSES</td>
<td>13,110.00</td>
<td>439,446.00</td>
<td>2,327,200.00</td>
<td>1,887,754.00</td>
<td>73,241.00</td>
<td>104,875.22</td>
</tr>
<tr>
<td>0210</td>
<td>OTHER NONBUSINESS LICENSES AND FEES</td>
<td>100.00</td>
<td>3,250.00</td>
<td>40,000.00</td>
<td>36,750.00</td>
<td>541.67</td>
<td>2,041.67</td>
</tr>
<tr>
<td>0410</td>
<td>CHARGES FOR SERVICES</td>
<td>0.00</td>
<td>0.00</td>
<td>5,000.00</td>
<td>5,000.00</td>
<td>0.00</td>
<td>277.78</td>
</tr>
<tr>
<td>0505</td>
<td>FINES AND FORFEITS</td>
<td>4,500.00</td>
<td>26,000.00</td>
<td>50,000.00</td>
<td>24,000.00</td>
<td>4,333.33</td>
<td>1,333.33</td>
</tr>
<tr>
<td>0605</td>
<td>INTEREST AND INVESTMENTS</td>
<td>256.11</td>
<td>1,683.22</td>
<td>10,000.00</td>
<td>8,316.78</td>
<td>280.54</td>
<td>462.04</td>
</tr>
<tr>
<td>0975</td>
<td>OTHER REVENUE</td>
<td>840.00</td>
<td>6,294.02</td>
<td>25,000.00</td>
<td>18,705.98</td>
<td>1,049.00</td>
<td>1,039.22</td>
</tr>
</tbody>
</table>

**Total**  
18,806.11  476,673.24  2,457,200.00  1,980,526.76  79,445.54  110,029.26

## TRANSFER OUT

<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2100</td>
<td>TRANSFER OUT TO DEPT OF HUMAN SERVICES</td>
<td>0.00</td>
<td>1,755.00</td>
<td>0.00</td>
<td>-1,755.00</td>
<td>292.50</td>
<td>-97.50</td>
</tr>
<tr>
<td>2443</td>
<td>TRANSFER OUT TO OREGON HEALTH AUTHORITY</td>
<td>0.00</td>
<td>208,000.00</td>
<td>208,000.00</td>
<td>0.00</td>
<td>11,555.56</td>
<td>11,458.06</td>
</tr>
</tbody>
</table>

**Total**  
0.00  1,755.00  208,000.00  206,245.00  292.50  11,458.06

## PERSONAL SERVICES

<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>3110</td>
<td>CLASS/UNCLASS SALARY &amp; PER DIEM</td>
<td>44,679.71</td>
<td>225,733.37</td>
<td>855,336.00</td>
<td>629,602.63</td>
<td>37,622.23</td>
<td>34,977.92</td>
</tr>
<tr>
<td>3160</td>
<td>TEMPORARY APPOINTMENTS</td>
<td>0.00</td>
<td>0.00</td>
<td>3,717.00</td>
<td>3,717.00</td>
<td>0.00</td>
<td>206.50</td>
</tr>
<tr>
<td>3170</td>
<td>OVERTIME PAYMENTS</td>
<td>4,970.98</td>
<td>5,430.55</td>
<td>3,575.00</td>
<td>-1,855.55</td>
<td>905.09</td>
<td>-103.09</td>
</tr>
<tr>
<td>3210</td>
<td>ERB ASSESSMENT</td>
<td>8.50</td>
<td>51.00</td>
<td>287.00</td>
<td>236.00</td>
<td>8.50</td>
<td>13.11</td>
</tr>
<tr>
<td>3220</td>
<td>PUBLIC EMPLOYEES’ RETIREMENT SYSTEM</td>
<td>6,894.99</td>
<td>32,951.85</td>
<td>123,464.00</td>
<td>90,512.15</td>
<td>5,491.98</td>
<td>5,028.45</td>
</tr>
<tr>
<td>3221</td>
<td>PENSION BOND CONTRIBUTION</td>
<td>2,824.64</td>
<td>12,996.57</td>
<td>49,432.00</td>
<td>36,435.43</td>
<td>2,166.10</td>
<td>2,024.19</td>
</tr>
<tr>
<td>3230</td>
<td>SOCIAL SECURITY TAX</td>
<td>3,784.14</td>
<td>17,555.41</td>
<td>71,160.00</td>
<td>53,604.59</td>
<td>2,925.90</td>
<td>2,979.03</td>
</tr>
<tr>
<td>3250</td>
<td>WORKERS’ COMPENSATION ASSESSMENT</td>
<td>16.36</td>
<td>99.57</td>
<td>413.00</td>
<td>313.43</td>
<td>16.60</td>
<td>17.41</td>
</tr>
<tr>
<td>3260</td>
<td>MASS TRANSIT</td>
<td>267.72</td>
<td>1,280.75</td>
<td>5,581.00</td>
<td>4,300.25</td>
<td>213.46</td>
<td>238.90</td>
</tr>
<tr>
<td>3270</td>
<td>FLEXIBLE BENEFITS</td>
<td>8,116.58</td>
<td>49,806.73</td>
<td>201,638.00</td>
<td>151,831.27</td>
<td>8,301.12</td>
<td>8,435.07</td>
</tr>
</tbody>
</table>

**Total**  
71,563.62  345,905.80  1,314,603.00  968,697.20  57,650.97  53,816.51

## SERVICES and SUPPLIES

<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>4100</td>
<td>INSTATE TRAVEL</td>
<td>2,670.36</td>
<td>12,315.29</td>
<td>46,655.00</td>
<td>34,339.71</td>
<td>2,052.55</td>
<td>1,907.76</td>
</tr>
</tbody>
</table>

**Attachment # 1**
<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>4125</td>
<td>OUT-OF-STATE TRAVEL</td>
<td>248.28</td>
<td>7,243.54</td>
<td>24,672.00</td>
<td>17,428.46</td>
<td>1,207.26</td>
<td>968.25</td>
</tr>
<tr>
<td>4150</td>
<td>EMPLOYEE TRAINING</td>
<td>0.00</td>
<td>2,230.00</td>
<td>6,617.00</td>
<td>4,387.00</td>
<td>371.67</td>
<td>243.72</td>
</tr>
<tr>
<td>4175</td>
<td>OFFICE EXPENSES</td>
<td>1,502.01</td>
<td>19,680.73</td>
<td>78,445.00</td>
<td>58,764.27</td>
<td>3,280.12</td>
<td>3,264.68</td>
</tr>
<tr>
<td>4200</td>
<td>TELECOMM/TECH SVC AND SUPPLIES</td>
<td>1,568.96</td>
<td>5,810.73</td>
<td>8,557.00</td>
<td>2,746.27</td>
<td>968.46</td>
<td>152.57</td>
</tr>
<tr>
<td>4225</td>
<td>STATE GOVERNMENT SERVICE CHARGES</td>
<td>32.90</td>
<td>35,322.57</td>
<td>78,170.00</td>
<td>42,847.43</td>
<td>5,887.10</td>
<td>2,380.41</td>
</tr>
<tr>
<td>4250</td>
<td>DATA PROCESSING</td>
<td>162.50</td>
<td>1,156.25</td>
<td>5,400.00</td>
<td>4,243.75</td>
<td>192.71</td>
<td>235.76</td>
</tr>
<tr>
<td>4275</td>
<td>PUBLICITY &amp; PUBLICATIONS</td>
<td>0.00</td>
<td>2,545.02</td>
<td>13,084.00</td>
<td>10,538.98</td>
<td>424.17</td>
<td>585.50</td>
</tr>
<tr>
<td>4300</td>
<td>PROFESSIONAL SERVICES</td>
<td>2,443.92</td>
<td>20,306.42</td>
<td>118,219.00</td>
<td>97,912.58</td>
<td>3,384.40</td>
<td>5,439.59</td>
</tr>
<tr>
<td>4315</td>
<td>IT PROFESSIONAL SERVICES</td>
<td>4,500.00</td>
<td>4,500.00</td>
<td>50,000.00</td>
<td>45,500.00</td>
<td>750.00</td>
<td>2,527.78</td>
</tr>
<tr>
<td>4325</td>
<td>ATTORNEY GENERAL LEGAL FEES</td>
<td>4,185.25</td>
<td>36,043.65</td>
<td>188,592.00</td>
<td>152,548.35</td>
<td>6,007.28</td>
<td>8,474.91</td>
</tr>
<tr>
<td>4375</td>
<td>EMPLOYEE RECRUITMENT AND DEVELOPMENT</td>
<td>0.00</td>
<td>0.00</td>
<td>621.00</td>
<td>621.00</td>
<td>0.00</td>
<td>34.50</td>
</tr>
<tr>
<td>4400</td>
<td>DUES AND SUBSCRIPTIONS</td>
<td>1,078.00</td>
<td>4,618.95</td>
<td>8,276.00</td>
<td>3,657.05</td>
<td>769.83</td>
<td>203.17</td>
</tr>
<tr>
<td>4425</td>
<td>FACILITIES RENT &amp; TAXES</td>
<td>5,645.33</td>
<td>34,454.15</td>
<td>139,571.00</td>
<td>105,116.85</td>
<td>5,742.36</td>
<td>5,839.83</td>
</tr>
<tr>
<td>4475</td>
<td>FACILITIES MAINTENANCE</td>
<td>0.00</td>
<td>0.00</td>
<td>514.00</td>
<td>514.00</td>
<td>0.00</td>
<td>28.56</td>
</tr>
<tr>
<td>4575</td>
<td>AGENCY PROGRAM RELATED SVCS &amp; SUPP</td>
<td>624.50</td>
<td>7,649.25</td>
<td>143,176.00</td>
<td>135,526.75</td>
<td>1,274.88</td>
<td>7,529.26</td>
</tr>
<tr>
<td>4650</td>
<td>OTHER SERVICES AND SUPPLIES</td>
<td>373.55</td>
<td>6,772.33</td>
<td>40,300.00</td>
<td>33,527.67</td>
<td>1,128.72</td>
<td>1,862.65</td>
</tr>
<tr>
<td>4700</td>
<td>EXPENDABLE PROPERTY $250-$5000</td>
<td>0.00</td>
<td>0.00</td>
<td>5,140.00</td>
<td>5,140.00</td>
<td>0.00</td>
<td>285.56</td>
</tr>
<tr>
<td>4715</td>
<td>IT EXPENDABLE PROPERTY</td>
<td>0.00</td>
<td>0.00</td>
<td>5,140.00</td>
<td>5,140.00</td>
<td>0.00</td>
<td>285.56</td>
</tr>
</tbody>
</table>

**SPECIAL PAYMENTS**

<table>
<thead>
<tr>
<th>Budget Obj</th>
<th>Budget Obj Title</th>
<th>Monthly Activity</th>
<th>Biennium to Date Activity</th>
<th>Financial Plan</th>
<th>Unobligated Plan</th>
<th>Monthly Avg to Date</th>
<th>Monthly Avg to Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100</td>
<td>DISTRIBUTION TO DEPT OF HUMAN SERVICES</td>
<td>0.00</td>
<td>0.00</td>
<td>226,292.00</td>
<td>226,292.00</td>
<td>0.00</td>
<td>12,571.78</td>
</tr>
<tr>
<td>6443</td>
<td>DIST TO OREGON HEALTH AUTHORITY</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**SUMMARY TOTALS**

<table>
<thead>
<tr>
<th></th>
<th>BOARD OF DENTISTRY</th>
<th>Month Activity</th>
<th>Biennium Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOARD OF DENTISTRY</td>
<td></td>
<td></td>
<td>18,806.11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>476,673.24</td>
</tr>
<tr>
<td>REVENUES</td>
<td></td>
<td>18,806.11</td>
<td>476,673.24</td>
</tr>
<tr>
<td>EXPENDITURES</td>
<td></td>
<td>71,563.62</td>
<td>345,905.80</td>
</tr>
<tr>
<td>SERVICES AND SUPPLIES</td>
<td></td>
<td>25,035.56</td>
<td>200,648.88</td>
</tr>
<tr>
<td>TRANSFER OUT</td>
<td></td>
<td>96,599.18</td>
<td>546,554.68</td>
</tr>
<tr>
<td>SPECIAL PAYMENTS</td>
<td></td>
<td>0.00</td>
<td>1,755.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.00</td>
<td>1,755.00</td>
</tr>
<tr>
<td></td>
<td>Month Activity</td>
<td>Biennium Activity</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>BOARD OF DENTISTRY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>
1 How do you rate the timeliness of the services provided by the OBD?
E= 44%  G= 34%  F= 13%  P= 7%  DK= 2%

2 How do you rate the ability of the OBD to provide services correctly the first time?
E= 52%  G= 34%  F= 6%  P= 4%  DK= 4%

3 How do you rate the helpfulness of the OBD?
E= 48%  G= 34%  F= 7%  P= 6%  DK= 5%

4 How do you rate the knowledge and expertise of the OBD?
E= 50%  G= 28%  F= 5%  P= 4%  DK= 13%

5 How do you rate the availability of information at the OBD?
E= 45%  G= 40%  F= 9%  P= 4%  DK= 3%

6 How do you rate the overall quality of services provided by the OBD?
E= 49%  G= 37%  F= 5%  P= 6%  DK= 3%
This Page

Left Blank
December 16, 2011

Dear Dr. Calnon:

The Oregon Board of Dentistry (OBD) recently reviewed the resolution passed by the American Dental Association (ADA) House of Delegates regarding the development of a portfolio-style examination for initial licensure.

The OBD also recently reviewed the request by the ADA Workgroup on Development for Portfolio-Style Examinations and is very concerned that the ADA has entered into an area that is beyond the mission and purpose of the ADA.

The stated mission of the ADA: "The ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public." Clearly this mission does not and should not have anything directly related to the initial licensure of dentists or dental hygienists; this authority is left to the state dental boards.

The stated mission of the OBD: The Mission of the Oregon Board of Dentistry is to protect the public by assuring that the citizens of Oregon receive the highest possible quality oral health care." Clearly the licensure of dentists and dental hygienists falls under this mission.

The OBD urges the ADA to stop this invasion upon the mission, rights and responsibilities found in the dental practice acts of each state board. Licensure of dentists and dental hygienists is left to the state dental boards, not the ADA.
The OBD believes that in this time of serious economic difficulties that face our state and nation, as well as the ADA, according to recent review of ADA publications, that the ADA not waste any more of its precious financial and time resources on issues that are not within their mission or purview.

We encourage our fellow dental boards to join in this effort to have the ADA return to its core mission and leave the licensure, regulation and discipline of dental care professionals to the state dental boards where it belongs.

Sincerely yours,

Mary W. Davidson, M.P.H., R.D.H., L.A.P., President
Oregon Board of Dentistry

Patricia Parker, D.M.D., Vice-President
Oregon Board of Dentistry

cc: Dr. White Graves, President-AADB
All State Dental Boards
January 27, 2012

Mary W. Davidson, President
Patricia Parker, Vice President
Oregon Board of Dentistry
1600 SW 4th Avenue, Suite 770
Portland, OR 97201-5519

Dear Ms. Davidson and Doctor Parker:

Thank you for your recent correspondence to the American Dental Association (ADA) regarding the House of Delegates' action directing the ADA to prepare a Request for Proposals (RFP) calling for the development of a portfolio-style examination for initial licensure purposes (Resolution 42H-2010). We appreciate all opinions expressed on this issue.

The ADA fully supports the state dental board's role in regulating the practice of dentistry. The intent of Resolution 42H-2010 is for the ADA to seek the expertise of a qualified agency to develop a portfolio-style examination that could be used by state dental boards as another avenue to evaluate a candidate for licensure, such as the PGY-1 (NY, CT, CA, MN, WA), the National Dental Examining Board of Canada's two part examination (MN) and the portfolio examination recently adopted in California. The RFP was sent to all the dental clinical testing agencies as well as some private test development companies with experience in dental testing.

ADA recognizes the challenges of a portfolio-style examination and hopes that the testing community will view the ADA's action as an opportunity to develop an alternative clinical assessment tool that could be utilized and supported by the state boards.

I hope this clarifies the intent of Resolution 42H-2010.

Sincerely,

William R. Calnon, D.D.S.
President

WRC/lijh:kb
cc: Dr. White Graves, president, American Board of Dental Boards (AADB)
    Executive Directors, state licensing boards
    Members, ADA Workgroup on Resolution 42H-2010 (Portfolio Style Examination)
    Dr. Anthony Ziebert, senior vice president, Education/Professional Affairs
    Ms. Karen Hart, director, Council on Dental Education and Licensure
December 22, 2011

William R. Calnon, D.D.S.
President, American Dental Association
211 E. Chicago Ave.
Chicago, Illinois 60611-2678

Re: Correspondence of October 25, 2011
RFP for Portfolio-Style Examination

Dear Dr. Calnon:

This letter will acknowledge the October 25, 2011 correspondence of Dr. Samuel B. Low regarding the ADA’s request for proposal for the development of a portfolio-style assessment of clinical skills for the purposes of state dental licensure. The board reviewed the referenced correspondence during our December 3, 2011 board meeting.

The Louisiana State Board of Dentistry is strongly opposed to the ADA becoming involved in the licensing process for the obvious conflict of interest it will cause. It is the sole responsibility of each dental board to evaluate candidates for licensure in their respective states. Individual state dental boards rely on the American Association of Dental Examiners not the ADA to provide examination assessment forms. The Louisiana board believes this function should remain independent of the ADA and vested in the powers and duties of the individual state licensing boards. Accordingly, the board respectfully requests that the ADA reconsider their position on this matter and discontinue the development of the portfolio-style licensing examination.

Thanking you for your attention to this matter, I remain

Respectfully,

Romell J. Madison, D.D.S.
President

Cc: Dr. Samuel B. Low, Trustee, Seventeenth District
Executive directors, state licensing boards
January 27, 2012

Romell J. Madison, D.D.S.
President
Louisiana State Board of Dentistry
One Canal Place
365 Canal Street, Suite 2680
New Orleans, LA 70130

Dear Doctor Madison:

Thank you for your recent correspondence to the American Dental Association (ADA) regarding the House of Delegates’ action directing the ADA to prepare a Request for Proposals (RFP) calling for the development of a portfolio-style examination for initial licensure purposes (Resolution 42H-2010). We appreciate all opinions expressed on this issue.

The ADA fully supports the state dental board’s role in regulating the practice of dentistry. The intent of Resolution 42H-2010 is for the ADA to seek the expertise of a qualified agency to develop a portfolio-style examination that could be used by state dental boards as another avenue to evaluate a candidate for licensure, such as the PGY-1 (NY, CT, CA, MN, WA), the National Dental Examining Board of Canada’s two part examination (MN) and the portfolio examination recently adopted in California. The RFP was sent to all the dental clinical testing agencies as well as some private test development companies with experience in dental testing.

ADA recognizes the challenges of a portfolio-style examination and hopes that the testing community will view the ADA’s action as an opportunity to develop an alternative clinical assessment tool that could be utilized and supported by the state boards.

I hope this clarifies the intent of Resolution 42H-2010.

Sincerely,

William R. Calnon, D.D.S.
President

WRC/ljh:kb
cc: Executive Directors, state licensing boards
Members, ADA Workgroup on Resolution 42H-2010 (Portfolio Style Examination)
Dr. Anthony Ziebert, senior vice president, Education/Professional Affairs
Ms. Karen Hart, director, Council on Dental Education and Licensure
Tuesday, December 20, 2011

Ms. Lois Haglund  
Portfolio RFP  
American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611

Dear Ms. Haglund:

At its meeting on November 12, CRDTS Steering Committee, composed of active Board Members from 17 member State Boards, directed CRDTS’ officers to provide a written response to the ADA’s request for a proposal to develop a portfolio-style assessment of clinical skills for the purposes of state dental licensure. Therefore, this letter is to advise the ADA of some of the many reasons why CRDTS will not be submitting a proposal.

1. First and foremost, licensure is a governmental function. State Boards of Dentistry are established by state laws as an arm of the state legislature for the sole purpose of protection of the public by assuring the competence of licensed practitioners and, when necessary, policing the profession. In contrast, the ADA is a voluntary association of licensed, dental practitioners whose purpose is to promote and protect the profession. We recognize that in many instances our purposes are parallel—that is to say, what is in the best interests of the public is often in the best interests of the profession. However, our common interests cannot be extrapolated to the extent that a voluntary association can assume the mantle of a governmental agency and usurp the responsibilities of determining methodologies for the assessment of clinical skills while leaving State Boards in a position of “oversight” as interested bystanders. Indeed, there have been a number of State Board members who have already experienced and commented on the vacuous position of “oversight” as defined in the accreditation process.

The fact that state laws have granted the health profession of dentistry the authority for self-regulation is a privilege rather than a right. It is a privilege that is currently being challenged in North Carolina by the Federal Trade Commission. Indeed, there has been at least one case in which the court ruled that state licensure standards which were based in part on a determination made by a non-governmental agency constituted an unlawful delegation of the Legislature’s authority to license professionals within the State, Gumbhir v. Kansas State Board of Pharmacy, 228 Kan. 579 (1980). It is quite likely that if National Board Examinations were being developed today instead of 78 years ago, the ADA would not be allowed to either develop or administer those licensure examinations. Will the right to administer National Boards be met with unwelcome scrutiny if the ADA pursues the revision of state laws/regulations to replace clinical examinations with portfolio-based assessments? We are still operating under the 1979 agreement between ADA and AADB (formerly AADE) whereby the responsibility for theoretical examinations is left, however reluctantly, with the ADA Joint Commission on National Dental Examinations and clinical examinations are solely within the purview of State Boards. However, it should be realized that in the 32 years
Central Regional Dental Testing Service, Inc.

since that agreement was struck, regional groups of State Boards have coalesced, organized themselves and matured into sophisticated testing agencies applying psychometrically sound measurement principles in the development and administration of clinical examinations. The ADA is putting itself, and the entire profession’s privilege of self-regulation, in a perilous position when it extends itself further into governmental functions of not only accreditation, but also licensure.

2. We are not trying to say that other dental groups, such as ADA or ADEA, should have no interest or involvement in the evolution of clinical exams. For more than 30 years CRDTS has been responding to concerns and challenges to clinical exams as they have been raised by the ADA, ADEA or ASDA. CRDTS, along with others in the examining community, has responded to most of these concerns and has implemented guidelines, protocols and methodologies that have addressed such issues. In the late 1970’s, the issue was criterion-referenced scoring rubrics. Accordingly, CRDTS began developing a criterion-referenced scoring system in 1979 and it was fully implemented by 1981, along with calibration exercises, a protocol to ensure candidate anonymity, independent scoring by examiners and an innovative analysis program to provide statistical data on the examination itself, as well as examiner profiles and comparative reports to the schools. We have participated in ADA-sponsored activities such as the Agenda for Change and the ITEM meetings; and a series of AADB initiatives to develop guidelines for the development and administration of valid and reliable examinations. In the mid 90’s we eliminated one patient-based procedure of an indirect cast restoration, and began testing fixed prosthodontics on a manikin. Most recently, we have incorporated the Curriculum Integrated Format into our examination process, as well as integrating into our manuals the ADA document on ethical considerations. So it cannot be imputed that CRDTS, and the entire examining community, are resistant to change or unwilling to work with parties of interest to enhance communications and achieve consensus. Indeed, that is the role that ADA can and should play as the representative of the practicing profession: foster communication, understanding and consensus among all interested parties. To continue to pursue the path that is outlined in the RFP will only serve to alienate the examining community, an important segment of the dental profession, the vast majority of whom are long-term members of the ADA.

3. ADEA and ASDA have been beating the drums for the elimination of patient-based clinical examinations for at least 15 years. But rather than educating those associations and the ADA House of Delegates about the reality of state laws and the rigorous demands of measurement principles, the ADA has allowed itself to be enlisted as the vehicle to force the issue, creating a divisive situation that has the potential to make a national clinical examination ever more difficult to achieve. During the meetings of the ITEM Committee, it was clearly articulated by not only examiners, but also by measurement specialists, that the portfolio assessment model is not psychometrically sound for multiple reasons:
   a. It is neither appropriate nor legal for faculty to be assessing its own educational product for licensure purposes. While CRDTS allows faculty members to observe an examination to gain a better understanding of what is expected of their students, and we utilize a number of faculty members who have been identified by their State
Board as deputy examiners, we do not allow a faculty member to either observe or examine at their own institution.
b. Using faculty in the role of examiners voids the possibility of maintaining candidate anonymity to eliminate examiner bias.
c. An examination cannot be valid unless security of the testing process is maintained. The testing agency, as an independent third party, has no way of verifying that the digital records that they may review are actually the work of the candidate.
d. CRDTS uses many digital photographs to calibrate examiners. While they are good teaching mechanisms, they are woefully inadequate for clinical evaluation. The lighting or angulation of a photograph can make an open contact appear closed. We cannot effectively evaluate the depth of the pulpal floor or axial wall, the width of the isthmus, proximal or gingival clearance, etc. Without an explorer, floss or other instruments, we cannot evaluate a margin, contact, occlusion or discriminate between stain, caries or decalcification.
e. For a number of years we have been listening to reports of shortages of qualified faculty—400+ unfilled faculty positions in the United States. The one-on-one relationship required for a portfolio assessment, will be expensive and time-consuming for existing faculty. In addition, schools rarely, if ever, have the luxury of utilizing even two, much less three, independent examiners to evaluate each case. The possibility is remote of maintaining the same level of examiner reliability as clinical testing agencies are able to document.
f. CRDTS’ calibration is constantly commended by our educator/examiners, many of whom ask for copies to use for teaching. Repeatedly we receive reports that calibration is very difficult to accomplish within dental schools. When schools utilize a significant number of adjunct or part-time faculty, it becomes impossible. Since studies have shown that the effects of calibration decline within a short period of time; CRDTS’ examiners are recalibrated prior to every examination. How are calibrated faculty/examiners going to be maintained across multiple portfolio evaluations? Maintaining standardized, calibrated examiners across 60 or more dental schools is an insurmountable obstacle to validity and reliability.
g. Fidelity is diminished in the portfolio assessment. The target domain is the clinical skill required for actual practice. A portfolio assessment is a report of how those skills were applied rather than an actual demonstration of those skills in a clinical setting.
h. Dr. Thomas Haladyna, a measurement specialist who should be well-known to you, has reported to us that although well-developed technology exists for setting cut scores on tests, there is no technology for setting cut scores on portfolio assessments. When done, it is very subjective. “If scoring is mostly subjective, then all the threats to validity that come from subjectivity are present: halo, severity/leniency, central tendency, idiosyncracy, disinterest, and logical (the scorer redefines what is being rated”).
i. We find item 2.e. on page 7 of the RFP to be unprecedented in the testing process. ADA proposes to allow a student who has completed the portfolio evaluation process to decide whether the case will be submitted to an independent third party evaluation prior to any “feedback” by the faculty/examiner. Would you allow a candidate to go
Central Regional Dental Testing Service, Inc.

through all of Part II National Boards and then decide to withhold their answers because things didn’t go well and they want to have “do overs”?

These are but some of the reasons that CRDTS’ Steering Committee was unanimous in its decision not to devote CRDTS’ resources to pursuit of the portfolio methodology. Portfolios were created by educators for educators; and that is the domain in which they should remain. We believe portfolios can be an excellent teaching tool, and they are undoubtedly useful for educators to document their teaching experience and expertise; but they are not a valid and reliable substitute for clinical examinations.

We would encourage the ADA, ADEA and ASDA to revisit their examination policies. The mobility landscape has changed drastically since resolutions were introduced in the 90’s to eliminate clinical exams. CRDTS is now accepted in 40 plus states, and collaborative efforts are ongoing. We are very close to universal acceptance of most regional exams. We believe it is inappropriate to be espousing the elimination of our traditional licensure standards at a time when there is a confirmed shortage of faculty and there are currently six new dental schools in development with as many as 20 new schools proposed by 2020. There is also a constant influx of international graduates from non-accredited schools. We need to utilize all instruments at our disposal to distinguish the competent from the incompetent, uphold the standards of our profession and continue to earn the respect and confidence of the public in their dental practitioners.

Sincerely,

Deena Kuempel, DDS

Deena Kuempel, DDS
President

Cc: CRDTS’ Steering Committee
Council of Interstate Testing Agencies, Inc.
Western Regional Examining Board
Northeast Regional Board
Southern Regional Testing Agency
American Association of Dental Boards
American Dental Educators’ Association
American Student Dental Association
January 27, 2012

Dr. Deena Kuempel
President
Central Regional Dental Testing Service
1725 SW Gage Blvd.
Topeka, KS 66604-3333

Dear Doctor Kuempel:

On behalf of the American Dental Association and the ADA Workgroup, thank you for considering a response to the Request for Proposals for Development of a Portfolio-Style Assessment of Clinical Skills for the Purposes of State Dental Licensure.

Your correspondence states that licensure is a governmental function, which the ADA fully recognizes and supports. The 2010 House of Delegates Resolution 42H-2010 directed the ADA to seek the expertise of a qualified agency to develop a portfolio-style examination that could be used by state dental boards as another avenue to evaluate a candidate for licensure, such as the PGY-1 (NY, CT, CA, MN, WA), the National Dental Examining Board of Canada’s two part examination (MN) and the portfolio examination recently adopted in California. The RFP was sent to all the dental clinical testing agencies as well as some private test development companies with experience in dental testing.

ADA recognizes the challenges of a portfolio-style examination and hopes that the testing community will view the ADA’s action as an opportunity to develop an alternative clinical assessment tool that could be supported and utilized by the state dental boards.

Sincerely,

William R. Calnon, D.D.S.
President

WRC/ih:kb
cc: Dental Regional Testing Agencies
    American Dental Education Association
    American Board of Dental Examiners
    American Student Dental Association
    Members, ADA Workgroup on Resolution 42H-2010 (Portfolio Style Examination)
    Dr. Anthony Ziebert, senior vice president, Education/Professional Affairs
    Ms. Karen Hart, director, Council on Dental Education and Licensure
    Dr. Tsung-Hsun Tsai, manager, Research and Development/Psychometrics
December 9, 2011

To: Dr. William R. Calnon, ADA President

Dr. Samuel B. Low
Trustee, Seventeenth District
Chair, ADA Workgroup on Development of RFP for Portfolio-Style Examination

Lois Haglund, Manager, Dental Licensure
Council on Dental Education and Licensure

From: Dr. Thomas Wells, President
Alaska Board of Dental Examiners

Subject: Request for Proposals

The Alaska Board of Dental Examiners (AKBODE) reviewed the directive from the ADA House of Delegates to develop a portfolio-style examination for initial licensure purposes. The assumption made by the House of Delegates is that the portfolio could assess clinical competence of candidates by the psychometrically valid and reliable third-party assessment process.

After careful evaluation and discussion, the AKBODE firmly opposes the ADA’s development of a clinical licensing examination and reaffirms the stated mission of the ADA: “The ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public.” It is the mission of the AKBODE to protect the public through effective licensing requirements. The AKBODE regularly evaluates and revises minimal licensing standards to meet its mission. Both the ADA and the AKBODE state their important and separate missions.

The AKBODE urges the ADA Workgroup on Development of RFP for Portfolio-Style Examination to withdraw the RFP and cease their attempt to involve themselves in the clinical dental licensing examination process. Licensing examinations and processes must remain with the state boards of dental examiners.
Sincerely,

Thomas Wells, DDS
President
AK Board of Dental Examiners
PO Box 110806
Juneau, AK 99811-0806

CC: Patrick Braatz, Executive Director
    OR Board of Dentistry
December 20, 2011

Patrick D. Braatz, Esq.
Executive Director
Oregon Board of Dentistry
1600 SW 4th Ave., Suite 770
Portland, OR 97201-5519

Dear Attorney Braatz:

The New Hampshire Board of Dental Examiners reviewed your letter regarding the ADA development of a portfolio-style licensure examination. The Board has referred your letter to its Examination Subcommittee for further study of the issues.

The NH Dental Practice Act does not authorize a portfolio-style examination to be substituted for a regional or state clinical examination.

Thank you for bringing your concerns to the Board.

Sincerely,

Neil S. Hiltunen, DMD
President

NSH/jtc
Dr. Samuel B. Low, Trustee  
Workgroup on Development of RFP for Portfolio-Style Examination  

Ms. Lois Haglund, Manager  
Council on Dental Education and Licensure  

American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611  

Dear Dr. Low and Ms. Haglund:  

On October 25, 2011, you submitted a Request for Proposals to the Presidents and Executive Directors of the American Board of Dental Examiners regarding a portfolio-style examination for initial licensure purposes that could assess clinical competence of candidates via a psychometrically valid and reliable third-party assessment process.  

At its meeting on December 15, 2011, the Delaware Board of Dentistry and Dental Hygiene reviewed your RFP as well as a letter from Patrick Braatz, Executive Director of the Oregon Board of Dentistry, expressing his concern about the ADA’s involvement in state dental board licensing. After review and discussion, the members of the Delaware Board unanimously moved to notify the ADA that it supports Mr. Braatz position that as a professional organization that promotes the profession, the ADA should not be involved in the clinical licensing examination process for Dentistry, but rather let the individual state boards regulate the licensing process.  

If you have any questions or concerns, please contact our Board office at (302)744-4500 or customerservice.dpr@state.de.us.  

Sincerely,  

Michele Howard  
Administrative Specialist II / Board Liaison  
DE Board of Dentistry & Dental Hygiene  

cc: Patrick Braatz, Oregon Board of Dentistry  
Allison Reardon, Deputy Attorney General, Counsel to the Board  
Dr. Blair Jones, Board President  

December 16, 2011

Ms Lois Haglund  
Portfolio RFP 
American Dental Association  
211 East Chicago Avenue  
Chicago, IL 60611

Dear Ms. Haglund,

The mission of the ADA is to promote the profession of dentistry. The mission of state dental licensing boards is the protection of the public. While these missions might parallel each other at times, the function of examining licensees for entrance to practice in our profession distinctly belongs in the realm of State Dental Examining Boards. The ADA as an organization that promotes the profession has an inherent problem in becoming involved in the clinical licensing examination process for dentistry. This could easily be construed as a conflict of interest by the public and the media.

The Minnesota Board of Dentistry reviewed your RFP for the development of a portfolio style exam at its December 2, 2011 public meeting. Members concluded that your document was not a request for ideas or proposals, but in actuality a prescription for an exam that included details and protocols usually left to the entity or organization responding to such a request. In studying the content of the Scope of Work, Specifications, and Requirements contained in this “prescription” the members agreed that any final product generated by a group responding would never be acceptable to our Board as a viable format to test entry level candidates to the practice of dentistry.

The Minnesota Board continues to review testing products and formats for the purposes of state dental licensure. We currently recognize and accept a wide range of exams and methods for initial dental licensure in our state. We utilize testing agencies and structures already in place to accomplish this task. The portfolio exam format described in your RFP does not meet our requirements for this purpose. We consider the ADA an unlikely organization to enter into such initiatives and see a clear conflict of interest in so doing. We discourage any State Board from participation in or acceptance of this proposal.

Yours in Health,

David A. Linde, D.D.S.  
2011 President  
Minnesota Board of Dentistry

cc: Central Regional Dental Testing Service (CRDTS): President Deena Kuempel, DDS  
Oregon Board of Dentistry: Executive Director Patrick Braatz
January 19, 2012

Dr. William R. Calnon, President
American Dental Association
211 E. Chicago Avenue
Chicago, IL 60611-2678

Dear Dr. Calnon:

The members of the West Virginia Board of Dental Examiners, at their meeting of January 6, 2012, reviewed the October 25, 2011, American Dental Association's Request for Proposals (RFP) to develop a portfolio-style examination for initial license purposes, along with the Oregon Board of Dentistry's response.

The Board agrees with the Oregon Board of Dentistry unanimously in that it is the responsibility and privilege of the different states to regulate the practice of dentistry and dental hygiene, which includes the responsibility of administering clinical license examinations. It is not the responsibility of the American Dental Association. All of the licensed members of our agency participate with some or all of the regional examination organizations. As a matter of fact our Board recognizes all regional and state clinical examinations as part of the requirements for license. The Board does not recognize licenses obtained through PGY-1 or other non-clinical means.

West Virginia Code, Chapter 30, Article 1, Section 1a, states in part as follows: "The Legislature finds and declares as a matter of public policy the practice of the professions... is a privilege and is not a natural right of individuals. The fundamental purpose of licensure and registration is to protect the public..." By statutory authority, the Board requires candidates for licensure graduate from a CODA approved school of dentistry or dental hygiene and must satisfactorily pass the National Boards as administered by the Joint Commission. However, the West Virginia Board will not abrogate its responsibility to ensure the public, its only master, that minimally competent dentists and dental hygienists are licensed. The license process includes an independent, third-party, clinical examination. To imply clinical examinations are onerous, or
unfair, or just a snapshot is utter nonsense. After all, the candidates are not being tested for proficiency or mastership, only minimal competency. With due respect to ASDA, ADEA, and the American Dental Association, licensure of candidates is the business of the state regulatory agencies.

Very truly yours,

[Signature]

George D. Conard, Jr., D.D.S., President
West Virginia Board of Dental Examiners

CC: All State Boards of Dentistry
House Bill 4009

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Health Care)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Eliminates monitoring entity from impaired health professional program. Requires program to report professional's participation in program and noncompliance with program directly to professional's licensing board.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to the impaired health professional program; creating new provisions; amending ORS 676.190 and 676.200; repealing ORS 676.195; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 676.190 is amended to read:

676.190. (1) The Oregon Health Authority shall establish or contract to establish an impaired health professional program. The program must:

(a) Enroll licensees of participating health profession licensing boards who have been diagnosed with alcohol or substance abuse or a mental health disorder;

(b) Require that a licensee sign a written consent prior to enrollment in the program allowing disclosure and exchange of information between the program, the licensee's board, the monitoring entity established under ORS 676.195, the licensee's employer, evaluators and treatment entities in compliance with ORS 179.505 and 42 C.F.R. part 2;

(c) Enter into diversion agreements with enrolled licensees;

(d) Assess and evaluate compliance with diversion agreements by enrolled licensees;

(e) Assess the ability of an enrolled licensee's employer to supervise the licensee and require an enrolled licensee's employer to establish minimum training requirements for supervisors of enrolled licensees;

(f) Report substantial noncompliance with a diversion agreement to the monitoring entity established under ORS 676.195, a noncompliant licensee's board within one business day after the program learns of the substantial noncompliance, including but not limited to information that a licensee:

(A) Engaged in criminal behavior;

(B) Engaged in conduct that caused injury, death or harm to the public, including engaging in sexual impropriety with a patient;

(C) Was impaired in a health care setting in the course of the licensee's employment;

(D) Received a positive toxicology test result as determined by federal regulations pertaining to drug testing;

(E) Violated a restriction on the licensee's practice imposed by the program or the licensee's board;

NOTE: Matter in boldfaced type in an amended section is new; matter in italic and bracketed is existing law to be omitted. New sections are in boldfaced type.
(F) Was admitted to the hospital for mental illness or adjudged to be mentally incompetent;
(G) Entered into a diversion agreement, but failed to participate in the program; or
(H) Was referred to the program but failed to enroll in the program; and
(g) At least weekly, submit a list of licensees who are enrolled in the program and a list of licensees who successfully complete the program to [the monitoring entity established under ORS 676.195] licensees’ boards.

(2) When the program reports noncompliance to [the monitoring entity] a licensee’s board, the report must include:
(a) A description of the noncompliance;
(b) A copy of a report from the independent third party who diagnosed the licensee under ORS 676.200 (2)(a) or subsection (5)(a) of this section stating the licensee’s diagnosis;
(c) A copy of the licensee’s diversion agreement; and
(d) The licensee’s employment status.

(3) The program may not diagnose or treat licensees enrolled in the program.

(4) The diversion agreement required by subsection (1) of this section must:
(a) Require the licensee to consent to disclosure and exchange of information between the program, the licensee’s board, [the monitoring entity established under ORS 676.195,] the licensee’s employer, evaluators and treatment providers, in compliance with ORS 179.505 and 42 C.F.R. part 2;
(b) Require that the licensee comply continuously with the agreement for at least two years to successfully complete the program;
(c) Based on an individualized assessment, require that the licensee abstain from mind-altering or intoxicating substances or potentially addictive drugs, unless the drug is approved by the program and prescribed for a documented medical condition by a person authorized by law to prescribe the drug to the licensee;
(d) Require the licensee to report use of mind-altering or intoxicating substances or potentially addictive drugs within 24 hours;
(e) Require the licensee to agree to participate in a treatment plan approved by a third party;
(f) Contain limits on the licensee’s practice of the licensee’s health profession;
(g) Provide for employer monitoring of the licensee;
(h) Provide that the program may require an evaluation of the licensee’s fitness to practice before removing the limits on the licensee’s practice of the licensee’s health profession;
(i) Require the licensee to submit to random drug or alcohol testing in accordance with federal regulations;
(j) Require the licensee to report at least weekly to the program regarding the licensee’s compliance with the agreement;
(k) Require the licensee to report any arrest for or conviction of a misdemeanor or felony crime to the program within three business days after the licensee is arrested or convicted;
(L) Require the licensee to report applications for licensure in other states, changes in employment and changes in practice setting; and
(m) Provide that the licensee is responsible for the cost of evaluations, toxicology testing and treatment.

(5)(a) A licensee of a board participating in the program may self-refer to the program.
(b) The program shall require the licensee to attest that the licensee is not, to the best of the licensee’s knowledge, under investigation by the licensee’s board. The program shall enroll the licensee on the date on which the licensee attests that the licensee, to the best of the licensee’s
knowledge, is not under investigation by the licensee's board.

(c) When a licensee self-refers to the program, the program shall:
(A) Require that an independent third party approved by the licensee's board to evaluate alcohol or substance abuse or mental health disorders evaluate the licensee for alcohol or substance abuse or mental health disorders; and
(B) Investigate to determine whether the licensee's practice while impaired has presented or presents a danger to the public.

(6) The authority shall adopt rules establishing a fee to be paid by the boards participating in the impaired health professional program for administration of the program.

(7) The authority shall arrange for an independent third party to audit the program to ensure compliance with program guidelines. The authority shall report the results of the audit to the Legislative Assembly, the Governor and the health profession licensing boards. The report may not contain individually identifiable information about licensees.

(8) The authority may adopt rules to carry out this section.

SECTION 2. ORS 676.200 is amended to read:

676.200. (1)(a) A health profession licensing board that is authorized by law to take disciplinary action against licensees may adopt rules opting to participate in the impaired health professional program established under ORS 676.190.
(b) A board may only refer impaired professionals to the impaired health professional program established under ORS 676.190 and may not establish the board's own impaired health professional program.
(c) A board may adopt rules establishing additional requirements for licensees referred to the impaired health professional program established under ORS 676.190.

(2) If a board participates in the impaired health professional program, the board shall establish by rule a procedure for referring licensees to the program. The procedure must provide that, before the board refers a licensee to the program, the board shall ensure that:
(a) An independent third party approved by the board to evaluate alcohol or substance abuse or mental health disorders has diagnosed the licensee with alcohol or substance abuse or a mental health disorder and provided the diagnosis and treatment options to the licensee and the board;
(b) The board has investigated to determine whether the licensee's professional practice while impaired has presented or presents a danger to the public; and
(c) The licensee has agreed to report any arrest for or conviction of a misdemeanor or felony crime to the board within three business days after the licensee is arrested or convicted.

(3) A board that participates in the impaired health professional program shall investigate reports received from the [monitoring entity established under ORS 676.195] program. If the board finds that a licensee is substantially noncompliant with a diversion agreement entered into under ORS 676.190, the board may suspend, restrict, modify or revoke the licensee's license or end the licensee's participation in the impaired health professional program.

(4) A board may not discipline a licensee solely because the licensee:
(a) Self-refers to or participates in the impaired health professional program;
(b) Has been diagnosed with alcohol or substance abuse or a mental health disorder; or
(c) Used controlled substances before entry into the impaired health professional program, if the licensee did not practice while impaired.

SECTION 3. ORS 676.195 is repealed.

SECTION 4. (1) The amendments to ORS 676.190 and 676.200 by sections 1 and 2 of this
2012 Act and the repeal of ORS 676.195 by section 3 of this 2012 Act become operative on July 1, 2012.

(2) The Oregon Health Authority or a health profession licensing board as defined in ORS 676.185 may take any action before July 1, 2012, that is necessary to enable the authority or board to exercise, on and after July 1, 2012, all the duties, functions and powers conferred on the authority or board by the amendments to ORS 676.190 and 676.200 by sections 1 and 2 of this 2012 Act and the repeal of ORS 676.195 by section 3 of this 2012 Act.

SECTION 5. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.
676.405 Release of personal information. (1) As used in this section, “health professional regulatory board” means the agencies listed in ORS 676.160 and the Oregon Health Licensing Agency created in ORS 676.605.

(2) Notwithstanding ORS 192.410 to 192.505, a health professional regulatory board may, at its discretion, release or withhold the personal electronic mail address, home address and personal telephone number for a person licensed, registered or certified by the board. If the personal electronic mail address, home address or personal telephone number is requested for a public health or state health planning purpose, the board shall release the information. [2009 c.756 §3]
This Page

Left Blank
UNFINISHED BUSINESS & RULES
This Page

Left Blank
You requested legislative history research of the amendment to ORS 680.205 deleting language that allowed the Board of Dentistry to authorize the provision of dental hygiene services by expanded practice dental hygienist (formerly called limited access permit dental hygienists) at locations that are underserviced of lack access to dental hygiene services. Prior to this amendment the Board of Dentistry had authority to authorize the provisions of dental hygiene services by a limited access permit dental hygienists at locations or to populations that are underserved or lack access to dental hygiene services. You have asked whether the Board of Dentistry’s authority was limited to populations by this amendment.

OL 2011 c 716 § 8 amended ORS 680.205 to provide, in part, that an expanded practice dental hygienist may render services to:

(e) Patients whose income is less than the federal poverty level.
(f) Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

[2] The Oregon Board of Dentistry may authorize the provision of dental hygiene services by a limited access permit dental hygienist at locations or to populations that are underserved or lack access to dental hygiene services.

This legislation changed the term “limited access permit dental hygienist” to “expanded practice dental hygienist.”

Short Answer:

The legislative history did not specifically address change which deleted “locations” from the statute and whether the Board of Dentistry had authority to authorize the provision of dental hygiene services by expanded practice dental hygienist at locations that are underserviced of lack access to dental hygiene services. This legislation was the result of mediation meetings and work group deliberations. Although the legislature’s amendment of ORS 680.205 deleted the provisions in subsection (2) which referred to consideration of both locations or to populations that were underserved, the legislative history did not
discuss intent to limit the scope of statute’s application only to populations. There was discussion regarding OHA determination of the populations the dental pilot projects were intended to serve, however there was no direct testimony regarding intent to remove Board of Dentistry’s authority to make determinations based on locations. The list of entities listed as specifying populations implies locations. The Board of Dentistry has the authority to adopt rules specifying locations where dental hygienists may work. ORS 680.150 (4) provides:

The Board of Dentistry may adopt rules specifying other locations where dental hygienists may work and shall specify in its rules the degree of supervision a dentist my exercise over the procedures of the hygienist performs.

The various drafts of this proposed legislation could be interpreted to indicate that the omission of the term “locations” in ORS 680.205 was most likely a drafting oversight and not an intended consequence.

The introduced draft of SB 738 proposed to amend ORS 680.150 by transferring language that was previously found in ORS 680.205 into ORS 680.150. This added language to ORS 680.150 derived from ORS 680.205 proposed to make the relevant changes at issue. Section 5 of the introduced draft of SB 738 proposed to delete (5) reference to locations described in ORS 680.205 (1) and (2):

SECTION 5. ORS 680.150 is amended to read:
680.150. (1) Any dentist may employ a dental hygienist who may engage in the practice of dental hygiene in the office of such dentist under the general supervision of a dentist.
(2) Any public institution, health care facility or health maintenance organizations, as those terms are defined in ORS 442.015, may employ a dental hygienist who may engage in the practice of dental hygiene under the general supervision of a dentist.
(3) A dental hygienist under the general supervision of a dentist may engage in the practice of dental hygiene in any place where limited access patients are located.
(4) The Oregon Board of Dentistry may adopt rules specifying other locations where dental hygienists may work and shall specify in its rules the degree of supervision a dentist must exercise over the procedures the hygienist performs.
(5) Notwithstanding ORS 679.010 (4), supervision by a dentist is not required when a dental hygienist determines the need for and appropriateness of sealants or fluoride, and applies sealants or fluoride [at the locations and for persons described in ORS 680.205 (1) and (2).] to:
(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:
(A) Nursing homes as defined in ORS 678.710;
(B) Adult foster homes as defined in ORS 443.705;
(C) Residential care facilities as defined in ORS 443.400;
(D) Adult congregate living facilities as defined in ORS 441.525;
(E) Mental health residential programs administered by the Oregon Health Authority;
(F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005; 
(G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005; 
(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or 
(I) Public and nonprofit community health clinics. 

(b) Adults who are homebound. 
(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program. 
(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives. 
(e) Other populations that the board determines are underserved or lack access to dental hygiene services.

ORS 680.205 was proposed to be amended in Section 7 of the introduced draft of SB 738 as follows:

SECTION 7. ORS 680.205 is amended to read:

680.205. (1) A [dental hygienist issued a permit to act as a limited access permit] community health dental hygienist [under ORS 680.200 shall be authorized to render] may perform all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the [limited access] community health dental hygienist permit. 

[to:] 
[(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:] 
[(A) Nursing homes as defined in ORS 678.710:] 
[(B) Adult foster homes as defined in ORS 443.705:] 
[(C) Residential care facilities as defined in ORS 443.400:] 
[(D) Adult congregate living facilities as defined in ORS 441.525:] 
[(E) Mental health residential programs administered by the Oregon Health Authority:] 
[(F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005:] 
[(G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005:] 
[(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620, youth]
correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or] [(I) Public and nonprofit community health clinics.] [(b) Adults who are homebound.] [(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and other similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.] [(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.] [(2) The Oregon Board of Dentistry may authorize the provision of dental hygiene services by a limited access permit dental hygienist at locations or to populations that are underserved or lack access to dental hygiene services.] [(3)] (2) At least once each calendar year, a [dental hygienist issued a permit to act as a limited access permit] community health dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident. (3) A community health dental hygienist may perform the following services under the general supervision of a dentist licensed under ORS chapter 679 and in accordance with a practice agreement approved by the board under ORS 680.200: (a) Administering local anesthesia; (b) Administering temporary restorations; (c) Prescribing prophylactic antibiotics and other drugs specified in the practice agreement; (d) Administering radiographs; and (e) Overall dental risk assessment and referral. (4) This section does not authorize a [limited access permit] community health dental hygienist to administer local anesthesia or temporary restorations except under the general supervision of a dentist licensed under ORS chapter 679, or to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679. (5) A [limited access permit] community health dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients. (6) A [person granted a limited access permit under ORS 680.200 shall] community health dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

Senate amendment to SB 738 dated April 28th by the Committee on Health Care, Human Services and Rural Health Policy, adopted the term “expanded practice dental hygienist” in lieu of the term “limited access permit dental hygienist” which had been in the statutes or the term “community health dental hygienist” as coined in the introduced draft.
Section 6 of A-Engrossed SB 738 amended ORS 680.150 to provide:

SECTION 6. ORS 680.150 is amended to read:
680.150. (1) Any dentist may employ a dental hygienist who may engage in the practice of dental hygiene in the office of such dentist under the general supervision of a dentist. (2) Any public institution, health care facility or health maintenance organization, as those terms are defined in ORS 442.015, may employ a dental hygienist who may engage in the practice of dental hygiene under the general supervision of a dentist. (3) A dental hygienist under the general supervision of a dentist may engage in the practice of dental hygiene in any place where limited access patients are located. (4) The Oregon Board of Dentistry may adopt rules specifying other locations where dental hygienists may work and shall specify in its rules the degree of supervision a dentist must exercise over the procedures the hygienist performs. (5) Notwithstanding ORS 679.010 [(4)] (3), supervision by a dentist is not required when a dental hygienist determines the need for and appropriateness of sealants or fluoride, and applies sealants or fluoride at the locations and for persons described in ORS 680.205 (1) [and (2)].

Of significance in the amendment of ORS 680.105 is that subsection (4) was left unchanged and subsection (5) stills refers to “locations and for persons described in ORS680.205 (1).”

The Senate amendments to ORS 680.205 restored the deleted language that had been moved to ORS 680.150 in the introduced draft. The A-Engrossed SB 738 amendment of ORS 680.205 provided:

SECTION 8. ORS 680.205 is amended to read:
680.205. (1) [A dental hygienist issued a permit to act as a limited access permit] An expanded practice dental hygienist [under ORS 680.200 shall be authorized to] may render all services within the scope of practice of dental hygiene, as defined in ORS 679.010, without the supervision of a dentist and as authorized by the [limited access] expanded practice dental hygienist permit to:
(a) Patients or residents of the following facilities or programs who, due to age, infirmity or disability, are unable to receive regular dental hygiene treatment:
(A) Nursing homes as defined in ORS 678.710;
(B) Adult foster homes as defined in ORS 443.705;
(C) Residential care facilities as defined in ORS 443.400;
(D) Adult congregate living facilities as defined in ORS 441.525;
(E) Mental health residential programs administered by the Oregon Health Authority;
(F) Facilities for mentally ill persons, as those terms are defined in ORS 426.005;
(G) Facilities for persons with mental retardation, as those terms are defined in ORS 427.005;
(H) Local correctional facilities and juvenile detention facilities as those terms are defined in ORS 169.005, regional correctional facilities as defined in ORS 169.620,
youth correction facilities as defined in ORS 420.005, youth care centers as defined in ORS 420.855, and Department of Corrections institutions as defined in ORS 421.005; or

(I) Public and nonprofit community health clinics.

(b) Adults who are homebound.

(c) Students or enrollees of nursery schools and day care programs and their siblings under 18 years of age, Job Corps and [other] similar employment training facilities, primary and secondary schools, including private schools and public charter schools, and persons entitled to benefits under the Women, Infants and Children Program.

(d) Patients in hospitals, medical clinics, medical offices or offices operated or staffed by nurse practitioners, physician assistants or midwives.

(e) Patients whose income is less than the federal poverty level.

(f) Other populations that the Oregon Board of Dentistry determines are underserved or lack access to dental hygiene services.

[(2) The Oregon Board of Dentistry may authorize the provision of dental hygiene services by a limited access permit dental hygienist at locations or to populations that are underserved or lack access to dental hygiene services.]

[(3)] (2) At least once each calendar year, [a dental hygienist issued a permit to act as a limited access permit] an expanded practice dental hygienist shall refer each patient or resident to a dentist who is available to treat the patient or resident.

(3) An expanded practice dental hygienist may render the services described in paragraphs (a) to (d) of this subsection to the patients described in subsection (1) of this section if the expanded practice dental hygienist has entered into an agreement in a format approved by the board with a dentist licensed under ORS chapter 679. The agreement must set forth the agreed-upon scope of the dental hygienist’s practice with regard to:

   (a) Administering local anesthesia;

   (b) Administering temporary restorations without excavation;

   (c) Prescribing prophylactic antibiotics and nonsteroidal anti-inflammatory drugs specified in the agreement; and

   (d) Overall dental risk assessment and referral parameters.

(4) This section does not authorize [a limited access permit] an expanded practice dental hygienist [to administer local anesthesia or temporary restorations except under the general supervision of a dentist licensed under ORS chapter 679, or] to administer nitrous oxide except under the indirect supervision of a dentist licensed under ORS chapter 679.

(5) [A limited access permit] An expanded practice dental hygienist may assess the need for and appropriateness of sealants, apply sealants and write prescriptions for all applications of fluoride in which fluoride is applied or supplied to patients.

(6) [A person granted a limited access permit under ORS 680.200 shall] An expanded practice dental hygienist must also procure all other permits or certificates required by the board under ORS 679.250.

The audio of the following hearings of Senate Health Care, Human Services and Rural Health Policy were reviewed: March 9th; March 28th; April 18th; and April 20th. During
these hearings reference was made to mediation and work group deliberations on this legislation. During March 28th hearing -1 amendments were submitted to the committee which proposed to reinstate the language which had been transferred from ORS 680.205 into ORS 680.150 back into ORS 60.205.

SB 738 was referred to the Ways and Means Committee by the house, the audio of the Ways and means Committee were not reviewed.
January 31, 2012

Paul S. Cosgrove  
220 NW Skyline Blvd.  
Portland, OR 97210-1069

Dear Mr. Cosgrove:

The Oregon Board of Dentistry received your letter and Petition to adopt an Administrative Rule on January 10, 2012.

The Petition will be placed on the February 10, 2012 Oregon Board of Dentistry (OBD) Agenda.

It would be helpful to the OBD in promulgation of a new administrative rule if you could provide information regarding the populations and areas that are covered under ORS 315.613 – 315.622. A review on the Oregon Statutes does not shed much light on where these areas and populations might be.

If you have any questions, please feel free to contact me.

I look forward to your reply.

Sincerely yours,

Patrick D. Braatz  
Executive Director
January 6, 2012

Patrick D. Braatz, Executive Director
Oregon Board of Dentistry
1600 SW 4th Ave., Suite 770
Portland, OR 97201-5519

Re: Petition to Adopt Administrative Rule

Dear Patrick:

Enclosed please find a Petition to Adopt and Administrative Rule on behalf of the Oregon Dental Hygienists Association.

Very truly yours,

[Signature]

Paul S. Cosgrove
Of Counsel
BEFORE THE BOARD OF
DENTISTRY: PETITION TO
ADOPT AN ADMINISTRATIVE
RULE

1. **OAR to be adopted:** The text of the proposed new rule is set forth in Exhibit 1 attached hereto and incorporated herein.

2. **Petitioner’s relevant facts and standing:** Petitioner is the state association representing Oregon’s registered dental hygienists. Petitioner’s address is c/o Spire Management, 3340 Commercial St SE, Suite 210, Salem, Oregon, 97302 and Petitioner’s telephone number is 503-371-7457. Petitioner’s local representative is Paul S. Cosgrove, Of Counsel to Lindsay Hart Neil & Weigler, LLP, 220 NW Skyline Blvd, Portland, OR, 97210, telephone number 503-291-6700.

3. **Intent of Rule.** To set forth in rule additional persons in underserved areas in Oregon who the Board has authorized Expanded Practice Dental Hygienists to serve.

4. **Need for the Rule.** The rule is needed to provide certainty and transparency regarding what persons the Board authorizes Expanded Practice Dental Hygienists to serve, beyond those set forth specifically in statute.

5. **Statutory Authority:** ORS 183.390; ORS 680.205.

6. **Proposed Effective Date:** As soon as possible after due notice of promulgation and public hearings.

7. **Continued need for the existing rules:** All existing Board rules will remain in effect.

8. **The complexity of the existing rule:** The rule is not expected to be complex.
818-035-xxxx

Services by Expanded Practice Dental Hygienists to Persons from Underserved Areas

In addition to the persons described in ORS 680.205(1) (a) through (e), a dental hygienist issued an Expanded Practice permit may provide dental hygiene services to persons who live in the following underserved areas:

1. Areas designated as Dental Health Manpower Shortage Areas;
2. Areas in which dental providers are eligible for rural practice tax credits pursuant to ORS 315.613 – 315.622; or
3. Other areas in which the board determines, upon request from a licensee or other person, that there is unmet need for oral health services, or where patients have difficulty accessing oral health care services.
9. **Extent to which rule overlaps or otherwise conflicts with other Federal/State/Local regulations:** None.

DATED: 1/6/12

Respectfully Submitted:

[Signature]

Paul S. Cosgrove, for the Oregon Dental Hygienists Association
This Page

Left Blank
CORRESPONDENCE
RE: Terms for Diagnosis and “Justification” for Cosmetic Dentistry (Board Response Attached.)

Dear Patrick Braatz and Oregon Board of Dentistry,

The role of the Oregon Board of Dentistry to promote the highest quality of dental treatment is very important and is commended and shared. I appreciate your December 2, 2011 response; however, it only answered part of my question: What is an approved diagnostic term and justification term for documenting in the patient’s chart? (A photograph of the teeth was included and a diagnosis of dental fluorosis provided.) The Board truncated my lead question, to: “Is the patient’s request for Veneers, Justification for Treatment?” The Board’s response is incomplete and confusing.

The term “cosmetic” is commonly used to indicate “beautifying” or “intended to beautify.” The Board’s 12/2/11 letter states, “documenting in the patient’s chart the word “cosmetic” is not a dental diagnosis that provides a reason or justification for initiating dental treatment.”

The Board’s response seems to indicate a patient does not have the right to be treated if their concerns are strictly for “cosmetic” (“beauty”) concerns. In other words, lacking a diagnosis of decay, fracture, or chemical damage of tetracycline or fluorosis, the Board finds procedures such as fillings, bleaching, or veneers are a violation of the Oregon standard of care and disciplining practitioners. I don’t have exact numbers, but estimates range in the millions of people who are having bleaching done in dental offices only with the request by the patient for whiter teeth, cosmetics. Apparently most cases of bleaching are below the Oregon Board of Dentistry’s standard of care. For example, I treat Mrs. Oregon Globe contestants and most have beautiful teeth but they are requesting even brighter smiles, extreme beauty/cosmetics.

Question A: Do I correctly understand the Board has rejected the World Health Organization’s International Classification of Diseases ICD-9-CM V50 “Elective surgery for purposes other than remedying health states” V50.1 “Other plastic surgery for unacceptable cosmetic appearance?” I expect an answer of “YES” or “NO.” If the Board has rejected “cosmetic” as a diagnosis, under public disclosure laws I am requesting a copy of the resolution of the Board, date of the resolution or vote, rejecting the term “cosmetic” as an acceptable diagnosis or Board rule.
Question B: “What Diagnostic terms and Justification terms are accepted by the Oregon Board of Dentistry for a dentist to document in the patient’s chart to comply with ORS 818-012-0070 as an acceptable substitute for V50 “Elective surgery for purposes other than remedying health states” V50.1 “Other plastic surgery for unacceptable cosmetic appearance?”

1. For example, a patient presents and states, “my teeth are ugly” or “I don’t like my dark teeth” or “my teeth look so dull” or “I’m not pleased with the appearance of my teeth” or “I don’t like the cosmetic or esthetic appearance of my teeth” or “I would like a brighter smile” or “I want more beautiful teeth” or “I want whiter teeth” or “the color of my teeth don’t match” and the practitioner does not see dental caries, dental fluorosis, fractured teeth or tetracycline stains, and the dentist agrees with the patient the teeth are not beautiful (cosmetic), what diagnostic term and what justification term is acceptable for documentation to comply with ORS 818-012-0070? (For 34 years of practice I have used the diagnostic term “cosmetic” V50.1 for these patients, both internal and external bleaching, veneers, and cosmetic recontouring (shaping) of teeth to make them more beautiful. Apparently I am in error and I want to correct my error and obey the Oregon Board of Dentistry with correct terms and procedures.)

2. What if the same patient in (1) requests a brighter smile (cosmetic bleaching or veneers) and I determine the teeth are an A1 shade looking just fine, certainly reasonable to me as the practitioner, but the patient wants, in fact demands, even whiter teeth, bleaching or veneers? What diagnostic term and what justification term would the Board of Dentistry accept for documentation to comply with ORS 818-012-0070?

At the heart of those two questions is whether the patient has the right to request treatment to be more beautiful.

Question C: “What ICD-9-CM diagnostic terms, if any, are NOT accepted by the Board of Dentistry?”

Either listing the International Classification of Disease terms NOT acceptable to the Board (if there are any other than Cosmetic), or listing the Oregon Classification of Diseases acceptable to the Board would fulfill the intent of Question C.

Thank you for your response.

Sincerely,

Bill Osmunson DDS, MPH

cc: American Academy of Cosmetic Dentistry, ACEsthetics, Oregon Dental Association
December 2, 2011

Bill Osmunson, D.D.S.
17720 Jean Way # 200
Lake Oswego, OR 97035

Dear Dr. Osmunson:

In answer to your e-mail dated November 22, 2011 referencing your July 1, 2011 letter that you previously sent to the Oregon Board of Dentistry (OBD) the following is the response.

Re: Is the Patient's Request for Veneers, Justification for Treatment?

The diagnosis of dental fluorosis can be a cosmetic issue, which provides a justification for the treatment you proposed.

Documenting in the patient's chart the word "cosmetic" is not a dental diagnosis that provides a reason or justification for initiating dental treatment.

Documenting in the patient's chart the words "dental fluorosis" is a diagnosis that provides a reason for the initiation of dental treatment.

I hope that this answers your questions.

Sincerely yours,

Patrick D. Braatz
Executive Director
This Page

Left Blank
Oregon Board of Dentistry
Mary Davidson, RDH
1600 SW 4th Avenue
Suite 770
Portland, OR 97201

Dear Ms. Davidson,

I am writing this letter to introduce myself to the Oregon Board of Dentistry and your working committee on Botox and Dermal Fillers. I wish to put my name forward for consideration to become a member / advisor of your group.

My name is Dr. Warren Roberts and I am a practicing dentist and a certified Botox Instructor and Provider. I graduated from the University Of British Columbia Faculty Of Dentistry in 1977 and am currently the president of the Pacific Training Institute for Facial Aesthetics, an educational facility I co-founded with my wife, Dr. Janet Roberts. Our program instructs dentists, physicians and other health care professionals on incorporating Botox Cosmetic and Therapeutic, facial esthetics and other modalities into a dental/medical practice.

I am very interested in becoming a member of the working group of the board and I would enjoy an opportunity to contribute towards improving and shaping regulation and policy within my profession. I bring a wealth of knowledge and experience in the field of facial rejuvenation that would allow me to contribute insightful, factual and well-balanced information to the issues being discussed. As a successful entrepreneur, I am an optimistic, positive person, able to find creative solutions while maintaining strong relationships with liaisons and peers.

For your consideration I am pleased to present my credentials in the areas of Dentistry and Botox Cosmetic and Therapeutic:

Graduate of University of British Columbia Faculty of Dentistry
Past president of the Fraser Valley Dental Society
Past president of the BC Academy of General Dentistry
Member of the Vancouver and District Dental Society
Member of the Canadian Academy of Esthetic Dentistry
Member of the American Academy of Cosmetic Dentistry
CE - Las Vegas Institute for Advanced Dental Studies
CE - California Center for Advanced Dental Studies
Speaker, Pacific Dental Conference
Published author - Oral Health, Team Work and Dentistry Today (Botox)
Speaker/instructor 2011 American Academy of Cosmetic Dentistry, (AACD), Basic and Advanced (Botox)
Founder of the Pacific Training Institute for Facial Aesthetics
#1 Dental Botox provider in Canada

Pacific Training Institute for Facial Aesthetics:
Founded in 2008, I designed the programs, course materials and have been the instructor for the majority of the courses offered. Now considered the premier Botox training program available, we strive to provide our course participants with an exceptional skill set which focuses on a blend of anatomy driven injection techniques and the science of Botox. Attached, please find a detailed listing of past courses.

The Pacific Training Institute offers the only Botox course that is both Academy of General Dentistry “PACE” and American Dental Association “CERP” approved. We have created the only botox study club in existence, operating throughout North America.

Courses are offered at two levels comprising of a Comprehensive 2 Day Introductory Botox Course and a Comprehensive Advanced 2 Day Botox Course. As the courses were developed by a dentist, there is a complete and total dental integration. The courses are continually refined to capture new and relevant advances in the many disciplines of Botox therapy, therefore such complete and comprehensive training has resulted in more medical professionals attending the sessions.

Course Topics Include:

The muscles of facial expression in detail
The progression of Dental Aesthetics
What is Botox? The multiple modes of action
The effect of muscles on Smile Design
The Botox-perio connection
The link between the platysma bands and gingival recession
The muscles of mastication/para functional habits and Botox therapy
Decreasing the muscle mass and the cosmetic benefits
Canted smile and muscle action
Botox and the relief of anxiety and depression
Current research articles
Up-coming studies
Headaches, TMJ, para functional habits and dystonias

Unique to the Pacific Training Institute is the Roberts Facial Rejuvenation Photography Series. This is a series of specifically posed photographs that aid in the record keeping and diagnostic analysis of facial rejuvenation and also allows the patient ample opportunity to determine the nature of treatment desired. We are considered to have one of the largest data banks of photographic Botox/Facial Rejuvenation records.

In addition to courses offered at the educational facility, I speak to various study groups throughout Canada and the USA. Utilizing a short presentation named “The Therapeutic Use of Botox in a Dental Office and the Cosmetic Side Effects”; I teach dentists, dental assistants and hygienists a 2 hour or half day overview of our programs which provides the groups with an opportunity to consider the use of botox in a dental environment. Please find attached a listing of study club presentations.

Thank you for your consideration of the matter; I look forward to hearing from you.

Sincerely,

Warren Roberts, DMD
1228 Pacific Drive
Tsawwassen BC
Canada V4M 2K6
botoxstudyclub@ptifa.com
Dr. Warren Roberts - Botox Presentations, Lecture

2008-03 Patterson Dental, Richmond, Botox presentation
2009-03-05 Pacific Dental Conference, Speaker, Botox Intro, Pacific Dental Conference, Speaker, Botox Advanced
2009-04-17 Fraser Valley Dental Society, Botox presentation
2009-07 Patterson Dental, Edmonton, Botox presentation
2009-07 Patterson Dental, Calgary, Botox presentation
2009-09-09 Coquitlam Hygiene Study Club, Botox presentation
2009-09-26 Pacific Alliance of Dental Specialties Study Club, Botox presentation
   Dr. Lee Colfer, mentor
2009-10 Toronto, Women in Dentistry
2009-11-27/28 Vancouver, Orafresh, Botox Presentation
2010-01-08 Pacific Training Institute, Botox Study Club
2010-01-21 Acadiana Study Club
2010-01-27 Zokol Rehabilative Study Club, Botox presentation
   Dr. Ron Zokol, mentor
2010-02-17 Western Restorative Seminars Study Club, Botox presentation
   Dr Dennis Nimchuck, mentor
2010-03 Orthodontic Aesthetic Study Club, Botox presentation
   Dr. Raymond Chen, mentor
2010-03-12 Pacific Training Institute, Botox Study Club, Botox presentation
2010-05-07 Wire Works Study Club, Botox presentation
   Dr. Nicki De Francesco
2010-05-17 Northwest Endodontic Study Club-A, Botox presentation
   Dr. Mahesh Lodhia
2010-06-04 Henry Schien, Botox presentation
2010-06-07 Pacific Training Institute, Botox Study Club
2010-06-21 Vancouver-Iranian Study Club, Botox presentation
   Dr. Masoud Haghi, mentor
2010-09-13 Lower Mainland Dental Hygiene Study Seminar, Botox presentation
2010-09-29 UBC Advanced Series Presentation, Botox Introduction
   Dr. Chris Wyatt, mentor
2010-10-21 Dental Ed - Webinar, Botox Intro
2010-10-28 Pacific Training Institute, Baton Rouge, LA, Study Club
2010-11-25 Parkland Orthodontic Study Club, Botox presentation
   Dr. Terry Carlyle, mentor
2010-12-10 Pacific Training Institute, Botox Study Club
2011-02-08 Pacific Training Institute, Botox Study Club
2011-02-08 Pacific Orthodontics Seminars, Botox presentation
2011-04-19 Comox Valley Hygiene Association Study Club
2011-05-11 American Academy of Cosmetic Dentistry, Speaker - Botox Intro
2011-05-11 American Academy of Cosmetic Dentistry, Speaker - Botox Advanced
2011-06-06 Pacific Training Institute, Botox Study Club
2011-07-28 Dental GPT, Kansas City, MO, Facial Rejuvenation presentation
2011-08-24 Dental XP - Webinar
2011-10-01 CDABC Conference
2011-10-29 4th International Heraeus Dental Symposium
2011-11-03 University of Maryland-Advanced General Dentistry
2011-11-22 Allergan Dental Face in Vancouver
2011-12-09 AACD Webinar

2 Day Hands-on Courses Facilitated By Dr. Warren Roberts
2009-01-16/17 Vancouver, BC
2009-02-13/14 Vancouver, BC
2009-03-07/08 Vancouver, BC
2009-04-03/04 Vancouver, BC
2009-05-15/16 Vancouver, BC
2009-06-05/06 Vancouver, BC
2009-07-24/25 Vancouver, BC
2009-08-07/08 Dallas, TX
2009-10-02/03 San Antonio, TX
2009-10-16/17 Vancouver, BC
2009-10-23/24 New Orleans, LA
2009-10-30/31 Dallas, TX
2009-11-20/21 Vancouver, BC
2009-11-27/28 Vancouver, BC
2010-01-22/23 Lafayette, LA
2010-01-29/30 Vancouver, BC
2010-03-19/20 Vancouver, BC
2010-04-16/17 Vancouver, BC
2010-05-14/15 Vancouver, BC
2010-06-18/19 Vancouver, BC
2010-07-16/17 Vancouver, BC
2010-09-17/18 Vancouver, BC
2010-10-15/16 Vancouver, BC
2010-10-29/30 Baton Rouge, LA
2010-11-19/20 Vancouver, BC
2011-01-28/29 Vancouver, BC
2011-02-11/12 Vancouver, BC
2011-02-18/19 Vancouver, BC
2011-03-9/10 Vancouver, BC
2011-04-29/30 Detroit, MI
2011-05-13/14 Vancouver, BC
2011-06-10/11 Columbus, OH
2011-06-17/18 Vancouver, BC
2011-07-15/16 Vancouver, BC
2011-07-22/23 Vancouver, BC
2011-09-09/10 Chicago, IL
2011-09-16/17 Salem NH
2011-09-23/24 Vancouver BC
2011-10-04/05 Columbia SC
2011-11-04/05 Columbus OH
2011-11-19/20 Kansas City MI
2011-11-25/26 Vancouver BC
2012-01-13/14 Vancouver BC
OTHER ISSUES
This Page

Left Blank
7. Request for Approval to become a Board Approved Provider for Expanded Practice Permit.

ORS 680.200 (1)(ii) Expanded Practice permit; requirements.
(1) Upon application accompanied by the fee established by the Oregon Board of Dentistry, the board shall grant a permit to practice as an expanded practice dental hygienist to an applicant who:
(a) Holds a valid, unrestricted Oregon dental hygiene license;
(b) Presents proof of current professional liability insurance coverage;
(c) Presents documentation satisfactory to the board of successful completion of an emergency life support course for health professionals, including cardiopulmonary resuscitation, from an agency or educational institution approved by the board; and
(d) Presents documentation satisfactory to the board that the applicant has:
(A)(i) Completed 2,500 hours of supervised dental hygiene practice; and
(ii) After licensure as a dental hygienist, completed 40 hours of courses, chosen by the applicant, in clinical dental hygiene or public health sponsored by continuing education providers approved by the board.

The Oregon Dental Association (ODA) has submitted an Expanded Practice Dental Hygiene Continuing Education (CE) Provider Application (Attachment 1). The ODA is requesting that the Board approve them as a Provider and that all their past, current and future courses be accepted.
Oregon Board of Dentistry  
1600 SW 4th Avenue, Suite 770  
Portland, OR 97201  
www.oregon.gov/dentistry  
(971) 673-3200

Expanded Practice Dental Hygiene  
Continuing Education (CE) Provider Application

<table>
<thead>
<tr>
<th>Provider Name (name of individual or facility):</th>
<th>Business Phone No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Dental Association</td>
<td>503-218-2010</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (street address, city, state, zip):</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 3710, Wilsonville, Oregon 97070</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email or Web site (optional):</th>
<th>Taxpayer ID Number:</th>
<th>Will Offer On-line Courses:</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.oregondental.org">www.oregondental.org</a></td>
<td>93-0243383</td>
<td>☑ No ☐ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization Type (select one):</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Association</td>
</tr>
<tr>
<td>☐ Licensed Health Facility</td>
</tr>
<tr>
<td>☐ Corporation</td>
</tr>
<tr>
<td>☐ 2 or 4 yr Institution of Higher Learning</td>
</tr>
<tr>
<td>☐ Other education organization Individual</td>
</tr>
<tr>
<td>☐ Other (please specify):</td>
</tr>
<tr>
<td>☐ Non-Profit Corporation</td>
</tr>
<tr>
<td>☐ Government Agency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CE Coordinator Name:</th>
<th>CE Coordinator Phone No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lauren Malone, Managing Director Meetings &amp; Membership</td>
<td>503-218-2010 x 101</td>
</tr>
</tbody>
</table>

Instructor's Education/Training (attach Instructor(s) resume or curriculum vitae (CV)):

See attached listing of courses that will be offered at the upcoming Oregon Dental Conference, April 12 - 14, 2012.

Please extend approval to all past and future Oregon Dental Conference courses.

CE Coordinator's Signature: [Signature]  
Date: [1/20/12]

Attachment 1  
1/1/2012
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Method</th>
<th>Presenter(s) Full Name</th>
<th>Course Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, April 12</td>
<td>1 pm - 5 pm</td>
<td>Lecture</td>
<td>Steven Beadnell, DMD; Brett Ueck, DMD, MD</td>
<td>Medical Emergency Update</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 10:30 am</td>
<td>Lecture</td>
<td>Patrick Braatz; Paul Kleinstub, DDS</td>
<td>Record Keeping from the Board's Perspective</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>11 am - 12 pm</td>
<td>Lecture</td>
<td>Patrick Braatz; Paul Kleinstub, DDS</td>
<td>Ask the Board</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 4:30 pm</td>
<td>Lecture</td>
<td>Douglas Damm, DDS</td>
<td>Fire In The Hole</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Nico de Werte, MD; Eric Dieke, DMD, MD; Wallace McKenzie, DMD</td>
<td>Dental Evaluation and Management of the Radiated Cancer Patient</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Patti DiGangi, RDH</td>
<td>Oral-Sytemic Health: Marketplace realities in Treating Oral Diseases</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Patti DiGangi, RDH</td>
<td>Firm Footing On Shifting Ground: Don't Get Lost In Translation</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Ann Eshenaur Spolarich, RDH, PhD</td>
<td>Women and Medications: Health Issues and Related Pharmacotherapies</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Ann Eshenaur Spolarich, RDH, PhD</td>
<td>Managing the Geriatric Patient: Practice Considerations for Oral Health Care Professionals</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Alex Fleury, DDS, MS</td>
<td>New Dimensions in Endodontics-Lecture</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Hands-On</td>
<td>Alex Fleury, DDS, MS</td>
<td>New Dimensions in Endodontics-Workshop</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>V. Kim Kutch, DMD</td>
<td>Caries Risk Assessment: Dental Caries GPS for GP's</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>V. Kim Kutch, DMD</td>
<td>Caries Risk Assessment: Dental Caries GPS for GP's</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Jay Malmquist, DMD, FACD, FICO</td>
<td>The Congenitally Missing Tooth: Implant Options for Treatment Is Esthetics and Function Possible?</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Jay Malmquist, DMD, FACD, FICO</td>
<td>Implant Esthetics: Established And New Concepts In Soft Tissue Management, Grafting And Temporization</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Karen McCullough</td>
<td>Branding Your Dental Practice- Love your Brand and Live Your Brand</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Karen McCullough</td>
<td>Supercharge Your Productivity - Get a Shot of Energy</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Kristy Menage Berrie, RDH, BS, RYT</td>
<td>Paradigm Shifts in Periodontal Therapy: Implementing Evolving Protocols</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>John Molinari, PhD</td>
<td>Infection in Immune Compromised Persons</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>John Molinari, PhD</td>
<td>Infection Control: That Thing You Do and Why Do You Do It?</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Linda Pressnell, MS</td>
<td>Exposure Control/Bloodbourne Pathogens</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 4:30 pm</td>
<td>Lecture</td>
<td>George Priest, DMD</td>
<td>Smile Line Revitalization With Crowns, Veneers And Implants</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Jorgen Slotte, DDS, DMD, PhD, MS, MBA</td>
<td>New Approaches for Antimicrobial Treatment of Periodontal Disease</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 4:30 pm</td>
<td>Lecture</td>
<td>Kevin Smith, DDS</td>
<td>Comprehensive Evaluation and Team Care for Cleft and Craniofacial Patients</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12:30 pm</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 5pm</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Christopher Verbiest</td>
<td>Risk Management</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 4:30 pm</td>
<td>Lecture</td>
<td>Charles Waxfield, DDS</td>
<td>Restorative Materials: What, Where, Why and How</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Education Method</td>
<td>Presenter(s) Full Name</td>
<td>Course Title</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>10 am - 12 pm</td>
<td>Lecture</td>
<td>Gary Waldron, DDS</td>
<td>Dentistry’s Amazing Digital Platform for Restorative Care</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 3:30 pm</td>
<td>Lecture</td>
<td>Gary Waldron, DDS</td>
<td>Dentistry’s Amazing Digital Platform for Restorative Care</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>James Wood, DDS</td>
<td>Introduction to Forensic Dentistry</td>
</tr>
<tr>
<td>Thursday, April 12</td>
<td>1:30 pm - 4:30 pm</td>
<td>Hands-On</td>
<td>James Wood, DDS</td>
<td>Forensic Dentistry – Computer Identification Workshop</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Steven Beadnell, DMD;</td>
<td>Management of Impacted Teeth: Canines, Second and Third Molars</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Brent Ueck, DMD, MD</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Dave Chin</td>
<td>The Art &amp; Science of Communication</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Victor DeNoble, PhD</td>
<td>Inside the Dark Side and Drug Addiction: It’s All in Your Brain</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Victor DeNoble, PhD</td>
<td>Inside the Dark Side and Drug Addiction: It’s All in Your Brain</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Ann-Marie DePalma, RDH;</td>
<td>TMD-TMJ: What is it All About?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MD, RDH, MD, FAADH</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Ann-Marie DePalma, RDH;</td>
<td>Habits of Effective Dental Offices: Do You Have What It Takes?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>MD, RDH, MD, FAADH</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 5 pm</td>
<td>Lecture</td>
<td>David Durcombe, DSS;</td>
<td>Medical Teams International: At Home and Abroad</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weston Herringer Jr.,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DMD; Hannah Meredith,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RDH; Susan Rusthold,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DMD; Matt Stiller</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 5 pm</td>
<td>Hands-On</td>
<td>Sameh El-Elbashsh, DDS;</td>
<td>Implant Therapy for the Edentulous: Enhancing Successful Outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS, FACP</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Robert Fazio, DMD</td>
<td>Antibiotics in Dentistry</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Robert Fazio, DMD</td>
<td>Medicine, Dentistry and Drugs</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Susan Gunn, CFE</td>
<td>For Your Eyes (And Ears) Only!: A Unique Study in Practice Embezzlement</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Susan Gunn, CFE</td>
<td>Take Charge Now: QuickBooks Practice Essentials</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 5 pm</td>
<td>Lecture</td>
<td>David Hornbrook, DDS</td>
<td>Hot Topics in Aesthetic and Restorative Dentistry</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>1 pm - 5 pm</td>
<td>Lecture</td>
<td>David Hewerton, DMD;</td>
<td>Medical Emergencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Gabriel Kennedy, DMD, MD</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Kristy Menage Bernie,</td>
<td>Remineralization Strategies: Advancements in Fluoride, Calcium and Phosphate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RDH, BS, RYT</td>
<td>Technologies</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 5 pm</td>
<td>Lecture</td>
<td>John Nase, DDS, FAGD, FICD</td>
<td>Clinical Operating Microscopes: They’re not just for Endodontists Anymore</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Stephen Niemczyk, DMD</td>
<td>Advanced Endodontic Concepts and Techniques for the General Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Lecture)</td>
<td></td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Hands-On</td>
<td>Stephen Niemczyk, DMD</td>
<td>Advanced Endodontic Concepts and Techniques for the General Practitioner</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Brian Novy, DDS</td>
<td>Be Very Afraid (If your name is Strep Mutans)</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Brian Novy, DDS</td>
<td>My Patient Keeps Getting Cavities, and I Don’t Know What to Do?</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Patricia Pine, RDH</td>
<td>Amazing Race: The Race against Time</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Patricia Pine, RDH</td>
<td>What are the Odds: It Starts and Ends with You</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Jay Reznick, DMD, MD</td>
<td>3-D Radiographic Imaging in Dentistry with Cone Beam Technology</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 3 pm</td>
<td>Lecture</td>
<td>Jay Reznick, DMD, MD</td>
<td>Stem Cells: Emerging Medical and Dental Therapies for the Dental Professional</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Method</td>
<td>Presenter(s) Full Name</td>
<td>Course Title</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------</td>
<td>-----------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>David Rosell</td>
<td>Financially Sound in 2012: Strategies to Live the Life You Have Imagined</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>David Rosell</td>
<td>Financially Sound in 2012: Strategies to Live the Life You Have Imagined</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Roy Shelbourne, DDS</td>
<td>Clinical Records Prevent Criminal Records, AKA: Do Dentistry, Not Time</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Michael Silverman, DMD</td>
<td>Oral Sedation Dentistry</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Michael Silverman, DMD</td>
<td>Oral Sedation Dentistry</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Jorgen Sko, DDS, DMD, PhD, MS, MBA</td>
<td>New Approaches for Antimicrobial Treatment of Periodontal Disease</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>Jane Soxman, DDS</td>
<td>Know When to Hold 'Em and Know When to Fold 'Em</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>2 pm - 5 pm</td>
<td>Lecture</td>
<td>Jane Soxman, DDS</td>
<td>Clinical Techniques in Pediatrics</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am-12:30 pm</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>1:30 pm - 6 pm</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
<tr>
<td>Friday, April 13</td>
<td>9 am - 12 pm</td>
<td>Lecture</td>
<td>James Wood, DDS</td>
<td>Forensic Case Files – Not Exactly What you See on CSI</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Deanna Alford; Cheri Perry</td>
<td>Keeping Ahead of the Fraud Curve</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11:30 am</td>
<td>Lecture</td>
<td>Leon Assael, DDS; Chaim Venek, MD; Bob Myall, BDS, MD; Robert Steiman, DDS, MD;</td>
<td>OSCOMS Symposium: Part 1</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Phyllis Beermanbow, MS, Ed D; Gary Chiodo, DDS, DM;</td>
<td>Ethics in the Business of Dentistry</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1 pm - 4:30 pm</td>
<td>Lecture</td>
<td>R. Bryan Bell, DDS, MD, FACS; Mark Engelstad, DDS, MH; Eric Dierker, DDS, MD; Jim Kradtchuk, DDS; Julie Ann Smith, DDS, MD; Jeffery Stewart, DDS, MS;</td>
<td>OSCOMS Symposium: Part 2</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Mark Berkman, DDS, MS</td>
<td>Advances in Orthodontics: Contemporary, Interdisciplinary, and Esthetic</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Mark Berkman, DDS, MS</td>
<td>Communication in the Dental Office: A State-Of-The-Art Discussion For All Team Members</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Robert Fazio, DDS</td>
<td>Periodontitis &amp; Peri-Implantitis: The Good, The Bad and The Ugly</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 3:30 pm</td>
<td>Lecture</td>
<td>Prashant Gagneja, DDS, MS; Karen Hall, RDH, LAP</td>
<td>&quot;First Tooth&quot; Pregnancy and Beyond</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Lisa Harper Mallonee, BSDH, MPH, RD, LD</td>
<td>Healthy Mouth, Healthy Body—Healthy Practical</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Lisa Harper Mallonee, BSDH, MPH, RD, LD</td>
<td>Fattening of America: Where does Dentistry Fit into the Puzzle?</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 4:30 pm</td>
<td>Hands-On</td>
<td>John Nase, DDS, FAGD, FICO</td>
<td>Suturing Techniques for the General Practitioner-Workshop</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Dan Nathanson, DDS, MD</td>
<td>Selection And Use Of Modern Restorative Materials</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Dan Nathanson, DDS, MD</td>
<td>Successful management of the Esthetically Demanding Patient</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Ove Peters, DDS, MD, PhD</td>
<td>The Fundamentals and Why They Still Matter: Advanced Endodontics for General Practitioners</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 4:30 pm</td>
<td>Lecture</td>
<td>Alfonso Pires, DDS; Chandrak Wadhwani, DDS, MS</td>
<td>Cement and Its Effects on Restoration</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 4:30 am</td>
<td>Lecture</td>
<td>Karen Raposa, RDH, MBA</td>
<td>Success and Preparation for Special Needs Patients …plus Treating Patients with Autism</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 4:30 pm</td>
<td>Lecture</td>
<td>Stanley Sharples, DDS</td>
<td>Its Not Your Parent’s Dentist: An Overview of New Technology</td>
</tr>
<tr>
<td>Date</td>
<td>Time</td>
<td>Education Method</td>
<td>Presenter(s) Full Name</td>
<td>Course Title</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>------------------</td>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Jeff Staats</td>
<td>Get Your Ask In Gear</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Michelle Stafford, DDS</td>
<td>Verblage: The Power of Storytelling</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Michelle Stafford, DDS</td>
<td>Parent Perceptions: &quot;But They’re Just Baby Teeth&quot;</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11 am</td>
<td>Lecture</td>
<td>Beth Thompson, RDH</td>
<td>Exploring Sleep Medicine In Dentistry And The Role Of The Dental Hygienist...Wake Up Your Team!</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:30 pm - 4:30 pm</td>
<td>Lecture</td>
<td>Beth Thompson, RDH</td>
<td>Dynamic Oral Care Therapies</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>8 am - 11:30 am</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
<tr>
<td>Saturday, April 14</td>
<td>1:00 pm - 4:00 pm</td>
<td>Lecture</td>
<td>Mary Ann Vaughan, RN, CEN, BSN</td>
<td>CPR for the Health Care Provider</td>
</tr>
</tbody>
</table>
NEWSLETTERS & ARTICLES OF INTEREST
Nothing to report under this tab
LICENSE RATIFICATION
16. **RATIFICATION OF LICENSES**

As authorized by the Board, licenses to practice dentistry and dental hygiene were issued to applicants who fulfilled all routine licensure requirements. It is recommended the Board ratify issuance of the following licenses. Complete application files will be available for review during the Board meeting.

**DENTAL HYGIENE**

<table>
<thead>
<tr>
<th>License</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>H6186</td>
<td>ASHLEY MARIE FELTON, R.D.H.</td>
<td>12/14/2011</td>
</tr>
<tr>
<td>H6187</td>
<td>TERESA L NGUYEN, R.D.H.</td>
<td>12/14/2011</td>
</tr>
<tr>
<td>H6188</td>
<td>KRISTINA ANN CASELMAN, R.D.H.</td>
<td>12/14/2011</td>
</tr>
<tr>
<td>H6189</td>
<td>CHELSEA A GRESS, R.D.H.</td>
<td>12/14/2011</td>
</tr>
<tr>
<td>H6190</td>
<td>FIKRET MUSTEDANAGIC, R.D.H.</td>
<td>12/21/2011</td>
</tr>
<tr>
<td>H6191</td>
<td>JAIME KENDYL MAJURE, R.D.H.</td>
<td>12/21/2011</td>
</tr>
<tr>
<td>H6192</td>
<td>MONICA G REYES, R.D.H.</td>
<td>1/9/2012</td>
</tr>
<tr>
<td>H6193</td>
<td>AMY LEENSTRA RASMUSSEN, R.D.H.</td>
<td>1/19/2012</td>
</tr>
<tr>
<td>H6194</td>
<td>STEFANIE N FISH, R.D.H.</td>
<td>1/25/2012</td>
</tr>
<tr>
<td>H6195</td>
<td>STACY VU, R.D.H.</td>
<td>1/26/2012</td>
</tr>
<tr>
<td>H6196</td>
<td>NICOLE DEBORAH WEAR, R.D.H.</td>
<td>1/26/2012</td>
</tr>
</tbody>
</table>

**DENTISTS**

<table>
<thead>
<tr>
<th>License</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9691</td>
<td>CYNTHIA D LEHNERTZ, D.M.D.</td>
<td>12/15/2011</td>
</tr>
<tr>
<td>D9692</td>
<td>ERIN A KOLLING, D.D.S.</td>
<td>12/21/2011</td>
</tr>
<tr>
<td>D9693</td>
<td>ANGELA JAMES TOY, D.D.S.</td>
<td>1/3/2012</td>
</tr>
<tr>
<td>D9694</td>
<td>TIMOTHY JOHN MANNING, D.M.D.</td>
<td>1/3/2012</td>
</tr>
<tr>
<td>D9695</td>
<td>IOAN PETRU BEC, D.M.D.</td>
<td>1/3/2012</td>
</tr>
<tr>
<td>D9696</td>
<td>NITALYA BONITA WILLIAMS, D.D.S.</td>
<td>1/9/2012</td>
</tr>
<tr>
<td>D9697</td>
<td>JEFFREY D HANZON, D.M.D.</td>
<td>1/26/2012</td>
</tr>
<tr>
<td>D9698</td>
<td>CHRISTOPHER ALLEN SWISHER, D.D.S.</td>
<td>1/26/2012</td>
</tr>
</tbody>
</table>