PUBLIC PACKET

OREGON BOARD OF DENTISTRY

BOARD MEETING
JUNE 12, 2026

Oregon
Tina Kotek, Governor

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
www.oregon.gov/dentistry

NOTICE OF REGULAR MEETING

PLACE: **BOARD OFFICE & VIRTUAL VIA ZOOM**
DATE: **June 12, 2026**
TIME: **8:00 a.m. – 2:00 p.m.**

Call to Order – Sheena Kalia, D.D.S. – President **8:00 a.m.**

OPEN SESSION (Zoom option available)
https://us02web.zoom.us/j/83344091068?pwd=rbL0ELF13YoZoIb6g7HOPHaPXj0GGy.1
Phone # 1-253 205 0468 Meeting ID: 833 4409 1068 Passcode: 176257

Confirm Quorum & Review Agenda

1. Approval of Minutes
   - April 24, 2026 Board Meeting Minutes

NEW BUSINESS

2. Association Reports
   - Oregon Dental Association
   - Oregon Dental Hygienists' Association
   - Oregon Dental Assistants Association

ADEX Report and Updates from Stephen Prisby, Regulatory and Educational Affairs Director

3. Committee and Liaison Reports
   - April 7, 2026 Licensing, Standards, and Competency Committee Meeting
   - May 26, 2026 Dental Assistant Workforce Shortage Advisory Committee Meeting
     - DRAFT Survey Re: Dental Assisting Data

4 Executive Director's Report
   - Board Member & Staff Updates
   - OBD Budget Report
   - Customer Service Survey
   - Memo – Delegated Duties
   - OBD Bylaws
   - Staff Speaking Engagements
   - Dental Testing and Regulatory Summit
   - CRDTS Annual Meeting

5. Unfinished Business and Rules
   - ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists
   - ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students
   - OPMC Pain Module Update

Notes:
(1) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
(2) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

- Draft 2026-29 Strategic Plan

6. Correspondence
   - Kimberly Pennington, RDH Support for Dental Assistant Registry
   - Dr. Smorra and Dr. Salathe Hygiene and Lasers Discussion
   - Karla Brumley Request for EFDA Restorative Endorsement
   - AAO Letter regarding 818-042-0110 Certification – EFODA

7. Other
   - DDH Compact Draft Rules from May 18, 2026 Meeting
   - Minimum Requirements for Board Courses
   - OHA Healthcare-Associated Infections Program Dental Resources
   - OBD Updated Protocols - DRAFT
   - Tribes – Open Comment Period
   - Open Public Comment Period – Public comment is limited to matters on the public meeting agenda or otherwise relevant to matters that may come before the OBD. Comments will not be allowed that are longer than the time allotted by the President or are disruptive to the OBD's conduct of its business.

8. Articles & Newsletters (No Action Necessary)
   - DANB Spring 2026 State Updates
   - California attorney general reaches settlement with Aspen Dental over corporate practice claims
   - A Cavity Doesn't Always Need a Filling - The New York Times
   - Oregon dental shortages leave gaps in access to care

EXECUTIVE SESSION **11:00 a.m.**

The Board will meet in Executive Session pursuant to ORS 192.345(4); ORS 192.660(2)(f) and (L); ORS 676.165, ORS 676.175(1) and ORS 679.320 to review records exempt from public disclosure, to review confidential materials and investigatory information, and to consult with counsel. No final action will be taken in Executive Session.

9. Review New Cases Placed on Consent Agenda
10. Review New Case Summary Reports
11. Review Completed Investigative Reports
12. Previous Cases Requiring Further Board Consideration
13. Compliance and Monitoring Reports
14. Licensing and Examination Issues
15. Consult with Counsel

LUNCH **11:30 a.m.**

OPEN SESSION **1:00 p.m.**
(Zoom option available)
https://us02web.zoom.us/j/83344091068?pwd=rbL0ELF13YoZoIb6g7HOPHaPXj0GGy.1
Phone # 1-253 205 0468 Meeting ID: 833 4409 1068 Passcode: 176257

Enforcement Actions (vote on cases reviewed in Executive Session)

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LICENSURE AND EXAMINATION

16. Ratification of Licenses Issued
17. License and Examination Issues
    - Request for reinstatement of an expired license – Michael J Longlet, D.D.S
    - Request for reinstatement of an expired license – Ashley Lee, D.D.S
    - Request for Approval of a Nitrous Oxide course - McKenzie Dental Practices of Oregon
    - Request for Approval of a Local Anesthesia Endorsement for Dental Hygienists or Oregon Local Anesthesia Functions Certificate (LAFC) for Dental Assistants – McKenzie Dental Practices of Oregon

The next regular Board Meeting is scheduled for August 21, 2026.

ADJOURN **2:00 p.m.**

Notes:
(1) A working lunch will be served for Board members at approximately 11:30 a.m.
(2) The meeting location is accessible to persons with disabilities. A request for an interpreter for the hearing impaired or for other accommodations for persons with disabilities should be made at least 48 hours before the meeting to Haley Robinson at (971) 673-3200.
(3) The Board may from time to time throughout the meeting enter into Executive Session to discuss matters on the agenda for any of the reasons specified in ORS 192.660. Prior to entering into Executive Session, the Board President will announce the nature of and authority for holding the Executive Session. No final action will be taken in Executive Session.

APPROVAL OF MINUTES

OREGON BOARD OF DENTISTRY
MINUTES
APRIL 24, 2026

MEMBERS PRESENT:	Aarati Kalluri, D.D.S., President Sheena Kalia, D.D.S., Vice President Reza Sharifi, D.M.D. Terrence Clark, D.M.D. Michelle Aldrich, D.M.D. Olesya Salathe, D.M.D. (via Zoom) Kristen Simmons, R.D.H., E.P.P. Sharity Ludwig, R.D.H., E.P.P. Ginny Jorgensen Kieshawn Lewis
STAFF PRESENT:	Haley Robinson, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Winthrop "Bernie" Carter, D.D.S., Dental Investigator Kathleen McNeal, Licensing Manager Gabriel Kubik, Investigator Dawn Dreasher, Office Specialist
ALSO PRESENT:	Joanna Tucker-Davis, Sr. Assistant Attorney General
VISITORS ALSO PRESENT:	Brett Hamilton, Director of Government and Regulatory Affairs (ODA); Lisa Rowley, Advocacy & Membership Director, Oregon Dental Hygienists' Association (ODHA); Dana Moody, Director-at-Large, ODHA; Mary Harrison, Vice President, Oregon Dental Assistants Association (ODAA)
VIA ZOOM*:	Amberlena Fairlee, D.M.D., President, Oregon Dental Association (ODA); Matthew Johnston, D.M.D.; Karla Brumley; Michelle Lee, V.P. External Relations and Policy, DANB; Karan Bershaw, R.D.H., CAMBRA Coalition; Mary Ellen Murray; Ronald Maple, D.M.D.

*This list is not exhaustive, as it was not possible to verify all participants on the Zoom.

Call to Order: The meeting was called to order by the President at 8:02 a.m. President Kalluri then read the Mission Statement as follows:

> The mission of the Oregon Board of Dentistry is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

President Kalluri reiterated that the Board's purpose and reason for meeting every other month included addressing regular and important ideas and proposals brought before the Board regarding regulations, scope of practice, education, discipline, operations, and issues that need the Board's attention. President Kalluri welcomed everyone to the meeting and had the Board Members, Joanna Tucker-Davis, Haley Robinson, and OBD staff introduce themselves. President Kalluri announced that the Board had a quorum.

NEW BUSINESS

Approval of February 27, 2026 Minutes

Dr. Kalluri moved and Dr. Sharifi seconded that the Board approve the minutes from the February 27, 2026, Board Meeting as amended. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

ASSOCIATION REPORTS

Oregon Dental Association (ODA)

Dr. Amberena Fairlee, President of ODA, reported that the 2026 Oregon Dental Conference was held April 9th through 11th at the Oregon Convention Center in downtown Portland. Dr. Fairlee said the ODA was pleased to welcome about 3,000 dental professionals from across Oregon and Southwest Washington.

Dr. Fairlee reported that the conference featured three full days of continuing education and that a highlight was their keynote, *The Heart of the Matter*, presented by Amber Auger, which focused on the important connection between oral health and cardiovascular health.

Dr. Fairlee thanked the Board of Dentistry for its strong participation this year and highlighted Director Robinson's presentation on the role and functions of the Board which included encouraging dentists to view the Board as a professional resource. Dr. Fairlee thanked Dr. Smorra for her presentation on record keeping and Board protocols. Dr. Fairlee also thanked Dr. Carter for his presentation on esthetic and functional crown lengthening as well as periodontal surgery for the general dentist. Dr. Fairlee shared that she attended Dr. Salathe's course on smile design and aesthetics with digital dentistry and that it was wonderful.

Dr. Fairlee reported that she facilitated a well-attended panel on the dental workforce shortage. Dr. Fairlee said panelists from the ODA, Virginia Garcia, Pacific University,

Oregon AGD, and Glencoe High School shared ideas around mentorship, educational partnerships, and workforce outreach. Dr. Fairlee shared that it was a great discussion and thanked Dr. Salathe and Ms. Jorgensen for attending and participating.

Dr. Fairlee reported that the conference offered 79 CE courses in total, including required topics like medical emergencies, infection control, and cultural competency which were all available daily. Dr. Fairlee added that attendees also had a chance to connect with 100 exhibitors during the exhibit hall on Thursday and Friday.

Dr. Fairlee announced that the 2027 Oregon Dental Conference will take place May 13th through 15th, 2027 and said she looked forward to seeing everyone there.

Dr. Fairlee stated that the ODA looks forward to the continuation of the strategic planning process and appreciates that the dental workforce shortage has been identified as an emerging challenge to dental practice and is appropriately recognized as a mission-critical priority. Dr. Fairlee concluded by saying that the ODA looks forward to continued collaboration and to the development of more robust, clearly defined action items as that work moves forward.

Oregon Dental Hygienists' Association (ODHA)

Lisa Rowley, Advocacy & Membership Director of ODHA, stated her appreciation to the ODA for including ODHA as a partner group again for the 2026 Oregon Dental Conference. Ms. Rowley said ODHA members enjoyed the many great continuing education courses and opportunities for professional networking.

Ms. Rowley congratulated the ODA on their legislative win regarding insurance reform.

Ms. Rowley shared that she had the pleasure of attending the Pinning Ceremony for 30 graduating dental hygiene students at **Concord Career College** in NE Portland the night before. Ms. Rowley noted that this was the second cohort to complete this program and that a third cohort is scheduled to graduate in November 2026.

Ms. Rowley reported that the dental hygiene program at **Rogue Community College** recently completed a successful accreditation site visit conducted by the Commission on Dental Accreditation (CODA). Ms. Rowley reported that the site visit team commended the dental hygiene program on its strong compliance with accreditation standards, well-organized documentation, and commitment to student success. Ms. Rowley gave special thanks to Dr. Aldrich for representing the Oregon Board of Dentistry during this accreditation site visit. Ms. Rowley announced that Rogue is scheduled to graduate its first cohort of 20 students in 2026.

Ms. Rowley reminded dentists who are looking for dental hygienists that they can send their job postings directly to the dental hygiene program directors, who will then forward

those job postings to all their graduates at no cost.

Oregon Dental Assistants Association (ODAA)

Mary Harrison, Vice President of ODAA, stated that she always enjoys the information in the Board meeting packets, but especially appreciated this one because of the reporting on so many special announcements for OBD staff. Ms. Harrison highlighted Dr. Smorra being named the Ambassador of Public Service and the OBD earning the Gold Star Certificate for work done on finances and reports from the Board. Ms. Harrison also highlighted the many compliments to Kathleen and staff for the help and encouragement they give when assisting people on the phone or in person. Ms. Harrison shared that she likes to say, “Make the Board and the OBD office your new best friend” and that OBD staff confirm her point.

Ms. Harrison reflected that another ODC has passed where old friends were seen, fun was had, and informative classes were held. Ms. Harrison reported that she attended the panel addressing the workforce issues where the audience provided input and recommendations that were the same as those offered by the ODAA two years ago. Ms. Harrison elaborated that those included seeking out high schools and career/job fairs, and doctors talking with young patients about all the career possibilities available in dentistry.

Ms. Harrison reported that during the previous week, ODAA was able to attend a job fair at Sherwood High School where they spoke with over 200 students, answered questions, and highlighted the benefits of being a dental professional. Ms. Harrison encouraged dentists to connect with nearby schools and arrange visits, adding how impressive it would be to have a dentist available to answer questions and share information. Ms. Harrison stated that ODAA looks forward to meeting with ODA and working together to address workforce issues.

Ms. Harrison thanked DANB for their work on a proposal to create a dental assistant registry and other topics from the OBD strategic plan.

Ms. Harrison reminded everyone that Mother’s Day is coming up and that plants and candy are good gifts.

COMMITTEE AND LIAISON REPORTS

Ms. Robinson presented the 2026-2027 Committee & Liaison Assignments and mentioned that Dr. Clark and Dr. Aldrich are placeholders on that list until new members join the Board. Ms. Robinson thanked Drs. Clark and Aldrich for graciously serving through the June 2026 meeting.

EXECUTIVE DIRECTOR'S REPORT

CODA – Site Accreditation Visits

State Board Representative: Michelle Aldrich, DMD
Rogue Community College
Grants Pass, OR
4/15/2026-4/16/2026
Program: Dental Hygiene

Dr. Aldrich completed her site visit at Rogue Community College.

OBD Budget Status Report

Director Robinson presented the attached budget report for the 2025 - 2027 Biennium. Ms. Robinson highlighted that this report, which is from July 1, 2025 through February 28, 2026, shows revenue of $ 1,448,060.46 and expenditures of $1,267,404.46. **Attachment #1**

OBD 2027 – 2029 Revenue Projection

Ms. Robinson introduced the 2027 – 2029 budget, which is in its initial planning and development stages, and reported that the revenue projection and supporting documentation was submitted to Department of Administrative Services & Legislative Fiscal Office per budget development instructions.
Attachment #2

2026 Dental License Renewal

Ms. Robinson reported that the 2026 Dental License renewal period ended on March 31, 2026, and that a majority of the dentists renewing their licenses had no issues and were generally pleasant when interacting with staff. Ms. Robinson reported the following 2026 Dental license renewal information: 1691 renewed, 185 expired, 18 retired and 2 deceased.

Customer Service Survey

Ms. Robinson presented the attached most recent customer service survey results for the period from July 1, 2025, through April 15, 2026. Ms. Robinson stated that the results of the survey show that the OBD continues to receive positive feedback from those that choose to submit a survey. **Attachment #3**

Staff Speaking Engagements

Ms. Robinson reported that Kathleen McNeal, Licensing Manager, gave a license application virtual presentation to the dental hygiene students at OIT- Klamath Falls on Tuesday, March 3, 2026.

Ms. Robinson reported that the Oregon Dental Conference was held at the Oregon Convention Center in Portland, April 9 - 11, 2026 and that OBD staffed a resource table outside the Exhibit Hall to answer questions and encourage safe oral health practice amongst the attendees. Ms. Robinson expressed her appreciation to the OBD staff who worked at the table. Ms. Robinson reported that OBD staff gave four presentations at the conference:

Dr. Angela Smorra gave a presentation on Thursday Apri 9, 2026, covering Record Keeping, Board Protocols, & Important Information.

Dr. Bernie Carter gave a presentation on Thursday Apri 9, 2026, covering The Gummy Smile—Surgery to Final Restorations: Esthetic and Functional Crown Lengthening Procedures.

Ms. Robinson gave a presentation on Friday, April 10, 2026, covering an overview of the Board, operations, budget, rulemaking, enforcement, CE and FAQs.

Dr. Bernie Carter gave a presentation on Friday April 10, 2026, covering Periodontal Surgery for the General Dentist.

Ms. Robinson thanked the Oregon Dental Association for inviting the OBD to present again at their well-attended conference.

Ms. Robinson reported that Dr. Angela Smorra gave a presentation on Monday Apri 13, 2026, to the dental students at OHSU covering Record Keeping, Board Protocols, & Important Information.

Ms. Robinson reported that Kathleen McNeal, Licensing Manager, gave a license application presentation to the dental students at OHSU on Wednesday, April 15, 2026.

Ms. Robinson reported that Kathleen McNeal, Licensing Manager, gave a license application presentation to the dental hygiene students at Concorde Career College on Thursday April 16, 2026.

Ambassador of Public Service

Ms. Robinson announced that Dental Director, Dr. Angela Smorra, was chosen as the OBD's Ambassador of Public Service as part of Public Service Recognition Week, May 3-9, 2026. Ms. Robinson nominated Dr. Smorra as someone who is a true Ambassador of Public Service and exemplifies this year's theme of leading with purpose. Ms. Robinson said that, in her role as Dental Director, Dr. Smorra exemplifies the highest standards of integrity, professionalism, and dedication to public service. Ms. Robinson added that Dr. Smorra approaches her work with a strong sense of purpose—prioritizing patient safety, upholding regulatory standards, and fostering trust within the dental community. Ms.

Robinson announced that Dr. Smorra was invited to attend a reception with Governor Kotek at Mahonia Hall (Governor's home) in Salem on May 21, 2026, to recognize her positive impact on our agency and the citizens of Oregon.

FY 2025 Accounts Receivable Honor Roll

Ms. Robinson announced that the OBD again was recognized for financial controls, and that this aligns with one of OBD's annual goals. Ms. Robinson stated that the OBD strives to submit timely and accurate A/R reports, and that this honor roll recognition memorializes the OBD's success. **Attachment #4**

Federal Rules: Accessibility of Web Information and Services

Ms. Robinson announced that the deadline for meeting the new federal rules has been extended until April 24, 2027, and will require all content published on state websites, including webpages and uploaded documents, to meet Americans with Disabilities Act (ADA) digital accessibility standards. Ms. Robinson explained that these requirements, known as WCAG 2.1 AA, apply to all public organizations nationwide and set new expectations for how digital materials are created and published online.

Newsletter

Ms. Robinson announced that the next OBD Newsletter is scheduled to be available later in the summer and will have important news and updates for our Licensees. Ms. Robinson encouraged Board Members to share any topics of interest and also asked staff members for articles of interest to be included.

2027 Proposed Board Meeting Dates

Ms. Robinson presented the attached draft of the proposed board meeting dates for 2027. Ms. Robinson explained that these dates follow the Board's regular annual schedule of holding them every other month. Ms. Robinson suggested the Board consider adopting these dates for next year's meetings so that all can plan accordingly. **Attachment #5**

Dr. Kalia moved and Ms. Simmons seconded that the Board approve proposed 2027 Board Meeting Dates as presented. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

CORRESPONDENCE

- March 3, 2026 email from Dr. Justin Jones regarding HB 4040

The Board discussed Dr. Jones's email and issues related to supervision of out-of-state dental students.

Dr. Sharifi moved and Ms. Jorgensen seconded that the Board refer the issue of HB 4040 to the Licensing, Standards and Competency Committee. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

- Kristen Gallaway Letter re Dental Health Aide Therapists (DHATs)

Ms. Rowley clarified that not all dental therapists in Oregon are dental hygienists. Ms. Rowley elaborated that the scope of practice for dental therapists and DHATs is the same.

- Dr. Mariya Costa letter supporting Scaling Assistants

Ms. Robinson stated that the scaling assistant issue currently resides in the Rules Oversight Committee. Ms. Robinson said she would include Dr. Costa's letter with all the other testimony delivered to the Rules Oversight Committee.

Ms. Rowley stated in response to Dr. Costa's letter that actual physical facilities constraints, not the ratio of faculty to students, is the barrier to growing the dental hygiene programs in Oregon. Ms. Rowley expressed opposition to increasing the number of students per instructor.

Ms. Robinson reiterated that OBD staff will be updating the OBD website in the coming months and offered that staff would review, update, and clarify information about course requirements that could be posted on the website. Ms. Robinson added that some of these updates might be the basis for discussion and development at the committee level. Ms. Robinson said she would report on the progress toward standardizing course requirements at the June Board meeting.

- Karla Brumley Request for DA EFDA and Restorative Rule Review

The Board discussed that California has a clinical state exam that it administers instead of ADEX or CRDTS and whether the Board should consider steps to ease migration of providers from neighboring states.

- Karla Brumley Request for Acceptance of Out of State Credentials

The Board moved deliberation of Karla Brumley's request to the June Board meeting and directed OBD staff to evaluate the California state clinical exam to help the Board determine if it is equivalent to ADEX or CRDTS exams and whether Ms. Brumley's request should be approved.

UNFINISHED BUSINESS AND RULES

Dr. Kalluri initiated a discussion about the need to improve interoperability of medical and dental records. Ms. Robinson offered that OBD staff would research the issue and post an article in the Newsletter and on the OBD website providing guidance to dental providers on how to access patients' medical records.

Ms. Robinson presented the Board's Strategic Priorities for 2026-2029. Ms. Coyne led a Board discussion of priorities and action items.

Dr. Clark initiated a discussion about requiring CE related to mental health, substance abuse, and suicide.

Dr. Clark moved and Ms. Ludwig seconded that the Board refer the issue of requiring CE related to mental health, substance abuse, and suicide to the Licensing, Standards and Competency Committee. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Dr. Salathe moved and Ms. Ludwig seconded that the Board refer the issue of dental hygienists administering Botox to the Licensing, Standards and Competency Committee. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Dr. Kalia initiated a discussion about access to dental care for special needs adults. Ms. Robinson said she would reach out to Dr. Ahmed Farag, Dental Director at OHA, to discuss possible approaches to this problem.

The Board discussed the 2025-2027 Affirmative Action Plan (AAP). Ms. Robinson said she would reach out to Juliet Valdez at the Office of Cultural Change for guidance on how to meet the Governor's expectations for the AAP and would report to the Board at the June Board meeting.

OTHER

Items were in the Board meeting packet for informational purposes.

- CAMBRA 2026 Position Paper
- Proposal – Oregon Dental Assistant Workforce Registry
- Memo – Election of Officers

Dr. Sharifi moved and Dr. Kalluri seconded that the Board elect Sheena Kalia, D.D.S. as Board President. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Dr. Sharifi moved and Dr. Kalluri seconded that the Board elect Sharity Ludwig as Board Vice-President. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

- Other Public Comment (no comments)
- Tribes (no comments)

ARTICLES AND NEWS

- CODA 2025 Annual Report
- ADEX At a Glance
- ADA and ADEX Advance Dental Licensure Examinations Through New Agreement
- DANB Welcomes Vice President of External Relations and Policy

EXECUTIVE SESSION: The Board entered into Executive Session pursuant to ORS 192.606 (2)(f)(L); ORS 676.165; ORS 676.175 (1), and ORS 679.320 to review confidential investigations, consider exempt records and to consult with legal counsel.

OPEN SESSION: The Board returned to Open Session at 1:36 p.m. President Kalluri took roll call and confirmed the Board had a quorum.

***Note the Board Members' votes are identified by their initials.**

CONSENT AGENDA

2026-0138, 2026-0139, 2026-0143, 2026-0136, 2026-0130, 2026-0128, 2026-0140, 2026-0151, 2026-0132, 2026-0137, 2026-0131, 2026-0129

Dr. Kalia moved and Dr. Kalluri seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

COMPLETED CASES

2026-0065, 2026-0028, 2026-0148, 2026-0022, 2026-0031, 2026-0030, 2026-0118, 2026-0066, 2026-0014, 2026-0105

Dr. Kalia moved and Dr. Sharifi seconded that the Board close the matters with a finding of No Violation or No Further Action. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

2026-0005

Dr. Sharifi moved and Dr. Kalluri seconded that the Board close the matter with a Letter of Concern. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

2026-0126

Ms. Jorgensen moved and Dr. Sharifi seconded that the Board close the matter with a Letter of Concern. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

PASCAL V. NGUYEN, D.M.D.; 2025-0166
Dr. Aldrich moved and Dr. Sharifi seconded that the Board issue a Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, refund patient CT $2,976.00, and issue a civil penalty of $500.00 payable within 60 days of the effective date of the Order. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

2026-0069
Ms. Ludwig moved and Dr. Aldrich seconded that the Board close the matter with a Letter of Concern. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

PREVIOUS CASES REQUIRING BOARD ACTION

GERALD L. TORGESON, D.D.S.; 2026-0027
Dr. Clark moved and Dr. Aldrich seconded that the Board issue an Amended Notice of Proposed Disciplinary Action and offer Licensee a Consent Order incorporating a reprimand, and civil penalty of $2,600.00 payable within 90 days of the effective date of the Order. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

LICENSING & EXAMINATION ISSUES

Mr. Lewis moved and Ms. Ludwig seconded that the Board deny the request from Dr. Jia Lin Goh to remove the public discipline related to Case 2008-0031. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

Ms. Simmons moved and Dr. Kalluri seconded that the Board deny the request from Linda Logston for confidential records related to Case 2026-0082 pursuant to ORS 676.175. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

RATIFICATION OF LICENSES

Dr. Sharifi moved and Ms. Jorgensen seconded that the Board ratify the licenses presented in Tab 16. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

LICENSE, PERMIT & CERTIFICATION

Ms. Jorgensen moved and Ms. Ludwig seconded that the Board approve the reinstatement of expired license for Sharen Strong, D.M.D. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, GJ, and KL voting Aye.

ADJOURNMENT

The next Board Meeting was scheduled for June 12, 2026, at 8:00 a.m.

The meeting was adjourned at 1:43 p.m.

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Aarati Kalluri, D.D.S., President

DRAFT

AMERICAN BOARD of DENTAL EXAMINERS

ADEX

The National Exam Standard

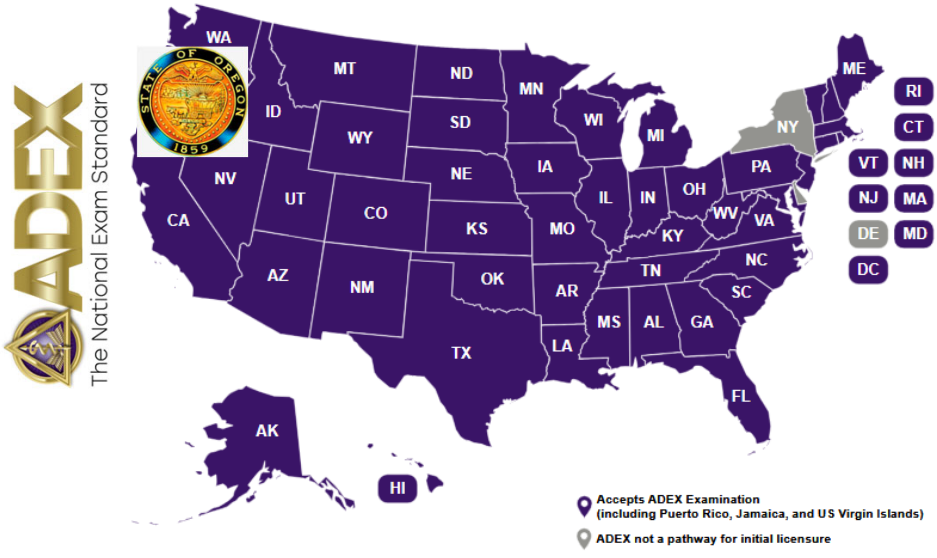
Prepared for the
Oregon Board of Dentistry

Stephen Prisby, ADEX Regulatory and Educational Affairs Director

June 12, 2026

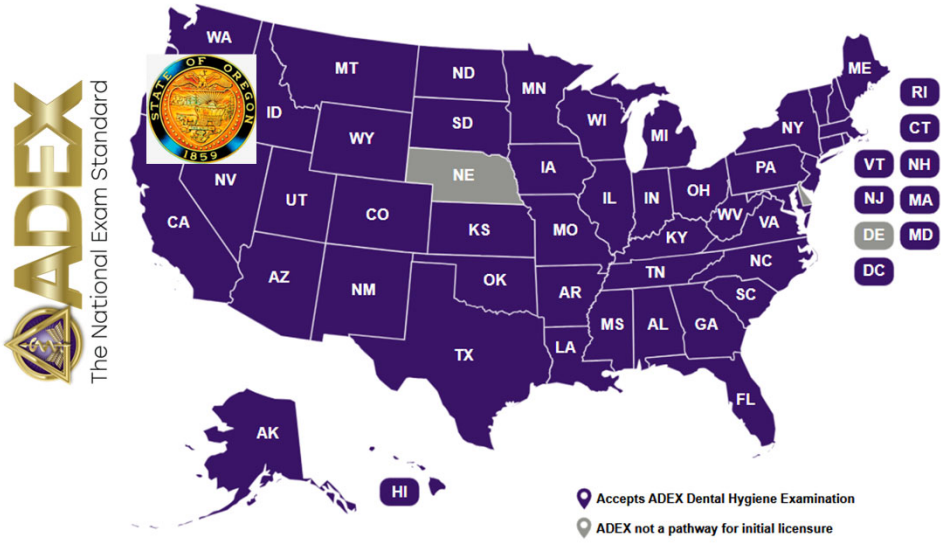
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National Dental Portability

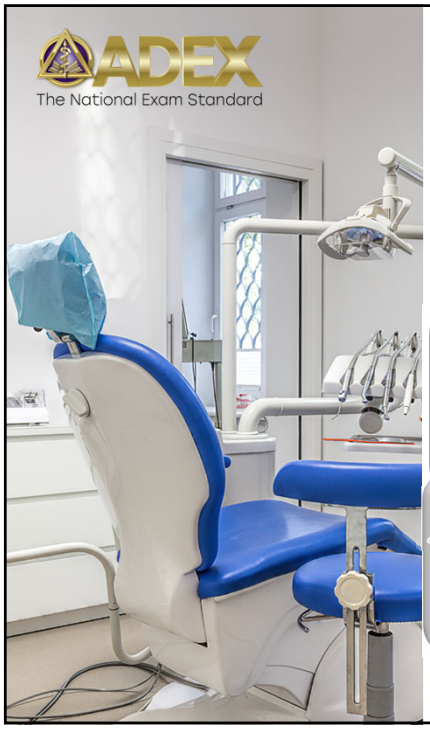


2

National Dental Hygiene Portability



3



ADEX DENTAL EXAM

OHSU School of Dentistry

- **April 24 - 25, 2026**
- **May 15 - 16, 2026**
- **November 21 - 22, 2026**

ADEX Dental Examinations

ADEX Dental Hygiene Examinations

All locations deliver ADEX Examinations with consistent standards, ensuring every candidate receives the same testing experience regardless of their chosen testing site.

This improves candidate access and increases testing capacity throughout the state, supporting Arkansas and the US commitment to developing qualified dental professionals.

4

What this Means for Candidates & Licensing

Reduced Travel Burden
More testing sites across the U.S. to minimize travel distance and expenses, making examinations more accessible to candidates the state and area.

Enhanced Scheduling Flexibility
Expanded geographic coverage reduces scheduling conflicts and provides more options for candidates to complete their licensure examinations at convenient times and locations.

Fully Equipped Facilities
All testing locations are equipped with necessary clinical resources, functional equipment and comprehensive protocols to ensure optimal examination conditions.

Accelerated Workforce Growth
Improved access to examinations supports timely licensure, helping address the growing demand for qualified oral healthcare professionals.

ADEX
The National Exam Standard

5

ADEX
AMERICAN BOARD of DENTAL EXAMINERS

Our Merger: What You Need to Know

Who

CDCA-WREB-CITA (the nation's leading dental exam administrator) and the American Board of Dental Examiners (ADEX), developer of the national ADEX licensure exam

What

Official merger into one organization:

American Board of Dental Examiners

What's Next

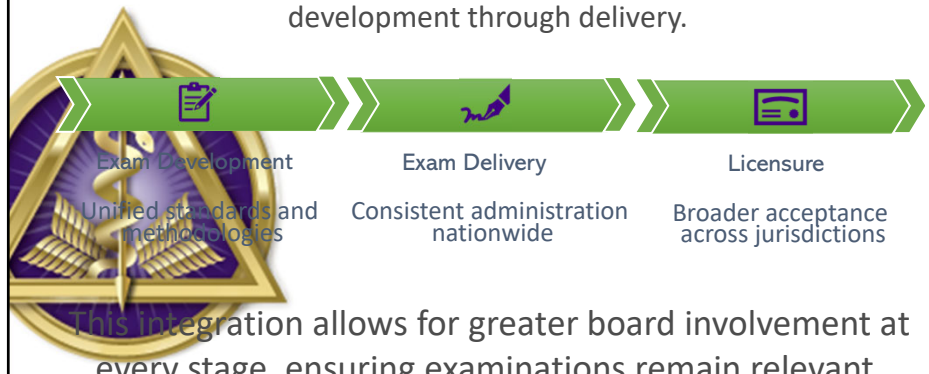
Now operating and initiating Council on Examinations appointment process and engagement opportunities

This strategic merger combines the strengths of both organizations to better serve dental professionals and regulatory boards across the nation.

6

Streamlined Examination Process

The merger unites the entire examination lifecycle under one organization, creating a more efficient and cohesive process from development through delivery.

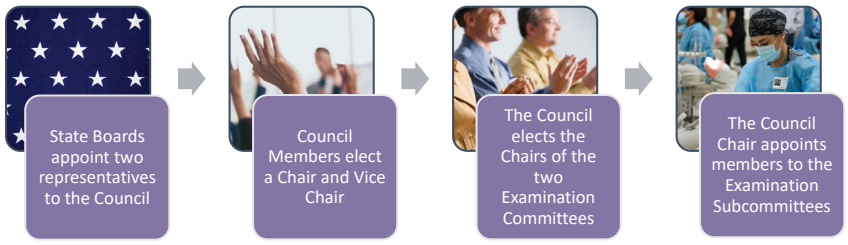


This integration allows for greater board involvement at every stage, ensuring examinations remain relevant, rigorous, and reflective of current dental licensure standards.

ADEX The National Exam Standard

7

Council on Examinations Structure



How Oregon contributes – scoring, content & criteria of the ADEX Exams

All members of the Council appointed by Dental Boards must be: (a) an active member of their Dental Board at the time of their appointment or have served on their Dental Board within the five-year period prior to their appointment, and (b) an Active Member of ADEX.

Dentists on the Council serve on the Dental Exam Committee.

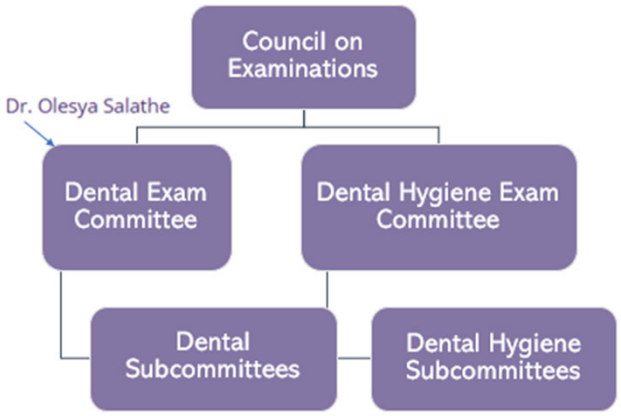
Dental Hygienists on the Council serve on the Dental Hygiene Exam Committee.

ADEX The National Exam Standard

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Council on Examinations Structure

Subcommittees support exam sections and special needs:



Dental
Prosthodontics
Endodontics
Periodontics
Restorative
Calibration

Dental Hygiene
Calibration

9

Appointees on the Council on Examinations

Oregon

Dr. Olesya Salathe *(Term Ends: 2028)*
Dr. Kristen Simmons *(Term Ends: 2027)*

All Oregon Dental Board Members are invited & encouraged to participate as Examiners.

The Public Members may participate in the examination process as well, but not as Examiners. They would have roles as Observers.

Dr. Jonna Hongo, a former OBD President and 8-year Board Member now serves on the ADEX Board of Directors.

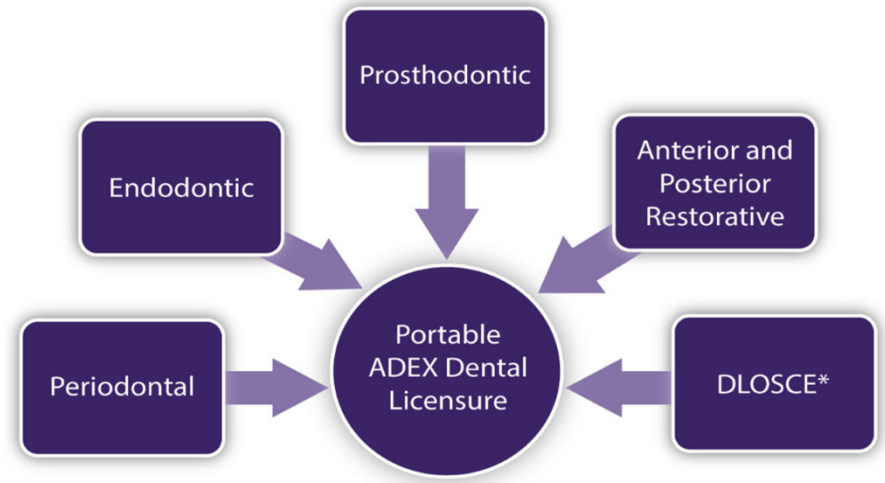
10

SHARED STANDARDS FOR PUBLIC PROTECTION

United States Medical Licensing Examination (USMLE – Medicine)	American Board of Dental Examiners (ADEX – Dentistry)
✓ National Licensure Exam for physicians	✓ National Licensure Exam for Dentist & Dental Hygienist
✓ Protection of Public through Standardized Exams	✓ Protection of Public through Standardized Exams – a single nationally recognized examination ensures consistent competency measures across all national candidates
✓ Portability of Licensure	✓ Portability of Licensure – Removes barriers to mobility increasing access to care nationally
✓ Continuous Evolution with Modern Healthcare	✓ Continuous Evolution with Modern Healthcare – OSCE and Patient Simulations

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2026 Dental Examination Updates



*The DLOSCE is overseen by the Joint Commission on National Dental Examinations, is the property of the American Dental Association (ADA), and is used by ADEX under an exclusive license from the ADA.

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2026
Dental Examination Updates

ADA American Dental Association®

April 14, 2026

American Dental Association and American Board of Dental Examiners Advance Dental Licensure Examinations Through New Agreement

ADEX to incorporate the Dental Licensure Objective Structured Clinical Examination (DLOSCE) into the ADEX Dental Examination no later than Aug. 1, 2026

FOR IMMEDIATE RELEASE

ADA American Dental Association®

AMERICAN BOARD of DENTAL EXAMINERS

Contact:
ADA:
mediarelations@ada.org

ADEX:
communications@adextesting.org

n Dental Association and American Board of Dental
's Advance Dental Licensure Examinations Through New Agreement

corporate the Dental Licensure Objective Structured Clinical Examination SCE) into the ADEX Dental Examination no later than Aug. 1, 2026

ril 14, 2026 – The American Dental Association (ADA) and the American Board of ers (ADEX) have finalized an agreement to license the ADA's Dental Licensure ctured Clinical Examination (DLOSCE) for incorporation into the ADEX Dental narking a significant step forward in modernizing dental licensure and advancing

t benefits public health, dental licensure candidates, the dental profession, and s to help ensure dentists enter the profession with proven competence and uphold ndards for patient safety.

n of the ADA's DLOSCE simplifies licensure pathways and supports licensure efiting candidates seeking to practice in 48 states and other jurisdictions—including .C., Puerto Rico, Jamaica, and the U.S. Virgin Islands — that currently accept or EX Dental Examination.

nt represents an important milestone for the dental profession," said Dr. Richard ., president of the ADA. "By aligning pathways to licensure and advancing ssment, we are strengthening licensure portability, supporting a more mobile and rkforce, and ensuring that patient safety remains paramount. The ADA has long lutions that modernize licensure while protecting the public, and this collaboration mmitment to shaping a strong, sustainable future for dentistry in service to public

ental Examination with its DLOSCE component represents a modernized, d approach to evaluating clinical competence and readiness for practice. The Examination will continue to assess candidates' clinical hand skills alongside their ing and decision-making abilities. Through inclusion of the DLOSCE, the ADEX ation will benefit from the DLOSCE's extensive use of images and 3D models that allow candidates to demonstrate their clinical judgment in scenarios that closely mirror real-world practice.

"ADEX has long served state dental boards to support licensure processes that reflect both public protection and clinical competence," said Dr. Mark Armstrong, Chair of ADEX. "This agreement

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Dental Examination Updates

AMERICAN BOARD of DENTAL EXAMINERS

Question: What is changing?

Answer: The American Dental Association (ADA) and the American Board of Dental Examiners (ADEX) have reached an agreement for ADEX to license and incorporate the Dental Licensure Objective Structured Clinical Examination (DLOSCE) into the ADEX Dental Examination.

The updated model will:

- Maintain the assessment of clinical hand skills
- Continue evaluating treatment planning and decision-making
- Incorporate DLOSCE components that assess clinical judgment through case-based scenarios

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Dental Examination Updates

Question: Why is this happening?

Answer: This agreement reflects a shared commitment to advancing clinical licensure in a way that supports public health, strengthens consistency in assessment, and ensures that dentists demonstrate the competence required for safe and effective practice.

It also supports ongoing efforts to align licensure assessments with current clinical practice, education, and technology.

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Dental Examination Updates

Question: When does it take effect?

Answer: Scheduling for the updated ADEX Dental Examination will open in June 2026 for candidates testing in 2027.

- The DLOSCE will no longer be offered or administered as a standalone examination to new DLOSCE candidates, except in conjunction with the ADEX Dental Examination, after August 1, 2026.
- All standalone administrations of the DLOSCE will cease after October 9, 2026

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Dental Examination Updates

AMERICAN BOARD of DENTAL EXAMINERS

Question: How will this support license portability?

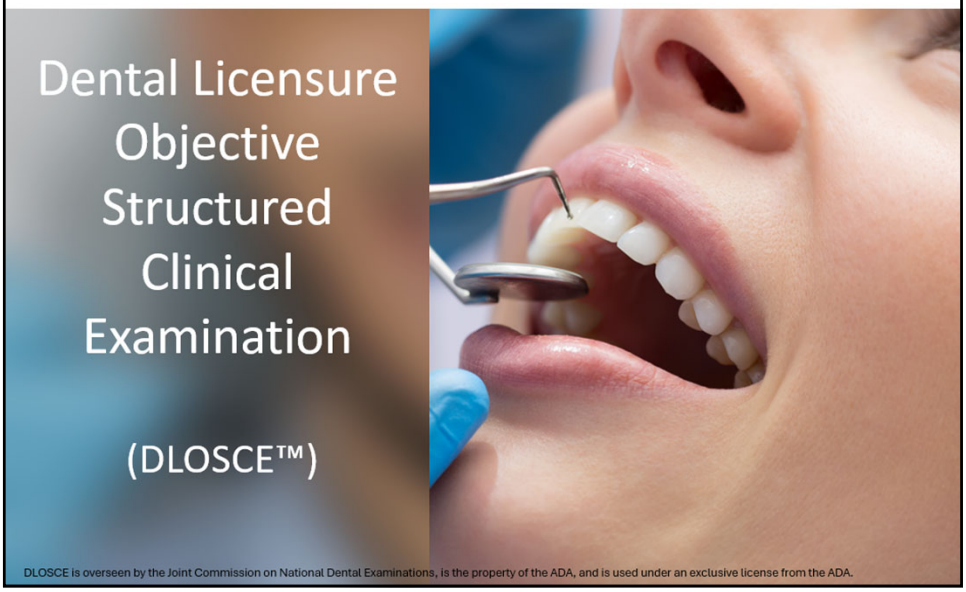
Answer: This change is intended to support greater consistency and portability in licensure pathways.

The ADEX Dental Examination is currently accepted or required in 48 states and additional jurisdictions, including Washington, D.C., Puerto Rico, Jamaica, and the U.S. Virgin Islands. Incorporating the DLOSCE supports further alignment in how clinical competence is assessed across jurisdictions.

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ADA American Dental Association®

AMERICAN BOARD of DENTAL EXAMINERS



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ADA American Dental Association®

AMERICAN BOARD of DENTAL EXAMINERS

- Candidates registered for the ADEX exam after June 1, 2026, will take the DLOSCE
- 150 questions administered at the Prometric Testing Center
- 75 or greater to pass
- Scores release timing will be announced in June

DLOSCE CONTENT	
Restorative	**24%**
Diagnosis, Preparations, Restorations	
Direct and Indirect	
Prosthodontics	**19%**
Removable, Fixed and Implants	
Oral Pathology, Pain Management, and Temporomandibular Dysfunction	**13%**
Oral Pathology/Oral Medicine & Orofacial Pain and TMD	
Periodontics	**10%**
Diagnosis, Treatment Planning and Etiology	
Oral Surgery	**9%**
Diagnosis, Treatment Planning and Extractions	
Endodontics	**8%**
Diagnosis, Treatment Planning, Emergency Management & Post-Treatment Evaluation	
Orthodontics	**6%**
Treatment Screening, Space Management	
Medical Emergencies	**6%**
Diagnosis, Management	
Prescriptions	**5%**
Antibiotic and Analgesic	

DLOSCE is overseen by the Joint Commission on National Dental Examinations, is the property of the ADA, and is used under an exclusive license from the ADA.

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ADA American Dental Association®

AMERICAN BOARD of DENTAL EXAMINERS

DLOSCE Administration Schedule	Section Minutes
Tutorial (optional)	25
Section 1 (37 Questions)	75
Scheduled Break (optional)	10
Section 2 (37 Questions)	75
Section 3 (2 Prescription Tasks)	10
Scheduled Break (optional)	30
Section 4 (37 Questions)	75
Scheduled Break (optional)	10
Section 5 (37 Questions)	75
Post-examination Survey	20
Total Time	**6 hours 45 minutes**

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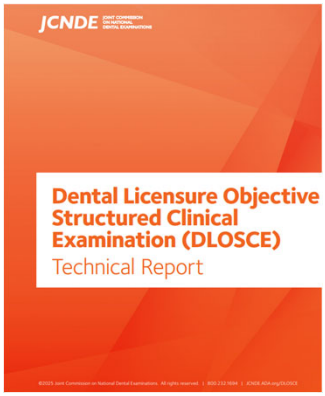


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Dental Examination Updates

AMERICAN BOARD of DENTAL EXAMINERS

[JCNDE.org: DLOSCE Technical Report]



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Dental Examination Updates

Table 16.1
DLOSCE Administration Volumes and Failure Rates, by Candidate Group and Year

	Accredited*				Non-Accredited**				Total	
	First Attempt		Retake		First Attempt		Retake		First Attempts and Retakes	
Year	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing	Number	% Failing
2020	231	9.5	2	0.0	14	57.1	1	100.0	248	12.5
2021	97	5.2	10	30.0	9	11.1	6	66.7	122	10.7
2022	52	21.2	5	40.0	6	0.0	2	50.0	65	21.5
2023	71	9.9	2	0.0	11	45.5	0	0.0	84	14.3
2024	53	11.3	5	0.0	9	22.2	3	33.3	70	12.9

* Indicates candidates educated by dental education programs accredited by CODA.
** Indicates candidates educated by dental education programs not accredited by CODA. Failure rates for this group should be interpreted with caution due to the small sample size present.

The quantity of exams taken will go up substantially with the DLOSCE integrated into the ADEX Dental Examination

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Dental Examination Updates

- **Periodontal Examination will be required (August 2026)**
- Adding Calculus Detection
- Adding Pocket Depth Measurements

Skills Assessment	Criteria	Points Possible
Calculus Detection	· 4 assigned maxillary teeth · 4 surfaces per tooth (M, D, F, L) · 16 surfaces evaluated for presence or absence of subgingival calculus (1 point each)	16

Calculus Removal
Complete Calculus Removal
	· One mandibular quadrant assigned for scaling
	· 12 assigned key surfaces evaluated for calculus removal (5.5 points each)
	· Evaluation of calculus removal on all remaining surfaces within assigned quadrant. Calculus remaining:
	  · 1 surface (-3 points)
	  · 2 or more surfaces (-6 points)
		66
		6

Periodontal Probing Measurement	· 2 assigned teeth (1 anterior; 1 posterior) · 6 measurements per tooth (DF, F, MF, DL, L, ML) · 12 measurements evaluated (1 point each)	12
	TOTAL	100

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ADEX Dental Statistics

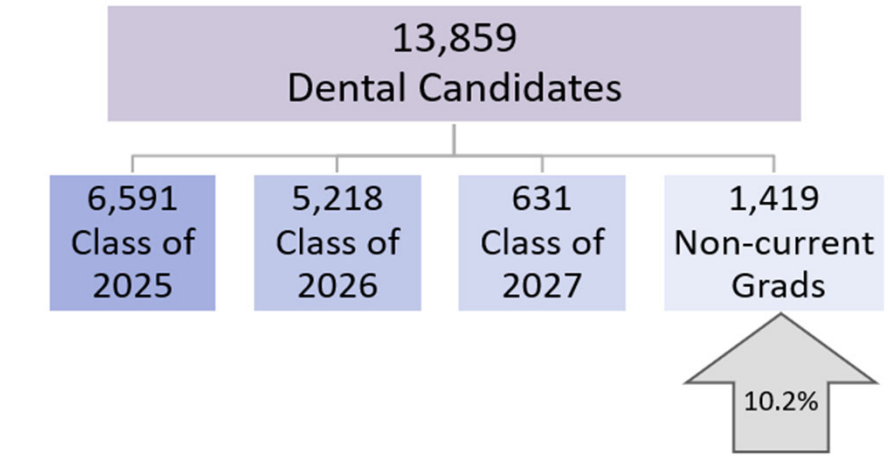
78 Dental Schools Offered ADEX

2024: **13,077** candidates

2025: **13,859** candidates

25

Exam Year 2025 only



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Dental Class of 2025

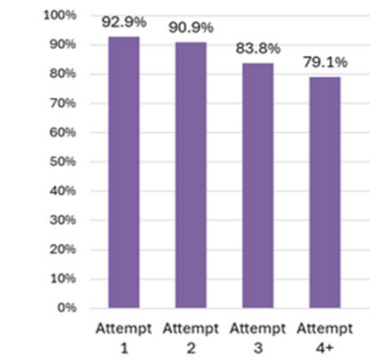
Initial and End of Year Pass Rate

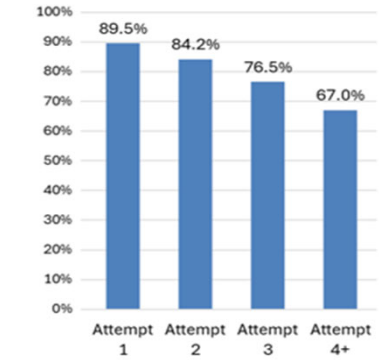
2025 Graduates

	# Cands	First Attempt	End of Year
Endodontics	6,750	77.10%	99.29%
Prosthodontics	6,752	87.81%	99.50%
Periodontics	6,738	99.23%	99.99%
Anterior Restorative	6,725	93.77%	99.69%
Posterior Restorative	6,726	88.91%	99.49%

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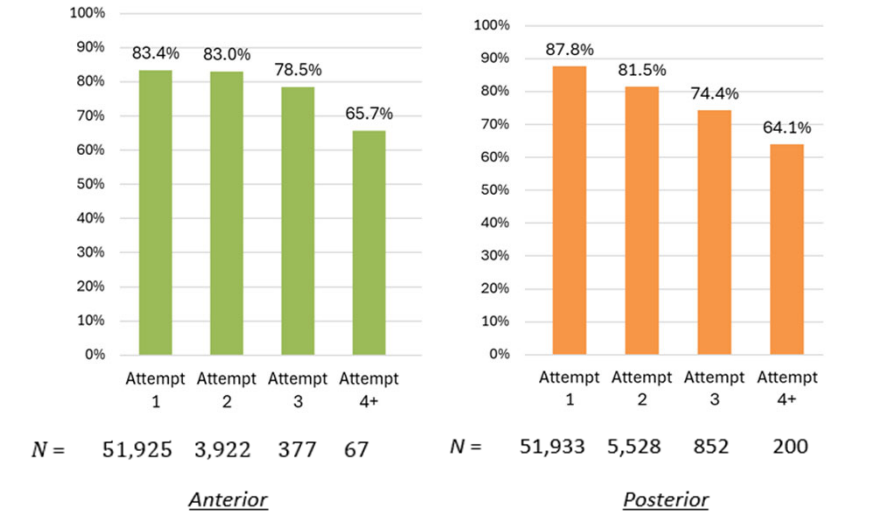
Anterior & Posterior Restorative 2015 to 2025 Passing Percentages by Attempt Number





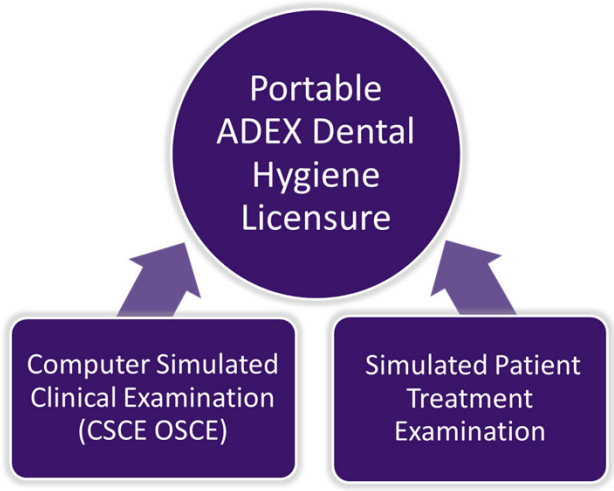
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Endodontics & Prosthodontics 2015 to 2025 Passing Percentages by Attempt Number



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ADEX Dental Hygiene Examination



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ADEX Dental Hygiene Statistics

Simulated Patient Examination

AMERICAN BOARD of DENTAL EXAMINERS

210 Dental Hygiene Schools Offered ADEX

2024: **7,092** candidates

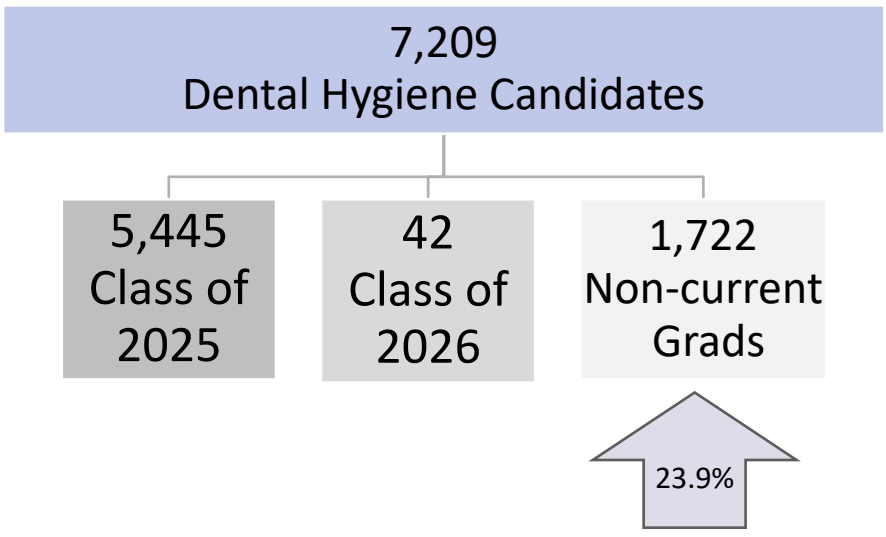
2025: **7,209** candidates

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2025 Dental Hygiene Candidates

Exam Year 2025 only

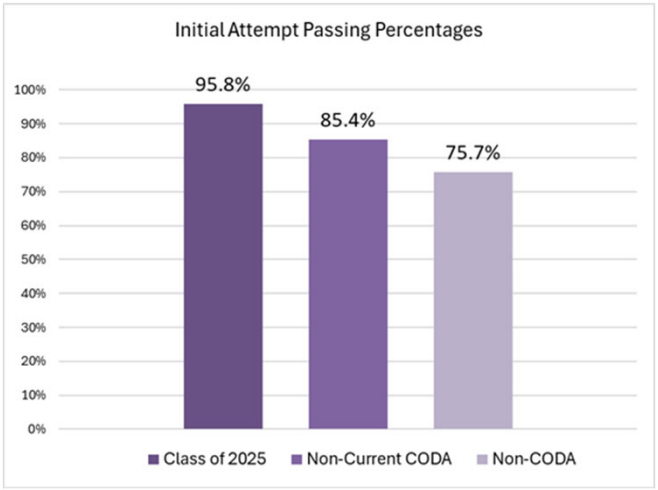
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Clinical Exam - Initial Attempt Passing

Class of 2025, CODA Non-Current, Non-CODA



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Dental Hygiene
Class of 2025

Initial and End of Year Pass Rate

2025 Graduates

	# Cands	First Attempt	End of Year
CSCE OSCE	5,330	99.47%	99.77%
Dental Hygiene Clinical Examination (SPTCE)	5,470	95.76%	99.63%

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2025 Candidates

AMERICAN BOARD of DENTAL EXAMINERS

6,750
Other Exam Candidates

- 2,934 Local Anesthesia
- 256 Auxiliary & DH Rest
- 3,552 Florida Laws & Rules
- 52 Dental Therapy
- 607 Nitrous Oxide

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AMERICAN BOARD of DENTAL EXAMINERS



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AMERICAN BOARD of DENTAL EXAMINERS

Educator Portal

ADEX EDUCATORS

SCHOOL INFORMATION | CANDIDATES | EXAMS | VIEW RESULTS | EXAM PREPARATION

CONTACT US | MY SETTINGS

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Faculty & Student Webinars available

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Please Bookmark & Contact Us for information

https://adextesting.org

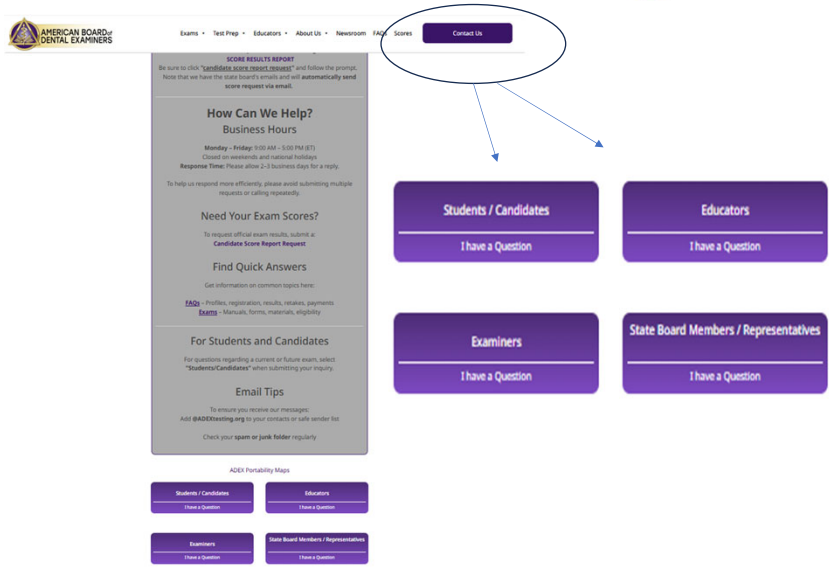


OTHER EXAMS

- Dental (ADEX)
- Dental Hygiene (ADEX)
- Dental – Sedation
- Dental Therapy
- Dental Hygiene – Nitrous Oxide
- Local Anesthesia
- EFDA – Expanded Function Dental Auxiliary
- Dental Hygiene Restorative
- Florida Laws & Rules
- Computer-Based Examinations
- Contact Us
- Register Now

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CONTACT US links you to resources



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Highlights and Strategic Initiatives

- **Dental Testing Summit – ADEX Annual Meeting Oct 15 - 17 at the Gaylord National Harbor outside Wash D.C.**
- **ADEX Exam in Saudi Arabia Jan 2026 – offered at first CODA-Accredited school in the Eastern Hemisphere**
- **Licensure Compact Monitoring**
- **ADA DLOSCE integration into ADEX Dental Exam**
- **ADEX is currently conducting an Occupational Job Task Analysis (OJTA) for the ADEX Dental Hygiene Exam**
- **ADEX Website updated**

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ADEX
The National Exam Standard

Thank You Oregon!

Stephen Prisby, ADEX Regulatory and Educational Affairs Director
sprisby@adextesting.org

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American Board of Dental Examiners (ADEX) Report

ADEX is proud to support the licensure needs of state dental boards and commissions across 50+ U.S. states and jurisdictions. In 2025, ADEX **administered** more than 570 examination **dates at 312 testing locations, serving over 466 individual dental education programs nationwide. ADEX will provide ongoing support for boards in all 51 jurisdictions where its examinations are accepted**.

Organizational Highlights and Strategic Initiatives

- **ADEX debuted its Dental Testing System 2.0 (DTS) technology**, further streamlining examination delivery and communication processes.
- **The ADEX Dental examination was administered at King Abdulaziz University (KAU) in Jeddah, Saudi Arabia in January 2026.** KAU is the first CODA-approved program in the eastern hemisphere.
- **Licensure Compact Monitoring -** ADEX continues to monitor and participate in discussions regarding oral health compacts and national mobility initiatives.
- **The 3rd Annual Dental Testing and Regulatory Summit will take place October 14-18, 2026**, at the Gaylord National Harbor just outside of Washington, DC. The Summit includes the Annual Meetings for the American Board of Dental Examiners, the American Association of Dental Administrators and the American Association of Dental Boards.
- **ADEX is currently conducting an Occupational Job Task Analysis (OJTA) for the ADEX Dental Hygiene Examination**. This process is an important step in ensuring that the examination continues to accurately measure the knowledge and clinical skills required for safe and competent entry-level dental hygiene practice.
- **Strategic Agreement Announced with the American Dental Association (ADA) to license and incorporate the ADA's DLOSCE into the ADEX Dental Exam.**

ADEX will continue targeted outreach focused on open dialogue, collaboration, and alignment. We remain committed to providing high-quality examinations, transparent communication, and data-driven licensure resources, while working closely with state boards to ensure licensure pathways protect the public and support the profession.

For questions or additional information, please contact:
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Regulatory and Education Affairs Director
sprisby@adextesting.org

Contact:
ADA:
mediarelations@ada.org

ADEX:
communications@adextesting.org

American Dental Association and American Board of Dental Examiners Advance Dental Licensure Examinations Through New Agreement

ADEX to incorporate the Dental Licensure Objective Structured Clinical Examination (DLOSCE) into the ADEX Dental Examination no later than Aug. 1, 2026

CHICAGO, April 14, 2026 – The American Dental Association (ADA) and the American Board of Dental Examiners (ADEX) have finalized an agreement to license the ADA's Dental Licensure Objective Structured Clinical Examination (DLOSCE) for incorporation into the ADEX Dental Examination, marking a significant step forward in modernizing dental licensure and advancing patient safety.

The agreement benefits public health, dental licensure candidates, the dental profession, and licensing boards to help ensure dentists enter the profession with proven competence and uphold the highest standards for patient safety.

The integration of the ADA's DLOSCE simplifies licensure pathways and supports licensure portability, benefiting candidates seeking to practice in 48 states and other jurisdictions—including Washington, D.C., Puerto Rico, Jamaica, and the U.S. Virgin Islands — that currently accept or require the ADEX Dental Examination.

"This agreement represents an important milestone for the dental profession," said Dr. Richard Rosato, D.M.D., president of the ADA. "By aligning pathways to licensure and advancing candidate assessment, we are strengthening licensure portability, supporting a more mobile and responsive workforce, and ensuring that patient safety remains paramount. The ADA has long championed solutions that modernize licensure while protecting the public, and this collaboration reflects our commitment to shaping a strong, sustainable future for dentistry in service to public health."

The ADEX Dental Examination with its DLOSCE component represents a modernized, evidence-based approach to evaluating clinical competence and readiness for practice. The ADEX Dental Examination will continue to assess candidates' clinical hand skills alongside their treatment-planning and decision-making abilities. Through inclusion of the DLOSCE, the ADEX Dental Examination will benefit from the DLOSCE's extensive use of images and 3D models that allow candidates to demonstrate their clinical judgment in scenarios that closely mirror real-world practice.

"ADEX has long served state dental boards to support licensure processes that reflect both public protection and clinical competence," said Dr. Mark Armstrong, Chair of ADEX. "This agreement

continues that work by strengthening alignment across assessment components while preserving the clinical hand-skills evaluation that remains central to licensure in most U.S. jurisdictions."

The agreement follows extensive collaboration among the ADA, ADEX, the Joint Commission on National Dental Examinations (JCNDE), and the ADA Council on Dental Education and Licensure (CDEL) that began in 2025. In March 2026, the ADA Board of Trustees and ADEX Board of Directors voted to approve the general terms that led to this joint agreement.

Central to discussions was a shared commitment to ensuring that dental licensure assessments continue to evolve in step with advancements in clinical education, technology, and patient care. Both organizations emphasized the importance of strengthening public protection while also enhancing the portability of dental licensure for candidates navigating an increasingly mobile profession.

ADEX will sunset its DSE OSCE no later than Aug. 1, 2026. Upon sunset of the DSE OSCE, all ADEX Dental Examination administrations will include the DLOSCE.

The DLOSCE will no longer be offered or administered as a standalone examination to new DLOSCE candidates, except in conjunction with the ADEX Dental Examination, after August 1, 2026. All standalone administrations of the DLOSCE will cease after October 9, 2026.

###

About the American Dental Association

The not-for-profit ADA is the nation's largest dental association, representing more 152,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance has long been a valuable and respected guide to consumer dental care products. *The Journal of the American Dental Association* (JADA), published monthly, is the ADA's flagship publication and the best-read scientific journal in dentistry. For more information about the ADA, visit ADA.org. For more information on oral health, including prevention, care and treatment of dental disease, visit the ADA's consumer website MouthHealthy.org.

About the American Board of Dental Examiners

The American Board of Dental Examiners (ADEX) is a not-for-profit organization dedicated to supporting dental boards in their mission to protect the public through the licensure of qualified oral health professionals. Established in 1969, ADEX administers independent competency examinations developed and approved by representatives of state dental boards. ADEX examinations are accepted or required by law in 51 U.S. jurisdictions and serve as the initial licensure pathway for 98% of dental and 85% of dental hygiene candidates nationwide. Through ongoing collaboration with dental boards and educators, ADEX continues to advance innovative, evidence-based assessment methods that uphold the highest standards of fairness, clinical competence, and public protection. Learn more at adextesting.org.

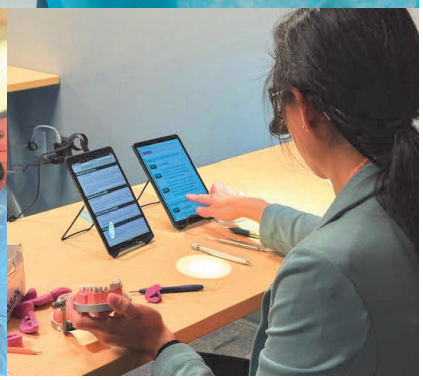
AMERICAN BOARD of DENTAL EXAMINERS

SUPPORTING **STATE BOARDS'** MISSION TO **PROTECT THE PUBLIC**



- Accepted or required by law in 51 U.S. states and territories
- Hundreds of trained and calibrated examiners
- Exams accessible to all dental & dental hygiene candidates
- Nationally coordinated scoring and quality assurance





Who We Are

The American Board of Dental Examiners (ADEX) is a national, non-profit organization dedicated to protecting the public through close collaboration with state dental boards. Together, we develop and administer evidence-based licensure assessments that support safe and competent dental practice.

ADEX upholds the highest standards of fairness, validity, and reliability through uniform computer-based and clinical manikin hand skills examinations, trusted by state boards to evaluate candidates' readiness for licensure. Today, ADEX examinations are accepted across nearly all U.S. jurisdictions and are utilized by the vast majority of dental and dental hygiene candidates.

ADEX administers a comprehensive portfolio of clinical examinations used by dental boards across the United States and internationally. The Council on Examinations, representing every U.S. state and territory, continuously reviews and refines these assessments to ensure clinical relevance, fairness, and accuracy.

Our organization is led by a national network of state dental board and educator-examiners, united by a shared commitment to integrity, consistency, and public protection.

Our Mission

Assess
Deliver psychometrically sound clinical examinations in dental and dental hygiene licensure. ADEX delivers more than 24,000 assessments annually.

Support
Support state regulatory agencies in standardizing and evaluating candidate competence.

Strengthen
Strengthen public trust in the licensure process while enabling portability for professionals.

WHY **BECOME** AN **EXAMINER?**

State dental board members play a critical role by participating in the examination administration process. Participation in the American Board of Dental Examiners allows regulators to uphold public protection and contribute to national consistency in dental and dental hygiene competency standards. Engagement ensures that the licensure pathways align with real-world practice, regulatory priorities, and evolving standards of care.

Examine

All members of state boards may participate in administering ADEX examinations at 400+ sites nationwide as available.

Lead

Opportunity to serve on the ADEX board of directors or other committees.

Develop

States select representatives to the Council on Examinations, participating in exam development and policy.

Connect

Represent your state board at meetings, conferences, and regulatory summits.

ADEX
AMERICAN BOARD of DENTAL EXAMINERS

QUICK FACTS
FOR PROSPECTIVE EXAMINERS

Honorarium and travel reimbursement

Training and calibration offered on demand

Professional development opportunities

PURSUE **EXCELLENCE** IN **LICENSURE**

Offering trusted, reliable examinations backed by professional expertise and a collaborative governance model, the American Board of Dental Examiners provides regulators with the tools they need to determine readiness for practice and standards for licensure.

JOIN TODAY

Ask your Executive Director to get started.



WHAT **IS** THE **COUNCIL ON EXAMINATIONS?**

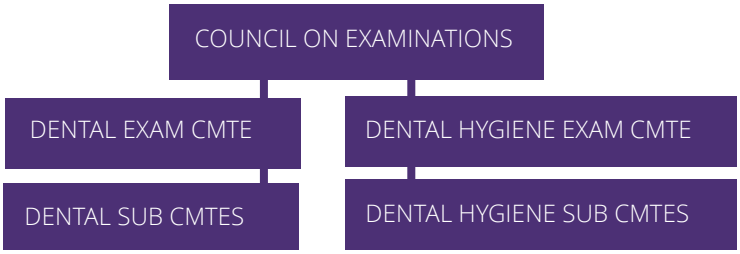


State dental board members play a critical role in the examination process. Through participation with the American Board of Dental Examiners, regulators directly support public protection while serving as stewards of a consistent, national standard for dental and dental hygiene licensure.

Examiner engagement provides the opportunity to collaborate with fellow state board members and respected professionals from across jurisdictions, fostering shared insight and alignment. It also ensures that licensure pathways remain grounded in real-world clinical practice, aligned with regulatory priorities, and responsive to evolving standards of care.

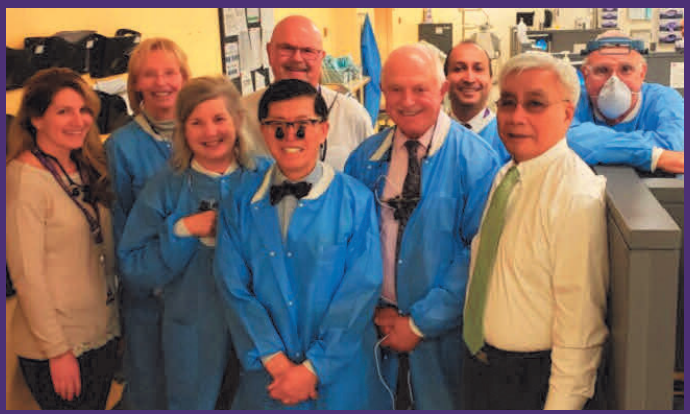
Council Appointment Eligibility & Term Length

Each state is asked to appoint a dentist and dental hygienist to the Council to serve three year terms. Persons who are current members of their state dental board, or have served within the past five years, are eligible to be appointed to the Council. Appointees will onboard with ADEX to access materials, information and be invited to examine. Active ADEX participation of five years or more is required to hold an office on the Council.



Council Member Commitments & Expectations

The Council will meet in person during the ADEX Annual Meeting. Exam Committees will meet virtually in advance and may gather in person at the Annual Meeting event as well. Virtual meetings typically last one to two hours. The time requirement can vary slightly depending on what (if any) subcommittees the person is appointed to serve.



Participation in the examining process, and the Council on Examinations provides state board members insight into how their service protects the public, firsthand. Ask for a presentation to your board to learn more.

WWW.ADEXTESTING.ORG

ASSOCIATION REPORTS

Oregon Board of Dentistry Meeting
June 12, 2026

Oregon Dental Hygienists' Association

The first class has completed the new dental hygiene program at **Rogue Community College**. All **20 students** have passed the National Board Dental Hygiene Exam and the Local Anesthesia Clinical Board Exam. They will receive their associate degrees on June 13, 2026 at Rogue's Commencement Ceremony

Oregon Institute of Technology is pleased to offer a new **Master of Science in Dental Hygiene** (MSDH) program. This program is the first of its kind in Oregon and one of a limited number offered nationwide. This fully online graduate program will allow dental hygiene students and graduates to earn the highest degree currently offered in the dental hygiene field. This degree can open career pathways in education, public health, research, administration, and business. The program officially launches in the summer term 2026. Darlene Swigart, MS, EPDH, FADHA will serve as MSDH program director and primary advisor. For more information, please contact Darlene at **darlene.swigart@oit.edu**.

COMMITTEE REPORTS

Draft

LICENSING, STANDARDS AND COMPETENCY COMMITTEE
Held as a Zoom Meeting

Minutes
April 7, 2026

MEMBERS PRESENT:	Sheena Kalia, D.D.S., Chair Michelle Aldrich, D.M.D. Sharity Ludwig, R.D.H. Kieshawn Lewis Julie Spaniel, D.D.S., ODA Rep. Heidi Klobes, R.D.H., ODHA Rep. Jill Lomax, ODAA Rep. Kristen Moses, R.D.H., D.T., DT Rep.
STAFF PRESENT:	Haley Robinson, Executive Director Angela Smorra, D.M.D., Dental Director/Chief Investigator Kathleen McNeal, Licensing Manager Dawn Dreasher, Office Specialist
VISITORS PRESENT:	Ginny Jorgensen, OBD Board Member; Mary Harrison, Oregon Dental Assistants Association (ODAA); Brett Hamilton, Oregon Dental Association (ODA) Lisa Rowley – ODHA; Mary Ellen Murphy

**Note - Some visitors may not be reflected in the minutes because their identity was unknown during the meeting.*

Call to Order: The meeting was called to order by Chair Dr. Sheena Kalia at 6:31 p.m. Dr. Kalia stated that the Committee's purpose is to improve licensing programs and assure competency of licensees and applicants.

Dr. Kalia invited Committee members and OBD staff to introduce themselves. Dr. Kalia stated that the purpose of the meeting was for Committee members to discuss the agenda items that have been brought to this Committee and to make recommendations to the full Board. Dr. Kalia clarified that the meeting was not a forum for public comment and that there would be opportunity for public comment at a future Board meeting or public rulemaking hearing before anything is finalized.

MINUTES

Ms. Ludwig moved and Dr. Aldrich seconded that the minutes of the May 20, 2025, Licensing, Standards and Competency meeting be approved as presented. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

OAR 818-021-0011(1)(b)

The Committee reviewed and discussed OAR 818-021-0011(1)(b) requiring completion of a two-year CODA accredited program for dental licensure and whether the Board would accept two one-year programs instead. The Committee discussed the two-year requirement with respect to foreign-trained dentists. The Committee discussed whether an official transfer from one program into another would meet the requirement. No action was taken.

OAR 818-042-0113

The Committee reviewed and discussed Dr. Fox's proposal to amend OAR 818-042-0113 to create an additional EFPDA Pathway. Ms. Lomax provided a brief history of the EFPDA certification and rule changes in 2025 to streamline the standardized exams administered by the Dental Assisting National Board (DANB). Ms. Lomax informed the Committee that there have been 136 dental assistants with EFPDA certification. Ms. Lomax articulated the ODAA's concern about removing the requirement for a standardized exam but expressed ODAA's openness to alternatives. The Committee decided to revisit the issue at a later time to see how the 2025 rule changes affect the number of EFPDAs flowing into the workforce. No action was taken.

OAR 818-042-0117

Background:

At the June 13, 2025, Board Meeting, the Board directed staff to draft proposed language and refer OAR 818-042-0117 to the Licensing, Standards and Competency Committee for review. At the September 23, 2025, DAWSAC Meeting committee members recommended the Board consider removal of barriers to dental assistants performing these procedures.

Dr. Sharifi moved and Dr. Kalluri seconded that the Board refer Proposed Amendment to OAR 818-042-0117 as presented in Option #1 to the Licensing, Standards and Competency Committee. The motion passed with AK, SK, RS, TC, MA, OS, KS, SL, and KL voting Aye.

Draft Option #1 All dental assistants can obtain Phlebotomy training:

OAR 818-042-0117

Initiation of IV Line and Phlebotomy Blood Draw

The Board may certify a Dental Assistant to perform the expanded function anesthesia duties below if the applicant submits a completed application, pays

the certification fee and:
(1) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a ~~Certified Anesthesia~~ Dental Assistant may initiate an intravenous (IV) infusion line for a patient being prepared for IV medications, sedation, or general anesthesia under the Indirect Supervision of a dentist holding the appropriate anesthesia permit.
(2) Upon successful completion of a course in intravenous access or phlebotomy approved by the Board, a ~~Certified Anesthesia~~ Dental Assistant may perform a phlebotomy blood draw under the Indirect Supervision of a dentist. Products obtained through a phlebotomy blood draw may only be used by the dentist, to treat a condition that is within the scope of the practice of dentistry.

The Committee reviewed and discussed a proposed amendment to OAR 818-042-0117 to allow all Dental Assistants to obtain phlebotomy training. Ms. Ludwig recalled that the Board discussed perhaps requiring an EFDA certification to allow phlebotomy training, but that the Board had concluded that it would be a barrier to dental assistants becoming certified as Anesthesia Dental Assistants. The committee discussed that assistants working in Oral Surgery-specific offices may not have their EFDA, which presented an additional barrier. Establishing a specific hour requirement with minimum didactic/clinical requirements was also discussed.

ACTION REQUESTED:
Dr. Spaniel moved and Dr. Aldrich seconded that the Committee refer the issue of phlebotomy training for dental assistants to the Board to establish more parameters around the amendment to OAR 818-042-0117. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

Dental Assistants – Nitrous Oxide
Background:
At the October 24, 2025, Board Meeting, the Board directed staff to refer OAR 818-026-0055 to the Licensing, Standards and Competency Committee for review. At the September 23, 2025, DAWSAC Meeting committee members recommended the Board consider allowing dental assistants to administer Nitrous Oxide under direct supervision after reviewing information from 14 states that allowed dental assistants to monitor/administer Nitrous Oxide.

The Committee discussed allowing dental assistants to assist in the administration of nitrous oxide under direct supervision. Dr. Spaniel expressed that the ODA had concerns regarding patient safety and putting specific, additional parameters around dental assistants potentially administering Nitrous Oxide.

ACTION REQUESTED
Ms. Ludwig moved and Dr. Spaniel seconded that the Committee refer the issue of dental assistants assisting in the administration of nitrous oxide under direct supervision to the Board for clarification. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

Dental Assistant Instructors Signing Off on Proficiency
The Committee discussed issues involved in allowing Dental Assistants who are Radiologic Proficiency Instructors to sign off on proficiency. No action was taken.

ADEX Merger
The Committee reviewed and discussed proposed rule changes related to the merger of CDCA-WREB-CITA into ADEX. The committee discussed removing testing agency-specific language since testing agencies change names which created administrative burden on staff to keep up with correct language in the rules.

ACTION REQUESTED
Ms. Ludwig moved and Dr. Kalia seconded that the Committee direct OBD Staff to draft proposed rule changes to OAR 818-035-0072 and OAR 818-042-0095 incorporating the merger of CDCA-WREB-CITA into ADEX. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

818-035-0072
Restorative Functions of Dental Hygienists
(1) The Board shall issue a Restorative Functions Endorsement (RFE) to a dental hygienist who holds an unrestricted Oregon license, and has successfully completed:
(a) A Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, and successfully passed the ~~CDCA-WREB-CITA's~~ **a** Dental Hygiene Restorative Examination ~~or other equivalent examinations~~ approved by the Board within the last five years; or
(b) If successful passage of the ~~CDCA-WREB-CITA's~~ **a** Dental Hygiene Restorative Examination ~~or other equivalent examinations~~ approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.
(2) A dental hygienist may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):
(a) These functions can only be performed after the patient has given informed consent

for the procedure and informed consent for the placement of the restoration(s) by a Restorative Functions Endorsement dental hygienist;
(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

818-042-0095
Restorative Functions of Dental Assistants
(1) The Board shall issue a Restorative Functions Certificate (RFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed:
(a) A Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, and successfully passed ~~the~~ ~~CDCA-WREB-CITA's~~ **a** Dental Hygiene Restorative Examination ~~or other equivalent examinations~~ approved by the Board within the last five years, or
(b) If successful passage of ~~the~~ ~~CDCA-WREB-CITA's~~ **a** Dental Hygiene Restorative Examination ~~or other equivalent examinations~~ approved by the Board occurred over five years from the date of application, the applicant must submit verification from another state or jurisdiction where the applicant is legally authorized to perform restorative functions and certification from the supervising dentist of successful completion of at least 25 restorative procedures within the immediate five years from the date of application.
(2) A dental assistant may perform the placement and finishing of direct restorations, except gold foil, under the indirect supervision of a licensed dentist, after the supervising dentist has prepared the tooth (teeth) for restoration(s):
(a) These functions can only be performed after the patient has given informed consent for the procedure and informed consent for the placement of the restoration by a Restorative Functions dental assistant.
(b) Before the patient is released, the final restoration(s) shall be checked by a dentist and documented in the chart.

Criminal Conviction Determination Process
The Committee reviewed and discussed proposed rule changes related to SB 1552.

ACTION REQUESTED
Dr. Kalia moved and Dr. Aldrich seconded that Committee approve the proposed rule changes in Tab 7, including changes to OAR 818-001-0087, as presented. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

847-001-xxxx
Criminal Conviction Determination Process
(1) As used in this rule:
(a) “Applicant” means a person who has applied for a license from the Oregon Board of

Dentistry (Board).
(b) “Petitioner” means a person who has requested the Board review their criminal history to determine whether it will prevent them from being granted a license by the Board.
(2) A person who was convicted of a crime may petition the Board for a determination as to whether a criminal conviction will prevent the person from receiving a license issued by the Board.
(3) The petitioner must submit the Board’s determination request form, relevant criminal history documentation, and the required $75 fee.
(4) The Executive Director has the authority to review a petitioner’s request under this rule and to determine whether the petitioner’s criminal conviction(s) prevent the person from obtaining a license issued by the Board.
(5) The Board will reconsider a determination that a criminal conviction prevents the person from obtaining a license if the person submits a completed application for a license.
(6) Upon reconsideration, the Board may rescind a previous determination that a criminal conviction does not prevent the person from obtaining a license if the applicant:
(a) Has allegations or charges pending in criminal court;
(b) Failed to disclose a previous criminal conviction;
(c) Has been convicted of another crime during the period between the determination and the person’s submission of a completed application for an occupational or professional license; or
(d) Has been convicted of a crime that, during the period between the determination and the person’s submission of a completed application for an occupational or professional license, became subject to a change in state or federal law that prohibits licensure for an occupational or professional license because of a conviction of that crime.
(7) Failure to disclose a previous criminal conviction includes any misrepresentation of a prior criminal conviction, any concealment or failure to disclose a material fact about a prior criminal conviction, or any other misinformation regarding a prior criminal conviction.
(8) Nothing in this rule prohibits the Board from denying licensure for a reason other than conviction of a crime.
(9) A determination made under this rule:
(a) Is subject to the same confidentiality requirements that are applicable to completed applications for a license; and
(b) Is not considered a final determination of the Board.

818-001-0087
Fees
(1) The Board adopts the following fees:
(a) Biennial License Fees:
(A) Dental —$490;

(B) Dental — retired — $0;
(C) Dental Faculty — $435;
(D) Volunteer Dentist — $0;
(E) Dental Hygiene —$279;
(F) Dental Hygiene — retired — $0;
(G) Volunteer Dental Hygienist — $0;
(H) Dental Therapy - $279;
(I) Dental Therapy - retired - $0;
(b) Biennial Permits, Endorsements or Certificates:
(A) Nitrous Oxide Permit — $40;
(B) Minimal Sedation Permit — $75;
(C) Moderate Sedation Permit — $200;
(D) Deep Sedation Permit — $400;
(E) General Anesthesia Permit — $400;
(F) Radiology — $75;
(G) Expanded Function Dental Assistant — $50;
(H) Expanded Function Orthodontic Assistant — $50;
(I) Instructor Permits — $40;
(J) Dental Hygiene Restorative Functions Endorsement — $50;
(K) Restorative Functions Dental Assistant — $50;
(L) Anesthesia Dental Assistant — $50;
(M) Dental Hygiene, Expanded Practice Permit — $75;
(N) Non-Resident Dental Background Check - $100.00;
(O) Predetermination on Licensure Fee - $75
(c) Applications for Licensure:
(A) Dental — General and Specialty — $445;
(B) Dental Faculty — $405;
(C) Dental Hygiene — $210;
(D) Dental Therapy - $210;
(E) Licensure Without Further Examination — Dental — $890.
(F) Licensure Without Further Examination — Dental Hygiene and Dental Therapy — $820
(d) Examinations:
(e) Jurisprudence — $0;
(f) Duplicate Wall Certificates — $50.
(2) Fees must be paid at the time of application and are not refundable.
(3) The Board shall not refund moneys under $5.01 received in excess of amounts due or to which the Board has no legal interest unless the person who made the payment or the person's legal representative requests a refund in writing within one year of payment to the Board.

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AI Guidelines

The Committee reviewed and discussed possible recommendations regarding rule changes concerning patient and diagnostic records and other guidelines for AI use. The Committee reviewed the Oregon Medical Board statement regarding AI.

ACTION REQUESTED

Ms. Ludwig moved and Dr. Kalia seconded that the Committee refer the issue of guidelines for AI use to the Board for consideration. The motion passed with SK, MA, SL, KL, JS, HK, JL, and KM voting Aye.

818-012-0070
Patient Records

(1) Each licensee shall have prepared and maintained an accurate and legible record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:
(a) Name and address and, if a minor, name of guardian;
(b) Date description of examination and diagnosis;
(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or its equivalent.
(d) Date and description of treatment or services rendered;
(e) Date, description and documentation of informing the patient of any recognized treatment
complications;
(f) Date and description of all radiographs, study models, and periodontal charting;
(g) Current health history; and
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.
(2) Each licensee shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.
(3) Each licensee shall maintain patient records and radiographs for at least seven years from the date of last entry unless:
(a) The patient requests the records, radiographs, and models be transferred to another licensee who shall maintain the records and radiographs;
(b) The licensee gives the records, radiographs, or models to the patient; or
(c) The licensee transfers the licensee's practice to another licensee who shall maintain the records and radiographs.
(4) When a dental implant is placed the following information must be given to the patient in writing and maintained in the patient record:
(a) Manufacture brand;
(b) Design name of implant;
(c) Diameter and length;

(d) Lot number;
(e) Reference number;
(f) Expiration date;
(g) Product labeling containing the above information may be used in satisfying this requirement.
(5) When changing practice locations, closing a practice location or retiring, each licensee must retain patient records for the required amount of time or transfer the custody of patient records to another licensee licensed and practicing dentistry in Oregon. Transfer of patient records pursuant to this section of this rule must be reported to the Board in writing within 14 days of transfer, but not later than the effective date of the change in practice location, closure of the practice location or retirement. Failure to transfer the custody of patient records as required in this rule is unprofessional conduct.
(6) Upon the death or permanent disability of a licensee, the administrator, executor, personal representative, guardian, conservator or receiver of the former licensee must notify the Board in writing of the management arrangement for the custody and transfer of patient records. This individual must ensure the security of and access to patient records by the patient or other authorized party, and must report arrangements for permanent custody of patient records to the Board in writing within 90 days of the death of the licensee.

818-012-0010
Unacceptable Patient Care
The Board finds, using the criteria set forth in ORS 679.140(4), that a licensee engages in or permits the performance of unacceptable patient care if the licensee does or permits any person to:
(1) Provide treatment which exposes a patient to risk of harm when equivalent or better treatment with less risk to the patient is available.
(2) Fail to seek consultation whenever the welfare of a patient would be safeguarded or advanced by having recourse to those who have special skills, knowledge and experience; provided, however, that it is not a violation of this section to omit to seek consultation if other competent licensees in the same locality and in similar circumstances would not have sought such consultation.
(3) Fail to provide or arrange for emergency treatment for a patient currently receiving treatment.
(4) Fail to exercise supervision required by the Dental Practice Act over any person or permit any person to perform duties for which the person is not licensed or certified.
(5) Fail to ensure radiographic and other imaging are of diagnostic quality.
(6) Render services which the licensee is not licensed to provide.
(7) Fail to comply with ORS 453.605 to 453.755 or rules adopted pursuant thereto relating to the use of x-ray machines.
(8) Fail to maintain patient records in accordance with OAR 818-012-0070.
(9) Fail to provide goods or services in a reasonable period of time which are due to a

patient pursuant to a contract with the patient or a third party.
(10) Attempt to perform procedures which the licensee is not capable of performing due to physical or mental disability.
(11) Perform any procedure for which the patient or patient's guardian has not previously given informed consent provided, however, that in an emergency situation, if the patient is a minor whose guardian is unavailable or the patient is unable to respond, a licensee may render treatment in a reasonable manner according to community standards.
(12) Use the behavior management technique of Hand Over Mouth (HOM) without first obtaining informed consent for the use of the technique.
(13) Use the behavior management technique of Hand Over Mouth Airway Restriction (HOMAR) on any patient.
(14) Fail to determine and document a dental justification prior to ordering a Cone Beam CT series with field greater than 10x10 cm for patients under 20 years of age where pathology, anatomical variation or potential treatment complications would not be otherwise visible with a Full Mouth Series, Panoramic or Cephalometric radiographs.
(15) Fail to advise a patient of any recognized treatment complications.
(16) Fail to maintain proper storage or handling of medications, including injectables, according to federal regulations, guidelines, standards, and manufacturer recommendations.
(17) Fail to obtain and maintain a written informed consent prior to administering Botulinum Toxin Type A or dermal fillers.

Potential statement on the use of AI

Example statement regarding AI from Oregon Medical Board Adopted April 2, 2024:

Artificial/Augmented Intelligence (AI) is a tool, or set of tools, residing on a spectrum. AI may be as simple as a chatbot on a smartphone or as complex as a complex, algorithmic black box capable of suggesting treatment pathways for cancer. AI is developing rapidly in reach, capability, and quality, and medical providers and regulators must prepare for the ubiquity of AI, which is sure to envelop medical care with astonishing speed.

AI has tremendous promise. It will undoubtedly advance the standard of care, and clinicians who carefully embrace AI tools will ultimately detect pathologic subtlety, improve accuracy, and spend more quality time in face-to-face patient care than those who do not. AI can improve patient access and engagement by shifting administrative tasks away from the clinician while simultaneously increasing empathy shown to patients in spite of pervasive health care provider shortages.

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Despite these technological advancements, the Oregon Medical Board will continue to hold licensees responsible for the care they provide to patients and expects licensees to use technology – including AI – responsibly and ethically. Regardless of who introduces AI into the practice, OMB licensees are expected to possess basic AI literacy in order to understand the technology and how to use it, explain its capabilities and limitations, assess the quality of AI outputs, and identify and guard against bias in AI algorithms. OMB licensees must guard against complacency and not compromise their own medical decision making by becoming overly reliant on AI.

The Oregon Medical Board recommends that clinicians become “tech-fluent" in relevant AI tools and incorporate them into their practice responsibly to keep pace with the increasing standard of care.

Chair Kalia thanked everyone for their attendance and contributions. Dr. Kalia announced that the Committee’s recommendations and the draft minutes from the meeting would be included in the June 12, 2026, Board meeting public packet and available on the OBD website.

The meeting adjourned at 7:50 p.m.

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OREGON BOARD OF DENTISTRY
DENTAL ASSISTANT WORKFORCE SHORTAGE ADVISORY COMMITTEE (DAWSAC)
MEETING MINUTES
May 26, 2026

MEMBERS PRESENT:	Olesya Salathe, DMD, Co-Chair (joined at 5:19 p.m.) Ginny Jorgensen, Co-Chair Amberena Fairlee, DMD – ODA Rep. (joined at 5:32 p.m.) Lindsay Tuel, RDH – ODHA Rep. Kari Hiatt – ODAA Rep. Alexandria Case Amanda Cameron Carmon Mons
STAFF PRESENT:	Haley Robinson, Executive Director Angela Smorra, DMD, Dental Director/Chief Investigator Dawn Dreasher, Office Specialist
VISITORS PRESENT VIA TELECONFERENCE*:	Mary Harrison, ODAA; Brett Hamilton, ODA; Nissa Newton

*This list is not exhaustive, as it was not possible to verify all participants at the teleconference.

Call to Order: The meeting was called to order by Chair Ginny Jorgensen at 5:02 p.m. via Zoom. Ms. Jorgensen announced that the Committee had a quorum.

Self-Introductions of Committee Members
Chair Jorgensen welcomed everyone to the meeting and had the DAWSAC Members introduce themselves and share information about their current positions in the dental field.

Public Meeting Notice
Ms. Jorgensen announced that the Committee is subject to Public Meetings Law. Ms. Jorgensen briefly explained the requirements of the law.

Approval of February 17, 2026 Minutes
Ms. Jorgensen moved and Ms. Cameron seconded that the Committee approve the minutes from the February 17, 2026, DAWSAC Meeting as presented. The motion passed with GJ, AC (Cameron), AC (Case), KH, CM, and LT voting Aye.

DAWSAC Packet Introduced
A copy of HB 3223 was attached for informational purposes. Ms. Jorgensen explained that a request to allow the Committee to meet as needed rather than quarterly was sent to the Governor. Ms. Robinson confirmed that the OBD has not yet received a response to that request.

DANB Article
Ms. Jorgensen presented a May 13, 2026, article from DANB entitled *4 Ways Dentists Can Make Dental Assistants Feel Valued*. The Committee discussed the article and workforce retention issues. Ms. Jorgensen said she would reach out to DANB to find out how and to whom they are distributing the article.

Ms. Robinson offered to include the article in the June 12, 2026, Board Book and to share it along with the upcoming survey.

Dental Assistant Registry
Ms. Jorgensen presented her research about how other states approach registration of dental assistants. The Committee discussed Oregon's various certification levels and issues related to creating a dental assistant registry.

Ms. Robinson suggested one pathway to create a registry could be adding a tab to the biennial dental license renewal in which dentists would provide information on the dental assistants working in their offices. Ms. Robinson clarified that this would be similar to the Qualified Provider tab in the current renewal applications. Ms. Robinson stated that she also is waiting for information from the OBD database provider about adding dental assistants to the existing licensing platform.

Dr. Salathe moved and Dr. Fairlee seconded that the Committee recommend that the Board discuss launching an effort to accumulate data about dental assistants, their certifications, and their years of experience and decide if it should be in the form of a survey or added to dental renewal applications. The motion passed with GJ, AC (Cameron), AC (Case), KH, CM, LT, OS, and AF voting Aye.

Ms. Robinson confirmed that the dental assistant registry issue will be included on the June 12, 2026, Board meeting agenda.

Ms. Jorgensen offered to continue her research to ascertain in which states dental boards are legislatively required to regulate dental assistants.

Dr. Salathe offered to research in which states medical boards are legislatively required to regulate medical assistants.

Ms. Case offered to assist with Ms. Jorgensen's research.

Dr. Fairlee offered to reach out to ADA representatives from different states to gather information about regulation of dental assistants.

The Committee discussed how to ensure compliance with Public Meetings Law while collaborating on research projects.

Ms. Robinson offered to coordinate research efforts by emailing DAWSAC members about their roles and inviting them to send their research results directly to her.

Dental Assistant Survey

The Committee discussed changes to the dental assistant survey. Ms. Robinson said she would present the revised survey at the June 12, 2026, Board meeting.

Classroom to Chairside Panel
Dr. Fairlee reported on the recent panel discussion on solving the workforce shortage, which took place at the Oregon Dental Conference. Dr. Fairlee highlighted topics around creating a pipeline for dental assisting recruits. DAWSAC members offered their perspectives on the panel and agreed that the discussion was very productive. The Committee discussed other promising outreach efforts.

Ms. Cameron offered to participate in future panel discussions.

Mr. Hamilton reported on ODA reaching out to the Department of Education to learn more about dental assisting programs and their efforts to connect members to those programs.

Open Comment
No comments presented.

ADJOURNMENT
The meeting was adjourned at 6:21 p.m. The next DAWSAC meeting will be scheduled at a later date.

DRAFT

2026 Dental Assisting Survey - DRAFT

1. Are you a dentist, registered dental hygienist, dental therapist, or dental assistant?

- ◯ Dentist
- ◯ Registered Dental Hygienist
- ◯ Dental Therapist
- ◯ Dental Assistant

2. What type of setting do you primarily practice/work in?

- ◯ Private Practice - Sole Practitioner
- ◯ Group Practice (4 or more providers)
- ◯ Public Health (FQHC, County, Corrections, Community etc.)
- ◯ Education
- ◯ No longer practicing (Retired, Disabled, etc.)
- ◯ Other
- ◯ Specialty Practice - please list the specialty below

3. How many dental assistants do you employ or work at your primary location?

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4+
- ◯ Not Applicable - No longer practicing

4. Which of the following Oregon certifications do you or dental assistant(s) in the office hold? (Check all that apply)

- ☐ Basic Chairside
- ☐ Sterilization Assistant
- ☐ Dental Hygiene Assistant
- ☐ Radiologic Proficiency
- ☐ Expanded Functions Dental Assistant (EFDA)
- ☐ EFDA with Restorative Endorsement
- ☐ Expanded Functions Orthodontic Assistant (EFODA)
- ☐ Expanded Functions Preventive Assistant (EFPDA)
- ☐ Dental Assistant with Local Anesthesia Functions Certificate (LAFC)
- ☐ Certified Anesthesia Dental Assistant

5. Within your practice where do you look for training materials for dental assistants when doing on the job training?

- ◯ The Oregon Board of Dentistry Website
- ◯ The Dental Practice Act
- ◯ Dental Assisting National Board (DANB)
- ◯ We do not train dental assistants in the office

Other (please specify)

6. When doing on the job training for the Radiologic Proficiency Certificate, EFDA, EFPDA, and EFODA, the dental assistant must submit within six months, certification by an Oregon licensed dentist, dental therapist or
dental hygienist that the assistant is proficient. Do you think 6 months is enough time to complete the checkoff sheet?

- ◯ Yes
- ◯ No
- ◯ If no, please specify a timeframe.

7. Which expanded function duties do yourself perform or you allow/supervise assistant(s) to perform once certified in Oregon? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instrument.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All of the above.
- [ ] N/A

8. Which EFDA duties, if any, do you consider obsolete? (Check all that apply)

- [ ] Polish the coronal surfaces of teeth with a brush or rubber cup as part of oral prophylaxis to remove stains.
- [ ] Remove temporary crowns for final cementation and clean teeth for final cementation.
- [ ] Preliminarily fit crowns to check contacts or to adjust occlusion outside the mouth.
- [ ] Place temporary restorative material (i.e., zinc oxide eugenol based material).
- [ ] Place and remove matrix retainers for alloy and composite restorations.
- [ ] Polish amalgam or composite surfaces with a slow speed hand piece.
- [ ] Remove excess supragingival cement from crowns, bridges, bands or brackets with hand instruments.
- [ ] Fabricate temporary crowns, and temporarily cement the temporary crown.
- [ ] Perform all aspects of teeth whitening procedures.
- [ ] All the above duties should remain as expanded function duties.
- [ ] None of the above duties should remain expanded function duties.

9. What duties would you like to see added to the expanded functions list?

10. How much does your office pay each type of dental assistant?

	<$25 per hour	$26-$29 per hour	$30-$33 per hour	$34-$37 per hour	>$38 per hour
Basic Chairside	◯	◯	◯	◯	◯
Sterilization Assistant	◯	◯	◯	◯	◯
Dental Hygiene Assistant	◯	◯	◯	◯	◯
Radiologic Proficiency	◯	◯	◯	◯	◯
Expanded Functions Dental Assistant (EFDA)	◯	◯	◯	◯	◯
EFDA with Restorative Endorsement	◯	◯	◯	◯	◯
Expanded Functions Orthodontic Assistant (EFODA)	◯	◯	◯	◯	◯
Expanded Functions Preventive Assistant (EFPDA)	◯	◯	◯	◯	◯
Dental Assistant with Local Anesthesia Functions Certificate (LAFC)	◯	◯	◯	◯	◯
Certified Anesthesia Dental Assistant	◯	◯	◯	◯	◯

11. How long on average does a dental assistant stay employed in your office?

- ◯ <1 year
- ◯ 1-3 years
- ◯ 3-6 years
- ◯ 6-9 years
- ◯ >9 years

12. In your experience, what affects the retention of dental assistants in the office?

13. If less than 3 years what do you believe is the reason(s) for dental assistants leaving your office?

14. What are your ideas to increase the number of dental assistants in the workforce?

EXECUTIVE DIRECTOR'S REPORT

EXECUTIVE DIRECTOR'S REPORT
June 12, 2026

Board Member and Staff Updates

On behalf of the OBD, I would like to thank Dr. Michelle Aldrich for her 4 years of service on the OBD from 2022 to 2026. As a private practitioner who started as a Registered Dental Hygienist, she brought an invaluable viewpoint, passion and scrutiny to Board actions and proceedings.

On behalf of the OBD, I would like to thank Dr. Terrence Clark for his 4 years of service on the OBD from 2022 to 2026. As a private practitioner and a licensed Oregon dentist for almost 40 years, he brought an important viewpoint, experience and perspective to Board actions and proceedings.

I'm pleased to share that Dr. Aaron Tinkle and Dr. Jared Thompson have been nominated for Senate confirmation on June 15. I will be scheduling onboarding and orientation sessions in July, and I look forward to officially welcoming them to the Board at their first meeting in August.

Thank you Sharity Ludwig for your continued service and willingness to serve a second term on the OBD. Sharity will be reappointed on June 15th.

OBD Budget Status Report

Attached is the budget report for the 2025 - 2027 Biennium. This report, which is from July 1, 2025 through May 17, 2026, shows revenue of $2,053,950.16 and expenditures of $1,607,489.85. **Attachment #1**

Customer Service Survey

Attached are the legislatively mandated survey results from July 1, 2025 through May 31, 2026. The results of the survey show that the OBD continues to receive positive ratings from the majority of those that submit a survey. **Attachment #2**

Memo - Delegated Duties for Executive Director & Staff

Every June the new President of the OBD takes the gavel for the first regular board meeting after being elected President at the April Board Meeting for a 1-year term of office. Every June Board Meeting, I submit to the Board for reauthorization, this memo outlining delegated duties to me as Executive Director and OBD staff along with my job description. **Attachment #3**
ACTION REQUESTED

OBD Bylaws

The OBD Bylaws were originally adopted in 2018 and are included for annual review by the Board. **Attachment #4**

Staff Speaking Engagements

Kathleen McNeal gave four License Application presentations to graduating Dental Hygiene Students in April and May:

Wednesday, 4/22/26 Pacific University
Monday, 5/18/26 Lane Community College
Tuesday, 5/19/26 Portland Community College

Dr. Bernie Carter gave a presentation titled “Record Keeping, Clinical Judgement and Risk Management” on April 18th to Permanente Dental Group.

Dr. Bernie Carter gave a presentation titled “Combat Periodontics” on May 2nd to the International College of Dentists – USA Section

Dental Testing & Regulatory Summit

This inaugural event brings together members of the American Board of Dental Examiners (ADEX), the American Association of Dental Administrators (AADA), and the American Association of Dental Boards (AADB) so that professionals in the dental testing and regulatory space can seamlessly attend multiple Annual Meeting events with fewer schedule shifts, lessening travel needs and easing financial barriers to participation. The meetings are scheduled October 14-18, 2026 in National Harbor, Maryland. Two Board Members are most welcome to attend and can contact me for more details. I would like to attend the summit and ask for the Board’s permission to do so. **Attachment #5 ACTION REQUESTED**

CRDTS Annual Meeting

The CRDTS Annual Meeting is scheduled for August 28 – 29, 2026 in Omaha, NE. Any Board Members interested in attending should confirm with me so I can assist with logistics and approve travel authorization. Thank you Dr. Simmons for attending this meeting. **Attachment #6**

Oregon Board of Dentistry

Date run: 5/17/2026

For the Month of **APRIL 2026** AY 2027 FY 2026

3400 BOARD OF DENTISTRY *REVENUE*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
0205	OTHER BUSINESS LICENSES	95,695.00	1,893,196.00	4,174,320.00	2,281,124.00
0210	OTHER NONBUSINESS LICENSES AND FEES	1,750.00	10,650.00	14,000.00	3,350.00
0410	CHARGES FOR SERVICES	409.50	13,446.50	146,000.00	132,553.50
0505	FINES AND FORFEITS	6,105.03	88,458.23	240,000.00	151,541.77
0605	INTEREST AND INVESTMENTS	5,780.72	47,689.43	60,000.00	12,310.57
0975	OTHER REVENUE	20.00	510.00	9,000.00	8,490.00
Grand Total		**109,760.25**	**2,053,950.16**	**4,643,320.00**	**2,589,369.84**

3400 BOARD OF DENTISTRY *TRANSFER OUT*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
2443	TRANSFER OUT TO OREGON HEALTH AUTHORITY	74,430.00	77,535.00	200,000.00	122,465.00
Grand Total		**74,430.00**	**77,535.00**	**200,000.00**	**122,465.00**

3400 BOARD OF DENTISTRY *PERSONAL SERVICES*

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
3110	CLASS/UNCLASS SALARY & PER DIEM	50,500.49	559,558.72	1,444,488.00	884,929.28
3115	BOARD MEMBER STIPENDS	0.00	17,444.00	0.00	(17,444.00)
3160	TEMPORARY APPOINTMENTS	0.00	0.00	4,778.00	4,778.00
3170	OVERTIME PAYMENTS	0.00	0.00	6,949.00	6,949.00
3180	SHIFT DIFFERENTIAL	0.00	24.00	0.00	(24.00)
3190	ALL OTHER DIFFERENTIAL	1,010.46	18,088.08	43,252.00	25,163.92
3210	ERB ASSESSMENT	15.00	174.00	504.00	330.00
3220	PUBLIC EMPLOYES' RETIREMENT SYSTEM	11,507.04	124,620.55	296,742.00	172,121.45
3221	PENSION BOND CONTRIBUTION	2,060.46	24,290.71	67,187.00	42,896.29
3230	SOCIAL SECURITY TAX	3,884.78	44,602.59	113,690.00	69,087.41
3241	PAID FAMILY MEDICAL LEAVE INSURANCE	203.14	2,326.87	5,572.00	3,245.13
3250	WORKERS' COMPENSATION ASSESSMENT	8.34	93.28	294.00	200.72
3260	MASS TRANSIT	309.05	3,465.83	10,321.00	6,855.17
3270	FLEXIBLE BENEFITS	10,945.64	112,263.65	296,856.00	184,592.35
Grand Total		**80,444.40**	**906,952.28**	**2,290,633.00**	**1,383,680.72**

3400 BOARD OF DENTISTRY *SERVICES AND SUPPLIES*

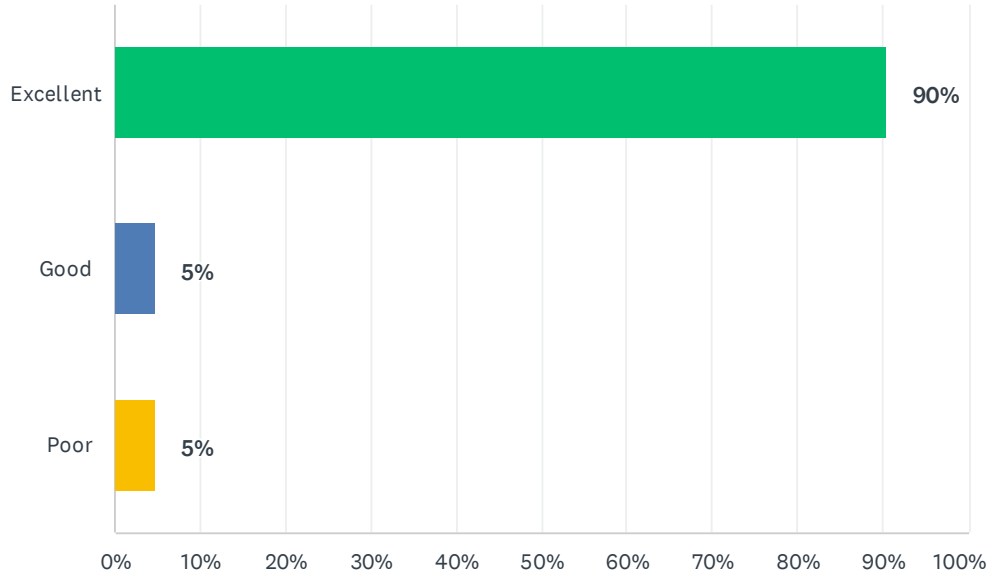
D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
4100	INSTATE TRAVEL	1,520.79	5,448.24	57,512.00	52,063.76
4125	OUT-OF-STATE TRAVEL	0.00	0.00	8,564.00	8,564.00
4150	EMPLOYEE TRAINING	500.00	3,012.06	61,404.00	58,391.94
4175	OFFICE EXPENSES	240.74	18,755.80	103,313.00	84,557.20
4200	TELECOMM/TECH SVC AND SUPPLIES	439.88	7,681.15	28,227.00	20,545.85
4225	STATE GOVERNMENT SERVICE CHARGES	2,269.41	134,054.94	266,545.00	132,490.06
4250	DATA PROCESSING	3,197.19	57,613.91	170,267.00	112,653.09
4275	PUBLICITY & PUBLICATIONS	180.00	1,021.54	37,519.00	36,497.46
4300	PROFESSIONAL SERVICES	12,275.00	82,374.35	557,636.00	475,261.65
4315	IT PROFESSIONAL SERVICES	619.00	2,964.00	176,116.00	173,152.00

D10 Compt Srce Grp	D10 Compt Srce Grp Ttl	Current Month	Bien_To_Date	Financial Plan	Unobligated Balance
4325	ATTORNEY GENERAL LEGAL FEES	1,654.40	83,360.95	459,308.00	375,947.05
4375	EMPLOYEE RECRUITMENT AND DEVELOPMENT	0.00	0.00	798.00	798.00
4400	DUES AND SUBSCRIPTIONS	0.00	600.00	11,807.00	11,207.00
4425	LEASE PAYMENTS & TAXES	6,917.50	68,395.00	215,252.00	146,857.00
4475	FACILITIES MAINTENANCE	1,424.00	8,259.00	661.00	(7,598.00)
4575	AGENCY PROGRAM RELATED SVCS & SUPP	3,393.47	15,540.32	148,652.00	133,111.68
4650	OTHER SERVICES AND SUPPLIES	14,004.95	131,884.07	97,723.00	(34,161.07)
4700	EXPENDABLE PROPERTY $250-$10000	0.00	0.00	6,609.00	6,609.00
4715	IT EXPENDABLE PROPERTY	81.11	2,037.24	26,593.00	24,555.76
Grand Total		**48,717.44**	**623,002.57**	**2,434,506.00**	**1,811,503.43**

				Current Month	Bien_To_Date	Rpt Mm Bal Ytd Avg
3400	**BOARD OF DENTISTRY**	Revenue	***REVENUE***	109,760.25	2,053,950.16	669,727.02
		Revenue Total		**109,760.25**	**2,053,950.16**	**669,727.02**
		Expenditures	***PERSONAL SERVICES***	80,444.40	906,952.28	319,758.54
			SERVICES AND SUPPLIES	48,717.44	623,002.57	305,750.86
			TRANSFER OUT	74,430.00	77,535.00	27,753.50
		Expenditures Total		**203,591.84**	**1,607,489.85**	**653,262.90**

Q1 How would you rate the timeliness of services provided by the Oregon Board of Dentistry?

Answered: 21 Skipped: 0

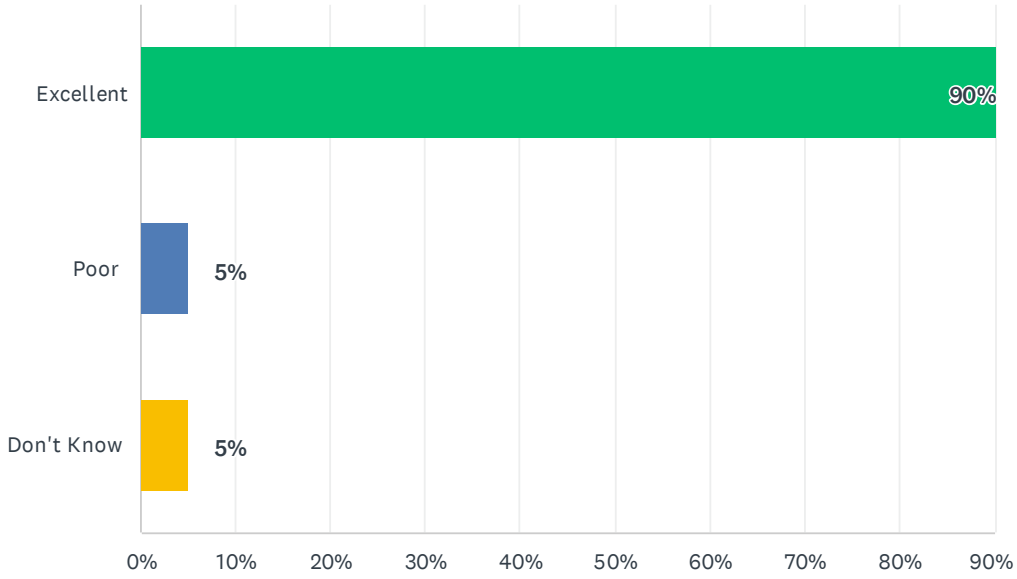


ANSWER CHOICES	RESPONSES	
Excellent	90%	19
Good	5%	1
Poor	5%	1
TOTAL		21

Attachment #2

Q2 How do you rate the ability of the Oregon Board of Dentistry to provide services correctly the first time?

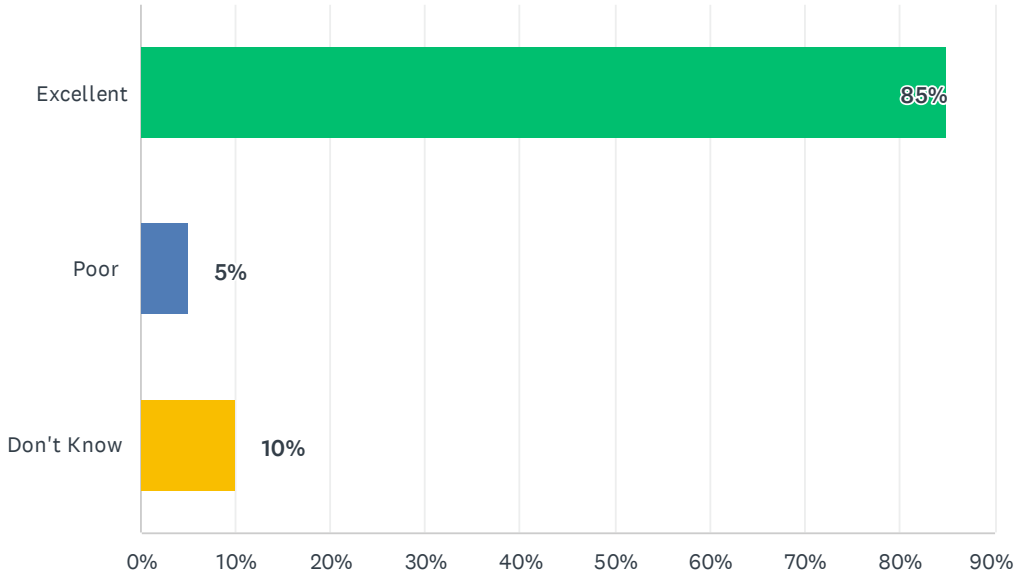
Answered: 20 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	90%	18
Poor	5%	1
Don't Know	5%	1
TOTAL		20

Q3 How do you rate the helpfulness of the Oregon Board of Dentistry employees?

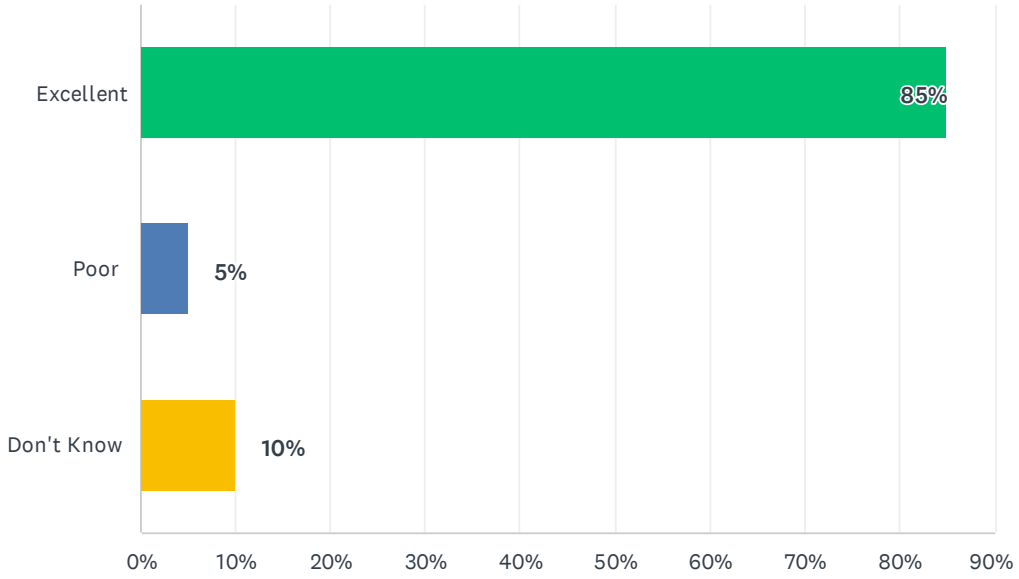
Answered: 20 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Poor	5%	1
Don't Know	10%	2
TOTAL		20

Q4 How do you rate the knowledge and expertise of the Oregon Board of Dentistry employees?

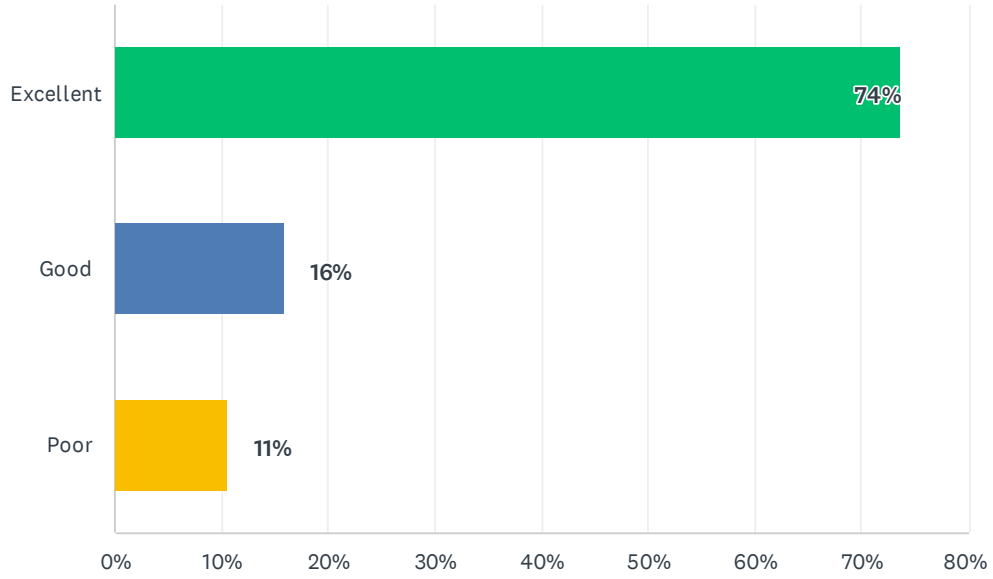
Answered: 20 Skipped: 1



ANSWER CHOICES	RESPONSES	
Excellent	85%	17
Poor	5%	1
Don't Know	10%	2
TOTAL		20

Q5 How do you rate the availability of information at the Oregon Board of Dentistry?

Answered: 19 Skipped: 2

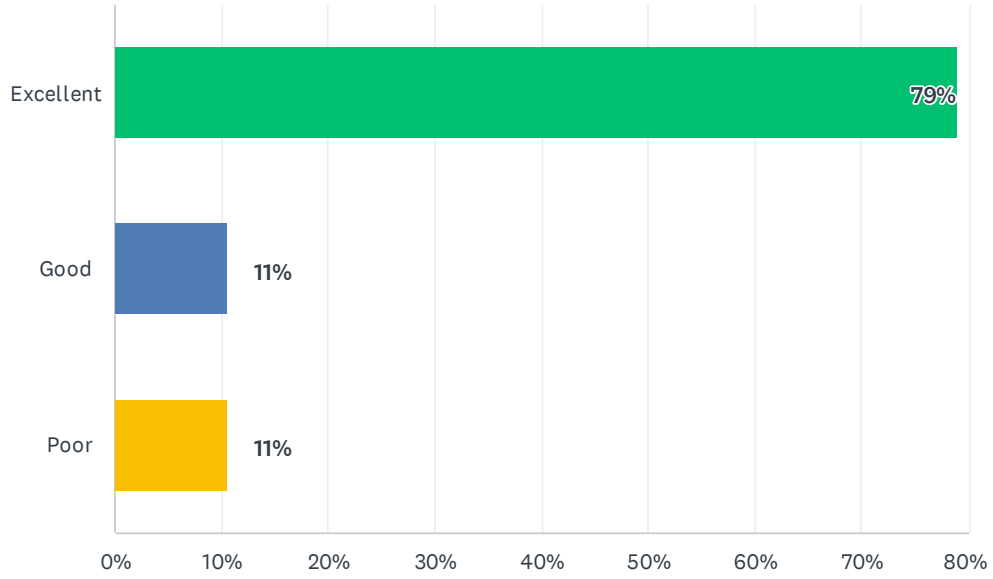


ANSWER CHOICES	RESPONSES	
Excellent	74%	14
Good	16%	3
Poor	11%	2
TOTAL		19

Attachment #2

Q6 How do you rate the overall quality of service provided by the Oregon Board of Dentistry?

Answered: 19 Skipped: 2



ANSWER CHOICES	RESPONSES	
Excellent	79%	15
Good	11%	2
Poor	11%	2
TOTAL		19

Q7 Do you have any additional comments?

Answered: 13 Skipped: 8

#	RESPONSES	DATE
1	Please consider implementing cultural competency continuing education modules on Health Authority website.	3/30/2026 8:44 PM
2	Thank you, Kathleen, for all your time and help getting my questions answered. I really appreciate it!	3/26/2026 1:00 PM
3	I had a technical question, and Kathleen responded thoroughly and promptly! Thank you!	3/2/2026 3:06 PM
4	Why was I not able to talk and discuss my issue regarding receiving basic dental because I was taken off Medicaid and put on Medicare who does apparently cover basic dental health since I was moved off Medicaid dental and now will not be able to maintain dental health because Medicare does not pay for dental needs Why ???	2/26/2026 2:40 PM
5	Kathleen is amazing	2/24/2026 1:06 PM
6	Thank you for all your help	2/20/2026 8:56 AM
7	Your website is exceptional compared to most state board of dentistry websites. Easy to navigate, updated info and I am easily able to find what I need. Great job!	2/11/2026 8:35 AM
8	I am still in the dental hygiene licensure application phase, but both Kathleen and Dawn have been extremely helpful throughout the process. I am very thankful to have been able to speak with a live person when I needed guidance, and I truly appreciate the kindness and patience they have shown while helping me navigate each step.	1/20/2026 8:16 AM
9	Ms. Robinson was clear and concise in answering my question, and it was easy to get in touch with the Board. Keep up the great work!	11/26/2025 1:53 PM
10	Clarifying info on what precisely qualifies as “cultural awareness” CE’s was hard to obtain. I just kept being referred to the section that is in writing, which s not very clear in real life. Otherwise, have always had great experiences for the business I’ve needed to do with the OBD	11/10/2025 5:39 PM
11	Kathleen McNeal is tops and Dawn who answered the phones so very polite and helpful too!	10/27/2025 12:18 PM
12	Useful, precise, and timely info provided with a wonderful attitude.	8/12/2025 10:41 AM
13	Office Specialist Dawn Dreasher has processed my data request so fast, really appreciate this!	7/7/2025 12:03 PM

Oregon
Tina Kotek, Governor

OBD Executive Director
Haley Robinson

Board of Dentistry
1500 SW 1st Ave, Ste 770
Portland, OR 97201-5837
(971) 673-3200
Fax: (971) 673-3202
www.oregon.gov/dentistry

DATE: June 1, 2026

TO: OBD Board Members

FROM: OBD Executive Director Haley Robinson

SUBJECT: OBD Delegated Duties to Executive Director & Staff

Annually at every June Board Meeting, I ask that the Board review and approve delegated duties to the Executive Director and staff. The Board convenes this June Board Meeting with a new President. I attached the delegated duties that I would like the Board to affirm as well as the Executive Director's job description.

Delegated Authority to OBD Executive Director and Staff

Investigations:

- Manage the Board's Confidential Diversion Program, including initiating investigations
- Grant extensions to respond within ten days to a Board request for information
- Initiate investigations on any and all matters under the Board's jurisdiction and statutory authority including CE noncompliance, malpractice claims, PLR, etc…
- Manage the compliance and annual CE auditing functions on behalf of the Board

Notices/Consent Orders/Orders/Interim Consent Orders:

- Issue Amended Notice to address errors or correct allegations
- Approve ordered continuing education courses
- Approve ordered community service arrangements
- Approve ordered mentorships and mentors
- Grant extension to complete ordered continuing education
- Grant extension to complete ordered community service
- Grant extension to pay ordered civil penalties, refunds and restitution
- Offer & Accept Interim Consent Orders for subsequent ratification by the Board

New, Renewal, Reinstatement Applications & Volunteers:

- Executive Director determines whether an applicant/licensee with a criminal record or disciplinary action record(s) needs to go to the Board for issuing or renewing a license.
- Executive Director determines whether volunteer Dentists, Dental Hygienists and Dental Therapists requesting to volunteer in Oregon from outside Oregon meet requirements and standards. These requests will be elevated to the Board as needed.

Dental Therapy Collaborative Agreements:

- Executive Director and OBD Staff under direction determine if dental therapist applicants and collaborative agreements meet OBD standards.

Recommendation: In the matter of delegated duties, move to authorize the listed duties for the OBD Executive Director and Staff.

_____ _____

President Oregon Board of Dentistry Date

STATE OF OREGON
POSITION DESCRIPTION

Position Revised Date:
June 1, 2011

This position is:
☐ Classified
☐ Unclassified
☒ Executive Service
☐ Mgmt Svc – Supervisory
☐ Mgmt Svc – Managerial
☐ Mgmt Svc - Confidential

Agency: Oregon Board of Dentistry

Facility:

☐ New ☒ Revised

SECTION 1. POSITION INFORMATION

a. Classification Title:	Principal Exec Manager E	**b.** Classification No:	Z7008
c. Pos. Est. Date:	July 1, 2003	**d.** Position No:	0000521
e. Working Title:	Executive Director	**f.** Agency No:	834000
g. Section Title:		**h.** Budget Auth No:	000927450
i. Employee Name:	Haley Robinson	**j.** Repr. Code:	MEAH

k. Work Location (City – County): Portland-Multnomah

l. Supervisor Name (Optional): Board President

m. Position: ☒ Permanent ☐ Seasonal ☐ Limited Duration ☐ Academic Year
☒ Full-Time ☐ Part-Time ☐ Intermittent ☐ Job Share

n. FLSA: ☒ Exempt ☐ Non-Exempt

If Exempt: ☒ Executive ☐ Professional ☐ Administrative

o. Eligible for Overtime: ☐ Yes ☒ No

SECTION 2. PROGRAM AND POSITION INFORMATION

a. Describe the program in which this position exists. Include program purpose, who's affected, size, and scope. Include relationship to agency mission.

The Oregon Board of Dentistry is established by ORS 679.230 to license and regulate the practice of dentistry, dental therapy and dental hygiene in the State of Oregon. The Board examines and licenses dentists and dental hygienists, certifies dental assistants in radiology and expanded functions, and regulates the use of anesthesia in the dental office. There are approximately 8,000 Oregon licensed dentists,dental therapists and dental hygienists. The Board investigates complaints of alleged violations of the Dental Practice Act and enforces the provisions of ORS 679 and 680.010-680.205 and 680.990 and OAR 818-001-0000 through 818-042- 0130. Services to these regulated individuals impact Oregonians statewide.

b. Describe the primary purpose of this position, and how it functions within this program. Complete this statement. The primary purpose of this position is to:

To direct all agency activities and represent the agency to the governor, legislature, other state/federal/local governmental and educational institutions, professional organizations, licensees, representatives of the dental community, citizen groups, the media and the general public.

SECTION 3. DESCRIPTION OF DUTIES

List the major duties of the position. State the percentage of time for each duty. Mark "N" for new duties, "R" for revised duties or "NC" for no change in duties. Indicate whether the duty is an "Essential" (E) or "Non-Essential" (NE) function.

% of Time	N/R/NC	E/NE	DUTIES
20	NC	E	Acts as the principal operations officer for the Board. Manages the Board office and is responsible for all personnel including recruitment, orientation, professional staff development and evaluation. Develops, prepares, and monitors agency budget, making adjustment as necessary to stay with legislatively adopted expenditure levels. Assures that all budget proposals and other fiscal documents are accurate and support Board goals; ensures establishment and implementation of sound audit procedures and internal controls. Develops administrative policies governing staff activities. Responsible for procurement and management of space, equipment and supplies to carry out agency mission.
20	NC	E	Functions as administrative agent for the Board. Prepares Board agendas and materials for Board and committee review. Assures that all hearings and meetings of the Board and its committees are noticed to the public and follow proper administrative procedure. Supervises preparation of minutes and maintenance of public records as required by law. Acts as Board spokesperson as delegated by the Board, serves as liaison between Board, Board committees and staff; conducts orientation of new Board members; and actively participates with Board in formulating policy. Assures that rulemaking proceedings are conducted in accordance with Oregon law and assures the optimum public input.
10	NC	E	Interfaces with other agencies whose activities affect the Board (i.e., Governor's Office, Department of Administrative Services, Secretary of State, other licensing boards within the state, related state and federal regulatory agencies (DEA, Board of Pharmacy, Radiation Control, Board of Nursing, OMAP, Boards of Dentistry in other states, etc.). Maintains liaison and effective relationships with Oregon Dental Association and its local components; Oregon Dental Hygienists' Association; Oregon Dental Assistants' Association; dental specialty organizations; dental and dental hygiene education programs at OHSU, School of Dentistry, and community colleges; regional and national dental, dental hygiene and dental assisting testing agencies, and the American Association of Dental Examiners. Represents the Board as a voting member of the American Association of Dental Administrators and the American Association of Dental Examiners.
10	NC	E	Supervises the review and approval of applications for initial licensure and renewal of licenses for dentists, dental therapists and dental hygienists. Oversees the administration of specialty examinations, the Board's jurisprudence examination, certification of dental assistants in expanded functions and the review and approval of anesthesia permits.

Note: *If additional rows of the below table are needed, place curser at end of a row (outside table) and hit "Enter".*

10	NC	E	Supervises the enforcement program assuring that complaints filed against licensees are handled in a fair and objective manner. Responsible for the investigation of complaints, preparation of Board orders, consultation with legal counsel, monitoring the flow of cases through the system to assure that priority issues are dealt with in a timely manner. Ensures the Boards enforcement procedures are followed and that licensees are provided with due process and confidentiality as required by Oregon law. Investigation of complaints frequently involves collaboration and cooperation with other regulatory agencies; i.e., Federal Drug Enforcement Agency, Department of Justice Medicaid Fraud Unit, Board of Pharmacy, Board of Nursing, Oregon Medical Board, and state and local law enforcement.
10	NC	E	Interprets and executes the provisions of the Dental Practice Act and rules of the Board and other regulations which determine the safe and legal practice of dentistry and dental hygiene in Oregon. Develops and recommends modification of the Dental Practice Act and rules of the Board. Prepares legislative concepts, appears before the Legislature in support of Board programs, presents and justifies the Board's budget to the Department of Administrative Services and the Legislature. Assures that Board Newsletter is produced on a regular basis, providing major articles and overseeing the format and distribution to licensees, legislators, professional organizations and other state Boards of Dentistry.
10	NC	E	Provides leadership and direction for a diversified staff of eight people. Supervise, hire, monitor performance, develop, coach, discipline and provide direction to employees. Respond to and resolve employee grievances. Assign and plan work. Promote safety training and practices in performance of all work activities. Implement Affirmative action and Diversity strategies and goals. Responsible for structuring activities that promote and foster a diverse workforce and discrimination/harassment-free workplace.
10	NC	E	Responsible for the monitoring of licensees under disciplinary action by the Board to assure compliance with the Board's Order. Work closely with treatment providers, substance abuse counselors, and the Oregon Dental Association Well-Being Committee to provide for evaluation, treatment, on-going care, and support of chemically impaired practitioners to ensure their safe return to work and maintenance of their sobriety and sound mental and physical health.
100%			

SECTION 4. WORKING CONDITIONS

Describe any on-going working conditions. Include any physical, sensory, and environmental demands. State the frequency of exposure to these conditions.

- Normal office environment.
- Some in-state and out-of-state travel which requires a valid Oregon Driver's License or an acceptable alternative.

- Exposure to licensees under investigation and disciplinary action.
- Exposure to infectious situations when visiting dental offices.
- Contributes to a positive, respectful and productive work environment;
- Establishes/maintains effective working relations with all sections of the Board and the public;
- Maintains regular and punctual attendance;
- Supports participative decision making and cooperative interactions among all people;
- Prepares for meetings, bringing issues and solutions for the team to resolve;
- Participates in achieving a safe and healthy workplace;
- Ensures sensitive and confidential information is handled in a secure manner;
- Commits to support and help other team members;
- Shares in leadership and actively supports decisions made by the management team; and
- Adheres to all OBD policies, processes and procedures.

SECTION 5. GUIDELINES

a. List any established guidelines used in this position, such as state or federal laws or regulations, policies, manuals, or desk procedures.

- Oregon statutes (ORS 679 & 680) and rules (OAR 818) as they apply to dentists, dental therapists, dental hygienists and dental assistants
- Oregon statutes and rules as they apply to health care professions that interrelate with the Board and its licensees (pharmacy, nursing, medicine, denturists, etc.)
- Oregon Public Records Law
- Oregon Public Meetings Law
- Oregon Attorney General's Administrative Procedures Act
- Service Employees International Union Local 503, OPEU Contract
- Federal regulations regarding reporting adverse actions taken against licensees of the Board (National Practitioners Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)
- Dept. of Administrative Services policy and procedures regarding personnel, purchasing, accounting, budgeting, etc.
- Historical records of the Board: court cases, contested case records, policies, Minutes of Board and committee meetings.

b. How are these guidelines used?

These laws, rules, policies, procedures, guidelines, etc. serve as references and provide general guidance to the daily administration of the Board and enforcement of the Dental Practice Act is consistent with the rules and regulations governing agency operations.

SECTION 6. WORK CONTACTS

With whom, outside of co-workers in this work unit, must the employee in this position regularly come in contact?

Who Contacted	How	Purpose	How Often?
Note: *If additional rows of the below table are needed, place curser at end of a row (outside table) and hit "Enter".*			
Board Members and the general public	Phone/writing/in person	Interpret laws and rules, and to explain Board policies and processes	Daily
Executive Officers of other state Boards	Phone/writing/in person	Interpret laws and rules, and to explain Board policies and processes	Daily
Licensees	Phone/writing/in person	Interpret laws and rules, and to explain Board policies and processes	Daily

Dept. of Justice	Phone/writing/in person	Discuss issues of enforcement, interpretation of DPA and related laws and regulations	Daily
Officers and staff of Professional Associations	Phone/writing/in person	Interpret laws and rules, and to explain Board policies and processes	Weekly
Educational Institutions	Phone/writing/in person	Interpret laws and rules, and to explain Board policies and processes	Weekly
State Legislators, Office of the Governor and the Department of Administrative Services	Phone/writing/in person	Explain Board laws and rules, support Board sponsored legislation, and respond to constituent concerns.	As needed
National and Regional Testing Entities	Phone/writing	Discuss testing protocols	As needed
Other state and federal agencies	Phone/writing	Discuss issues of mutual concern	As needed
Media	Phone/writing/in person	Explain Board policy	As needed

SECTION 7. POSITION RELATED DECISION MAKING

Describe the typical decisions of this position. Explain the direct effect of these decisions.

- Establishes work priorities to carry out Board policy
- Determines adequacy and availability of human, fiscal and equipment resources
- Determines policy issues to be presented to Board for consideration/action
- Develops, justifies, and manages biennial budget
- Recruits, selects, manages, develops, and disciplines Board personnel as necessary
- Establishes agency operating policy and procedures within state guidelines

Inappropriate decisions can result in adverse publicity; a lack of effective communication with licensees, the public and professional organizations; ineffective use of agency resources; and failure to accomplish Legislative policy and Board priorities.

SECTION 8. REVIEW OF WORK

Who reviews the work of the position?

Classification Title	Position Number	How	How Often	Purpose of Review
Oregon Board of Dentistry President	Varies upon appointment	Meetings in person and annual evaluations	Monthly	Determine if the goals and objectives of the agency are being met.

Note: *If additional rows of the below table are needed, place curser at end of a row (outside table) and hit "Enter".*

SECTION 9. OVERSIGHT FUNCTIONS

THIS SECTION IS FOR SUPERVISORY POSITIONS ONLY

a. How many employees are directly supervised by this position? 5

How many employees are supervised through a subordinate supervisor? 3

b. Which of the following activities does this position do?

- ☒ Plan work
- ☒ Assigns work
- ☒ Approves work
- ☒ Responds to grievances
- ☒ Disciplines and rewards
- ☒ Coordinates schedules
- ☒ Hires and discharges
- ☒ Recommends hiring
- ☒ Gives input for performance evaluations
- ☒ Prepares & signs performance evaluations

SECTION 10. ADDITIONAL POSITION-RELATED INFORMATION

ADDITIONAL REQUIREMENTS: List any knowledge and skills needed at time of hire that are not already required in the classification specification:

You must possess an extensive knowledge of the principles and practices of management, including planning, organizing, directing, motivating, controlling, decision making and of budgeting as it relates to agency management. You must also have a strong working knowledge of Oregon's legislative process and administrative rules establishment and revision.

As primary representative of the agency to all outside entities, you must thoroughly understand public relations and be able to establish good working relationships both within the agency and with outside entities including professional organizations, lawmaking bodies and the press.

In addition, you must have a very extensive knowledge of the laws and rules governing dental practice in Oregon. You must also have a thorough working knowledge of operating a criminal justice agency including investigations, prosecutions, mediation and negotiation, conduction of hearings and appeals, confidentiality issues, and compliance and rehabilitation methods and monitoring.

You must be proficient in using computers and word processing software to personally produce reports, and be able to access and use information in the Board's database.

As an employee of the Oregon Board of Dentistry, you are responsible for protecting our business information. Protecting this information entails knowing the risk classification level of the information and following the established protection procedures. It also involves reading and understanding the agency's information security policies and participating in employee awareness training.

You are subject to a criminal records check, which may require fingerprints. If you are offered employment, the offer will be contingent upon the outcome of a criminal records check (FBI and/or LEDS). Any history of criminal activity will be reviewed and could result in the withdrawal of the offer or termination of employment.

BUDGET AUTHORITY: If this position has authority to commit agency operating money, indicate the following:

Operating Area	Biennial Amount ($00000.00)	Fund Type

Note: *If additional rows of the below table are needed, place curser at end of a row (outside table) and hit "Enter".*

Entire agency	$4.2 million	Other

SECTION 11. ORGANIZATIONAL CHART

Attach a current organizational chart. Be sure the following information is shown on the chart for each position: classification title, classification number, salary range, employee's name and position number.

SECTION 12. SIGNATURES

SIGNATURE ON FILE		SIGNATURE ON FILE	
Employee Signature	Date	Supervisor Signature	Date

Appointing Authority Signature	Date

Oregon Board of Dentistry

EXECUTIVE DIRECTOR
Principal Executive/Manager E
Classification Z7008
Position 521 1.0 FTE

INVESTIGATION AND COMPLIANCE MONITORING

LICENSING/ADMINSTRATIVE SUPPORT

DENTAL DIRECTOR/
CHIEF INVESTIGATOR
Principal Executive/Manager E
Classification Z7008
Position 522 1.0 FTE

OPERATIONS MANAGER
Classification X0806
Position 524 1.0 FTE

DENTAL INVESTIGATOR
Classification C5911
Position 531 0 FTE
or .5 FTE POP 400

INVESTIGATOR 2
Classification C5232
Position 528 1.0 FTE

INVESTIGATOR 2
Classification C5232
Position 528 1.0 FTE

LICENSING &
EXAMINATION MANAGER
Admin Specialist 2
Classification CO 180
Position 525 1.0 FTE

ADMIN SUPPORT
Office Specialist 2
Classification C0104 Position
529 1.0 FTE

Oregon Board of Dentistry Bylaws

Article I. Name

Sec. 1. The name of the agency shall be the Oregon State Board of Dentistry. The word "Board" or "OBD" wherever used shall mean the Oregon State Board of Dentistry unless otherwise specifically identified.

Article II. Mission

Sec. 1. The Mission of the Oregon Board of Dentistry (OBD) is to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

Article III. Officers and Duties

Sec. 1. The President of the OBD shall preside at all meetings of the Board and shall have a vote on motions, if they so choose.
In addition, he/she shall perform the following duties:

a. The President shall be elected annually at the April Board Meeting.
b. They shall cause their signature to be placed upon all disciplinary orders approved by the Board.
c. They shall sign all monthly time sheets and expense forms, as well as any out-of-state trip request forms related to the Executive Director.
d. They shall appoint all standing and special committees. They shall cause whatever business may require attention to be brought before the Board.
e. They shall communicate with the Executive Director regarding the agenda for any regular or special Board Meetings.
f. They shall perform all other duties incumbent on their office.

Sec. 2. The Vice-President of the OBD shall preside at any Board meetings that the President cannot attend and shall have a vote on motions. In the event of a permanent vacancy in the Office of the President, the Vice-President shall become the President of the OBD until the next organizational meeting of the Board.
In addition, they shall perform the following duties:

a. The Vice-President shall be elected annually at the April Board Meeting.
b. They shall cause their signature to be placed upon all disciplinary orders approved by the Board if the president is unable to sign for any reason.

Sec. 3. The President of the OBD shall appoint all committee and workgroup chairs for any committees and workgroups of the OBD. Chairs shall preside at all meetings of their committees and workgroups.
In addition, they shall perform the following duties:

a. Committee and Workgroup Chairs shall work with the Executive Director to establish a meeting date when necessary.
b. They shall communicate with the Executive Director regarding the agenda for any committee and workgroup meetings.
c. Committee and Workgroup Chairs will report to the Board on any committee and workgroup meetings and any recommendations from the committee and workgroup to the Board.

Article IV. Voting

Sec. 1. Each member of the Board, any committee or workgroup, and other subordinate units of the Board shall have one vote in the respective body, at their respective meetings.

Sec. 2. Questions under consideration shall be decided by a majority vote of a quorum of the board, committee or workgroup meeting for business.

Sec. 3. The Board may authorize attendance and votes by conference call telephone, subject to notice requirements of Public Meeting Laws.

Article V. Quorum

Sec. 1. The Board has 10 members as prescribed by ORS 679.230. Six Board members present at any given meeting or gathering represents a quorum of the Board.

Article VI. Procedures and Rules

Sec. 1. Whenever these bylaws conflict with the Oregon Revised Statutes and Oregon Administrative Rules of the OBD, the statutes and then the rules shall take precedence.

Sec. 2. The Board will use at its discretion any Standard Code of Parliamentary Procedure for the transaction of the Board's affairs and the transaction of the affairs of any of its subordinate's bodies.

Article VII. Amendments

Sec. 1. The Board may adopt bylaws, or amend or repeal existing bylaws, at any regular meeting of the Board by a three-quarters majority vote of the members present and constituting a quorum. Unless otherwise specified, amendments or suspension of the bylaws shall become effective when approved by the Board.

Sec. 2. The text of any proposed bylaw adoption, amendment, or repeal shall be filed in writing with the President and the Executive Director at least 10 days prior to a regular scheduled Board meeting at which it is to be acted upon or considered. The Executive Director will include the proposal in the board packet and place the topic as part of the Board's agenda.

Sec. 3. A new bylaw, or an amendment or repeal of an existing bylaw, may be proposed by any of the following: a Board Member, a committee authorized for that purpose by the Board or the Executive Director of the Board. A majority vote of the members present at a scheduled Board meeting shall approve the proposal. Such proposed bylaw, amendment, or repeal shall be filed and presented for adoption in accordance with the preceding sections of this article.

Mark your calendars!



The 2026 Dental Testing & Regulatory Summit brings together leaders in dental regulation, examinations, and education.

What's Happening:

- AADA: Wednesday, October 14 (afternoon) & Thursday, October 15
- ADEX: Thursday, October 15 - Saturday, October 17
- Attendee Reception: Friday evening, October 16
- Educators Conference: October 17 (all day)
- AADB Annual Meeting: Saturday, October 17 - Sunday, October 18



Attachment #5

Join us to explore the latest trends in dental licensure, clinical examinations, professional discipline, and more. Learn from experts, share your experiences, and earn valuable continuing education—all while networking with regulators and educators alike in beautiful National Harbor, Maryland, just outside of Washington, DC!

Look for your personalized invitation coming from info@dental-summit.org in early August!

Attachment #5

From: Amelia <Amelia@crdts.org>
Sent: Thursday, May 14, 2026 10:08 AM
Subject: CRDTS Annual Meeting Invitation

Central Regional Dental Testing Service, Inc.

CRDTS + SRTA

1725 SW Gage Blvd |Topeka, KS 66604

(785) 273-0380|info@crdts.org

You are cordially invited to attend the 2026 Workshop and Annual Meeting August 28-29, 2026

Embassy Suites by Hilton Omaha Downtown Old Market, 555 S 10th St Omaha, NE 68102

Please refer to the expenditure and reimbursement policy below before making reservations.
Registration will be available through July 15th, 2026

Meeting Registration is available on our website, Annual Meeting Registration
Hotel Reservation at Annual Meeting Hotel Reservation

Examiners and Committee Members, make travel arrangements via www.concursolutions.com
Other Attendees use Corporate Travel Management, (844-378-2955) or
NA.travelrequest@travelctm.com

Expenditure & Reimbursement Policy

CRDTS will reimburse two nights lodging and airfare or roundtrip mileage reimbursement at the IRS rate, not to exceed coach airfare amount. All other travel expenses will be the responsibility of the attendee.

- **Member State Board Members, Member State Board Executive Directors, Dental & Dental Hygiene School Representatives (one per school) and All CRDTS Examiners, SME's & Proctors will be reimbursed for lodging, airfare, or mileage as outlined above.**

- **Committee Members with scheduled meetings will be emailed your meeting times and reimbursements.**

- Please Contact shanee@crdts.org with any questions.

Amelia Hursey

CAMP Coordinator & Office Administration
Central Regional Dental Testing Service, Inc.
1725 SW Gage Blvd|Topeka, KS|66604
785.273.0380| amelia@crdts.org www.crdts.org

UNFINISHED BUSINESS & RULES

ADA GUIDELINES
for the Use of Sedation and General Anesthesia by Dentists

Adopted by the ADA House of Delegates, October 2025

I. INTRODUCTION

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists must comply with their state laws, rules and/or regulations when providing sedation and anesthesia and will only be subject to Section III. Educational Requirements as required by those state laws, rules and/or regulations. Dental office-based sedation or general anesthesia may be administered by a qualified dentist or another independently qualified anesthesia healthcare provider, in accordance with state laws, rules and/or regulations for the benefit of patient safety.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

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For children, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures* and the American Dental Association's Council on Dental Education and Licensure's *Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students*. The American Dental Association further recognizes that other disciplines of dentistry may provide sedation/anesthesia care to children in accordance with their respective guidelines, Commission on Dental Accreditation Standards for anesthesia education and training, and state laws, rules and/or regulations.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[1]

For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

II. DEFINITIONS

METHODS OF ANXIETY AND PAIN CONTROL

MINIMAL SEDATION (PREVIOUSLY KNOWN AS ANXIOLYSIS) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's *normal response to verbal command*.[1]

They will also retain the ability to independently and continuously maintain an airway. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The administration of an enteral drug exceeding the maximum recommended dose for unmonitored home use during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

MODERATE SEDATION – a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[1]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or deeper levels of sedation:

titration – administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

DEEP SEDATION AND GENERAL ANESTHESIA

deep sedation – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[1]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

ROUTES OF ADMINISTRATION

enteral – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral – a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal – a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

TERMS

analgesia – the diminution or elimination of pain.

local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

qualified dentist – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

operating dentist – dentist with primary responsibility for providing operative dental care while a qualified dentist or independently practicing qualified anesthesia healthcare provider administers minimal, moderate or deep sedation or general anesthesia.

competent – while performing independently, displaying special skill or knowledge derived from training and experience.

must/shall – indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should – indicates the recommended manner to obtain the standard; highly desirable.

may – indicates freedom or liberty to follow a reasonable alternative.

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

time-oriented anesthesia record – documentation at appropriate time intervals of drugs, dosesand physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT PHYSICAL STATUS CLASSIFICATION[2]

ASA PS Classification	Definition	Adult examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, **ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or **ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

**The addition of "E" denotes Emergency surgery. (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part).

AMERICAN SOCIETY OF ANESTHESIOLOGISTS FASTING RECOMMENDATIONS*[3]

Ingested Material	Minimum Fasting Period†
Clear liquids‡	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk§	6 hours
Light meal**	6 hours
Fried foods, fatty meal, or meat	Additional fasting time (e.g. 8 or more hours) may be needed

Modifications to the above should be considered for patients with physiologic conditions or taking medications that delay gastric emptying (i.e., GLP-1 agonists).

*These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

†The fasting periods noted above apply to all ages.

‡Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.

§Since nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.

**A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

III. EDUCATIONAL REQUIREMENTS

A. Minimal Sedation

1. To administer minimal sedation, the dentist must be competent, as demonstrated by successful completion of:
   a. training in minimal sedation consistent with that prescribed in the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*,

      or

   b. comprehensive training in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

      or

   c. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

      and

   d. a current certification in Basic Life Support.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must be competent, as demonstrated by successful completion of:
   a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

      or

   b. an advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;

      and

   c. 1) A current certification in Basic Life Support and
      2) Current certification in Advanced Cardiac Life Support (ACLS). Current certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support.



C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must be competent, as demonstrated by successful completion of:
   a. An advanced education program accredited by the Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;

      and

   b. 1) A current certification in Basic Life Support and

      2) Current certification in Advanced Cardiac Life Support (ACLS). Current certification in Pediatric Advanced Life Support (PALS) is required for treating age-appropriate patients.
2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and their clinical staff to maintain current certification in Basic Life Support (BLS).

IV. CLINICAL GUIDELINES

A. Minimal sedation

1. Patient History and Evaluation

   Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of a review of their current medical history and medication use. In addition, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Evaluation and Preparation

   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation should be performed.
   - Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, and respiration rate must be obtained unless invalidated by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
   - Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
   - Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver.

3. Personnel and Equipment Requirements

   Personnel: At least one additional person trained in Basic Life Support must be present in addition to the dentist.

   Equipment:
   - A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, and oral pharyngeal airways.
   - Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
   - When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
   - An appropriate scavenging system must be available if gases other than oxygen or air are used.



4. Monitoring and Documentation

   Monitoring: A qualified dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

   Consciousness: Level of sedation (e.g., responsiveness to verbal commands) must be continually assessed.

   Oxygenation: Oxygen saturation by pulse oximetry.

   Ventilation:

   - The qualified dentist and/or appropriately trained individual must observe chest excursions.
   - The qualified dentist and/or appropriately trained individual must verify respirations.

   Circulation: Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

   Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, time administered and route of administration, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

   - Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
   - The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
   - The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
   - Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or caregiver.

6. Emergency Management

   - If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
   - The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.
   - All providers and offices must have written emergency protocols.
   - Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.

B. Moderate Sedation

1. Patient History and Evaluation

   Patients considered for moderate sedation must undergo an evaluation prior to the administration of any sedative. This should consist of at least a review at an appropriate time of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) should also require consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation

   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation must be performed.
   - Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless precluded by the nature of the patient, procedure or equipment. Body temperature should be measured when clinically indicated.
   - Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian or caregiver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.[3]

3. Personnel and Equipment Requirements

   Personnel: At least one additional person trained in Basic Life Support must be present in addition to the dentist.

   Equipment:

   - A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways, and supraglottic airways.
   - Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration of sedation must be performed.
   - When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravascular or intraosseous access should be available until the patient meets discharge criteria.
- The patient should be on supplemental oxygen throughout the procedure, as determined by the treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified allied team member may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness: Level of sedation (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation: Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation and/or breathing by monitoring end-tidal CO_2 unless precluded or invalidated by the nature of the patient, procedure or equipment. In addition, ventilation should be monitored by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiratory rate must be continually monitored and evaluated.

Circulation:

- The dentist must continually evaluate blood pressure and heart rate unless invalidated by the nature of the patient, procedure or equipment and this is noted in the time-oriented anesthesia record.
- Continuous ECG monitoring unless precluded or invalidated by the nature of the patient, procedure (e.g. fire risk), or equipment.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.



MODERATE SEDATION CONTINUED

- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management
   - If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
   - The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.
   - All providers and offices must have written emergency protocols.
   - Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.



C. Deep Sedation or General Anesthesia

1. Patient History and Evaluation

   Patients considered for deep sedation or general anesthesia must undergo an evaluation prior to the administration of any sedative. This must consist of at least a review of their medical history and medication use and NPO (nothing by mouth) status. In addition, patients with significant medical considerations (e.g., ASA III, IV) must have consultation with their primary care physician or consulting medical specialist. Assessment of Body Mass Index (BMI)[4] should be considered part of a pre-procedural workup. Patients with elevated BMI may be at increased risk for airway associated morbidity, particularly if in association with other factors such as obstructive sleep apnea.

2. Pre-operative Evaluation and Preparation
   - The patient, parent, legal guardian and/or caregiver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
   - Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
   - An appropriate focused physical evaluation must be performed.

- Baseline vital signs including body weight, height, BMI, blood pressure, pulse rate, respiration rate, and blood oxygen saturation by pulse oximetry must be obtained unless invalidated by the patient, procedure or equipment. In addition, body temperature should be measured when clinically appropriate.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, legal guardian and/or caregiver, including pre-operative fasting instructions based on the ASA Summary of Fasting and Pharmacologic Recommendations.[3]
- An intravenous (IV) line should be established and secured for the duration of the procedure, as needed.
  - In certain cases, deep sedation or general anesthesia may be administered without first establishing an indwelling intravenous line. These exceptions may apply to very short procedures or situations where intravenous access is delayed until after sedation or anesthesia is initiated, such as with uncooperative patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these *Guidelines* to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification in Basic Life Support (BLS).
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available. At minimum, the following must be available: bag-valve-mask with multiple mask sizes, portable oxygen tank with regulator and key, oral pharyngeal airways, and supraglottic airways.
- Documentation of compliance with manufacturers' recommended maintenance of monitors, anesthesia delivery systems, and other anesthesia-related equipment should be maintained. A pre-procedural check of equipment for each administration must be performed.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- The equipment necessary for monitoring end-tidal CO_2 and auscultation of breath sounds must be immediately available.
- Resuscitation medications and an appropriate defibrillator must be immediately available.
- The patient must be on supplemental oxygen throughout the procedure, as determined by the treating dentist, unless precluded by the nature of the patient, procedure (e.g., fire risk), or equipment.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation: Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO2 must be continuously monitored and evaluated.
- Non-intubated patient: End-tidal CO2 must be continually monitored and evaluated unless precluded or invalidated by the nature of the patient, procedure, or equipment. In addition, ventilation should be monitored and evaluated by continual observation of qualitative signs, including auscultation of breath sounds with a precordial or pretracheal stethoscope.
- Respiratory rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages (in weight, i.e., mg or mcg) and their administration times, including local anesthetics and monitored physiological parameters.
- Pulse oximetry and end-tidal CO2 measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, and parent, escort, guardian or caregiver.

6. Patients with Special Healthcare Needs

   Because many dental patients undergoing deep sedation or general anesthesia have mental and/or physical special healthcare needs, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

7. Emergency Management

   - The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.
   - All providers and offices must have written emergency protocols.
   - Documented training sessions, including rehearsed emergency drills, must be developed and rehearsed, at minimum, every six months. It is the responsibility of the qualified dentist to ensure training occurs as presented.

ENDNOTES

1 Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia*, 2024, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

2 Excerpted from *Standards and Practice Parameters: Statement on ASA Physical Status Classification System*, 2020, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

3 Excerpted from American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. *Anesthesiology*, 2017. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

4 Standardized BMI category definitions can be obtained from the Centers for Disease Control and Prevention or the American Society of Anesthesiologists.

GUIDELINES
for Teaching Pain Control and Sedation to Dentists and Dental Students

Adopted by the ADA House of Delegates, October 2025

I. INTRODUCTION

The administration of local anesthesia, sedation and general anesthesia is an integral part of the practice of dentistry. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists.

Anxiety and pain control can be defined as the application of various physical, chemical and psychological modalities to the prevention and treatment of preoperative, operative and postoperative patient anxiety and pain to allow dental treatment to occur in a safe and effective manner. It involves all disciplines of dentistry and, as such, is one of the most important aspects of dental education. The intent of these *Guidelines* is to provide direction for the teaching of pain control and sedation to dentists and can be applied at all levels of dental education from predoctoral through continuing education. They are designed to teach initial competency in pain control and minimal and moderate sedation techniques.

These *Guidelines* recognize that many dentists have acquired a high degree of competency in the use of anxiety and pain control techniques through a combination of instruction and experience. It is assumed that this has enabled these teachers and practitioners to meet the educational criteria described in this document.

It is not the intent of the *Guidelines* to fit every program into the same rigid educational mold. This is neither possible nor desirable. There must always be room for innovation and improvement. They do, however, provide a reasonable measure of program acceptability, applicable to all institutions and agencies engaged in predoctoral and continuing education.

The curriculum in anxiety and pain control is a continuum of educational experiences that will extend over several years of the predoctoral program. It should provide the dental student with the knowledge and skills necessary to provide minimal sedation to alleviate anxiety and control pain without inducing detrimental physiological or psychological side effects. Dental schools whose goal is to have predoctoral students achieve competency in techniques such as local anesthesia and nitrous oxide inhalation and minimal sedation must meet all of the goals, prerequisites, didactic content, clinical experiences, faculty and facilities, as described in these *Guidelines*.

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Techniques for the control of anxiety and pain in dentistry should include both psychological and pharmacological modalities. Psychological strategies should include simple relaxation techniques for the anxious patient and more comprehensive behavioral techniques to control pain. Pharmacological strategies should include not only local anesthetics but also sedatives, analgesics and other useful agents. Dentists should learn indications and techniques for administering these drugs enterally, parenterally and by inhalation as supplements to local anesthesia.

The predoctoral curriculum should provide instruction, exposure and/or experience in anxiety and pain control, including minimal and moderate sedation. The predoctoral program must also provide the knowledge and skill to enable students to recognize and manage any emergencies that might arise as a consequence of treatment. Predoctoral dental students must complete a course in Basic Life Support. Though Basic Life Support courses are available online, any course taken online should be followed up with a hands-on component and be approved by the American Heart Association or the American Red Cross.

Local anesthesia is the foundation of pain control in dentistry. Although the use of local anesthetics in dentistry has a long record of safety, dentists must be aware of the maximum safe dosage limit for each patient, since large doses of local anesthetics may increase the level of central nervous system depression with sedation. The use of minimal and moderate sedation requires an understanding of local anesthesia and the physiologic and pharmacologic implications of the local anesthetic agents when combined with the sedative agents.

Level of sedation is entirely independent of the route of administration. Moderate and deep sedation or general anesthesia may be achieved via any route of administration and thus an appropriately consistent level of training must be established.

For children, the American Dental Association supports the use of the *American Academy of Pediatrics/American Academy of Pediatric Dentistry Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures* and the American Dental Association's Council on Dental Education and Licensure's *Guidelines for Teaching Pediatric Pain Control and Sedation to Dentists and Dental Students.* The American Dental Association further recognizes that other disciplines of dentistry may provide sedation/anesthesia care to children in accordance with their respective guidelines, Commission on Dental Accreditation Standards for anesthesia education and training, and state laws, rules and/or regulations.

The knowledge, skill and clinical experience required for the safe administration of deep sedation and/or general anesthesia are beyond the scope of predoctoral and continuing education programs. Advanced education programs that teach deep sedation and/or general anesthesia to competency have specific teaching requirements described in the Commission on Dental Accreditation requirements for those advanced programs and represent the educational and clinical requirements for teaching deep sedation and/or general anesthesia in dentistry.

The objective of educating dentists to utilize pain control, sedation and general anesthesia is to enhance their ability to provide oral health care. The American Dental Association urges dentists to participate regularly in continuing education update courses in these modalities in order to remain current.

All areas in which local anesthesia and sedation are being used must be properly equipped with written emergency protocols, suction, physiologic monitoring equipment, a positive pressure oxygen delivery system suitable for the patient being treated and emergency drugs. Training sessions, including simulation, should be developed and rehearsed frequently. Protocols for the management of emergencies must be developed and training programs held at frequent intervals.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.[1]

For all levels of sedation, the qualified dentist must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

II. DEFINITIONS

METHODS OF ANXIETY AND PAIN CONTROL

MINIMAL SEDATION (PREVIOUSLY KNOWN AS ANXIOLYSIS) – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's *normal* response to verbal command.

They will also retain the ability to independently and continuously maintain an airway. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.[1]

The following definitions apply to administration of minimal sedation:

maximum recommended dose (MRD) – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

dosing for minimal sedation via the enteral route – minimal sedation may be achieved by the administration of a drug, either singly or in divided doses, by the enteral route to achieve the desired clinical effect, not to exceed the maximum recommended dose (MRD).

The administration of an enteral drug exceeding the maximum recommended dose for unmonitored home use during a single appointment is considered to be moderate sedation and the moderate sedation guidelines apply.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

If more than one enteral drug is administered to achieve the desired sedation effect, with or without the concomitant use of nitrous oxide, the guidelines for moderate sedation must apply.

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. The use of the MRD to guide dosing for minimal sedation is intended to create this margin of safety.

MODERATE SEDATION – a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.[1]

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to administration of moderate and deeper levels of sedation:

titration – administration of incremental doses of an intravenous or inhalation drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.[1]

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.[1]

ROUTES OF ADMINISTRATION

enteral – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral – a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal – a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

TERMS

analgesia – the diminution or elimination of pain.

local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must always be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression especially in combination with sedative agents.

qualified dentist – a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations.

must/shall – indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should – indicates the recommended manner to obtain the standard; highly desirable.

may – indicates freedom or liberty to follow a reasonable alternative.

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

time-oriented anesthesia record – documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

LEVELS OF KNOWLEDGE

familiarity – a simplified knowledge for the purpose of orientation and recognition of general principles.

in-depth – a thorough knowledge of concepts and theories for the purpose of critical analysis and the synthesis of more complete understanding (highest level of knowledge).

LEVELS OF SKILL

exposed – the level of skill attained by observation of or participation in a particular activity.

competent – while performing independently, displaying special skill or knowledge derived from training and experience.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT PHYSICAL STATUS CLASSIFICATION[2]

ASA PS Classification	Definition	Adult Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, **ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or **ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

**The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

AMERICAN SOCIETY OF ANESTHESIOLOGISTS' FASTING GUIDELINES[3]

Ingested Material	Minimum Fasting Period†
Clear liquids‡	2 hours
Breast milk	4 hours
Infant formula	6 hours
Nonhuman milk§	6 hours
Light meal**	6 hours
Fried foods, fatty meal, or meat	Additional fasting time (e.g. 8 or more hours) may be needed

Modifications to the above should be considered for patients with physiologic conditions or taking medications that delay gastric emptying (i.e., GLP-1 agonists).

*These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.

†The fasting periods noted above apply to all ages.

‡Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.

§Since nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.

**A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Additional fasting time (e.g., 8 or more hours) may be needed in these cases. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

EDUCATION COURSES

Education may be offered at different levels (competency, update, survey courses and advanced education programs). A description of these different levels follows:

1. **Competency Courses** are designed to meet the needs of dentists who wish to become competent in the safe and effective administration of local anesthesia, minimal and moderate sedation. They consist of lectures, demonstrations and sufficient clinical participation to assure the faculty that the dentist understands the procedures taught and can safely and effectively apply them so that mastery of the subject is achieved. Faculty must assess and document the dentist's competency upon successful completion of such training. To maintain competency, periodic update courses must be completed.

2. **Update Courses** are designed for persons with previous training. They are intended to provide a review of the subject and an introduction to recent advances in the field. They should be designed didactically and clinically to meet the specific needs of the participants. Participants must have completed previous competency training (equivalent, at a minimum, to the competency course described in this document) and have current experience to be eligible for enrollment in an update course.

3. **Survey Courses** are designed to provide general information about subjects related to pain control and sedation. Such courses should be didactic and not clinical in nature, since they are not intended to develop clinical competency.

4. **Advanced Education Courses** are a component of an advanced dental education program, accredited by the Commission on Dental Accreditation in accord with the *Accreditation Standards* for advanced dental education programs. These courses are designed to prepare the graduate dentist or postdoctoral student in the most comprehensive manner to be competent in the safe and effective administration of minimal, moderate and deep sedation and general anesthesia.

III. TEACHING PAIN CONTROL

These *Guidelines* present a basic overview of the recommendations for teaching pain control.

A. General Objectives: Upon completion of a predoctoral curriculum in pain control the dentist must:

1. have an in-depth knowledge of those aspects of anatomy, physiology, pharmacology and psychology involved in the use of various anxiety and pain control methods;
2. be competent in evaluating the psychological and physical status of the patient, as well as the magnitude of the operative procedure, in order to select the proper regimen;
3. be competent in monitoring vital functions;
4. be competent in prevention, recognition and management of related complications;
5. have in-depth knowledge of the appropriateness of and the indications for medical consultation or referral;
6. be competent in the maintenance of proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs administered and patient response.

B. Pain Control Curriculum Content:

1. Philosophy of anxiety and pain control and patient management, including the nature and purpose of pain
2. Review of physiologic and psychologic aspects of anxiety and pain
3. Review of airway anatomy and physiology
4. Physiologic monitoring
   a. Observation
      1). Central nervous system
      2). Respiratory system
         a. Oxygenation
         b. Ventilation
      3). Cardiovascular system
   b. Monitoring equipment
5. Pharmacologic aspects of anxiety and pain control
   a. Routes of drug administration
   b. Sedatives and anxiolytics
   c. Local anesthetics
   d. Analgesics and antagonists
   e. Adverse side effects
   f. Drug interactions
   g. Drug abuse

6. Control of preoperative and operative anxiety and pain
    a. Patient evaluation
        1). Psychological status
        2). ASA physical status
        3). Type and extent of operative procedure
    b. Nonpharmacologic methods
        1). Psychological and behavioral methods
            a). Anxiety management
            b). Relaxation techniques
            c). Systematic desensitization
        2). Interpersonal strategies of patient management
        3). Hypnosis
        4). Acupuncture/Acupressure
        5). Other
    c. Local anesthesia
        1). Review of related anatomy, and physiology
        2). Pharmacology
            a). Dosing
            b). Toxicity
            c). Selection of agents
        3). Techniques of administration
            a). Topical
            b). Infiltration (supraperiosteal)
            c). Nerve block – maxilla-to include:
                (aa). Posterior superior alveolar
                (bb). Infraorbital
                (cc). Nasopalatine
                (dd). Greater palatine
                (ee). Maxillary (2nd division)
                (ff). Other blocks
            d. Nerve block – mandible – to include:
                (aa). Inferior alveolar-lingual
                (bb). Mental-incisive
                (cc). Buccal
                (dd). Gow-Gates
                (ee). Closed mouth
            e. Alternative injections-to include:
                (aa). Periodontal ligament
                (bb). Intraosseous
    d. Prevention, recognition and management of complications and emergencies

C. Sequence of Pain Control Didactic and Clinical Instruction: Beyond the basic didactic instruction in local anesthesia, additional time should be provided for demonstrations and clinical practice of the injection techniques. The teaching of other methods of anxiety and pain control, such as the use of analgesics and enteral, inhalation and parenteral sedation, should be coordinated with a course in pharmacology. By this time the student also will have developed a better understanding of patient evaluation and the problems related to prior patient care. As part of this instruction, the student should be taught the techniques of venipuncture and physiologic monitoring. Time should be included for demonstration of minimal and moderate sedation techniques.

Following didactic instruction in minimal and moderate sedation, the student must receive sufficient clinical experience to demonstrate competency in those techniques in which the student is to be certified. It is understood that not all institutions may be able to provide instruction to the level of clinical competence in pharmacologic sedation modalities to all students. The amount of clinical experience required to achieve competency will vary according to student ability, teaching methods and the anxiety and pain control modality taught.

Clinical experience in minimal and moderate sedation techniques should be related to various disciplines of dentistry and not solely limited to surgical cases. Typically, such experience will be provided in managing healthy adult patients.

Throughout both didactic and clinical instruction in anxiety and pain control, psychological management of the patient should also be stressed. Instruction should emphasize that the need for sedative techniques is directly related to the patient's level of anxiety, cooperation, medical condition and the planned procedures.

D. Faculty: Instruction must be provided by qualified faculty for whom anxiety and pain control are areas of major proficiency, interest and concern.

E. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

IV. TEACHING ADMINISTRATION OF MINIMAL SEDATION

The faculty responsible for curriculum in minimal sedation techniques must be familiar with the ADA Policy Statement: *Guidelines for the Use of Sedation and General Anesthesia by Dentists*, and the Commission on Dental Accreditation's Accreditation *Standards* for dental education programs.

These *Guidelines* present a basic overview of the recommendations for teaching minimal sedation. These include courses in nitrous oxide/oxygen sedation, enteral sedation, and combined inhalation/enteral techniques.

General Objectives: Upon completion of a competency course in minimal sedation, the dentist must be able to:

1. Describe the adult anatomy and physiology of the respiratory, cardiovascular and central nervous systems, as they relate to the above techniques.
2. Describe the pharmacological effects of drugs.
3. Describe the methods of obtaining a medical history and conduct an appropriate physical examination.
4. Apply these methods clinically in order to obtain an accurate evaluation.
5. Use this information clinically for ASA classification risk assessment and pre-procedure fasting instructions.
6. Choose the most appropriate technique for the individual patient.
7. Use appropriate physiologic monitoring equipment.
8. Describe the physiologic responses that are consistent with minimal sedation.
9. Understand the sedation/general anesthesia continuum.
10. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

INHALATION SEDATION (NITROUS OXIDE/OXYGEN)

A. Inhalation Sedation Course Objectives: Upon completion of a competency course in inhalation sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of inhalation sedation.
4. List and discuss the indications and contraindications of inhalation sedation.
5. List the complications associated with inhalation sedation.
6. Discuss the prevention, recognition and management of these complications.
7. Administer inhalation sedation to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other untoward effects of inhalation agents.



B. Inhalation Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in inhalation sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of inhalation sedation.
8. Review of dental procedures possible under inhalation sedation.
9. Patient monitoring using observation and monitoring equipment (i.e., pulse oximetry), with particular attention to vital signs and reflexes related to pharmacology of nitrous oxide.
10. Importance of maintaining proper records with accurate chart entries recording medical history, physical examination, vital signs, drugs and doses administered and patient response.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with inhalation sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Inhalation Sedation Course Duration: While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should be a minimum of *14 hours* plus management of clinical dental cases, during which clinical competency in inhalation sedation technique is achieved. The inhalation sedation course most often is completed as a part of the predoctoral dental education program. However, the course may be completed in a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Inhalation Sedation Instruction: Competency courses in inhalation sedation techniques must afford participants with sufficient clinical experience to enable them to achieve competency. This experience must be provided under the supervision of qualified faculty and must be evaluated. The course director must certify the competency of participants upon satisfactory completion of training. Records of the didactic instruction and clinical experience, including the number of patients treated by each participant must be maintained and available.

E. Faculty: The course should be directed by a dentist qualified by experience and training. This individual should possess an active permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. In addition, the participation of highly qualified individuals in related fields should be encouraged.

A participant-faculty ratio of not more than ten-to-one when inhalation sedation is being used allows for adequate supervision during the clinical phase of instruction; a one-to-one ratio is recommended during the early state of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

ENTERAL AND/OR COMBINATION INHALATION-ENTERAL MINIMAL SEDATION

A. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Objectives: Upon completion of a competency course in enteral and/or combination inhalation-enteral minimal sedation techniques, the dentist must be able to:

1. Describe the basic components of inhalation sedation equipment.
2. Discuss the function of each of these components.
3. List and discuss the advantages and disadvantages of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
4. List and discuss the indications and contraindications for the use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
5. List the complications associated with enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
6. Discuss the prevention, recognition and management of these complications.
7. Administer enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation) to patients in a clinical setting in a safe and effective manner.
8. Discuss the abuse potential, occupational hazards and other effects of enteral and inhalation agents.
9. Discuss the pharmacology of the enteral and inhalation drugs selected for administration.
10. Discuss the precautions, contraindications and adverse reactions associated with the enteral and inhalation drugs selected.
11. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for management of life-threatening situations.
12. Demonstrate the ability to manage life-threatening emergency situations, including current certification in Basic Life Support.
13. Discuss the pharmacological effects of combined drug therapy, their implications and their management. Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.



B. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological profiling.
3. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
4. Description of the stages of drug-induced central nervous system depression through all levels of consciousness and unconsciousness, with special emphasis on the distinction between the conscious and the unconscious state.
5. Review of adult respiratory and circulatory physiology and related anatomy.
6. Pharmacology of agents used in enteral and/or combination inhalation-enteral minimal sedation, including drug interactions and incompatibilities.
7. Indications and contraindications for use of enteral and/or combination inhalation-enteral minimal sedation (combined minimal sedation).
8. Review of dental procedures possible under enteral and/or combination inhalation-enteral minimal sedation).
9. Patient monitoring using observation, monitoring equipment, with particular attention to vital signs and reflexes related to consciousness.
10. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
11. Prevention, recognition and management of complications and life-threatening situations.
12. Administration of local anesthesia in conjunction with enteral and/or combination inhalation-enteral minimal sedation techniques.
13. Description, maintenance and use of inhalation sedation equipment.
14. Introduction to potential health hazards of trace anesthetics and proposed techniques for limiting occupational exposure.
15. Discussion of abuse potential.

C. Enteral and/or Combination Inhalation-Enteral Minimal Sedation Course Duration:
Participants must be able to document current certification in Basic Life Support and have completed a nitrous oxide competency course to be eligible for enrollment in this course. While length of a course is only one of the many factors to be considered in determining the quality of an educational program, the course should include a minimum of *16 hours*, plus clinically-oriented experiences during which competency in enteral and/or combined inhalation-enteral minimal sedation techniques is demonstrated. Clinically-oriented experiences may include simulation, group observations on patients undergoing enteral and/or combination inhalation-enteral minimal sedation. Clinical experience or simulation training in airway management is critical to the prevention of life-threatening emergencies and must be included in the course. The faculty should schedule participants to return for additional clinical experience if competency has not been achieved in the time allotted. The educational course may be completed in a predoctoral dental education curriculum or a postdoctoral continuing education competency course.

D. Participant Evaluation and Documentation of Instruction: Competency courses in combination inhalation-enteral minimal sedation techniques must afford participants with sufficient clinical understanding to enable them to achieve competency. The course director must certify the competency of participants upon satisfactory completion of the course. Records of the course instruction must be maintained and available.

E. Faculty: The course should be directed by a dentist qualified by experience and training. This individual should possess a current permit or license to administer moderate sedation in at least one state, have had at least three years of experience, including the individual's formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields should be encouraged. The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies.

V. TEACHING ADMINISTRATION OF MODERATE SEDATION

These *Guidelines* present a basic overview of the requirements for a competency course in moderate sedation. These include courses in enteral and parenteral moderate sedation. The teaching guidelines contained in this section on moderate sedation reflect the delivery methodologies and practice environment in dentistry.

Completion of a pre-requisite nitrous oxide-oxygen competency course is required for participants combining moderate sedation with nitrous oxide-oxygen.

A. Course Objectives: Upon completion of a course in moderate sedation, the dentist must be able to:

1. List and discuss the advantages and disadvantages of moderate sedation.
2. Discuss the prevention, recognition and management of complications associated with moderate sedation.
3. Administer moderate sedation to patients in a clinical setting in a safe and effective manner.
4. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation.
5. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques.
6. Discuss the pharmacology of the drug(s) selected for administration.
7. Discuss the precautions, indications, contraindications and adverse reactions associated with the drug(s) selected.
8. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner.



9. List the complications associated with techniques of moderate sedation.
10. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations.
11. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent.
12. Demonstrate the ability to manage emergency situations.
13. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended.

B. Moderate Sedation Course Content:

1. Historical, philosophical and psychological aspects of anxiety and pain control.
2. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations.
3. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions.
4. Definitions and descriptions of physiological and psychological aspects of anxiety and pain.
5. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state.
6. Review of adult respiratory and circulatory physiology and related anatomy.
7. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications.
8. Indications and contraindications for use of moderate sedation.
9. Review of dental procedures possible under moderate sedation.
10. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs, ventilation/breathing and reflexes related to consciousness.
11. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters.
12. Prevention, recognition and management of complications and emergencies.
13. Description, maintenance and use of moderate sedation monitors and equipment.
14. Discussion of abuse potential.
15. Intravenous access: anatomy, equipment and technique.
16. Prevention, recognition and management of complications of venipuncture and other parenteral techniques.
17. Description and rationale for the technique to be employed.
18. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems.

C. Moderate Sedation Course Duration and Documentation:
The Course must include:

- A minimum of 60 hours of instruction.
- Supervised individual administration of moderate sedation for at least twenty (20) dental patients receiving moderate sedation.
- Certification of competence in moderate sedation technique(s).
- Certification of competence in rescuing patients from a deeper level of sedation than intended including managing the airway, intravascular or intraosseous access, and reversal medications.
- Provision by course director or faculty of additional clinical experience if participant competency has not been achieved in time allotted.
- Records of instruction and clinical experiences (i.e., number of patients managed by each participant in each modality/route) that are maintained and available for participant review.

D. Documentation of Instruction: The course director must certify the competency of participants upon satisfactory completion of training in each moderate sedation technique, including instruction, clinical experience, managing the airway, intravascular/intraosseous access, and reversal medications.

E. Faculty: The course must be directed by a dentist qualified by experience and training. This individual shall possess a current permit or license to administer moderate or deep sedation and general anesthesia in at least one state, have had at least three years of experience, including formal postdoctoral training in anxiety and pain control. Dental faculty with broad clinical experience in the particular aspect of the subject under consideration should participate. In addition, the participation of highly qualified individuals in related fields should be encouraged.

A participant-faculty ratio of not more than four-to-one when moderate sedation is being taught allows for adequate supervision during the clinical phase of instruction. A one-to-one ratio is recommended during the early stage of participation.

The faculty should provide a mechanism whereby the participant can evaluate the performance of those individuals who present the course material.

F. Facilities: Competency courses in moderate sedation must be presented where adequate facilities are available for proper patient care, including drugs and equipment for the management of emergencies. These facilities may include dental and medical schools/offices, hospitals and surgical centers.

ENDNOTES

1 Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/ Analgesia*, 2024, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

2 Excerpted from *Standards and Practice Parameters: Statement on ASA Physical Status Classification System*, 2020, of the American Society of Anesthesiologists. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

3 Excerpted from American Society of Anesthesiologists: Practice Guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures. *Anesthesiology*, 2017. A copy of the full text can be obtained from ASA, 1061 American Lane Schaumburg, IL 60173-4973 or online at **www.asahq.org**.

Oregon Board of Dentistry







Strategic Plan
2026-2029

Draft 1.0
As of June 1, 2026



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Oregon Board of Dentistry

2026-2029 Strategic Plan

Board members and staff of the Oregon Board of Dentistry who participated in the development of this strategic plan at the February 27-28 Planning Session, and Board Meeting on April 24th:

Board Members

Aarati Kalluri, DDS - President
Sheena Kalia, DDS - Vice-President
Reza J. Sharifi, DMD
Terrence Clark, DMD
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Sharity Ludwig, RDH
Kristen Simmons, RDH
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Haley Robinson – Executive Director
Kathleen McNeal – Licensing Manager
Winthrop "Bernie" Carter, DDS – Dental Investigator
Angela M. Smorra, DMD, Dental Director/Chief Investigator
Dawn Dreasher – Office Specialist
Gabriel Kubik – Investigator
Joanna Tucker Davis – Sr. Assistant Attorney General

Meeting Facilitators:

Jennifer Coyne, CEO, Lead Consultant, The PEAK Fleet
Sarah Rosenberg Brown, Consultant Contractor, The PEAK Fleet

Oregon Board of Dentistry
Strategic Plan Overview

The Oregon Board of Dentistry's (OBD) responsibilities and oversight authority is bestowed from the Oregon Revised Statutes Chapter 679 (Dentists), Chapter 680.010 to 680.205 (Dental Hygienists) Oregon Administrative Rules Chapter 818. In addition, direction for Dental Therapists is guided by HB 2528 (2021) and the addition of Interim Therapeutic Restorations, HB 2627 (2021) for Expanded Practice Dental Hygienists. These statutes task the OBD with regulation and oversight of the practice of dentistry and dental hygiene by enforcing standards of practice established in the Oregon Legislature statute and rule.

The Oregon Board of Dentistry has established an ongoing process for developing a Strategic Plan which is actively monitored, advanced by the Board and Staff, and updated every 3 years. In late 2025, the Board and staff of OBD agreed to secure professional, external strategy and facilitation services in the creation of their next multi-year strategic plan, building upon the efforts of the 2022-2025 Plan. This new strategic plan is built upon the Mission updated and affirmed by the board in the last strategic cycle: *To promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.*

The 2026-2029 Oregon Board of Dentistry Strategic Plan was developed through:

- External Market Research
- Analysis of licensee surveys
- Facilitated meetings with the Board and Staff between December 2025 and April 2026

It is also built upon the strong relationships with the Governor's office, Oregon Legislature, Oregon Health Authority, peer professional organizations, and national associations that provide context and direction.

Through the Planning process, five key strategic priorities were defined and goals established. Actions needed to meet the strategic goals were drafted and prioritized.

Covered in more detail in the subsequent pages, focus for the next 3 years will be on: the Future of Dental Regulation, Emerging Dental Practice Challenges, Community & Access to Care, Workplace Environment, and Technology & Processes.

Oregon Board of Dentistry
Mission Statement & Core Values

Mission of the Oregon Board of Dentistry:

To promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals.

Oregon Board of Dentistry Core Values:

- Integrity
- Fairness
- Responsibility
- Community

SWOT will be placed here next when PDF version is created for Board (see separate pdf)

STRATEGIC PRIORITY A

Future of Dental Regulation

The Oregon Board of Dentistry's primary function centers around rule making and regulation for the scope of Licensees it oversees. The regulatory landscape is a changing environment due to influences such as workforce shortages, an aging workforce, access disparities, changing trends and technologies in dental care solutions, and cost & coverage of care. From workforce shortages and changes in staffing cost models, arise discussions about what licenses cover various practices and procedures. Workforce shortages and demographic/geographic shifts also have given rise to the desirability to consider license portability, and the introduction of Interstate Licensure Portability (also known as Dentist & Dental Hygienist Compact, or DDH Compact). The Board considered these environmental factors in developing priorities related to the Future of Dental Regulation in the State of Oregon.

Goals

1. Clarify & Communicate Rules for Dental Assistants; increase visibility & accountability
2. Improve Board Communication, Scope of Practice Enforcement, and Education
3. Determine OBD position on Dental Compact & related action items needed

Action Items

1a) Create or provide access to a Dental Assistant Registry within OBD

1b) Create ability for Dentists to voluntarily register and disclose employed Dental Assistants (changed from Required to Voluntary based on survey input)

2a) Address use of Artificial Intelligence via OARs or assign to committee to create policy

3a) Review budget annually and determine actions for budget to keep pace with needed staffing / oversight

3b) Explore Dental Compact progress across other states; provide informational updates to Board for consideration including how funding would work. (updated to be more informational and analytical and not for OBD to take other rules action at this time)

Removed due to Survey &/or board/staff lack of ability or jurisdication :
Original Survey item 1b: Assign DAWSAC to review rules, provide clarity to enable simple guidelines to be created – only 57% agreed to include; not agreement this is within the purview of DAWSAC.

Original Survey item 2a: Patient safety oversight: Ensure oversight & violations of Tooth Gems, Whitening Kiosks by HLQ – only 57% agree to include; ED Haley Robinson indicates unlikely this will be enforced by OR DOJ.

STRATEGIC PRIORITY B

Emerging Dental Practice Challenges

With the evolving state of dental regulations, workforce shortages, care & cost model changes, and other dental practice challenges, the Board looks to consider how to both provide support and relief to Dental practitioners while maintaining the highest level of safety and care to the community. Research shows a high percentage (as high as over 80%) of dentists reporting career-related stress. Burnout remains a significant issue. These circumstances can lead to wellness issues for providers as well as can contribute to the decline in workplace culture and collaboration or collegiality amongst dental providers. The OBD is committed to supporting the wellbeing of the profession and its licensees and prioritizes Goals for this Strategic Cycle that aim to aid in improving these circumstances.

Goals

1. Address workforce shortage of Registered Dental Hygienists, Dental Assistants, and Dental Therapists
2. Support provider wellness, specifically addressing emergent provider challenges
3. Foster mutual respect & collaboration among dental professionals including the Board

Action Items

1a) Research recommendations of Oregon dentistry professionals to improve the workforce shortage through questions in the annual or separate survey

sent by OBD This was originally “Expand Scope of Licensee Functions”, now modified based on the Board survey to be a more actionable item.

1b) Encourage associations to promote dental professional paths in high schools, community colleges, and 4-year colleges through website, newsletters and other communication pathways

2a) Publish newsletter articles / website content to address mental health & addiction challenges; led by Communication Committee

2b) Promote wellness tools & resources including continuing education; leverage best practices from other states

2c) Implement a 1-hour Continuing Education requirement focused on mental health & addiction challenges and solutions

3a) Board to advance collaborative teamwork through development of Board behavioral norms in alignment with OBD values

Removed due to Survey &/or board/staff lack of ability or jurisdication :

Original Survey Goal 4: Pursue legislative change to increase insurance reimbursement and associated Action item 4a) Share dental “state of the industry” with legislator; work in collaboration with other related agencies – 70% of survey didn’t want to include, Exec director agrees this is not in jurisdiction.

STRATEGIC PRIORITY C

Community & Access to Care

The Oregon Board of Dentistry recognizes that systemic inequities exist in our society which have resulted in practices that have not always provided equitable access to dental care across our community. Within the scope and spirit of OBD's Mission and Values, the Board believes it can do more to help the community understand their options for care, help providers gain access to necessary information and tools, and support both providers and the community through the complaint and investigation process. Communication clarity is a central element to this, and the OBD will prioritize access to services and information in this strategic cycle.

Goals

1. Strengthen Community Engagement and support improved communication with Dental Providers
2. Communicate clarification of full scope of services by licensee type

Action Items

1a) Increase ease of community access to OBD services & information as committed in Affirmative Action Plan

1b) Create easier access to information on OBD email communications and website; provide summarization of important topics; highlight access to minutes & video recordings

1c) Gather demographic information, store in InLumon, when new licensees apply, in support of understanding equity in investigation outcomes

1d) Communicate Best Practices for addressing complaints within a dental practice, to lower formal OBD complaints filed – moved from Strategic Priority E for continuity and subject matter – this pertains more to encouraging dentists and consumers to resolve complaints together first before escalating to formal complaints

2a) Document & clearly communicate scope of each license including expanded practices and scope; better enable provider interpretation & implementation choice

Removed due to Survey &/or board/staff lack of ability or jurisdication: Originally Goal 10: Decrease waiting time for OHP patients / increase number of OHP

providers – Goal 10a – Partner & provide support to ODA/OHP/Legislature to influence reimbursement rates --- survey support

Survey Goal 11 – Increase overall providers available – combined with Section B, see Action 1b

STRATEGIC PRIORITY D

Workplace Environment

Creating an engaging work environment for the Oregon Board of Dentistry is an ongoing investment. In the last Strategic Cycle, advancements were implemented to increase workplace flexibility and employee satisfaction. More recently, the Board's Staff Leadership has undergone a significant change with the transition of Executive Director to new leadership. This new leadership as well as other Board and Staff transitions continues to offer opportunities for additional cross-training, succession planning, and overall expectation-setting.

Additionally, the implementation of new technology in the last cycle and the emergence Artificial Intelligence (AI) tools require consistent development of new skills. Investment in Continuing Education in alignment with Process and Technology development will help staff and board members keep pace with new ways of working, such as Agentic AI analysis and other methods of leveraging AI.

Goals

1. Ensure OBD Staff and Board Member talent & continuity
2. Organizational practices & skills are state of the art and current with technology (within budgetary limitations)
3. Ensure all committed Affirmative Action Plan Deliverables are completed

Action Items

1a) Responsibility cross-training completed

1b) Validate needed Committees, determine appropriate meeting frequency, establish proactive committee leadership

2a) Invest in continuing education to support changing industry & technology landscape

3a) In support of Affirmative Action Plan, reinforce State policies, provide training & development to the Board and Staff as needed

STRATEGIC PRIORITY E

Technology & Processes

All organizations are affected by technology developments, and Oregon Board of Dentistry and the dental profession is no exception. In the last Strategic Cycle, OBD took leaps forward through the digitization and modernization of Board Books, implementing a digital database of licensee records, a digital archive of investigation files, and finishing the initial implementation of the InLumon system. records and implementation. These accomplishments have set the organization up to further improve the efficiency of the organization and of the investigation processes. As technology continues to advance, the emergence of Artificial Intelligence is both an opportunity for the profession and a potential risk area to be addressed. Setting a baseline for utilization of this technology will help set expectations for responsible usage and accountability within Dental Practices.

Goals

1. Improve efficiency leveraging technology resulting in decreased staff time per case, fewer calls, and number of cases
2. Establish rules governing Artificial Intelligence within Dental Practices Act (DPA)

Action Items

1a) Explore implementation of standard patient records portal

1b) Increase Licensee understanding of the complaint process

1c) Implement InLumon updates to increase automation & reduce data entry

1d) Complete Website improvements for clarity of overall content and navigation & licensing process

2a) Create a statement of position on Artificial Intelligence within the DPA that aligns with regulatory oversight of OBD

Placeholder for Strategy-on-a-Page (will update and insert after finalization of the content above)

Preliminary SWOT

STRENGTHS

- Team cohesion & leadership
- Foundation of known, common values: Integrity, Fairness, Responsibility, Community and commitment to the mission
- Emphasis on professional standards
- Skilled, experienced, and dedicated staff
- Strong regulatory framework
- Board composition provides a breadth of perspectives
- Responsive and accessible organization
- Increased feedback engagement from members / licensees / stakeholders

WEAKNESSES / IMPROVEMENT AREAS

- Team and board succession planning processes
- Lack of clarity of requirements for each type of license and/or desire for more scope for “mid level” licenses & DAs
- Limited control over budget/funding impact ability to adjust staffing plans to meet overall strategic plan needs
- Legislature changes can create significant increases in staff work that are not in alignment with staffing capacity
- Perception of limited communication and outreach
- Process & technology inefficiencies for staff & licensees
- Perceived underrepresentation of certain groups

OPPORTUNITIES

- Use technology & innovations to enhance stakeholder engagement
- Continued technology improvements to improve licensee experience, overall processes efficiency
- Clarify and continue to lead on dental practice and license standards including education requirements
- Determine the future of dentistry including portability / participation in Dental Compact

THREATS

- Continued lagging technology infrastructure / Rise of AI
- Group dentistry influence expressed as a concern
- Insurance maximums dating to the 1960’s influence patient care recommendations
- Affordability for patients overall + access esp OHP
- Cost and profit pressures influencing standard of care
- Board member turnover creates loss of continuity and historical knowledge
- Continued cost pressures on OBD budget and resulting pressure to increase fees

CORRESPONDENCE

04/15/2026

Oregon Board of Dentistry

1500 SW 1st Avenue, Suite 770

Portland, OR 97201

Dear Members of the Oregon Board of Dentistry,

As Dean of Dental Sciences at Portland Community College, I am writing to express my strong support for establishing a formal registry for dental assistants in Oregon and to endorse the efforts of the Oregon Dental Assistants Association (ODAA) in advancing this important initiative.

Dental assistants play a critical role in patient care and safety, yet Oregon currently lacks a formal mechanism to recognize them as registered professionals. Creating a registry would elevate the profession, provide appropriate recognition, and allow for more accurate tracking of the dental assisting workforce information that is valuable for educators, employers, and policymakers alike.

I propose that individuals who complete Expanded Function Dental Assistant (EFDA) training and the DANB exam be eligible for state registration. This would formally recognize their advanced skills, support professional growth, and improve mobility for those seeking to practice in states requiring Registered Dental Assistant (RDA) credentials.

I also encourage the Board to consider implementing continuing education requirements similar to those in states such as California. Structured CEU requirements promote lifelong learning, strengthen clinical competency, and enhance public trust. At a minimum, required coursework should include CPR, Medical Emergencies, and Infection Control, aligning with existing renewal standards for dental hygienists in Oregon.

Dental assistants complete rigorous training and contribute significantly to the delivery of care. They should be recognized and supported as professionals within the healthcare system. Based on my experience observing effective models in California, I believe a registry system would strengthen the profession and benefit the public.

Thank you for your consideration.

Kimberly Pennington

Kimberly Pennington, MEd, BSDH, RDH, CDA

Program Dean - Dental Sciences

Portland Community College
Vanport Building
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Portland, OR 97201
Kimberly.Pennington@PCC.EDU

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From: Olesya Salathe
Sent: Sunday, April 12, 2026 5:54 PM
To: ROBINSON Haley * OBD <Haley.ROBINSON@obd.oregon.gov>
Subject: Hygiene and Laser Rules

Hi Haley,

It was great seeing you at the ODC this weekend. I attended a lasers for hygienists course and wanted to follow up with a few clarifications specific to Oregon's current guidelines.

There were a few areas I want to ensure I'm interpreting things correctly and aligning our protocols appropriately:

- **Laser-assisted curettage:** What is the current stance in Oregon regarding hygienists performing curettage with a laser? Is this considered within scope, and are there any specific limitations or definitions we should be aware of? Curettage with SRP is allowed, correct?
- **Initiated tip usage:** Is the use of an initiated tip by a hygienist permitted under current rules, or is this restricted due to how it may be interpreted clinically (e.g., soft tissue curettage or sulcular debridement)? Other states allow this and it's such a great debridement tool. Would this fall under the same theme as cavitron, piezo etc?
- **Supervision requirements:** How does the Board currently differentiate between indirect vs. direct supervision when it comes to laser use by hygienists? Are there specific procedures or levels of invasiveness that dictate the level of supervision required?
- **Certification requirements:** Is formal laser certification mandatory for hygienists in Oregon to utilize lasers in clinical practice? If so, are there specific courses, hours, or credentialing bodies that the Board recognizes or requires?

I ask because technologies are changing so rapidly and the evidence supports this. This is a fantastic area for hygiene to grow. I just want Oregon to be clear and the hygienist at the course this weekend had lots of questions.

Thank you!

Good morning, Dr. Salathe,

You raise excellent questions about the use of lasers in dental hygiene. At this time, Board rules don't adequately address these questions. It would be wonderful to have an existing committee meet to discuss emerging technologies to determine if the Board should adopt related rules. Your expertise and experiences would be invaluable and appreciated. I will attempt to take a crack at your four questions.

Question 1) Laser-assisted curettage: What is the current stance in Oregon regarding hygienists performing curettage with a laser? Is this considered within scope, and are

there any specific limitations or definitions we should be aware of? Curettage with SRP is allowed, correct?

The legislature included curettage in the dental hygienists scope of practice:
679.010 Definitions. As used in this chapter and ORS 680.010 to 680.205, unless the context requires otherwise:

(2) "Dental hygiene" is that portion of dentistry that includes, but is not limited to:
(a) The rendering of educational, preventive and therapeutic dental services and diagnosis and treatment planning for such services;
(b) Prediagnostic risk assessment, scaling, root planing, curettage, the application of sealants and fluoride and any related intraoral or extraoral procedure required in the performance of such services; and
(c) Prescribing, dispensing and administering prescription drugs for the services described in paragraphs (a) and (b) of this subsection.

Question 2) **Initiated tip usage:** Is the use of an initiated tip by a hygienist permitted under current rules, or is this restricted due to how it may be interpreted clinically (e.g., soft tissue curettage or sulcular debridement)? Other states allow this and it's such a great debridement tool. Would this fall under the same theme as cavitron, piezo etc?

At this time, Board rules don't adequately address these questions. Possible verbiage addition? Curettage can be performed with traditional instruments such as scalers; however, laser therapy offers a more selective approach, targeting and removing diseased tissue while preserving healthy tissue. I could see value in clarifying the scope language to specify that an initiated tip is used for curettage purposes only, rather than for soft tissue cutting procedures.

Question 3) Supervision requirements: How does the Board currently differentiate between indirect vs. direct supervision when it comes to laser use by hygienists? Are there specific procedures or levels of invasiveness that dictate the level of supervision required?

Board rules don't make any specific supervision carve outs related to lasers. New rules would be required to address the supervision requirements of RDH's using lasers. This just needs to be defined.

Question 4) Certification requirements: Is formal laser certification mandatory for hygienists in Oregon to utilize lasers in clinical practice? If so, are there specific courses, hours, or credentialing bodies that the Board recognizes or requires?

Board rules don't adequately address these questions. This might fall into the jurisdiction of OHSA. Laser certifications may be a required credential in various States or internationally. I typically look at California, Washington, Florida, and New York rules first to see what they have brewing. I am also researching laser certification for myself to obtain a better understanding of the technology, requirements, and pitfalls. Do you know of any great, affordable, training? I am not sure if the OBD budget would allow for training.

The FAQ I made for implants was a significant time investment- but has paid immense dividends on streamlining staff responses to implant questions. My hope is that we can work

through committees to create a FAQ framework for laser use in Oregon.

I attended Joy's afternoon CE lecture on Saturday. I heard her mention the Oregon "Laser" guidance and questions. Here is the current OBD template response that the Board staff sends out. So far, no one has answered the list of nine rhetorical questions!

> Hello XXX,
>
> Thank you for emailing the Oregon Board of Dentistry. While the Oregon Dental Practice Act (DPA) does make mention of the use of lasers within the scope of practice, there is no certification for using lasers that is required by the OBD.
>
> The basic guidelines when providing any therapeutic modality or using any instrument is that the licensee is trained in using it and that the licensee is performing a treatment which is allowed under the DPA. The DPA does not have any rules about the use of lasers as they pertain to dental
>
> hygiene. This is similar to the DPA not having any rules governing the use of ultrasonic scalers. The basic guidelines for any dental professional are that when using a laser, the same as with any instrument, you are trained in using it and that you are performing a treatment which is allowed under the DPA.
>
> Please consider and answer some of the following questions:
>
> - What training opportunities are available for hygienists to use this laser?
> - What information is required to indicate the dentist (and if appropriate hygienists) has been trained to competence?
> - What is the goal of laser therapy, and what is the therapeutic modality of how this is being achieved?
> - What oversight and training would the supervising dentists have for use of lasers by a hygienist?
> - How is it being verified that the hygienist only uses the appropriate settings, and does not use one of the surgical or other tissue penetration settings?
> - What position does your malpractice carrier(s) have about the use of lasers by hygienists?
> - Has the FDA approved the use of this device for use by
> -

hygienists? Has the manufacturer approved the use of this device for use by hygienists?

- How will the dentist ensure no surgical cutting or tissue penetration is occurring, and that the hygienist is not performing any prohibited acts, or working outside their scope of practice?

Please review the excerpt from the DPA below:

Division 35

DENTAL HYGIENE

818-035-0025

Prohibited Acts

A dental hygienist may not:

(1) Diagnose and treatment plan other than for dental hygiene services;

(2) Cut hard or soft tissue with the exception of root planing, except as provided in OAR 818-035-0065 (Expanded Practice Dental Hygiene Permit);

(3) Extract any tooth;

(4) Fit or adjust any correctional or prosthetic appliance except as provided by OAR 818-035-0030(1)(h);

(5) Prescribe, administer or dispense any drugs except as provided by OAR 818-035-0030, OAR 818- 035-0040, OAR 818-026-0060(12), OAR

818-026-0065(12) and 818-026-0070(12);

(6) Place, condense, carve or cement permanent restorations except as provided in OAR 818-035-0072, or operatively prepare teeth;

(7) Irrigate or medicate canals; try in cones, or ream, file or fill canals;

(8) Use the behavior management techniques of Hand Over Mouth (HOM) or Hand Over

Mouth Airway Restriction (HOMAR) on any patient.

(9) Place or remove healing caps or healing abutments, except under direct supervision.

(10) Place implant impression copings, except under direct supervision.

Statutory/Other Authority: ORS 679 & 680

Statutes/Other Implemented: ORS 679.020(1)

History:

OBD 1-2021, amend filed 11/08/2021, effective 01/01/2022

Please use this link to bookmark or link to this rule.

I hope you find this information helpful.

Thank you for initiating this discussion, as I believe the work we put into these questions will be beneficial for patient care. We should discuss in public session which committee is best positioned to tackle these questions.

Hi Angela,

Thank you for your response.

There's strong interest from our hygiene team in implementing these protocols. With new photobiomodulation (PBM) codes being introduced this year, it feels like a timely opportunity to support hygienists practicing at the top of their scope.

I've completed multiple laser trainings over the years. Much of my initial education was through Fotona with our equipment, which is quite comprehensive. I've also participated in both hands-on and didactic courses through the American Dental Association and the Oregon Dental Association.

I attended Joy's course and purchased her online program to evaluate it as a potential foundational resource. I'm currently considering bringing the team to one of her in-person courses later this year. I'll keep you posted if the online course is a good foundational option.

Laser safety, mechanics and science behind them are critical. Much of today's equipment has multiple modes which makes it user-friendly. Just as a scaler or a handpiece can cause damage, dental team members should be able to operate this equipment with proper training.

I can prepare something for June's meeting? Bring it to the board as an introduction and get a recommendation on which committee to take it to.

See above for additional comments in pink.

From: _____

To: ROBINSON Haley * OBD

Subject: Info regarding RDAEF exam as requested.

Date: Monday, April 27, 2026 7:48:16 AM

Good morning Haley,

Here's the information I attained for the California RDAEF exams.

In California, the RDAEF process includes both a written exam and a hands-on restorative exam. Since I graduated in 2022 during COVID restrictions, I completed the hands-on restorative portion through a portfolio of 25 restorations done on real patients (no typodonts) under my supervising doctor at his office. (I can provide my full portfolio if needed).

I also reached out to Kelly Fong at UOP San Francisco, she directed me to the Dental Board of California, since they handle the exam information.

Here is the link California Dental Board had sent me regarding the RDAEF written exam outline.

https://www.dbc.ca.gov/applicants/rdaef_exam_outline2022.pdf

If more details are needed, I was told that you can contact them directly at dentalboard@dca.ca.gov as I am only allowed limited information. Since you are on the Oregon Dental Board you may have more access to specific requests.

Please let me know if there's anything else I can provide that could be helpful.

Thank you,
Karla Brumley
RDAEF (CA), EFDA (OR)

Registered Dental Assistant Extended Functions Written Examination Outline

1. *Preliminary Patient Evaluations (25%) – This area assesses the candidate's knowledge of evaluating the patients' medical and dental history and identifying conditions that may impact treatment. This area also assesses the candidate's knowledge of preparing diagnostic records and charting conditions or oral abnormalities related to treatment. These functions are performed under the supervision of a licensed dentist.*

Section	*Task Statement*	*Knowledge Statement*
1A. Patient Information and Evaluations (18%)	T1. Review patient medical and dental history to identify conditions that may affect treatment.	K1. Knowledge of types of common medical conditions or medications that affect treatment. K2. Knowledge of dental conditions that affect treatment. K3. Knowledge of methods for collecting information about patient medical and dental history.
	T2. Evaluate patient's oral health under dentist's direction to assist with overall patient assessment.	K4. Knowledge of methods for evaluating conditions of the oral cavity. K5. Knowledge of signs of decay or stain formations that cause oral health problems. K6. Knowledge of signs of periodontal disease. K7. Knowledge of effects of dietary habits on oral health. K8. Knowledge of effects of substance use on oral health. K9. Knowledge of effects of smoking or tobacco use on oral health.
	T3. Conduct a preliminary myofunctional evaluation of the head and neck to identify function of oral and facial muscles.	K10. Knowledge of types of muscles and physiological structures in the head and neck. K11. Knowledge of techniques for performing evaluations of myofunction of the head and neck. K12. Knowledge of signs of abnormal or limited myofunction of the head and neck. K13. Knowledge of signs of temporal mandibular dysfunction.
	T4. Perform intraoral and extra-oral evaluation of soft tissue to identify conditions related to patient's oral health.	K14. Knowledge of types of anatomical structures and landmarks of the oral cavity. K15. Knowledge of signs of healthy hard and soft tissue. K16. Knowledge of signs of intraoral and extra-oral pathology. K17. Knowledge of methods for performing intraoral and extra-oral evaluations. K18. Knowledge of the relationship between facial or oral abnormalities and dental problems.
	T5. Determine classification of occlusions and malocclusions to identify the relationships of the maxillary and mandibular teeth.	K19. Knowledge of classifications of occlusion and malocclusion. K20. Knowledge of effects of occlusion and malocclusion on oral health.
1B. Imaging and Documentation (7%)	T6. Determine type of imaging needed to assist in gathering diagnostic information.	K21. Knowledge of types of radiographic imaging. K22. Knowledge of criteria for determining type of digital or X-ray images to be performed.
	T7. Chart oral conditions to document patient characteristics for treatment.	K23. Knowledge of types of dental nomenclature and morphology. K24. Knowledge of universal numbering and Palmer quadrant notation systems. K25. Knowledge of methods for charting oral conditions and problems.

2. *Treatment Procedures (57%) – This area assesses the candidate's knowledge of preparing for and providing treatment services. These services include preparing for and taking final impressions and activities related to placing and finishing direct and indirect restorations that restore tooth form and function. These functions are performed under the supervision of a licensed dentist.*

Section	*Task Statement*	*Knowledge Statement*
2A. Tissue Retraction and Final Impression Procedures (18%)	T8. Evaluate patient periodontal or medical conditions to identify contraindications for chemical retraction.	K26. Knowledge of types of periodontal conditions contraindicated for chemical retraction. K27. Knowledge of types of medical conditions contraindicated for chemical retraction.
	T9. Select retraction cord or retraction material to displace tissue.	K28. Knowledge of types of chemical compounds associated with impregnated cords. K29. Knowledge of physiological effects of chemical compounds used in cord retraction. K30. Knowledge of types of retraction cords and their sizing. K31. Knowledge of criteria for selecting retraction cords based on clinical indications. K32. Knowledge of types of retraction pastes. K33. Knowledge of criteria for selecting retraction paste based on clinical indications.
	T10. Place retraction cord or retraction paste to prepare tissue for impression procedures.	K34. Knowledge of techniques for placing retraction cords or retraction paste. K35. Knowledge of types of instruments used to place retraction cords or retraction paste.
	T11. Observe patient during retraction process to monitor tissue or physiological responses.	K36. Knowledge of signs of irritation or tissue damage during cord retraction. K37. Knowledge of techniques for managing irritation or tissue damage in response to cord retraction.
	T12. Remove retraction cord according to guidelines to prevent soft tissue damage.	K38. Knowledge of the relationship between retraction time and periodontal response. K39. Knowledge of techniques for removing retraction cords. K40. Knowledge of methods for preventing tissue damage during cord removal.
	T13. Take final impression to capture oral conditions for fixed indirect restorations.	K41. Knowledge of techniques for taking final impressions. K42. Knowledge of methods for managing sulcular fluids during final impressions. K43. Knowledge of methods for managing impression materials and conditions that impact quality of impression.
	T14. Take final impression to capture oral conditions for tooth-borne removable prosthesis.	K41. Knowledge of techniques for taking final impressions. K43. Knowledge of methods for managing impression materials and conditions that impact quality of impression.

2. *Treatment Procedures (57%), continued – This area assesses the candidate's knowledge of preparing for and providing treatment services. These services include preparing for and taking final impressions and activities related to placing and finishing direct and indirect restorations that restore tooth form and function. These functions are performed under the supervision of a licensed dentist.*

Section	*Task Statement*	*Knowledge Statement*
2B. Direct and Indirect Restorations (34%)	T15. Isolate oral cavity to preserve integrity of restorative area.	K44. Knowledge of techniques for isolating restorative area. K45. Knowledge of types of devices and materials used to isolate restorative area.
	T16. Select materials for direct restoration to address clinical indications.	K46. Knowledge of types of material used for direct restorations and their indications. K47. Knowledge of methods for selecting material based on location and type of direct restoration. K48. Knowledge of contraindications associated with direct restoration materials.
	T17. Place and contour direct restorations to restore proper tooth form, function, and margins.	K49. Knowledge of techniques for placing and contouring direct restorations. K50. Knowledge of methods for evaluating form and function of direct restorations.
	T18. Adjust direct restorations to customize them to patient's oral conditions.	K51. Knowledge of methods for evaluating occlusion, margins, and contact discrepancies. K52. Knowledge of techniques for adjusting direct restorations.
	T19. Finish direct restorations to provide a smooth surface or prevent irritation.	K53. Knowledge of techniques for finishing and polishing direct restorations. K54. Knowledge of effects of improper or incomplete finishing and polishing.
	T20. Adjust indirect restorations to ensure proper fit.	K55. Knowledge of techniques for adjusting indirect restorations.
	T21. Cement final indirect restorations to restore tooth function.	K56. Knowledge of types of cement and their indications. K57. Knowledge of techniques for cementing indirect restorations. K58. Knowledge of types of instruments used to cement indirect restorations.
	T22. Remove excess subgingival cement to prevent periodontal infection or inflammation.	K59. Knowledge of techniques for removing subgingival cement. K60. Knowledge of instruments used to remove subgingival cement. K61. Knowledge of signs of infection or inflammation associated with residual subgingival cement.
	T23. Identify factors impacting proper placement of restorations to prevent damage or decay.	K62. Knowledge of the relationship between occlusion and potential for damage or decay. K63. Knowledge of signs of postoperative complications.
	T24. Recognize conditions requiring additional attention to involve dentist in evaluation of preparation.	K64. Knowledge of enamel and oral histology. K65. Knowledge of types of preparation characteristics associated with indirect restorations.
2C. Treatment Specialty Area (5%)	T25. Select endodontic master and accessory points to fill canal.	K66. Knowledge of materials associated with master and accessory points.
	T26. Verify size of master points to ensure proper cone fit for canal	K67. Knowledge of techniques for fitting master points and accessory points.
	T27. Cement endodontic master and accessory points to seal canal.	K68. Knowledge of types of endodontic cement material. K69. Knowledge of techniques for cementing endodontic master and accessory points.

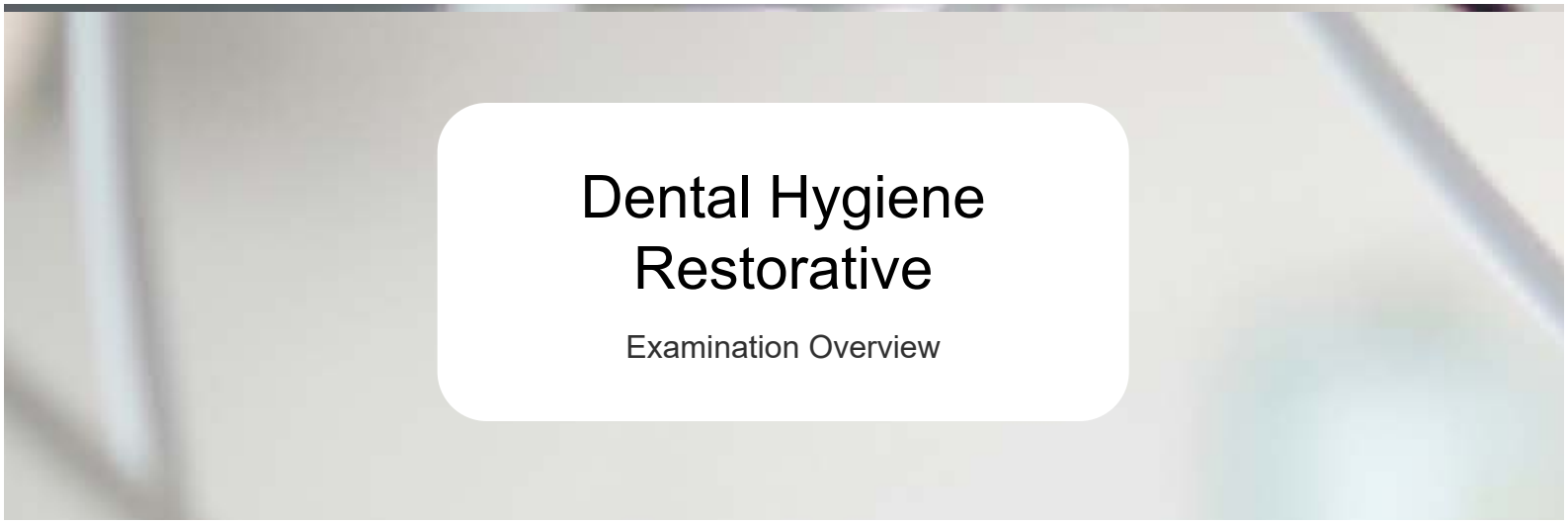
3. *Infection Control and Health and Safety (8%) – This area assesses the candidate's knowledge of maintaining a safe and sanitary work environment and adhering to infection control protocols and standard precautions.*

Section	*Task Statement*	*Knowledge Statement*
	T28. Identify signs of medical emergencies to address situations that require immediate intervention.	K70. Knowledge of signs of allergic reaction or anaphylactic shock. K71. Knowledge of signs of medical crisis or emergency. K72. Knowledge of methods for administering emergency first aid and Basic Life Support (BLS).
	T29. Implement safety precautions to minimize risk to patient and dental healthcare personnel during treatment.	K73. Knowledge of guidelines for providing for patient safety during dental health care procedures. K74. Knowledge of guidelines for providing for health care personnel safety during dental health care procedures. K75. Knowledge of types of adverse events or injury that can result from inadequate safety dental health care precautions.
	T30. Implement infection prevention and control procedures to mitigate disease transmission during dental treatment.	K76. Knowledge of types of infections or communicable diseases and their route of transmission. K77. Knowledge of methods for preventing the spread of infectious and communicable pathogens. K78. Knowledge of guidelines for sterilization and disinfection in dental health care delivery.
	T31. Implement protocols regarding hazardous or medical waste to manage materials used or generated during dental treatment.	K79. Knowledge of types of waste associated with dental treatments and their contamination potential. K80. Knowledge of guidelines for handling and disposing of hazardous or medical waste materials.

4. *Laws and Regulations (10%) – This area assesses the candidate's knowledge of laws and regulations regarding licensing requirements, scope of practice, professional conduct, and professional responsibilities.*

Section	*Task Statement*	*Knowledge Statement*
	T32. Comply with laws regarding consent to respect patients' right to make informed treatment decisions.	K81. Knowledge of laws regarding patient consent.
	T33. Comply with Health Insurance Portability and Accountability Act (HIPAA) laws to respect patient right to privacy in dental health care delivery	K82. Knowledge of laws related to the Health Insurance Portability and Accountability Act (HIPAA).
	T34. Report instances of suspected abuse, neglect, and exploitation to protect vulnerable populations.	K83. Knowledge of signs of child abuse or neglect. K84. Knowledge of signs of dependent adult abuse, neglect, or exploitation. K85. Knowledge of signs of elder adult abuse, neglect, or exploitation. K86. Knowledge of methods for reporting child, elder, or dependent adult abuse.
	T35. Comply with laws about record-keeping to document, store, and dispose of patient charts or records.	K87. Knowledge of legal standards for patient record-keeping and documentation. K88. Knowledge of laws regarding the storage and disposal of patient charts or records.
	T36. Comply with laws about professional conduct to maintain professional integrity.	K89. Knowledge of laws regarding professional conduct.
	T37. Comply with laws about scope of practice to maintain professional boundaries.	K90. Knowledge of laws regarding scope of practice.

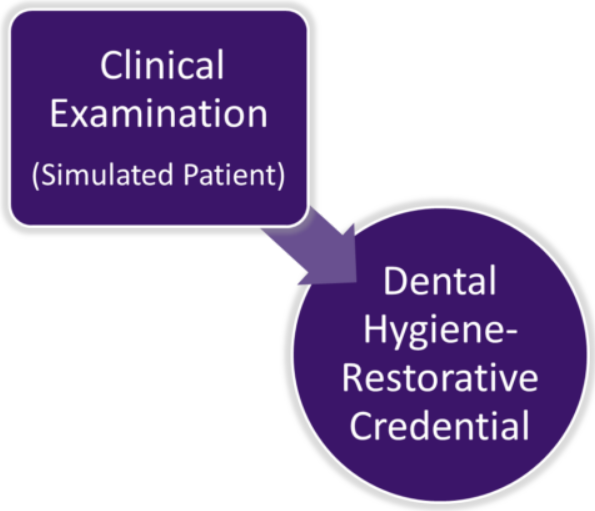
AMERICAN BOARD of DENTAL EXAMINERS



Dental Hygiene Restorative

Examination Overview

The purpose of the **Dental Hygiene Restorative Examination** is to evaluate a candidate's ability to utilize professional judgment and competency in providing restorative procedures as allowed by state statute. This typodont-based examination consists of the placement, carving, and finishing of one (1) Class II amalgam and one (1) Class II composite restoration. The assignment consists of one mesiocclusal (MO) and one distocclusal (DO) maxillary and mandibular molar preparation. Candidates should confirm their state requirements for acceptance before registering for this exam.



Candidates are responsible for understanding content included in the **Candidate Guide**, **Candidate Manual**, and **forms** regarding examination procedures, protocols and processes.

Candidate Guide (Policies)

Download Policy Guide

Candidate Manual (Exam Procedures)

Download Manual

Examination Fees – Dental Hygiene Restorative

Clinical Examination Fee: $460 plus **Facility Fee** *(varies by Clinical location)*

Extended Registration & Transfer Fee
Request submitted ***after*** Clinical Registration Deadline = **$145** Extended Registration & Transfer Fee

Refund Requests via Contact Us:
• Withdrawal ***prior to*** Clinical Registration Deadline = Full Refund
• Withdrawal ***after*** Clinical Registration Deadline** = Refund minus **$145** Extended Registration & Transfer Fee (applicable only to exam parts not attempted)

Dental Hygiene Restorative Clinical Examination

2026 CANDIDATE MANUAL

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Exam Year 2026 | Version 20251228

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PREPARING FOR THE RESTORATIVE EXAMINATION

General Information

The purpose of the American Board of Dental Examiners **Dental Hygiene Restorative Examination** is to evaluate a candidate's ability to utilize professional judgment and competency in providing restorative procedures as allowed by state statute.

Official Resources. Candidates are responsible for reading and understanding the **Candidate Manual** in conjunction with the Candidate Guide and noted materials published by the American Board of Dental Examiners. Candidates bear all risk of any misunderstanding resulting from the use of or reliance on unofficial information or materials.

- **Candidate Guide.** Refer to the Candidate Guide for information regarding exam eligibility, education requirements, identification requirements, candidate conduct/misconduct policies, computer-based testing accommodations, and more available at ADEXtesting.org.
- **Candidate Manual** (criteria, performance expectations) clinical examination review presentations, and examination forms are available at ADEXtesting.org.
- **Test Prep.** Dental Hygiene Restorative Clinical examination review video is accessible via the Test Prep page or the ADEX Testing Media YouTube page.
- **Site Info Sheet.** Site-specific information pertaining to the exam site host, such as school-provided supplies, rental equipment, infection control protocols, etc. can be found in the *Site Info Sheet* for the respective exam site host on the ADEXtesting.org website.
- Submit any **exam-related questions** via Contact Us prior to the exam or onsite to American Board of Dental Examiners personnel.

Clinical Scheduling Requests. Scheduling requests may be submitted via the "My Registration" button of your Candidates.ADEXtesting.org profile or via Contact Us prior to the **Registration Deadline** for a given exam for consideration. Scheduling requests are **not guaranteed**.

Scheduling request options may include:

- Specific clinical examination day
- Specific clinic entrance time (AM/PM)

Examination Schedules. Approximately one (1) month prior to the clinical exam, individual examination schedule will be posted to the Candidates.ADEXtesting.org online portal.

Clinical Evaluation. The examination consists of the placement, carving, and finishing of one (1) Class II amalgam and one (1) Class II composite restoration on a typodont. The assignment consists of one mesiocclusal (MO) and one distocclusal (DO) maxillary and mandibular molar preparation.

Equipment and Materials

The Acadental ModuPRO® One (MP_R320) typodont with corresponding gum tissue is the only model accepted for the American Board of Dental Examiners Dental Hygiene Restorative Examination.

Armamentarium. Candidates must provide the following:

- Acadental ModuPRO® One (MP_R320) Typodont
- Box or container for transport of typodont to evaluation area
- Restorative armamentarium (instruments sterilization not required)
- Handpiece(s)
- Metal or plastic air/water syringe tip(s)
- Dental materials or equipment for restorative procedures not supplied by the school

American Board of Dental Examiners requires and accepts only **A4 or A4B composite shades** and only **A1 flowable**. Opaque shades are not acceptable.

Composite surface sealer, flowable or unfilled resin/glaze(s) may not be applied to any surface of the finished restoration. A 2.00 is the maximum score possible for Occlusal, Margins and Proximal if an Examiner determines surface sealer, unfilled resin, glaze or flowable has been applied to any surface of the finished restoration.

Polishing agents are allowed. The use of petroleum jelly products (i.e. Vaseline®, etc.) is not allowed.

Site Provided Equipment and Supplies. The exam site host (school) provides expendable materials for the Candidate to use during the examination (see grid). The school is responsible for any deviation from this list. The materials provided are the brands used by the school. Candidates may utilize their own amalgamator and curing light (with curing light shield or protective eyewear), and preferred product brands.

Do not assume that exam site hosts (schools) will have extra instruments or equipment available for rent. Site-specific information can be found in the ***Site Info Sheet*** for the respective exam site host on the ADEXtesting.org website. Contact the exam site host (school) directly with any questions regarding site-specific equipment connections, rental availability, etc.

Note that **water** use is restricted to a disposable cup and not accessible via the operatory unit air/water syringes/handpiece.

Equipment Malfunctions. School personnel are available throughout the examination to resolve malfunctions of operatories and school equipment. Candidates should familiarize themselves with available school equipment during the clinic tour. Neither American Board of Dental Examiners nor school personnel will be responsible for time lost due to the malfunction of any personal equipment.

Notify the Chief Examiner immediately of any malfunction of school equipment. The Chief Examiner may assign a time compensation if the problem is not resolved within five (5) minutes. An appeal cannot be based on loss of clinic time if the incident is not reported to the onsite Chief Examiner.

Expendable Restorative Materials provided by Exam Site Host (School)		
2x2 gauze squares	Drinking Cups	Sanitizing materials
Air syringe tips	Face masks	Typodont mounting posts
Amalgamator/Tricherator	Facial Tissue	Soap
Amalgam scrap container(s)	Gloves, nonlatex (S,M,L,XL)	Surface disinfectant
Barrier covers/tape	Instrument trays, disposable	Tray covers
Cotton-tip applicators	Paper towels	Trash bags

American Board of Dental Examiners provides Examiners with the following instruments and materials. (Examiners do not use candidate instruments for grading.)

- Johnson & Johnson Reach® Waxed Dental Floss
- Front surface #4 or #5 mouth mirror
- UNC 1-12 mm periodontal probe
- Hu-Friedy 2R/2L pigtail explorer
- Screwdriver

Typodont Criteria

The typodont must meet the following criteria:

- Acadental ModuPRO® One (MP_R320) typodont with full dentition (32 teeth)
- Only the two (2) assigned, exam-marked Class II molar preparations are present
- All remaining teeth are virgin (i.e. no sealants)
- Adjacent teeth are anatomically correct and properly placed
- Tooth preparations and adjacent teeth are secure

Onsite Question and Answer Session/Clinic Tour

An onsite Question and Answer (Q&A) Session is held prior to the scheduled examination. The Chief Examiner or Exam Technical Coordinator (ETC) will verify candidate identification and distribute exam materials.

The optional Clinic Tour will familiarize candidates with the exam site host (school) clinic layout, emergency protocols, infection control policies, proper disposal of biohazardous materials, and equipment operation.

Exam-marked Preparations. The preparation assignment for each group is announced at the end of the onsite Question and Answer (Q&A) Session.

"No Show" Candidate. A Candidate may opt to withdraw from the exam, forfeiting their examination attempt and registration fees, for the following reasons. Withdrawal for any other reason constitutes failure of the exam.

- Candidate does not have required items or is not dressed in proper clinic attire at assigned clinic time
- Candidate is late for the start of clinic set-up time
- Restoration fractures during restorative procedures

Day of the Exam

Clinic Entrance and Operatory Set Up

Candidates will be notified when to enter the clinic and will have 30 minutes to complete set up of their operatory unit, instruments and typodont. All candidates must exit the clinic after the 30-minute set up time period is complete.

Two (2) exam-marked standardized preparations are available at each operatory. During set up, carefully review the preparation combination to ensure that both teeth correctly match that of the group assignment. Notify the Chief Examiner immediately of any discrepancies.

- **Assigned Molar Preparations.** Remove the original teeth from the typodont and insert the assigned, exam-marked preparations. Secure the tooth preparations and teeth adjacent to the preparations. To avoid breaking or stripping the screw, do not over-tighten it. A screwdriver may be used during setup but must be stowed during the examination.
- **Typodont.** Affix **Candidate ID Label** to top side of typodont [maxillary arch]. Position the typodont on the rod post to properly mimic a natural treatment position.
- **Composite/Flowable.** The Chief Examiner will verify that each candidate has the correct composite (A4 or A4B) and flowable (A1) shades.
- **Personal Belongings.** Stow all personal belongings, screwdriver and any non-exam materials. Only the **Candidate Manual** and Candidate Guide are permitted in clinic. Handwritten notes, illustrations or other non-sanctioned materials are prohibited.

Typodont Check-In Procedures. The Chief Examiner will evaluate that the typodont meets American Board of Dental Examiners criteria, that the two (2) assigned exam-marked teeth are properly placed, and tighten any tooth that is not secured in the typodont.

- If the typodont is accepted and the teeth are properly placed, the Chief Examiner will complete the *Restorative Assignment Sheet* listing the assigned teeth, surfaces, and restorative materials for each preparation. The restorative material is randomly assigned.
- If the typodont does not meet American Board of Dental Examiners criteria, the reason is listed on the *Restorative Assignment Sheet* and an *Instructions to Candidate Form (ITC)* is completed and the candidate will be registered as a “No Show”.

  The candidate has the option of continuing the examination and re-submitting a typodont that meets the criteria. Resubmissions are not eligible for time compensation.

Restorative Examination Procedures

- The Chief Examiner will announce when candidates may re-enter the clinic; the examination begins upon clinic entry. One-and-a-half (1.5) hours are allowed for the examination.
- Appropriate protective eyewear, gloves and mask must be worn during all procedures.

- Operator position and typodont should reflect a position that is similar to the treatment of a patient in a clinical setting.
- Do not place instruments or any other armamentarium on the patient chair.
- Candidates may not leave the clinic for any reason during the examination. If finished early, the candidate may leave the clinic but will not be allowed to re-enter until the clean-up time is announced.
- There will be a "Five Minutes Remaining" announcement prior to the end of the one-and-a-half (1.5) hour clinic time and a "Stop Working" announcement at the completion of the one-and-a-half (1.5) hours.
- As a reminder, the Chief Examiner must be notified immediately of any malfunction of school equipment. Time compensation may be given for issues not resolved within five (5) minutes.
- All Candidates must stop working after the announcement. For each minute worked after the announcement, a 0.02-point penalty will be deducted per preparation.
- Typodonts will be transported to another area for evaluation. Examiners independently evaluate and assign three grades to each of the restorations. The hard tissue and soft tissue surrounding the restoration and adjacent teeth are evaluated for damage.

Post-Examination Clean up. Candidates are allowed 20 minutes to dispose of biohazardous materials and prepare the operatory for the next session.

Removal of Restored Preparations from Typodont. After grading is completed, the typodont is returned to the candidate. Remove the two (2) exam-marked restorations and place them in the small envelope identified with Candidate ID Number. Return the prep envelope, any unused Candidate ID Labels, and any applicable *ITC*s, to the appropriate American Board of Dental Examiners personnel. Official examination results will be withheld if all items are not returned.

American Board of Dental Examiners strictly prohibits the photographing of preparations, restorations or any aspect of the examination.

PERFORMANCE EVALUATION

Scoring Information. Each category (Occlusal, Margins, and Proximal) of this examination is graded independently by three Examiners on a 5 to 1 scale according to the Grading Criteria Chart located in the manual. A final value of 3.00 or higher is required to pass the Restorative examination. The value of 3.00 is defined to reflect minimally competent performance for all scoring criteria and can be interpreted as corresponding to 75% in states where the passing level is legislated as 75%.

The recorded score for each category is based on the middle (median) score of the three (3) scores assigned for each category. Using the median score corrects for a score assigned by one (1) Examiner that varies from the consensus of the other Examiners. The median grade for each category is then weighted as follows:

Occlusal = 30%
Margins = 35%
Proximal = 35%

The two (2) restorations are graded separately, and any additional point deductions are applied at that time. The average of the two (2) determines the final grade.

Failure of the examination will result when:

- The incorrect restorative material is placed in the tooth (for example composite is assigned, and amalgam is placed).
- The natural treatment position of the typodont is intentionally altered on the rod post.

Tissue Management. It is to the Candidate's benefit to submit gum tissue that is free of hard and soft tissue lacerations. If validated by two Examiners at Check-Out, 0.10 will be deducted for **each** site of tissue damage to the hard or soft tissue (prepped or adjacent teeth).

- Damage to soft tissue is trauma in excess of 3 mm.
- Damage to hard tissue is trauma in excess of 1 mm on assigned preps or adjacent teeth.

Preliminary Results Reporting

Candidates are notified of their preliminary examination **results via text** (844). If not received, check the "spam" filter of your SMS/RCS text messaging app. Or edit the phone number displayed in the "My Account–Personal Info" section of your online Candidates.ADEXtesting.org profile. If necessary, contact the onsite ETC to resend the preliminary results text.

If unsuccessful, any applicable criterion (reason for failure) will be displayed. Discussion with examiners or staff regarding performance or reasons for failure is prohibited.

To register for the onsite retake exam session, utilize the "**Schedule Retake - Today**" link provided in your preliminary examination results text. Complete payment using a valid credit or debit card—Visa or Mastercard. Once complete, contact the onsite ETC to receive your assigned retake time and examination schedule.

Optional Onsite Retake Examination

Onsite fee-based retake session is available at each exam site for eligible candidates and generally scheduled on the last day of the examination. An onsite retake is considered a separate examination and is included in the total number of examination attempts. Candidates are permitted up to four (4) attempts to pass the Clinical Examination at two (2) separate exam locations prior to remediation (Clinical + onsite Retake = two attempts per exam location).

One of the finished restorations must score 3.00 or higher to be eligible for an onsite retake. Only the restoration that scored below 3.00 is performed during the onsite retake session. If re-attempted at another location, the candidate will perform both maxillary and mandibular (2) preparation assignments.

The onsite retake assignment consists of the same tooth, surface and restorative material, which must be completed within one (1) hour.

Performance Evaluation. A final value of 3.00 or higher is required to pass the Restorative examination.

Notification of Results. Candidates will be notified via email once official examination results are posted to your online profile, generally within 72 hours of the last date of the scheduled clinical examination. Candidate portal can be accessed via Candidates.ADEXtesting.org.

The American Board of Dental Examiners is a testing agency, not a licensing authority. Successful completion of an examination does not constitute licensure in any state or jurisdiction. It is illegal to render patient treatment until a license or certificate is issued by the state or jurisdiction. Contact the respective licensing authority directly for information regarding licensure or certification. See Candidate Guide and Scores page of ADEXtesting.org website for results reporting information.

REFERENCES

Ferracane, J. (2001). *Materials in Dentistry; Principles and Applications (2nd ed.).* Philadelphia: Lippincott, Williams, and Wilkins.

Fuller, J., Denay, G. & Hall, S. (2001). *Concise Dental Anatomy and Morphology (4th ed.).* Iowa City, IA: University of Iowa.

Nelson, Stanley J. (2015). *Wheeler's Dental Anatomy, Physiology and Occlusion (10th ed.).* St. Louis, MO: W. B. Saunders.

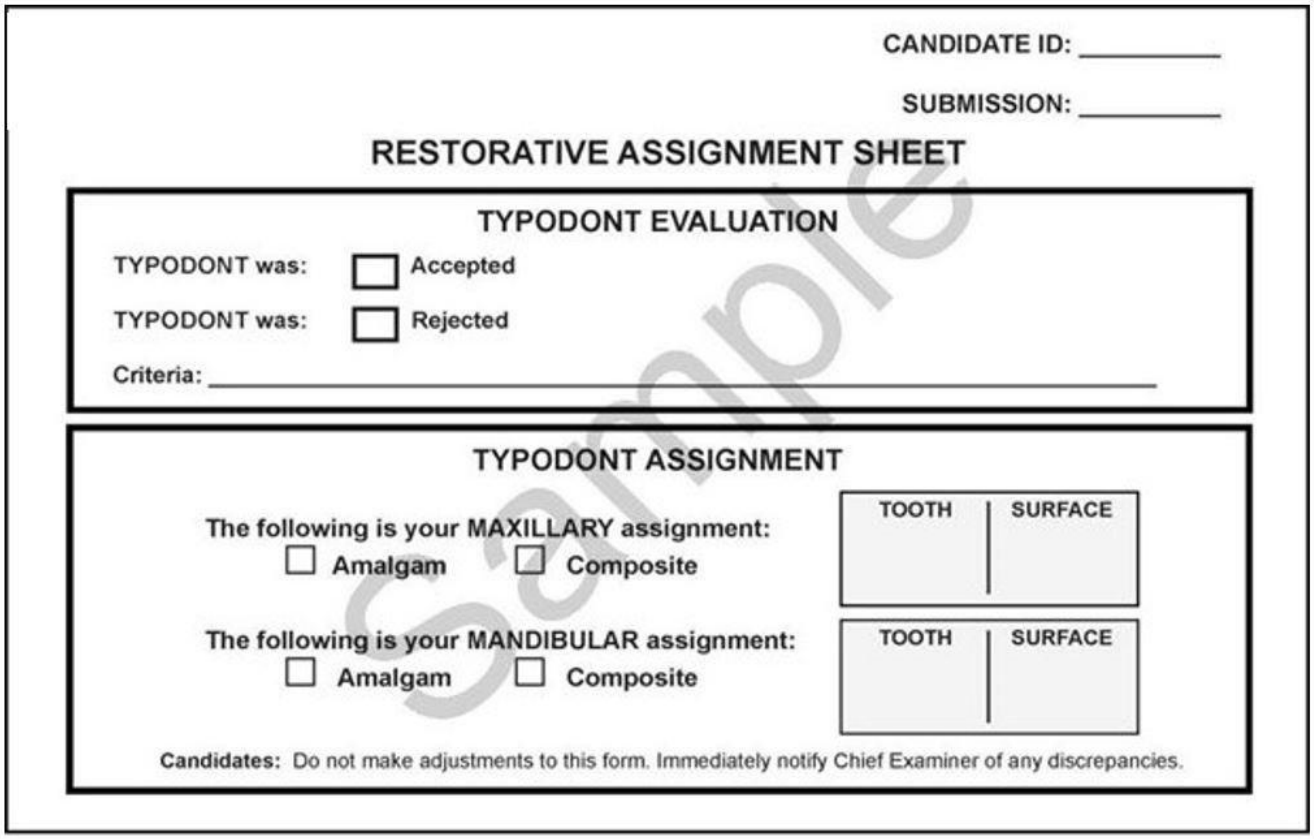
RESOURCES

Acadental ModuPRO® One (MP_R320) Typodont
Acadental.com

RESTORATIVE GRADING CRITERIA

	5	4	3	2	1
OCCLUSAL (30%)	Replicates proper anatomy restoring harmonious form. No pitting or voids.	Slight variation of harmonious form. Major grooves, fossae and ridges present. Slight surface irregularities (pitting or voids).	Anatomy functional. Moderate variation of harmonious form. Anatomy improved with minimal finishing and/or polishing. Moderate surface irregularities (pitting or voids).	Anatomy critically alters function. Marginal ridge contour/height improper. Pits, grooves, fossae and/or ridges inadequately placed. Critical surface irregularities (pitting or voids). Placement of glazing/unfilled resin.	Anatomy grossly alters function. Marginal ridge contour/height incorrect; height > 1 mm (+/-). Pits, grooves, fossae and/or ridges not present. Gross surface irregularities or defects (pitting, voids and/or fractures). Uncured resin.
MARGINS (35%)	Minimal variation of cavosurface margin (+). Scarring of tooth structure (one area).	Slight variation of cavosurface margin (+/-). Scarring of tooth structure (multiple areas).	Cavosurface margin (+/-); improved with minimal finishing and/or polishing. Flashing present (multiple areas); removed with minimal polishing. Moderate scarring of tooth structure. Integrity of restoration not compromised.	Cavosurface margin open > .5 mm (not correctable). 1 mm excess; not correctable with minimal polishing. Critical damage affects integrity of tooth structure and/or restoration. Placement of glazing/unfilled resin.	Gross variation of cavosurface margin open > 1 mm (not correctable). Greater than 1 mm excess; not correctable with minimal polishing. Gross damage affects integrity.
PROXIMALS (35%)	Replicates harmonious form. Flosses with proper resistance. No pitting or voids.	Slight variation of proximal contour, shape and/or position of contact area. Flosses with proper resistance. Slight surface irregularities (pitting or voids).	Moderate variation of proximal contour, shape and/or position. Gingival-occlusal embrasures are functional. Flosses with near proper resistance (may shred floss). Moderate surface irregularities (pitting or voids).	Critical variation of proximal contour, shape and/or position. Tight contact (breaks floss). Visibly open contact with resistance. Critical surface irregularities (pitting or voids). Placement of glazing/unfilled resin.	Gross variation of proximal contour, shape and/or position of contact area. Floss will not pass through contact. Open contact (visibly open with no resistance). Gross surface irregularities (pitting, voids and/or fractures). Uncured resin.

RESTORATIVE ASSIGNMENT SHEET SAMPLE



CANDIDATE ID: _____

SUBMISSION: _____

RESTORATIVE ASSIGNMENT SHEET

TYPODONT EVALUATION

TYPODONT was: ☐ Accepted

TYPODONT was: ☐ Rejected

Criteria: _____

TYPODONT ASSIGNMENT

The following is your MAXILLARY assignment:

☐ Amalgam ☐ Composite

TOOTH	SURFACE

The following is your MANDIBULAR assignment:

☐ Amalgam ☐ Composite

TOOTH	SURFACE

Candidates: Do not make adjustments to this form. Immediately notify Chief Examiner of any discrepancies.

Sample

CLINICAL EXAMINATION OVERVIEW

Group Designation (refer to individual Examination Schedule): __

Prep Assignment: Maxillary Tooth/Surface_____

Mandibular Tooth/Surface_____

_____Setup Time (30-minutes)

- Place assigned exam-marked preps in typodont
- Position typodont on rod post
- Attach plastic cover for amalgam scraps
- Set up examination armamentarium
- Questions? See Chief Examiner

_____Clinical Examination Start Time (1.5-hours)

- Refer to *Candidate Assignment Sheet* for materials assignment
- ***ITC*** form at operatory? See Chief Examiner

_____Clinical Examination Stop Time

- Place typodont in container labeled with Candidate ID Number
- Leave clinic area

_____Post-Examination Clean-up (20-minutes)

- Properly clean operatory and surrounding area
- Biohazardous materials disposal in designated containers

_____Pick up Typodont Time

- Supervised removal of restored exam-marked preps
- Return preps, any unused Candidate ID Labels, and any *ITC* forms to American Board of Dental Examiners personnel

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May 26, 2026

Oregon Board of Dentistry
Attn: Haley Robinson, Executive Director
1500 SW 1st Ave., Ste. 770
Portland, OR 97201

Sent via email to information@obd.oregon.gov

Re: Reconsideration and Discussion of OAR 818-042-0110

Dear Dr. Kalluri and Members of the Board:

On behalf of the American Association of Orthodontists (AAO) and the Oregon State Society of Orthodontists (OSSO), we respectfully request that the Board provide review and consider additional discussion on recently finalized rulemaking related to **OAR 818-042-0110** during the Board's June 12, 2026 meeting date. We ask the Board to consider additional information regarding the amended rule's potential implications for orthodontic care delivery, particularly in rural and underserved areas of Oregon.

The AAO and OSSO appreciate the Board's ongoing commitment to patient safety and high standards of clinical practice. However, reiterating concerns raised during the rulemaking process, including Dr. Jonathan Yih's public comments to the Board back in October 2025, we remain concerned that the Final Rule's structure—particularly as it has been interpreted to require dental assistants pursuing certain certification pathways to apply for Expanded Function Orthodontic Dental Assistant (EFODA) certification through the Dental Assisting National Board (DANB) within six months of beginning clinical work, and to limit the performance of EFODA duties beyond that six-month window absent certification—may unintentionally constrain workforce capacity in communities that already face provider shortages.

Orthodontic practices, especially those serving rural areas, frequently rely on a "train-from-within" model to build and sustain their workforce. Given the limited availability of formally trained dental assistants in many parts of the state, orthodontists often hire individuals locally and provide hands-on training over time to develop the competencies necessary for EFODA responsibilities. Under the prior interpretation of the rule, this approach was workable, as assistants who were actively progressing toward certification could continue performing EFODA functions while completing their training at the pace appropriate for them and within the practical realities of working within a rural practice.

The revised six-month certification framework, as applied in practice, significantly narrows that flexibility. For rural practices, where recruiting already-certified assistants is often not feasible, this change may disrupt care delivery by limiting the ability of trained but not yet certified assistants to contribute fully in clinical settings. In turn, this could reduce patient access to orthodontic services, lengthen wait times, and strain already limited provider capacity in underserved regions.

In addition, the rule's different certification pathways do not operate consistently, which has created confusion for licensees. The examination pathway includes a defined six-month period during which assistants can continue performing certain functions while working toward certification. However, other pathways—such as certification under OAR 818-042-0120—require assistants to complete 1,000 hours of qualifying experience but do not clearly explain how those hours may be obtained if the assistant is not yet certified. Many of the duties that would count toward those hours are the same expanded functions associated with EFODA certification, yet the rule does not specify whether, or under what level of supervision, those duties may be performed during the training period. As a result, assistants may have limited ability to gain the experience needed to become certified, and practices are left uncertain about how to structure training in a compliant manner. This creates a practical challenge where experience is required for certification, but the pathway to obtaining that experience is not clearly defined.

These questions remain unresolved for licensees attempting to comply in good faith. In addition, licensees have identified potential inconsistencies between publicly available guidance and the rule text itself, which further contributes to uncertainty in implementation.

For example, licensees have noted that publicly available guidance suggests certification by credential may be limited to assistants already certified in other states, while the rule text in OAR 818-042-0120 appears to provide a broader pathway

based on work experience within Oregon. Similarly, it is unclear whether the six-month provisional period applies only to assistants pursuing the examination pathway or more broadly. These inconsistencies make it difficult for practices to determine how to properly train and utilize assistants while remaining in compliance. In addition, licensees have expressed concern that the current framework may unintentionally limit opportunities for dental assistants who develop an interest in orthodontics later in their careers, as the timing and structure of the certification pathways may make it more difficult to transition into expanded function roles.

We respectfully encourage the Board to consider whether additional clarification, flexibility, or implementation guidance may be warranted to ensure that the rule does not inadvertently hinder access to care or create uncertainty in compliance expectations across certification pathways. The AAO and OSSO stand ready to serve as a resource to the Board and to collaborate on solutions that uphold patient safety while preserving access to high-quality orthodontic care across all communities in Oregon.

Thank you for your consideration.

Sincerely,

Nathan Mick
VP, Federal and State Advocacy
American Association of Orthodontists

Dr. Gemma Hill
Vice President
Oregon State Society of Orthodontists

OTHER ISSUES

DDH Dentist and Dental Hygienist Compact

1.2 Clinical Assessment

As set forth in Section 2.D., satisfaction of the Clinical Assessment requirement shall be interpreted to include any examination or process recognized or accepted by a Participating State as providing evidence of clinical competence in dentistry or dental hygiene for licensure. Consistent with Section 2.D.:

(a) Examination shall mean successful completion of a clinical competency examination or evaluation approved by a Participating State for purposes of licensure. Such examinations or evaluations may include a psychomotor performance examination involving hand skills, objective structured clinical examination, a combination of the foregoing, or any other clinical competency examination or evaluation recognized by a Participating State for the purposes of licensure.

(b) Process shall mean successful completion of a competency-based clinical pathway recognized by a Participating States for purposes of licensure. Such processes may include dental residency experience, including any clinical assessments conducted therein, a portfolio-based assessment of clinical competence, or any other evaluative process accepted, recognized or approved by a Participating State for purposes of licensure.

DRAFT

Oregon Dental Permit, Certification & Endorsement Guide

This guide summarizes the key requirements, training expectations, supervision levels, and approval requirements for common Oregon dental certifications and endorsements.

Botox Certification

Rule: OAR 818-012-0005(3)

Who Can Perform?

Dentists treating conditions within the oral and maxillofacial region.

Board Approval Required?

❌ No

Training Requirements

- Minimum **10 hours** of hands-on clinical training
- Multiple courses may be combined to meet the 10-hour requirement

Course Provider Requirements

Must be:

- AGD PACE approved, or
- ADA CERP approved

Alternative Qualification

- Training completed through a CODA-accredited dental program

---

Dermal Fillers Certification

Rule: OAR 818-012-0005(4)

Who Can Perform?

Dentists treating conditions within the oral and maxillofacial region.

Board Approval Required?

❌ No

Training Requirements

- Minimum **10 hours** of hands-on clinical training
- Courses may be combined

Course Provider Requirements

Must be:

- AGD PACE approved, or
- ADA CERP approved

Alternative Qualification

- Training completed through a CODA-accredited dental program

---

Vaccine Administration

Rule: OAR 818-012-0006

Who Can Perform?

Dentists

Board Approval Required?

✅ Yes

Training Requirements

- OHSU is only current Board-approved course
- Minimum **10-12 hours** of didactic and hands-on clinical training for full vaccine administration training
- There is a specific COVID and Influenza vaccine Board-approved course that is shorter in length
- The vaccines are administered in accordance with the "Model Standing Orders" approved by the Oregon Health Authority (OHA).

Course Provider Requirements

Additional requirements:

- Prior to administering vaccines, the dentist must follow all of the requirements of OAR 818-012-0007.

Radiologic Proficiency Certificate

Rule: OAR 818-042-0060

Board Approval Required?

✅ Yes, in accordance with OAR 333-106-0055 or submits evidence that the Oregon Health Authority, Center for Health Protection, Radiation Protection Services recognizes that the equivalent training has been successfully completed

Training Requirements

- Complete an Oregon Board-approved radiology course
- Must include:
    - Lecture
    - Clinical training
    - Radiation safety requirements

Examination Requirement

Must pass:

- DANB Radiation Health & Safety Exam, or
- Board-approved equivalent

Clinical Requirements

Must demonstrate ability to:

- Place sensors/films
- Operate x-ray equipment
- Expose radiographs

Training must occur under indirect supervision of:

- Dentist
- Dental therapist
- Registered dental hygienist
- Dental assistant who holds an Oregon Radiologic Proficiency Certificate

Final Requirement

Within 6 months:

- Oregon licensee certifies competency

Sealants Certification

Rules: OAR 818-042-0090 & 818-042-0114

Course Requirements

- Minimum **6-hour course**
- Lecture
- Laboratory
- Clinical training

Board Approval Required?

✅ Yes, unless completed through a CODA-accredited program

Examination

- 25-question exam
- Minimum passing score: **80%**
- Must pass before lab participation

Laboratory Requirement

- Place sealants on **2 extracted teeth**
- Instructor evaluation required

Clinical Requirement

- Successfully place sealants on **2 fully erupted teeth**
- Evaluated by licensee before patient dismissal

Supervision

- Per licensee prescription

Soft Relines Certification (Currently, no formal application packet)

Rule: OAR 818-042-0090

Course Requirements

- Minimum **6-hour course**
- Lecture
- Clinical training

Board Approval Required?

✅ Yes, unless completed through a CODA-accredited program

Examination

- 25-question exam
- Minimum passing score: **80%**

Clinical Requirement

- Demonstrate successful placement on a patient

Supervision

- Indirect supervision of a licensee

Instructor Approval

Requires Board review and submission of:

- Syllabus
- Exam
- Clinical evaluation forms
- Educational materials
- CV
- Written approval request

Cord Packing Certification

Rule: OAR 818-042-0090

Course Requirements

- Minimum **6-hour course**
- Lecture
- Clinical training

Board Approval Required?

✅ Yes, unless completed through a CODA-accredited program

Examination

- 25-question exam
- Minimum passing score: **80%**

Clinical Requirement

- Successfully place retraction material on **10 patients**

Supervision

- Indirect supervision of a licensee

Nitrous Oxide Permit

Rule: OAR 818-026-0040

Applicant Requirements

- Oregon dental, or Registered Dental Hygiene license

Board Approval Required?

❌ No, unless completed as a postgraduate and not part of CODA-accredited program

Training Requirements

- Minimum **14 hours**
- Didactic and clinical training as applicable

Documentation Required

- BLS certification
- Health history form
- Informed consent form
- Emergency protocols

Scope of Practice

- Indirect supervision

Verification

- Primary source verification required

Facility Requirements

Training and use must occur in a properly equipped facility including:

- Oxygen delivery system
- Nitrous delivery system with fail-safe
- Scavenger system
- Suction equipment
- Emergency equipment
- Blood pressure monitoring equipment

Local Anesthesia Endorsement/Certificate

Applicant Requirements

Must hold:

- Registered Dental Hygiene License, or
- Expanded Functions Dental Assistant (EFDA) Certification

Board Approval Required?

✅ Yes, unless completed through a CODA-accredited program

Training Requirements

- Minimum **50 hours** as voted on by Board at December 13, 2024 meeting.
- Didactic and clinical components

Documentation Required

- Current BLS certification

Scope of Practice

- General supervision

Verification

- Primary source verification required

Restorative Functions Endorsement

Applicant Requirements

Must hold:

- Registered Dental Hygiene License, or
- Expanded Functions Dental Assistant (EFDA) Certification

Board Approval Required?

✅ Yes

Training Requirements

Minimum **64 hours** consisting of:

Component	Hours
Didactic	18
Laboratory	22
Clinical	24
Total	64

Course Requirements

- Classroom and clinical training
- Didactic and clinical competency exams

Documentation Required

- Informed consent forms
- Certificate of completion
- Proof of passing clinical exam

Scope of Practice

- Indirect supervision
- Dentist must prepare the tooth/restoration first

Approval Requirement

Clinical exam passage is required before endorsement approval.

Interim Therapeutic Restorations (ITR)

Background

Created following HB 2627 and implemented beginning in 2021.

Applicant Requirements

- Expanded Practice Dental Hygienist (EPDH)

Board Approval Required?

✅ Yes

Training Requirements

No specific hour requirement in rule.

Typically includes:

- Online modules
- Independent study
- Lab practice
- Clinical competency assessment

Documentation Required

- Consent forms

Scope of Practice

- Collaborative agreement

Competency Verification

Following training:

- Collaborating dentist evaluates restorations
- Dentist issues certificate of approval

Board-approved course comparison

Comparison of OHSU, Pacific and Capitol Dental ITR programs:

Feature	Capitol Dental	OHSU	Pacific University
Didactic Time	2 hours	1 – 1.5 hours	3 hours
Module Count	5 core content modules (+ 2 resource modules)	6 content modules	Not specified
Passing Quiz Score	100%	75% or above	75% or above
Lab Prep Work	Dentists must prepare 10 teeth	Dentist can prepare or purchase 5-10 prepped teeth	Students will assess suitability and practice on typodont tooth then place glass ionomer temporary restoration
Min. Lab Placements	10 ITRs required	5 ITRs required	Pass 5 our of 10 ITR Restoration Experiences
In-Person Training Time	8:00 AM – 4:00 PM (8 hours)	9:00 AM – 2:15 PM (5.25 hours)	10 hours
Clinical Session Length	9:00 AM – 2:00 PM (5 hours)	10:00 AM – 1:30 PM (3.5 hours)	13 hour course with didact and lab skill practice hours combined

Anesthesia Assistant / Sedation Support Courses

(DAANCE, OMSA, OAGD, Resuscitation Group, Jeff Kobernik DMD)

Board Approval Required?

✅ Yes

Common Curriculum Elements

All programs emphasize:

Airway Management

- Airway anatomy
- Difficult airway recognition
- Airway adjuncts
- Capnography

Emergency Management

- Cardiac emergencies
- Respiratory emergencies
- Allergic reactions
- Seizures
- Syncope

IV Therapy

- Venipuncture
- IV equipment
- Fluid administration
- IV complications

Pharmacology

- Benzodiazepines
- Opioids
- Reversal agents

- Emergency drugs

Patient Assessment

- Medical histories
- ASA classifications
- Risk assessment

Clinical Skills

- Monitoring
- Documentation
- Emergency simulations
- Hands-on competency evaluation

Key Takeaway

These courses differ in length and format, but all focus on:

- Safe anesthesia support
- Airway management
- Emergency response
- IV therapy
- Patient monitoring

Comparison Matrix: Five Anesthesia-Related Courses

Category	DAANCE	OAGD (Moderate IV Sedation)	OMSA	Resuscitation Group Anesthesia Assistant	Kobernik IV Access
Primary Audience	Dental anesthesia assistants in OMS practices	Dentists seeking certification in moderate IV sedation	Oral and maxillofacial surgery assistants	Dental or anesthesia assistants needing emergency + anesthesia support skills (Oregon Board aligned)	Assistants learning IV catheter placement skills; minimal sedation readiness (under review by Board)
Core Sciences Taught	Cardiovascular, respiratory, nervous system physiology	Same core sciences; includes ECG interpretation day	Extensive physiology across multiple systems (CV, endocrine, immune, respiratory)	Physiology integrated into emergency and airway response training	Anatomy focused on venous structures and airway assessment components
Pharmacology	Sedation/anesthetic drugs: benzos, opioids, adjuncts, reversals, local anesthetics	Benzodiazepines, opioids, adjuncts, sedation agents	Comprehensive pharmacology including emergency medications and metabolism	Emergency-response medications; IV therapy drug considerations	Limited pharmacology; related to IV therapy complications and sedation readiness
Airway Assessment & Management	Extensive airway management modules with adjuncts and monitoring devices	Dedicated airway sessions; respiratory depression management	Airway anatomy, peds vs adult differences, ventilation monitoring	Airway evaluation, capnography, recognition of respiratory compromise	Very detailed airway assessment (LEMON, TMD, dentition,

Category	DAANCE	OAGD (Moderate IV Sedation)	OMSA	Resuscitation Group Anesthesia Assistant	Kobernik IV Access
					mobility) for IV placement safety
Patient Evaluation	History, ROS, ASA class, systemic disease risk evaluation	Healthy vs systemic disease sedation risk considerations	Systems-based evaluation across multiple organ systems	Pre-procedure evaluation for safe anesthesia support; identify airway or hemodynamic risks	Evaluation tied to IV access safety + airway prediction
Medical Emergencies Covered	Full emergency protocols: cardiac, respiratory, allergic, endocrine, seizures, syncope	Emergency pharm, multi-hour emergency sessions, SimMan training	MI, hypoglycemia, laryngospasm, anaphylaxis, etc. across systems	Hypoxia, hypotension, bradycardia, arrest, allergy, stroke, syncope, hypoglycemia, respiratory collapse	IV-related emergency complications: hematoma, infiltration, intra-arterial injection, air embolism
IV Therapy / Venipuncture	Covered but not central; foundational knowledge for assisting sedation	Included as part of moderate IV sedation delivery	Included within anesthesia support context but not primary focus	Major component: flow rates, troubleshooting, restarting, discontinuing, complication management	Entire focus: IV catheter placement, anatomy, step-by-step technique, complications
Monitoring Skills	BP, EKG, pulse oximetry, capnography; sedation monitoring standards	Full monitoring suite including sedation depth and respiratory monitoring	Ventilation/oxygenation monitoring; sedation stability checks	Airway/circulation monitoring and rapid physiological assessment (incl. capnography)	Focus mainly on monitoring IV stability, physiology indicators, and airway safety

Category	DAANCE	OAGD (Moderate IV Sedation)	OMSA	Resuscitation Group Anesthesia Assistant	Kobernik IV Access
Safety & Documentation	Documentation, anesthesia recordkeeping, equipment checks, regulations	Documentation standards for moderate sedation cases	Safety protocols, equipment knowledge, strict exam standards	Heavy emphasis on sterile technique, legal risk prevention, safe procedure steps, documentation	Documentation of IV attempts, safety procedures, complication tracking
Hands-On / Skills Training	Didactic + quizzes + final exam; clinical application in OMS offices	Multi-day didactic + in-clinic sedation cases (20+ patients) + SimMan	Multiple quizzes, proctored final exam; skills tied to OMS environment	Hands-on IV therapy, airway exams, simulation-based emergency drills	Extensive hands-on IV placement, airway assessments, technique demonstration
Regulatory Alignment	Used for anesthesia assistant certification in OMS; supported by professional boards	Meets board requirements for moderate IV sedation permits	Includes strict certification exams + BLS/ACLS requirements	Board-aligned anesthesia assistant training	Designed to meet didactic + hands-on standards
Program Structure	Self-study (~36 hrs) + PSI exam; 6-month window	~80 + didactic + 43 clinical hours; broad sedation curriculum	3 courses: modules + review + online exam; 36 CE hours (initial)	40 hours didactic + simulation + clinical supervision	40 hrs (24 didactic + 16 clinical) with heavy IV practice

Phlebotomy Courses

Common Requirements Across Programs

Board Approval Required?

✅ Yes

Core Skills

- Venipuncture techniques
- Vein identification
- Infection control
- Equipment use
- Patient communication

Complication Management

- Hematomas
- Infiltration
- Nerve injury
- Collapsed veins

Hands-On Training

- Simulation and/or live practice
- Repeated successful venipunctures

Typical Prerequisite

- Existing healthcare training or licensure

PHLEBOTOMY COMPARISON MATRIX

Category	IV-Phlebotomy CE Courses	Kobernik Venipuncture & IV Access	Resuscitation Group AA Program	PCC Phlebotomy for Health Professionals	Medtexx Basic Phlebotomy	OAGD IV Placement & Blood Product Collection
Source Document	OBD CE provider list	Kobernik course details	AA training curriculum	PCC program description	Medtexx workshop description	OAGD IV placement course description
Course Type	CE blood-draw courses	Venipuncture foundational course	Phlebotomy within anesthesia assistant program	Healthcare professional phlebotomy program	1-day certification workshop	4-hour IV placement + blood collection training
Primary Purpose	Meet AnA-IV phlebotomy requirement	Build detailed venipuncture skills	Train AA students in vascular access	Clinical phlebotomy for working professionals	Hands-on live and manikin phlebotomy	Venipuncture + PRF/PRP blood product collection
Duration / Format	4 hrs minimum hands-on CE	Hours not fully specified; extensive hands-on	40 hours (didactic + clinical)	45 hours (40 lab + 5 self-study) hybrid format	1 full day (live draws + manikin)	4-hour hands-on course
Anatomy Coverage	None	Extensive venous anatomy	Vascular access anatomy	Not specified	Not specified	Anatomy & physiology (IV & blood collection)
Hands-On Requirements	4 hrs minimum	Integrated hands-on	IV/vascular access training	100+ supervised clinical blood draws required	Live + manikin practice	Hands-on catheter & blood product collection

Category	IV-Phlebotomy CE Courses	Kobernik Venipuncture & IV Access	Resuscitation Group AA Program	PCC Phlebotomy for Health Professionals	Medtexx Basic Phlebotomy	OAGD IV Placement & Blood Product Collection
Techniques Taught	Basic venipuncture	Detailed venipuncture technique	Venipuncture for anesthesia IV access	Clinical blood draw procedures	Tube systems, pediatric, smears, butterfly	Venipuncture, aseptic catheterization, PRF/PRP
Equipment	Not listed	Standard venipuncture tools	Vascular access tools	Standard phlebotomy supplies	All supplies provided	IV catheters, PRP/PRF supplies
Complications Covered	Not listed	Rolling/fragile veins, hematoma	Vascular access complications	Not specified	Not specified	Local/systemic reaction prevention
Scope	Narrow	Medium	Broad (anesthesia context)	Clinical phlebotomy	Introductory workshop	Blood draw + IV placement

IV Therapy Courses

Common Requirements Across Programs

Board Approval Required?

✅ Yes

Clinical Skills

- Peripheral IV placement
- Catheter stabilization
- Fluid administration

Knowledge Areas

- Vascular anatomy
- Physiology
- IV equipment
- Documentation

Complication Management

- Infiltration
- Extravasation
- Phlebitis
- Air embolism
- Arterial puncture

Hands-On Requirements

- Supervised insertions
- Competency demonstration

Typical Prerequisite

- Healthcare licensure or clinical experience

IV THERAPY COMPARISON MATRIX

Category	Resuscitation Group AA	Kobernik IV Access Course	Various Board Approved IV-Phlebotomy Courses	PCC IV Therapy	Medtexx IV Therapy	OAGD Moderate Sedation
Source Document	AnA training program summary	Kobernik IV access content	OBD CE list (not an IV course)	PCC IV therapy outline	Medtexx IV cert description	OAGD sedation course description
Course Type	Full anesthesia assistant program	IV catheter placement specialty	Phlebotomy CE only	Intro IV therapy course	Full IV therapy certification	Sedation program including IV access
Primary Purpose	Provide IV therapy within anesthesia	Teach IV access technique & troubleshooting	Meet phlebotomy requirement	Provide current IV therapy skills for providers	Complete IV therapy competence	Train DAs in sedation & IV access
Duration / Format	40 hrs program (didactic + clinical)	Hours not fully provided; hands-on emphasized	4 hrs CE only (no IV content)	8-hour in-person training	48 hrs (18 workshop + 30 home study)	103 hrs (60 didactic + 43 clinical)
IV Therapy Role	Central to anesthesia care	Primary focus	None	Core training	Complete competency pathway	Critical part of sedation training
Hands-On IV	5 instructor-observed + 10 supervised	Many catheter placements	None	Demonstrations & skills practice	Workshop hours + hands-on exam	≥20 live IV starts
Anatomy	Vascular anatomy	Detailed venous anatomy	None	Minimal anatomy	Full venous & vascular anatomy	Anatomy for sedation & venipuncture

Category	Resuscitation Group AA	Kobernik IV Access Course	Various Board Approved IV-Phlebotomy Courses	PCC IV Therapy	Medtexx IV Therapy	OAGD Moderate Sedation
Fluids & Infusion	Fluids, infusion, meds	NS, LR, D5W	None	Peripheral IV care	Fluids, electrolytes, drugs, flow rates	Sedation & IV medication delivery
Equipment	Lines, infusion devices, monitors	Catheters, tubing, stands	None	Peripheral IV equipment	Pumps, filters, catheters, PICC/CVC	Full sedation monitors + IV tools
Monitoring	ECG, capnography, SpO_2, NIBP	Minimal	None	Documentation/legal	Regulatory + complications	Full monitoring suite
Complications	IV + anesthesia emergencies	Extravasation, phlebitis, nerve damage	None	Legal/safety	Extensive adverse reactions	Sedation + IV complications
Scope	Broadest (full anesthesia IV therapy)	Technical mastery of access	No IV scope	Foundational	Comprehensive	Highest complexity (sedation + IV)

Quick Reference Table

Certification	Hours Required	Exam Required	Clinical Requirement	Board Approval Required
Botox	10	No	Hands-on training	No
Dermal Fillers	10	No	Hands-on training	No
Radiologic Proficiency	Varies	Yes	Radiology competency	Yes*
Sealants	6	Yes (80%)	2 teeth lab + 2 patients	Yes*
Soft Relines	6	Yes (80%)	1 patient	Yes*
Cord Packing	6	Yes (80%)	10 patients	Yes*
Nitrous Oxide	14	Course dependent	Clinical training	Only if postgraduate
Local Anesthesia	50	Yes	Clinical competency	Yes*
Restorative Functions	64	Yes	Clinical exam	Yes
ITR	No set minimum	Course dependent	Clinical evaluation	Yes
Vaccine Administration	No set minimum	No	None specified	Yes

* Board approval generally **not** required when completed through a CODA-accredited program.

DENTAL WATERLINE MANAGEMENT IS CRUCIAL IN INFECTION CONTROL.



WHERE IS THE RISK?

Know where germs live to stop spread and protect patients



- Waterlines are used for providing water to dental handpieces during routine oral health treatments.
- Waterlines have unique characteristics that make them prone to germ growth.
- If waterlines are not maintained properly, the water flowing through them can be contaminated, leading to harmful germs entering a patient's body.

Germs That Live in Waterlines

- *Legionella pneumophila*
- *Pseudomonas aeruginosa*
- *Mycobacterium obscessus*

Healthcare Tasks Involving Waterlines

- Oral surgery procedures
- Flushing the mouth during dental procedures

Infection Control Actions to Reduce Risk

- Purge waterlines nightly and when units are out of service.
- Regularly test, treat, and shock waterlines with disinfectants to meet EPA standards for drinking water.
- Use sterile saline or water as a coolant/irrigant when performing surgical procedures.

Dental Unit Waterline Infection Control



Your role in a dental clinic puts you on the frontline of infection prevention and control. Untreated dental water systems can be the source of germs found in water that can cause serious infections. For example, contaminated water from dental practices has been linked to outbreaks of *Mycobacteria* infections in children.

With proper maintenance and monitoring of waterlines in your clinic, you can ensure that dental treatment water is safe for patient care.

What should I know first?

Water: Waterlines should be treated regularly with disinfectants to meet the Environmental Protection Agency (EPA)'s drinking water standards, which is ≤500 colony forming units [CFU]/mL of heterotrophic water bacteria.

Testing: Maintaining and monitoring dental unit waterlines includes frequent flushing and regular testing.

Manufacturer: Consult with the dental equipment manufacturer for methods and equipment to maintain and monitor the quality of dental water.

Policies: Every practice should have a designated infection control coordinator, and a policy and procedure manual for maintaining dental unit waterlines.

The following waterlines should be flushed and tested:

- ✓ High-speed handpiece lines
- ✓ Air/water syringe lines
- ✓ Ultrasonic scaler lines
- ✓ Source water
- ✓ Evacuation lines
- ✓ Unused water lines

When should waterlines be flushed?

- ✓ According to the manufacturer's instructions
- ✓ 20-30 seconds after each patient
- ✓ After the final patient of the day

What should I document when testing waterlines?

- ✓ Test date
- ✓ Location (chair, operatory #, etc.)
- ✓ Water source
- ✓ Test results
- ✓ Waterline maintenance or shock product name and lot #
- ✓ Pooling details (if samples pooled)*
- ✓ Name of team member sampling

** Sampling from multiple waterlines that are then combined for testing*

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For more information, visit https://www.cdc.gov/dental-infection-control/hcp/dental-ipc-faqs/best-practices-dental-unit-water-quality.html

Cleaning and Disinfection Checklist



In the fight against infectious disease, your dental practice or medical clinic is an important battleground. Use these infection control reminders and sample checklists (see back) to keep all parts of your facility safe for your patients, your team and yourself.

KNOWLEDGE REFRESHER:

The difference between cleaning and disinfecting

Cleaning

Cleaning removes visible dirt, dust, spills, smears and grime, as well as some germs, from surfaces. Clean a surface by washing it with water and a cleaning product such as enzymatic cleaners or detergents.

Disinfecting

Disinfecting kills germs on surfaces. Disinfect a surface by using an EPA-registered disinfectant according to manufacturer's instructions. Do not substitute a disinfectant for a cleaning product unless it is a combined detergent-disinfectant product.

Before you start, read the label

It's important to read the cleaning and disinfecting product label and understand the instructions for use. Understand what PPE may be necessary before you begin. PPE could include gloves, gowns, masks and eye protection.



Special instructions for spills of blood and body fluids

1. Wear appropriate PPE.
2. Confine the spill and wipe it up immediately with absorbent (paper) towels, cloths or absorbent granules (if available). Granules are spread over the spill to solidify the blood or body fluid. Dispose of used materials appropriately.
3. Clean with detergent and water.
4. Disinfect using an EPA-approved disinfectant. Immediately clean and disinfect all reusable supplies and equipment.

PATIENT CARE AREAS: Clean and disinfect

Sample checklist #1

Area	Task	Frequency	Initials
Exam room	• High-touch surfaces (e.g., tables, door handles, keyboards) • Low-touch surfaces (e.g., walls, floors) • Countertops and sinks	After each patient, at end of day	
	Clinical contact surfaces that were previously covered by surface barriers during patient care. Do this step before applying new surface barriers for the next patient.	After each patient	
	Reusable medical and dental equipment	After each patient, at end of day	
Waiting and admission	High-touch and low-touch surfaces and floors	Daily and as needed	

NON-PATIENT CARE AREAS: Clean only

Sample checklist #2

Furnishings/Equipment	Tasks	✓
Surfaces	Use detergent and water to clean surfaces in administrative offices and other non-patient-care areas such as staff break room or clinic lobby.	
Carpet	Periodically perform a deep cleaning of carpeting with a method that minimizes the production of aerosols and leaves little or no residue. Make sure to thoroughly dry wet carpeting to prevent the growth of fungi. Replace carpeting that remains wet for more than 72 hours.	
Plants	Designate maintenance of flowers and potted plants to staff not directly involved with patient care, or instruct staff to wear gloves when handling the plants and flowers, and perform hand hygiene after glove removal.	
Furniture	Avoid the use of upholstered furniture and furnishings in areas with increased potential for body substance contamination. Repair tears and holes.	

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PPE CHECKLIST FOR DENTAL HEALTH CARE PERSONNEL DURING PATIENT CARE

Ten Steps to Don and Doff



People who work in dental settings are routinely exposed to blood, saliva and other potentially infectious materials. Handpieces, ultrasonic scalers and other dental tools produce a spray that contains droplets, spatter and aerosols. It's important to wear personal protective equipment, or PPE, whenever there is potential for contact with spray or spatter of blood, or other body fluids, especially to mucous membranes of the face.

Always wear the right PPE for the task being performed. Keep in mind that the selection of PPE used will be determined by the patient interaction and potential for exposure to blood, bodily fluids and/or infectious material.

FIVE STEPS: Donning (putting on) PPE for patient care



1 Hand hygiene.

- Use soap and water when hands are visibly soiled; otherwise, an alcohol-based hand rub may be used.



2 Put on a clean gown or protective clothing.

- Make sure it covers your personal clothing and skin. This includes forearms and other areas that could become soiled with blood, saliva or other potentially infectious materials.
- Don fluid-resistant or impermeable gowns over protective clothing when a procedure is expected to generate a large amount of splash/spray.
- Note that PPE should be changed between each patient. Gowns and protective clothing also should be changed during patient care if items become soiled or no longer provide protection.



3 Put on face protection.

- If you are using a surgical mask, the mask tie should be secured on the crown of the head with the top tie, and at the base of the neck with the bottom tie.
- If the mask has loops, hook them around your ears.
- If you are using a respirator, the strap should be placed on the crown of the head with the top strap and the base of the neck with the bottom strap.
- Perform a user seal check each time you put on a respirator.



4 Put on eye protection.

- This includes protective eyewear or a face shield.
- For dental procedures that may cause spray or spatter, a face shield is recommended and may provide better protection than eyewear.
- Note that safety glasses, trauma glasses or other eyewear that leaves gaps between the glasses and the face are not likely to protect eyes from all splashes and sprays.
- Personal eyeglasses and contact lenses are not considered adequate eye protection.



5 Clean hands. Put on clean, non-sterile gloves.

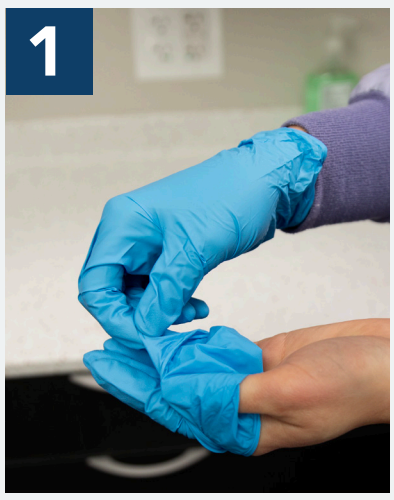
- Gloves should be changed if they become torn or heavily contaminated.
- Perform hand hygiene every time gloves are changed.

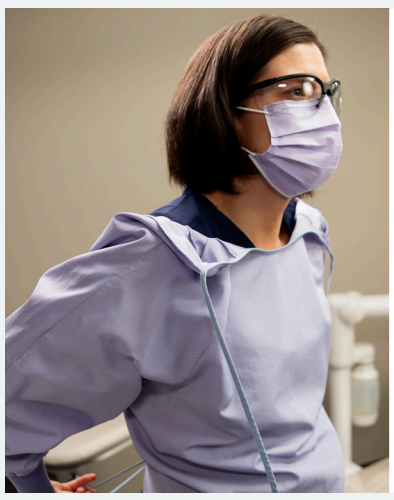
PPE CHECKLIST FOR DENTAL HEALTH CARE PERSONNEL DURING PATIENT CARE

Ten Steps to Don and Doff



FIVE STEPS: Doffing (removing) PPE after patient care





1 Remove gloves and gown.

- After completing the dental treatment, remove gloves and perform hand hygiene.
- Then remove gown or protective clothing.
- Place items in a dedicated container for waste or soiled linen.
- Discard disposable gowns after each use.
- Launder cloth gowns or protective clothing after each use.
- Exit the patient room or care area.



2 Perform hand hygiene.

- Use soap and water when hands are visibly soiled (e.g., blood, body fluids); otherwise, an alcohol-based hand rub may be used.



3 Remove eye protection.

- Start by grabbing the strap and pulling upward and away from the head.
- Do not touch the front of the eye protection.
- Discard disposable eye protection after use.
- If you are using reusable eye protection, clean and disinfect it according to the manufacturer's reprocessing instructions after each use.



4 Remove and discard face protection.

- It is important that you do not touch the front of the respirator or mask.
- Carefully untie the mask or unhook it from the ears.
- Pull it away from the face without touching the front.
- Then, discard it in a waste container.
- If wearing a respirator, remove the bottom strap by touching only the strap, then bring it carefully over the head. Grasp the top strap and bring it carefully over the head. Then pull the respirator away from the face without touching the front of the respirator.



5 Perform hand hygiene.

- Use soap and water when hands are visibly soiled (e.g., blood, body fluids); otherwise, an alcohol-based hand rub may be used.

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Best Practices for Cleaning and Sterilizing Dental Burs

Kelli Ngariki • November 18, 2025

From Dirty to Sterile—Without Guesswork or Risk



If you've ever wondered about the right way to clean and sterilize dental burs, you're not alone. The CDC gives general guidance for sterilizing dental instruments, but doesn't get into bur-specific details. Regardless of which autoclave you use, the process for burs remains largely the same. Here's how to do it right.

The CDC's Take: General Guidelines

The Centers for Disease Control and Prevention (CDC) classifies burs as critical or semi-critical instruments, depending on how they're used. That means they need to be heat sterilized. But before you toss them in the autoclave, they need to be properly cleaned and packaged.

Step-by-Step: Best Practices for Burs

Here's how to apply infection control principles in your practice:

1. Identify Your Burs

- Single-use or Reusable? Check manufacturer instructions. If there are no validated reprocessing instructions, consider the bur single-use and toss it after one use.

2. Pre-clean and Inspect

- Remove debris immediately after use.
- Use an ultrasonic cleaner or manually scrub with a detergent or enzymatic solution.
- Rinse and dry completely.
- Inspect for damage or wear. If damage, wear, or corrosion:
    - Remove the bur from use (even if minor damage)
    - Discard it in the sharps container
    - For quality control and tracking, consider documenting the discard and the reason.
- Never try to repair or reuse.

3. Packaging for Autoclaving

- Best Practice: Use a Bur Holder or Cassette
- Place burs in a bur block, bur guard, or instrument cassette designed for sterilization.
- Choose holders that are autoclave-safe (heat-resistant and able to withstand moisture).
- Then wrap or pouch the holder itself—not the loose burs.

Bonus Tip:

Some bur blocks come with color-coded or numbered slots so you can standardize bur sets per procedure.

If you're using a pouch: make sure the bur holder fits comfortably and the pouch is sealed with chemical indicators inside.

- Use sterilization pouches or wraps approved for steam sterilization.
- For small batches, individual pouches work fine. Larger loads can go in wrapped cassettes.
- Seal all packaging properly and include internal and external chemical indicators.

4. Load Placement in the Autoclave

- Place pouches paper side up (or follow your pouch manufacturer’s instructions).
- Don’t overcrowd the trays. Allow space between items.
- Do not let pouches or cassettes touch the chamber walls.
- Cassettes should be placed horizontally unless your autoclave manual says otherwise.

5. Choose the Right Cycle

- Pick the cycle that matches your packaging: "Pouches," "Wrapped Cassettes," or similar.
- Make sure to allow full drying time to prevent moisture-related contamination.

6. Post-Sterilization Handling

- Let packs cool and dry fully before handling.
- Store in a clean, dry area away from sinks or contamination zones.
- Reprocess any items in compromised packaging.

A Note on Sterility and Performance

Burs are small and intricate, making them tricky to clean. Over time, reusing them can reduce cutting efficiency and increase the risk of breakage. Keep track of how often burs are reused and inspect regularly.

Documentation Matters

Make sure your infection control manual includes:

- Bur inventory (type and classification)
- Manufacturer instructions for cleaning and sterilization
- Step-by-step packaging and sterilization protocol
- Inspection and discard criteria

Final Thoughts

Using your autoclave the right way means following a solid protocol: proper cleaning, smart packaging, and correct cycle selection. When in doubt, refer to the bur manufacturer's IFU and document everything.

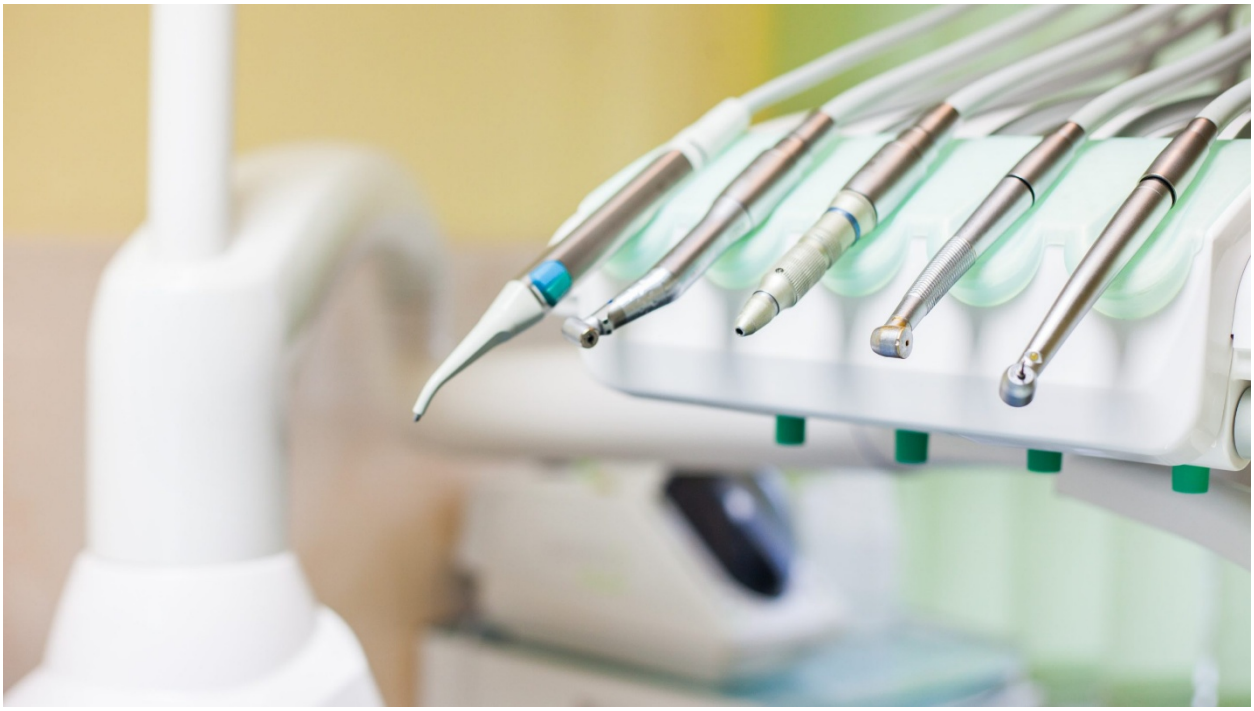
Ready to Step Up Your Compliance Game?

Book a Compliance Risk Review with us today. We'll evaluate your sterilization protocols, OSHA readiness, HIPAA safeguards, and infection control practices to make sure your office is fully protected and audit-ready. Don’t wait for an inspector to find the gaps—let’s fix them now. **Call Lindsay at 541-345-3875 ext. 3**.

Best Practices for Dental Handpieces

Key points

- Clean and heat sterilize handpieces and other intraoral instruments that can be removed from the air- and waterlines of dental units.
- If a dental handpiece cannot be heat sterilized and does not have US Food and Drug Administration (FDA) clearance with validated instructions for reprocessing, do not use that device.



Why it matters

The internal components of air-driven dental handpieces (both low-speed and high-speed devices) can become contaminated with patient material during use.

If these devices are not properly cleaned and heat sterilized, the next patient may be exposed to potentially infectious materials.

Background

Dental handpieces include high-speed, low-speed, electric, endodontic, and surgical handpieces and all attachments, such as prophy angles and nose cones. These devices should always be heat sterilized between patients. For any device that can be removed from the dental unit air- or waterline, dental health care personnel (DHCP) should follow the validated manufacturer's instructions for reprocessing these devices. These

instructions for cleaning, lubrication, and sterilization ensure effectiveness of the process and longevity of handpieces.

Neither surface disinfection nor immersion in germicides are acceptable methods for reprocessing. Do not subject the handpiece to high-level disinfection and do not simply wipe the surface with a low-level disinfectant.

If a dental handpiece cannot be heat sterilized and does not have FDA clearance with validated instructions for reprocessing, **DHCP should not use that device**.

Recommendations

CDC recommends that DHCP use FDA-cleared devices and reprocess instruments between each patient according to the manufacturer's instructions for use.

More information on dental handpieces can be found on pages 30–31 and 45 in *Guidelines for Infection Control in Dental Health-Care Settings—2003*.

Special considerations

Some handpieces are independent of air- and waterlines (e.g., cordless devices). For these items, CDC recommends that DHCP follow current FDA regulations. DHCP should utilize only FDA-cleared devices and follow the validated manufacturer's reprocessing instructions (cleaning, lubricating, and/or sterilizing).

DHCP should also follow the validated manufacturer's instructions for reprocessing handpiece couplers.

DRAFT for Board approval and discussion

~~STANDARD PROTOCOLS~~ GUIDELINES FOR VIOLATIONS OF THE DENTAL PRACTICE ACT AND GENERAL CONSENT ORDERS

In keeping with its obligation and mission to promote quality oral health care and protect all communities in the State of Oregon by equitably and ethically regulating dental professionals, the Oregon Board of Dentistry (OBD/Board) has updated the following recommended ~~protocols~~ guidelines for the most common violations of the Dental Practice Act.

The Board carefully considers the totality of the facts and circumstances in each individual case, with the safety of the public being paramount. To the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of the licensee.

These ~~protocols serve as~~ guidelines serve as a description of the Board's practices and prior decisions and are provided as suggestions to guide the Board's decisions in similar matters to ensure consistency. These are not mandated or required, and the Board acknowledges that there may be departures in individual cases depending the individual facts of a case, including ~~upon~~ mitigating or aggravating circumstances. The guidelines do not constitute rules, policies, or statements of rights.

CIVIL PENALTIES

The following language is typically included in Board settlement agreements, and a description of the Board's typical payment plan in the "note" sections:

Licensee shall pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board ~~will~~ allows licensed dentists a 30-day payment period for each civil penalty increment of $2,500.00.
>
> **NOTE:** The Board ~~will~~ allows licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board ~~will~~ allows licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.

REFUND AND/OR RESTITUTION PAYMENTS

Licensee shall pay $(**XX**) *refund or restitution*, by a single payment, in the form of a cashier's, bank, or official check made payable to patient (PATIENT INITIALS) and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** The Board ~~will~~ allows licensed dentists a 30-day payment period for each restitution and/or refund increment of $2,500.00.
>
> **NOTE:** The Board ~~will~~ allows licensed dental therapists a 30-day payment period for each civil penalty increment of $500.00.
>
> **NOTE:** The Board ~~will~~ allows licensed dental hygienists a 30-day payment period for each civil penalty increment of $500.00.

REFUND: To restore money paid by patient for treatment.

RESTITUTION: Money to repair unacceptable treatment.

REIMBURSEMENT PAYMENTS

Licensee shall provide the Board with documentation verifying reimbursement payment made to (COMPANY NAME), patient (PATIENT INITIALS) insurance carrier, within (**XX**) days of the effective date of the Order.

NOTE: The Board ~~will~~ allows licensed dentists a 30-day payment period for each reimbursement increment of $2,500.00.

NOTE: The Board ~~will~~ allows licensed dental therapists a 30-day payment period for each reimbursement increment of $500.00.

NOTE: The Board ~~will~~ allows licensed dental hygienists a 30-day payment period for each reimbursement increment of $500.00.

RESTRICTIONS

Licensee shall abide by any practice restriction(s) imposed by the Board until the Licensee receives written notice from the Board that the restriction(s) have been removed.

NOTE: If a license becomes inactive (expired, retired, etc.) while restriction(s) are in place, and the license is subsequently reinstated, the restriction(s) shall remain in place pending further order of the Board.

REMEDIAL CONTINUING EDUCATION (CE) – BOARD ORDERED

Licensee shall submit documentation to the Board verifying successful completion of (**XX**) hours of (**XX**) (OPTIONS: Board approved, hands-on, mentored), CE in the area of (**XX**) within (**XX**) (OPTIONS: years, months) of the effective date of the Order, unless the Board grants an extension, and advises Licensee in writing. This ordered CE is in addition to the CE required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX, or October 1, XXXX to September 30, XXXX).

FALSE/INACCURATE CERTIFICATION OR STATEMENTS ON DOCUMENTS OR RECORDINGS

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

NOTE: The civil penalties are **typically** $2,000.00 for dentists, $1,000.00 for dental therapists, and $1,000.00 for dental hygienists.

FAILURE TO MEET CONTINUING EDUCATION (CE) STANDARDS

NOTE: If Licensee completes <100% of the required CE, the Board ~~will~~ **typically** requests a letter of explanation, review extenuating circumstances, and audits an additional two-year cycle. Discipline may be recommended after review of circumstances.

NOTE (ANESTHESIA PERMIT HOLDERS): If Licensee fails to provide the CE required to maintain their anesthesia permit (i.e. for a CE audit), the Licensee **may have a case investigation opened to determine if the anesthesia permit revocation is indicated.** ~~will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.~~

FAILURE TO MAINTAIN BASIC LIFE SUPPORT (BLS) FOR HEALTHCARE PROVIDERS

If Licensee fails to maintain **a current** BLS for Healthcare Providers **certification** for any period of time **within a licensure period,** the Board ~~will~~ **may** request a letter of explanation and review extenuating circumstances. **The Board considers the BLS expiration date to be the last day of the month that the BLS instructor indicates that the certification expires.**

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

1. **NOTE:** If Licensee fails to maintain **a current** BLS for Healthcare Providers **certification** for one day to three months **past the month BLS renewal is due within a licensure period,** discipline may be recommended after review of circumstances.

   NOTE: If Licensee fails to maintain **a current** BLS for Healthcare Providers **certification** for three months to six months **past the month BLS renewal is due within a licensure period,** the Licensee may be reprimanded and required to pay a $500.00 (DENTIST) civil penalty, a $250.00 (DENTAL THERAPIST) civil penalty, or a $250.00 (DENTAL HYGIENIST) civil penalty.

   NOTE: If Licensee fails to maintain **a current** BLS for Healthcare Providers **certification** for longer than six months **past the month BLS renewal is due within a licensure period,** the Licensee may be reprimanded and required to paya $1,000.00 (DENTIST) civil penalty, a $500.00 (DENTAL THERAPIST) civil penalty, or a $500.00 (DENTAL HYGIENIST) civil penalty.

   NOTE (ANESTHESIA PERMIT HOLDERS): If an anesthesia permit holder fails to **a current** BLS for Healthcare Providers **certification** for longer than six months **past the month BLS renewal is due within a licensure period,** the Licensee may be reprimanded and pay a $1,500.00 (DENTIST) civil penalty or a $1,000.00 (DENTAL HYGIENIST) civil penalty. If Licensee fails to provide or maintain a current BLS for Healthcare Providers **certificate a case investigation may be opened to determine if Licensee should have their anesthesia permit revoked.**, ~~the licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.~~

FAILURE TO MAINTAIN ADVANCED CARDIOVASCULAR LIFE SUPPORT (ACLS) AND/OR PEDIATRIC ADVANCED LIFE SUPPORT (PALS) CERTIFICATION.

If Licensee who is required to maintain a~~n~~ **current** ACLS and/or PALS certification fails to maintain ACLS and/or PALS for any period of time, the Board will request a letter of explanation and review extenuating circumstances. **The Board considers the BLS expiration date to be the last day of the month that the BLS instructor indicates that the certification expires.**

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and may be required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** If Licensee fails to provide or maintain **a current** ACLS and/or PALS for one day to three months **past the month BLS renewal is due within a licensure period,** discipline may be recommended after review of circumstances.
>
> **NOTE:** If Licensee fails to provide or maintain **a current** ACLS and/or PALS for longer than three months **past the month BLS renewal is due within a licensure period,** Licensee may be reprimanded and required to pay at minimum a $1,500.00 civil penalty.
>
> **NOTE:** (ANESTHESIA PERMIT HOLDERS): If an anesthesia permit holder who is required to maintain a~~n~~ **current** ACLS and/or PALS certification fails to provide or maintain a current ACLS and/or PALS, **certificate a case investigation may be opened to determine if the anesthesia permit should be revoked.**~~, the licensee will be notified that the permit has been removed from their license and will not be added back onto their license until documentation is provided to and accepted by the Board.~~

PRACTICING WITHOUT A CURRENT LICENSE

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

> **NOTE:** A licensed dentist, who practiced any number of days without an active license ~~will be~~ **is typically** issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $2,000.00 civil penalty.
>
> **NOTE:** A licensed dental therapist who practiced any number of days without an active license or without a valid Collaborative Agreement, ~~will be~~ **is typically** issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and a requirement to pay at minimum a $1,000.00 civil penalty.
>
> **NOTE:** A licensed dental hygienist who practiced any number of days without an active license ~~will be~~ **is typically** issued a Notice of Proposed Disciplinary Action and offered a Consent Order incorporating a reprimand and requirement to pay at minimum a civil penalty of $1,000.00.

ALLOWING A PERSON TO PERFORM DUTIES FOR WHICH THE PERSON IS NOT LICENSED OR CERTIFIED

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee shall be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

NOTE: The civil penalties are **typically** $2,000.00 for the first offense. Increased civil penalties may be assessed in the event of repeated or egregious offenses.

FAILURE TO RESPOND WITHIN TEN DAYS TO A BOARD REQUEST FOR INFORMATION

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check, made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

NOTE: The Board ~~may issue~~ **typically issues** a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $1,000.00 civil penalty, to a licensed dentist, who fails to respond within ten days to a Board request for information.

NOTE: The Board ~~may issue~~ **typically issues** a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental therapist, who fails to respond within ten days to a Board request for information.

NOTE: The Board ~~may issue~~ **typically issues** a Notice of Proposed Disciplinary Action and offer a Consent Order, incorporating a reprimand and a $500.00 civil penalty, to a licensed dental hygienist, who fails to respond within ten days to a Board request for information.

FAILURE TO CONDUCT WEEKLY BIOLOGICAL TESTING OF STERILIZATION DEVICES

~~Failures are calculated as a percentage of required biological monitoring, based on the number of weeks per calendar year that patients were scheduled, multiplied by the number of testing devices in use.~~ **Failures are calculated by the number of missed weeks when no required biological monitoring was completed within a 12-month calendar year. Biological monitoring is required for all weeks when an office is opened one day or more days in which scheduled patients are treated.**

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within (**XX**) days of the effective date of the Order.

Licensee may be required to submit documentation to the Board verifying successful completion of (**XX**) hours of Board approved continuing education in the area of infection control within (**XX**) (OPTIONS: years, months) of the effective date of the Order. This ordered continuing education is in addition to the continuing education required for the licensure period(s) (**XX**) (i.e. April 1, XXXX to March 31, XXXX or October 1, XXXX to September 30, XXXX).

For a period of one year of the effective date of the Order, Licensee may be required to submit, on a quarterly basis, the results of the previous month's weekly biological monitoring testing of sterilization devices. Periods of time Licensee is not practicing in Oregon shall not apply to reduction of the one-year requirement.

NOTE: ~~Failure to complete ≤5% of required biological monitoring testing within the previous calendar year and current year-to-date will result in a Letter of Concern.~~
Typically, failure to complete 1 - 5 weeks of required biological monitoring testing within a 12- month calendar year results in a Letter of Concern.

NOTE: ~~Failure to complete >5% to 10% of required biological monitoring testing within a calendar year will result in the issuance of a Notice of Proposed Disciplinary Action and an offer of a Consent Order incorporating a reprimand.~~ **Failure to complete 1 - 5 weeks of required biological monitoring testing within a 12- month calendar year after a previous Letter of Concern for the same issue typically results in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $2,500.00 civil penalty, two hours of Board approved continuing education in the area of infection control within (XX), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.**

NOTE: ~~Failure to complete >10% to 20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $3,000.00 civil penalty, two hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.~~ **Failure to complete 6 - 10 weeks of required biological monitoring testing within a 12-month calendar year typically results in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $3,000.00 civil penalty, two hours of Board approved continuing education in the area of infection control within (XX), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.**

NOTE: ~~Failure to complete >20% of required biological monitoring testing within a calendar year will result in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $6,000.00 civil penalty, four hours of Board approved continuing education in the area of infection control within (**XX**), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.~~ **Failure to complete 11 or more weeks of required biological monitoring testing within a 12-month calendar year typically results in the issuance of a Notice and an offer of a Consent Order incorporating a reprimand, a $5,000.00 civil penalty, four hours of Board approved continuing education in the area of infection control within (XX), and quarterly submission of spore testing results for a period of one year from the effective date of the Order.**

FAILURE TO REGISTER WITH THE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP). Effective July 1, 2020.

The following language is typically included in Board settlement agreements, and a description of the Board's discipline is within in the "note" sections:

Licensee may be disciplined and required to pay a $(**XX**) civil penalty, by a single payment, in the form of a cashier's, bank, or official check made payable to the Oregon Board of Dentistry and delivered to the Board offices within 30 days of the effective date of the Order.

NOTE: **Generally, the Board has interpreted** ~~R~~required date **to** mean~~s~~ the date that the rule became effective (July 1, 2020), the date of initial licensure in Oregon, or the date the licensee obtains a DEA number, whichever comes latest.

NOTE: Failure to be registered with the PDMP for one day to three months from the required date ~~may result~~ **typically results** in a Letter of Concern.

NOTE: Failure to be registered with the PDMP for three months to six months from the required date ~~may result~~ **typically results** in a reprimand.

NOTE: Failure to be registered with the PDMP for longer than six months from the required date ~~may result~~ **typically results** in a reprimand and a $1000.00 civil penalty.

STANDARD ~~PROTOCOLS~~ GUIDELINES FOR CONSENT ORDERS RELATED TO DIAGNOSED SUBSTANCE USE DISORDER

The following language is typically included in Board settlement agreements.

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall voluntarily enter the State's Health Professionals' Services Program (HPSP) and abide by all of the terms and conditions established by the HPSP vendor, per Oregon law ORS 676.

Licensee shall contact and initiate procedures to enter HPSP within one (1) business day of the effective date of this Order. Business days are defined as days Monday through Friday excluding holidays. Licensee understands that failure to enroll in HPSP will result in notification to the Board.

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, or dental hygiene as a dental hygienist in Oregon, shall not apply to reduction of the five-year requirement.

Licensee shall not use alcohol, marijuana, illegal drugs, stimulants, narcotics, sedatives, or any other mind altering substances at any place or time unless prescribed by a licensed practitioner for a bona fide medical condition and upon prior notice to the Board and care providers, except that prior notice to the Board and care providers shall not be required in the case of a bona fide medical emergency.

Licensee shall undergo an evaluation by a Board approved evaluator or treatment provider within 30 days of the effective date of the Order and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of this Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any positive test results or any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this

Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall submit to a Board approved, random, supervised, urinalysis, hair, or blood testing program, at Licensee's expense, with the frequency of the testing to be determined by the Board, but initially at a minimum of 36 random tests per year. Licensee shall arrange for the results of all tests, both positive and negative, to be provided promptly to the Board.

Licensee shall advise the Board, within 72 hours, of any alcohol, illegal or prescription drug, or mind altering substance related relapse, any positive urinalysis test result, or any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

Licensee shall, within three days, report the arrest for any misdemeanor or felony and, within three days, report the conviction for any misdemeanor or felony.

Licensee shall assure that, at all times, the Board has the most current addresses and telephone numbers for residences and offices.

IF APPROPRIATE –

Licensee, agree to not order, store, inventory, audit, access, draw, administer, dispense, waste, or have unilateral access to any Scheduled controlled drugs for any clinic setting.

Licensee shall immediately begin using pre-numbered triplicate prescription pads for prescribing controlled substances. Said prescription pads will be provided to the Licensee, at his/her expense, by the Board. Said prescriptions shall be used in their numeric order. Prior to the 15th day of each month, Licensee shall submit to the Board office, one copy of each triplicate prescription used during the previous month. The second copy to the triplicate set shall be maintained in the file of the patient for whom the prescription was written. In the event of a telephone prescription, Licensee shall submit two copies of the prescription to the Board monthly. In the event any prescription is not used, Licensee shall mark all three copies void and submit them to the Board monthly.

Licensee shall maintain a dental practice environment in which nitrous oxide is not present or available for any purpose, or establish a Board approved plan to assure that Licensee does not have singular access to nitrous oxide. The Board must approve the proposed plan before implementation.

Licensee shall immediately surrender his/her Drug Enforcement Administration Registration.

STANDARD ~~PROTOCOLS~~ GUIDELINES FOR CONSENT ORDERS SPECIFICALLY RELATED TO SEXUAL VIOLATIONS

SEX RELATED VIOLATIONS

The following language is typically included in Board settlement agreements,

Licensee shall, for an indefinite length of time, be subject to the following conditions of this Consent Order:

Licensee shall not apply for relief from these conditions within five years of the effective date of the Order, and must do so in writing. Periods of time Licensee is not practicing dentistry as a dentist in Oregon, shall not apply to reduction of the five-year requirement.

Licensee shall undergo an assessment by a Board approved evaluator, within 30 days of the effective date of the Order, and make the written evaluation and treatment recommendations available to the Board.

Licensee shall adhere to, participate in, and complete all aspects of any and all residential care programs, continuing care programs and recovery treatment plans recommended by Board approved care providers and arrange for a written copy of all plans, programs, and contracts to be provided to the Board within 30 days of the effective date of the Order.

Licensee shall advise the Board, in writing, of any change or alteration to any residential care programs, continuing care programs, and recovery treatment plans 14 days before the change goes into effect.

Licensee shall instruct all health care providers participating in the residential, continuing care, and recovery programs to respond promptly to any Oregon Board of Dentistry inquiry concerning Licensee's compliance with the treatment plan and to immediately report to the Board, any substantial failure to fully participate in the programs by the Licensee. Licensee shall instruct the foregoing professionals to make written quarterly reports to the Board of Licensee's progress and compliance with the treatment programs.

Licensee shall waive any privilege with respect to any physical, psychiatric, or psychological evaluation or treatment in favor of the Board for the purposes of determining compliance with this Order, or the need to modify this Order, and shall execute any waiver or release upon request of the Board.

Licensee shall report all arrests or interaction with law enforcement within 72 hours.

Licensee shall advise the Board, within 72 hours, of any substantial failure to participate in any recommended recovery program.

Licensee shall personally appear before the Board, or its designated representative(s), at a frequency to be determined by the Board, but initially at a frequency of three times per year.

IF APPROPRIATE –

Require Licensee to advise his/her dental staff or his/her employer of the terms of the Consent Order at least on an annual basis. Licensee shall provide the Board with documentation attesting that each dental staff member or employer reviewed the Consent Order. In the case of a Licensee adding a new employee, the Licensee shall advise the individual of the terms of the Consent Order on the first day of employment and shall provide the Board with documentation attesting to that advice.

STANDARD ~~PROTOCOLS~~ GUIDELINES FOR CONSENT ORDERS REQUIRING CLOSE SUPERVISION

The following language is typically included in Board settlement agreements where the Board has determined close supervision is appropriate:

CLOSE SUPERVISION

For a period of at least (XX) months, Licensee shall only practice dentistry in Oregon under the close supervision of a Board approved, Oregon licensed dentist (Supervisor), in order to demonstrate that clinical skills meet the acceptable level of patient care. Periods of time Licensee does not practice dentistry as a dentist in Oregon, shall not apply to reduction of the (six) month requirement

Licensee will submit the names of any other supervising dentists for Board approval. Licensee will immediately advise the Board of any change in supervising dentists.

Licensee shall only treat patients when another Board approved Supervisor is physically in the office and shall not be solely responsible for emergent care.

The Supervisor will review and co-sign Licensee's treatment plans, treatment notes, and prescription orders.

Licensee will maintain a log of procedures performed by Licensee. The log will include the patient's name, the date of treatment, and a brief description of the procedure. The Supervisor will review and co-sign the log. Prior to the 15th of each month, Licensee will submit the log of the previous month's treatments to the Board.

For a period of two weeks, or longer if deemed necessary by the Supervisor, the Supervisor will examine the appropriate stages of dental work performed by Licensee in order to determine clinical competence.

After two weeks, and for each month thereafter for a period of six months, the Supervisor will submit a written report to the Board describing Licensee's level of clinical competence. At the end of six months, the Supervisor, will submit a written report attesting to the level of Licensee's competency to practice dentistry in Oregon.

At the end of the restricted license period, the Board will re-evaluate the status of Licensee's dental license. At that time, the Board may extend the restricted license period, lift the license restrictions, or take other appropriate action.

STANDARD ~~PROTOCOLS~~ GUIDELINE DEFINITIONS

Group practice: On 10/10/08, the Board defined "group practice" as two or more Oregon licensed dentists, one of which may be a respondent, practicing in the same business entity and in the same physical location.

STANDARD ~~PROTOCOLS~~ LANGUAGE FOR SETTLEMENT AGREEMENTS – PARAGRAPHS

WHEREAS, based on the results of an investigation, the Board has filed a Notice of Proposed Disciplinary Action, dated (**XX**), and hereby incorporated by reference; and

Licensee shall successfully complete the Board/OAGD Mentor Program at Licensee's expense. Licensee will remain in the Mentor Program until such time as the mentor advises the Board that Licensee achieved an acceptable level of skill in the listed areas of XXX and the Board advises Licensee in writing that he met the provisions of this Order. Participation in the Mentor Program requires that Licensee successfully complete continuing education and/or engage in a study club, as recommended by the Mentor and move to adopt the Mentor's recommendations on treatment. In the event Licensee's mentor agreement ends prematurely, the Board may require an alternative education program for Licensee.

NEWSLETTERS & ARTICLES OF INTEREST

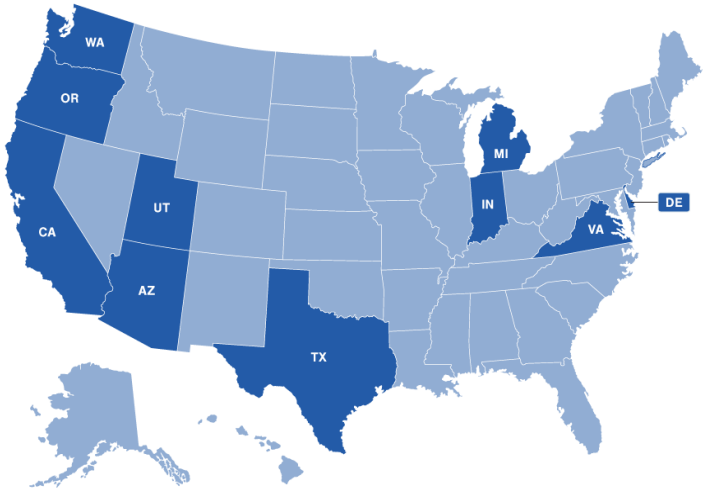
STATE OF THE STATES

Spring 2026

DANB's compilation of state dental assisting requirements is one of the most comprehensive resources available on this topic. The updates below highlight dental assisting state legislative and regulatory changes from August 2025 to April 2026.

Arizona

Following a new state law enacted March 31, 2025, the Arizona State Board of Dental Examiners filed Substantive Policy Statement #1: Board Approved Oral Preventive Assistant Training Courses, effective Aug. 8, 2025. It outlines the minimum standards for prerequisites, curriculum, and clinical instruction that a course must meet to be considered Board approved.



California

On Oct. 10, 2025, Gov. Gavin Newsom signed SB 861, which updates requirements for multiple professional boards and agencies, including the Dental Board of California. The legislation changes the composition of the Board by removing a requirement that it include a registered dental hygienist and replacing this role with a second registered dental assistant. The registered dental assistant members must be registered in the state for at least five years before their appointment.

Delaware

On Sept. 3, 2025, Gov. Matt Meyer signed SB 122, Health Care Workforce Planning, which requires that state regulators work with professional boards to determine what data should be collected during licensing and renewal processes for a range of healthcare professions including medical, dental, and social work. By improving data collection and analysis, the bill seeks to address workforce gaps, support educational program alignment, and help the state better support its aging population and increasing rates of chronic disease.

Indiana

Gov. Mike Braun signed SB 180/HB 1254 on March 3, 2026. The new law, which goes into effect July 1, 2026, amends the requirements for administration of nitrous oxide by a dental assistant by updating training requirements to include completion of courses approved by the Board and also allows a foreign-trained dentist to practice as a dental hygienist.

Michigan

Signed by Gov. Gretchen Whitmer on Oct. 5, 2025, HB 4706 allocates $2 million for federally qualified health center (FQHC) training programs to partner with a state health center careers training program to provide additional recruitment and training opportunities for FQHC employees, including medical and dental assistants.

Oregon

At its Oct. 24, 2025, meeting, the Oregon Board of Dentistry (OBD) approved amended administrative rules clarifying state certification requirements. As they discontinued the administration of the Oregon Basic (ORB) exam in 2024, these regulations remove references to that exam. Candidates are instead required to pass DANB's Infection Control (ICE) exam for the Expanded Function Dental Assistant, Expanded Function Orthodontic Dental Assistant, and Expanded Function

Preventive Dental Assistant certificates. Candidates who passed the ORB before its discontinuation are still able to use their ORB result to qualify for an Oregon expanded function certificate. The new rules also add provisions for the Board to issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon Certified Anesthesia Dental Assistant Certificate and has successfully completed a Board-approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board. The new rules went into effect Dec. 1, 2025.

Texas

The Texas State Board of Dental Examiners (TSBDE) recently revised a number of rules relating to registration requirements for dental assistants, including:

- Rule §114.2 Registration of Dental Assistants, to reflect the current TSBDE online application process. Effective March 16, 2026, the new rule also revises radiography requirements to include both film and digital formats, and adds a provision for the proper disposal of chemicals used in developing radiographs.
- Rule §114.6 General Qualifications for Registration for Dental Assistants, to specify the documentation required to ensure that only qualified and legally authorized individuals can practice in the state. The rule went into effect March 15, 2026.
- Rule §114.7 Exemption from Registration for Certain Military Service Members and Military Spouses, to modify application requirements and expedite application processing time from 30 days to 10 days for the TSBDE to notify the military member or spouse about the status of their application. The revision was effective March 12, 2026.

Utah

Regulations approved Nov. 24, 2025, establish a Dental Education Advisory Committee (DEAC) membership including one dental assistant with an expanded function certification. The DEAC will assist the Board in its duties, functions, and responsibilities, including advising on proposed practice areas for each expanded function dental auxiliary certification, recommending the minimum required education and training, the scope and limitations for each certification, and education courses for each expanded function.

Virginia

Gov. Abigail Spanberger signed HB 970/SB 178 into law April 9, 2026. The new law, which goes into effect July 1, 2026, allows a Dental Assistant I or II with 1,800 hours of clinical experience to perform supragingival scaling and coronal polishing under dentist supervision.

Washington

A new rule approved Dec. 18, 2025, amends licensure requirements for Expanded Function Dental Auxiliaries (EFDAs) by modifying the training requirements for amalgam restorations. Previously, EFDAs were required to complete training on both typodonts and clinical patients. The amendment makes this dual training optional, allowing EFDAs to complete training on either typodonts or clinical patients. A separate rule requires a minimum age of 18 for registered dental assistants, allowing exceptions for those under 18 who are enrolled in a recognized healthcare career training or vocational education program. Both new rules went into effect Jan. 18, 2026.

ADVERTISEMENT



California attorney general reaches settlement with Aspen Dental over corporate practice claims

Company allegedly exceeded administrative support role

by **Mary Beth Versaci**

May 12, 2026



California Attorney General Rob Bonta announced May 7 that his office had reached a settlement with Aspen Dental Management Inc. for allegedly violating the state's ban on the corporate practice of dentistry and engaging in false and misleading advertising.

Aspen Dental, which is a dental support organization owned by private equity firms, provides business management and administrative services to dental offices that operate under the "Aspen Dental" name and branding. However, the DSO is accused of exceeding that role by interfering with and unlawfully directing the practice, ownership and management of dentistry in California, according to a news release from the attorney general's office.

The attorney general alleges that when Aspen Dental entered California in 2019, it did not contract with existing dental offices but instead selected, purchased, staffed and advertised its offices without clearly identifying an independent dentist-owner, the release stated. The company also allegedly selected, purchased and installed all dental equipment across offices.

The attorney general further alleges Aspen Dental encouraged the sale of particular products and services through direct incentives to practices' clinical employees, including offering dental hygienists $50 per sale of clear aligners to new patients and $100 per sale to existing patients, according to the release.

It is also alleged that Aspen Dental advertisements contained misleading or false representations, including misleading testimonials, ambiguity, misleading cost claims and inexact pricing language, the release stated.

The settlement remains subject to court approval and includes $2 million in penalties, $300,000 in restitution funds for certain patients and several injunctive terms. These terms include:

- Not replacing any practice owner with another dentist of its choosing.
- Not requiring practice owners to effectively give up ownership of any dental practices if they decide to terminate their contractual relationship with Aspen Dental.
- Not owning the property for any practice.
- Not practicing dentistry, including, but not limited to, owning or managing any dental office.
- Not basing service fees on revenue, sales or profits.
- Not suggesting, directing or encouraging any licensed clinician, other than a practice owner, to sell or increase revenue for any service or product.
- Not compensating any of its employees based on the sales or revenue of practices.
- Not paying any practice employees incentives based on practice sales, revenue or profit, including the sale of a particular service or product.

• Discontinuing the use of and not enforcing any existing contractual provision that restricts where any licensed clinician may practice or be employed.
• Providing a written fee schedule for products and laboratory services.
• Registering with the Dental Board of California as a dental group advertising and referral service.
• Clearly and conspicuously identifying the practice owner's name when creating, publishing or disseminating advertisements.

Aspen Dental previously reached a settlement in 2015 with the Office of the New York State Attorney General that barred it from making patient care decisions at its locations in New York. The company had been accused of incentivizing and pressuring staff to increase sales of dental services and products; implementing revenue-oriented patient scheduling systems; hiring and overseeing clinical staff, including associate dentists and dental hygienists; and taking a pre-set percentage of each dental office's monthly gross profit.



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Attorney General Bonta Announces Settlement with Aspen Dental Over Corporate Practice of Dentistry and False Advertising

Thursday, May 7, 2026

Contact: (916) 210-6000, agpressoffice@doj.ca.gov

Settlement includes first-in-state injunctive terms, $2 million in penalties, and $300,000 in restitution

OAKLAND — California Attorney General Rob Bonta announced reaching a settlement with Aspen Dental Management, Inc. (Aspen Dental) for allegedly violating California's ban on the corporate practice of dentistry and engaging in false and misleading advertising. Owned by private equity firms, Aspen Dental describes itself as a dental support organization that provides business management and administrative services to dental offices, each of which operates under the "Aspen Dental" name and branding. However, the company is alleged to have exceeded that role by, among other things, interfering with and unlawfully directing the practice, ownership, and management of dentistry in California. The settlement, which remains subject to court approval, includes

unprecedented injunctive terms to protect California consumers and clinical staff, $2 million in penalties, and $300,000 in restitution funds for certain patients.

"As Americans face an affordability crisis, there is no room for unlawful business practices that can increase healthcare costs or harm consumers. We allege that Aspen Dental went beyond providing business support services and became involved in managing dental operations, while also using advertising that misrepresented services to consumers," **said Attorney General Bonta.** "With this settlement, my office is making clear that patient care must remain in the hands of licensed professionals. If you believe you are a victim of false or misleading advertising, please report it to oag.ca.gov/report."

Since its founding in 1998, Aspen Dental has expanded to more than a thousand offices nationwide. It entered California in 2019 and has since opened 19 offices and served tens of thousands of patients. As part of this expansion, it is alleged that Aspen Dental did not contract with existing dental offices, but rather selected, purchased, staffed, and advertised its offices without clearly identifying an independent dentist-owner. For example, Aspen Dental designed, built out, and furnished all of its offices and made detailed decisions about each location, down to the artwork in bathrooms. It also selected, purchased, and installed all dental equipment across offices.

Aspen Dental also encouraged the sale of particular products and services through direct incentives to practices' clinical employees. For example, Aspen Dental developed and implemented an incentive program for hygienists to encourage the sale of clear aligners. The program offered hygienists $50 per sale to new patients or $100 per sale to existing patients. Business practices of this kind limited dentist-owners, restricted staff, misguided patients, and purportedly violated California's ban on the corporate practice of dentistry and California's Unfair Competition Law.

Further, many advertisements that Aspen Dental created contained misleading and/or false representations, including misleading testimonials, ambiguity, misleading cost claims, and inexact pricing language. Some Aspen Dental advertisements represented that its offices worked with all insurance or no insurance. However, Aspen Dental offices did not accept state or federally funded insurance programs. Other advertisements described low prices for certain products or procedures without clearly disclosing the factors that affect the price or what's provided.

As a part of the settlement, Aspen Dental has agreed to $2 million in penalties, $300,000 in restitution funds, and injunctive terms, including:

- Not replacing any practice owner with another dentist of its choosing.
- Not requiring practice owners to effectively give up ownership of any dental practices if they decide to terminate their contractual relationship with Aspen Dental.
- Not owning the property for any practice.
- Not practicing dentistry, including but not limited to owning or managing any dental office.
- Not basing service fees on revenue, sales, or profits.
- Not suggesting, directing, or encouraging any licensed clinician, other than a practice owner, to sell or increase revenue for any service or product.
- Not compensating any of its employees based on the sales or revenue of practices.
- Not paying any practice employees incentives based on practice sales, revenue, or profit, including the sale of a particular service or product.
- Discontinuing the use of and not enforcing any existing contractual provision that restricts where any licensed clinician may practice or be employed.
- Providing a written fee schedule for products and laboratory services.
- Registering with the Dental Board of California as a Dental Group Advertising and Referral Service.
- Clearly and conspicuously identifying the practice owners name when creating, publishing, or disseminating advertisements.

# # #

STATE OF CALIFORNIA DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL

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The New York Times https://www.nytimes.com/2026/05/04/well/cavity-filling-second-opinion.html

A Cavity Doesn't Always Need a Filling

How to weigh your dental options.

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By Erik Vance

May 4, 2026

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Getting a filling at the dentist can be painful, expensive and generally miserable. A crown or a root canal is even worse. Still, you do it because your dentist says you should.

But in a surprising number of cases, you might have another choice. Where one dentist sees a crown, another might see just a filling. And where one recommends drilling, another might suggest trying some prescription toothpaste first. In other words, a dentist's prognosis is not always the final word. Training, personal philosophy and economics can all play a role.

"A dentist that graduates in 2026 versus a dentist that graduates in 1999, they might have two completely different treatment plans," said Shelbey Arevalo, the chief executive of National Dental Advocacy Program, which helps patients navigate the dental health care system.

So how do you know if you have gotten the right prognosis for you? And when should you seek a second opinion? Here is what you need to know for your next visit.

Not all dentists agree when to drill.

Cavities (called caries by dentists) are any damage to a tooth's surface caused by acid produced by bacteria in your mouth. The deeper the decay goes, the bigger the problem. While this may sound clear-cut, it often isn't.

If the acid is wearing through the outside enamel but hasn't gotten to the next layer of the tooth, called the dentin, then it's a judgment call whether to intervene, said Dr. Sara Stuefen, a dentist in Vinton, Iowa, and a spokeswoman for the American Dental Association.

"Sometimes we still have a chance," she said. Better brushing and flossing, plus cutting back on sweets or coffee, could stop the damage.

"A lot of our patients don't realize that you can actually reverse a carie when it's in its earliest stages," added Dr. Diana K. Nguyen, an associate clinical professor of dentistry at the University of California, San Francisco.

Once the decay gets into the softer dentin layer, most dentists will immediately recommend a filling. But even then, approaches differ. Some dentists will use a crown once 50 percent of a tooth is gone or filled. Others might set that threshold higher.

Standards of care are changing.

Like any branch of medicine, dentistry is constantly evolving. One of the biggest trends is toward minimally invasive dentistry, which limits drilling when possible.

"In the last 50 or 60 years, we have gotten much more conservative than we were before," said Dr. Margherita Fontana, a professor of dentistry at the University of Michigan. "There are a lot of preventive interventions that cost very little."

For example, we've known for decades that prescription-strength fluoride toothpaste and mouthwash can help halt and reverse early tooth decay, Dr. Nguyen said. Dentists can also sometimes stop cavities with fluoride varnishes and prevent them with dental sealants, which were once recommended only for children, Dr. Fontana said.

There are also newer, less studied products that can help rebuild a tooth. One is Curodont, a liquid that dentists apply to a problem spot that attracts calcium and phosphate from saliva, reconstructing tooth enamel. Another is MI paste, which releases minerals into a person's teeth, Dr. Nguyen said.

Dentists have also developed alternatives to root canals over the decades, Dr. Fontana added. Sometimes a deep cavity close to a tooth's nerve can be sealed off, a little like an Egyptian tomb, in an approach called selective caries removal.

It's worth noting that newer prevention treatments might not be covered by insurance, Dr. Fontana said.

And while these practices are spreading, not all dentists are familiar with them, Dr. Stuefen said. And new dentists can receive mixed messages in their training, Dr. Fontana added. Dental schools tend to emphasize conservative treatment, yet when the students take the test for most dentistry licenses, not treating a cavity that is halfway through the enamel generally means failure.

Money plays a role.

Of course, dentistry is not just medicine: It's also a business. And fillings and crowns are more lucrative than cleanings, which can create unconscious incentives to drill a tooth with a borderline cavity.

"The more surgical intervention you do, the greater the financial payout," Dr. Nguyen said. "You can't bill out for watching something over and over."

Another trend in dentistry is the rise of dental support organizations, or D.S.O.s. These are corporate institutions that partner with or buy dentist offices and manage their administration. While D.S.O.s are generally barred from directly influencing medical decisions, several states have brought lawsuits citing a corporate culture that pressures dentists to maximize profit. California recently passed legislation meant to limit D.S.O.s' power and New York has been considering a similar law.

"They promise high salaries but they also expect a certain level of productivity that may not necessarily align with a more conservative practice of dentistry," Dr. Nguyen said.

What should you do?

Ask questions.

To get a feel for a new dentist, the experts recommended asking about their philosophy or approach before starting treatment. It's a good sign when a dentist is familiar with preventive measures, looks for minimalist approaches and communicates clearly, Dr. Nguyen said.

"If the dentist is rushing and says, 'I don't have time to explain this to you, you can speak to one of my staff,'" she said, "I would consider that a red flag."

When you have a cavity, make sure you understand the prognosis, said Ms. Arevalo of the National Dental Advocacy Program. Ask if there are any preventive options you might try before drilling. Is there a way to avoid replacing the whole tooth? Are there more affordable materials for a crown?

How to get a second opinion.

If you have any doubt about a diagnosis and are not in immediate pain, you can always get a second opinion. Telling your dentist that you want this can be awkward, Ms. Arevalo acknowledged. But if a dentist dissuades you from getting one, Dr. Nguyen said, that's another red flag.

Either way, a second opinion means going to another office and sitting for another examination. Simply sending X-rays to a second dentist is not enough, she added.

Some dental insurance plans will cover second opinions; others will not. Sending your X-rays (which you have the right to request) will save some money, but Ms. Arevalo recommended not sharing the prognosis, so as to get an unbiased opinion.

Build trust.

It's helpful to develop a relationship with your dentist, the experts said, where they listen to you and know your history, and where you trust their advice. And you need to do the work at home.

Remember that dentists make judgments based in part on patient history. If you have immaculate teeth and excellent habits, your dentist may be more inclined to hold off drilling, said Dr. Nguyen. But if you don't come in as often, have a mouthful of fillings and crowns or take medications that might dry out your mouth, that can influence the prognosis.

"You come to us, what, twice a year?" Dr. Fontana said, adding: "I can recommend products that work. I can use things in office to help prolong the prognosis of everything we're going to do. But ultimately, it's up to you."

Erik Vance is a staff editor for The Times's Well desk, where he focuses on coverage of fitness and a healthy lifestyle.

A version of this article appears in print on , Section D, Page 6 of the New York edition with the headline: Do You Need a Filling, A Crown, or Neither?

Oregon dental shortages leave gaps in access to care

Expert panel says Oregon leaders need to focus on creativity, efficiency to address inequities affecting people in rural and lower-income communities



SHUTTERSTOCK

by

Joanne Zuhl

May 5, 2026

Oral health is an important part of overall health, yet shortages of dental professionals in much of the state have Oregonians waiting months or longer to get care.

That problem is particularly acute for the 1.4 million Oregonians on the Oregon Health Plan, the state's version of Medicaid. But thanks to state paperwork and low reimbursement rates, fewer than half of Oregon dentists are willing to serve those lower-income people.

The challenges facing dentists in Oregon were discussed by a panel of dental care experts and policy leaders on Monday in an online event sponsored by the Oregon Health Forum, an affiliate of The Lund Report.

The panel came together even as a state advisory group is meeting in secret to discuss potential cuts to the Medicaid program in Oregon. Unlike other benefits, adult dental care

is an optional Medicaid benefit, and not all states offer it. Among the questions the panel discussed was how to prepare for the expected cuts to Medicaid payments without dropping adult dental care altogether.

More providers? Not necessarily.

For Dr. Michael Shirtcliff, a 60-year veteran in the field, the question of access to care starts much further upstream than what most people think of when they think of dentistry. Every cavity, he says, is a failure to treat the disease that caused it.

“We think the problem is we don't have enough dentists. We think it's dental-centric,” said Shirtcliff, who, in addition to his own practice, has been involved in Oregon dental policy for decades, including the creation of the state’s managed care dental system. “This is really a community public health issue, and it's not a dental issue,” he said.

“If you’re the patient, would you like to have access to no disease? Or would you like to have access to get your disease fixed as it gets worse?” said Shirtcliff, who has researched silver diamine fluoride to treat caries in individual patients. “We know how much dentistry is getting done. And we can measure how we're failing with children in producing cavities. And there are a lot of things we could do about that. So I look at it from that perspective. I call it increasing access by reducing demand.”

State Rep. Hai Pham, a pediatric dentist who represents South Hillsboro and West Beaverton in the Legislature, said, “Access is different for everybody. It looks different for everybody,” said Pham, whose dental practice specializes in underserved children in Washington County. Pham said he sees a severe shortage in other providers that accept patients with intellectual and developmental disabilities.

“There are not enough providers that will see children or adults with IDD in those populations,” Pham said. “It's very important that the individuals get customized care that is appropriate to them. So that can be a barrier for some of these families to try to get into a provider, because there's just not enough providers that feel comfortable enough to see some of these families.”

Another issue is federal immigration enforcement actions, according to Pham. “They're not showing up to these appointments because they're afraid. … And this is a real problem that we're seeing right here, around the entire state, but more so in certain communities that have higher populations of Latino families.”

Dr. Ahmed Farag, who leads on oral health as dental director of the Oregon Health Authority’, acknowledged the need for more dental providers, but said access depends on where they are located. Oregon has about 3,700 licensed dentists, Farag said, which is well

within recommended guidelines to cover the state's 4.2 million residents, but they are concentrated in the Portland metro region. Other variables, such as social determinants of health, housing status, and cultural needs, all go into assessing whether access is adequate, Farag said

"We have enough dentists in the communities to provide care. They're just not adequately distributed across the geographic needs." Farag said.

State payments lag what's needed

Oregon's low reimbursement rates for dental services to lower-income patients are a major hurdle to improving access to dental care. Oregon's Medicaid reimbursement covers only 28% of dentists' charges for adult dental services, compared to 43% and 45%, respectively, in neighboring states of Washington and California, according to a 2024 report by the state health authority and Oregon Health & Science University researchers.

That, along with daunting administrative requirements, helps explain why 33 of Oregon's 36 counties lack adequate Medicaid dental providers to meet the needs of enrolled patients. In a state where one-third of the population relies on the Oregon Health Plan to cover medical costs, more than half of all dentists don't accept Oregon Health Plan patients. According to the state health authority, nearly all of the Medicaid dental services delivered in Oregon are provided by only 12% of its dentists.

While Medicaid payments are often just a portion of a dental clinic's revenue, it can be a significant one. So by contributing to higher overall reimbursements, the state could improve the number of dentists practicing in rural areas overall.

"How do we entice providers to want to come to the table and be able to afford to see some of these patients at the end of the day?" Pham asked. "My guess is, if you made it incentivizing enough, where they can at least break even or make a little bit of profit, I can guarantee you would probably have a few more providers sign up for the Oregon Health Plan."

The future of state-funded dental care

But while increasing payments under the Oregon Health Plan is one option, another option to consider is that they might go away.

Oregon doesn't have to offer dental services in its Medicaid program at all. Not all states do. It's an optional benefit under federal law, and one that some health care observers say could be in jeopardy as the state looks to buffer itself against federal Medicaid cuts expected in 2027.

“What happens when adults are no longer able to have access to oral health care because Medicaid no longer covers it here in the state of Oregon?” asked the forum’s moderator, Dr. Rosemarie Hemmings, CEO and owner of Black Therapist Company.

Farag, with the Oregon Health Authority, emphasized that no decision has been made at this point; however, he said, “Whenever a state goes through financial challenges, specifically the federal implication of the finances for our Medicaid program, all options are always on the table to be studied and to understand the impact.” Farag said.

Dr. Lisa Bozzetti, the dental director at Virginia Garcia Memorial Health Center, called for encouraging opportunities for dental careers beyond a doctorate degree, including more dental therapists — a relatively new profession — and assistants. At Virginia Garcia, Bozzetti has expanded services to include seven clinics, a school-based sealant program, integrated dental hygiene in primary care, and dental therapy, utilizing therapists and assistants.

“I really am looking forward to the possibility of more dental therapists coming into play, and being able to serve more rural regions,” Bozzetti said. “I really wanted to stress the need for dental assistants and dental hygienists, and I would love to see programs that allow folks to work full-time or part-time, and at least be able to make a living while going to school. If we only have programs that provide full-time programs, full-time education, it really limits the number of folks that can access those programs.”

If dental services are dropped from the Oregon Health Plan, Bozzetti fears more people showing up in emergency departments with more serious, untreated conditions. “They’re still going to need care,” she said.

In addition to caries and other dental conditions, poor oral health has been linked to endocarditis, cardiovascular disease, complications during pregnancy and birth, and pneumonia, among other serious health concerns.

“We're really at the nexus,” said Dr. Manu Chaudhry, the president of Capitol Dental Care. “We need a moonshot, given everything going on around us, to build a better delivery system.”

LICENSE RATIFICATION

RATIFICATION OF LICENSES

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

DENTAL HYGIENISTS

H9224	Marquez, Fatima Noemi	2026-04-17
H9225	Partida, Miriam Amairani	2026-04-17
H9226	Caro, Evelyn	2026-04-17
H9227	Lopez, Francisco Abrann	2026-04-22
H9228	Gegner, Samuel Thomas	2026-04-27
H9229	Salinas Munoz, Estefani Marlene	2026-04-30
H9230	Duncan, Jordan Clare	2026-05-05
H9231	Rehms, Tammy Christine	2026-05-08
H9232	Reed, Rachel	2026-05-11
H9233	Mitchell, Komal Kaur	2026-05-12
H9234	Adams, Emma-Jean	2026-05-19
H9235	Price, Brianna Mae	2026-05-22
H9236	Virell, Emily Patricia	2026-05-22
H9237	Brittnie, Nicole	2026-05-22
H9238	Craun, Makena Kaylee	2026-06-01

DENTISTS

D12320	Sorensen, Stanford	2026-04-15
D12322	Fagbamigbe, Joseph Olufemi	2026-04-21
D12323	Collins, Quinten Michael	2026-04-21
D12324	Ayer, Uma	2026-04-22
D12325	Saad, Ali	2026-05-01
D12326	Khodabandeh, Elahe	2026-05-01
D12327	Castro, Richelle Torio	2026-05-05
D12328	England, Addyson	2026-05-05
D12329	Marsh, William Preston	2026-05-06
D12330	Staines, Cole Anthony	2026-05-07

D12331	Sookhlall, Chayanne Stanley	2026-05-08
D12332	Singh, Harprit	2026-05-08
D12333	Moradi, Farzad	2026-05-08
D12334	Hunt, Melissa A	2026-05-19
D12335	Patel, Neha	2026-05-21
D12336	Amer, Nadia	2026-05-22
D12337	Karp, Remy Brooke	2026-05-22
D12338	Patel, Jainik Parag	2026-06-01
D12339	Alkhouri, George	2026-06-01
D12340	Long, Christopher Warren	2026-06-01

LICENSE, PERMIT & CERTIFICATION

Request for reinstatement of an expired license – Michael J Longlet, D.D.S.

The Board has received a request for the reinstatement of an expired license. OAR 818-021-0085 requires that before a license that has been expired may be reinstated, the applicant must complete a number of steps. One of the requirements for reinstatement is that the applicant "passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials."

Michael J Longlet, D.D.S. (D10402) held a license to practice dentistry in Oregon that expired on March 31, 2024. Since Dr. Longlet's dental license expired, Dr. Longlet has held an active license in Minnesota (since 2014) and Washington (since 2025). Dr. Longlet would now like to reinstate his Oregon dental license so he can resume practicing dentistry in Oregon. Dr. Longlet has submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycle during which his license was expired, passed the Board's Jurisprudence Examination, and has submitted a background check. No disciplinary actions have been taken against Dr. Longlet in any of the states in which he has been licensed. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Dr. Longlet has been filed by any other entity in either of these data banks.

Pursuant to OAR 818-021-0085, the Board needs to determine if it is necessary for Dr. Longlet to take any further examination and whether to reinstate Dr. Longlet's dental license.

Relevant Rules:

818-021-0085 – Renewal or Reinstatement of Expired License

Any person whose license to practice as a dentist or dental hygienist has expired, may apply for reinstatement under the following circumstances:

(1) If the license has been expired 30 days or less, the applicant shall:
- (a) Pay a penalty fee of $50;
- (b) Pay the biennial renewal fee; and
- (c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.

(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
- (a) Pay a penalty fee of $100;
- (b) Pay the biennial renewal fee; and
- (c) Submit a completed renewal application and certification of having completed the continuing education requirements.

(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
- (a) Pay a penalty fee of $150;
- (b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;

(c) Pay a reinstatement fee of $500; and
(d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

(4) If the license has been expired for more than one year but less than four years, the applicant shall:
(a) Pay a penalty fee of $250;
(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;
(c) Pay a reinstatement fee of $500;
(d) Pass the Board's Jurisprudence Examination;
(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;
(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and
(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

(5) If a dentist or dental hygienist fails to renew or reinstate his or her license within four years from expiration, the dentist or dental hygienist must apply for licensure under the current statute and rules of the Board.

OREGON BOARD OF DENTISTRY
LICENSE AND PERMIT REINSTATEMENT APPLICATION

Return to: Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395

RECEIVED
MAY 11 2026
Oregon Board of Dentistry

2104 $822.00
1290 $750.00
1706 $100.00
1707 $8.00

Name MICHAEL J LONGLET D.D.S.
License # D10402

Licensure Fees:	$822.00
Penalty Fee:	$250.00
Reinstatement:	$500.00
PDMP Fees:	$100.00
OWHI Survey Fees:	$8.00
Total:	$1,680.00

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☐ Primary Business Address

☒ Home Address

Phone:

Email Address:

NOTE: ALSO COMPLETE AND SIGN ON THE REVERSE
INCOMPLETE FORMS WILL BE RETURNED

Request for reinstatement of an expired license – Ashley Lee, D.D.S.

The Board has received a request for the reinstatement of an expired license. OAR 818-021-0085 requires that before a license that has been expired may be reinstated, the applicant must complete a number of steps. One of the requirements for reinstatement is that the applicant "passes any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials."

Ashley Lee, D.D.S. (D11671) held a license to practice dentistry in Oregon that expired on March 31, 2024. Since Dr. Lee's dental license expired, Dr. Lee has held an active Hospital Dental Officer (Limited) license in Rhode Island, which was initially issued in 2025. Dr. Lee would now like to reinstate her Oregon dental license so she can resume practicing dentistry in Oregon. Dr. Lee submitted a License and Permit Reinstatement Application, fees, proof of continuing education for the renewal cycles during which her license was expired, passed the Board's Jurisprudence Examination, and has submitted a background check. No disciplinary actions have been taken against Dr. Lee in any of the states in which she has been licensed. Board staff submitted an inquiry to the National Practitioners Data Bank and the Healthcare Integrity Data Bank and no negative information regarding Dr. Lee has been filed by any other entity in either of these data banks.

Pursuant to OAR 818-021-0085, the Board needs to determine if it is necessary for Dr. Lee to take any further examination and whether to reinstate Dr. Lee dental license.

Relevant Rules:

818-021-0085 – Renewal or Reinstatement of Expired License

Any person whose license to practice as a dentist or dental hygienist has expired, may apply for reinstatement under the following circumstances:

(1) If the license has been expired 30 days or less, the applicant shall:
    (a) Pay a penalty fee of $50;
    (b) Pay the biennial renewal fee; and
    (c) Submit a completed renewal application and certification of having completed the Board's continuing education requirements.

(2) If the license has been expired more than 30 days but less than 60 days, the applicant shall:
    (a) Pay a penalty fee of $100;
    (b) Pay the biennial renewal fee; and
    (c) Submit a completed renewal application and certification of having completed the continuing education requirements.

(3) If the license has been expired more than 60 days, but less than one year, the applicant shall:
    (a) Pay a penalty fee of $150;
    (b) Pay a fee equal to the renewal fees that would have been due during the period the license was expired;
    (c) Pay a reinstatement fee of $500; and
    (d) Submit a completed application for reinstatement provided by the Board, including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board

may request evidence of satisfactory completion of continuing education courses.

(4) If the license has been expired for more than one year but less than four years, the applicant shall:

(a) Pay a penalty fee of $250;

(b) Pay a fee of equal to the renewal fees that would have been due during the period the license was expired;

(c) Pay a reinstatement fee of $500;

(d) Pass the Board's Jurisprudence Examination;

(e) Pass any other qualifying examination as may be determined necessary by the Board after assessing the applicant's professional background and credentials;

(f) Submit evidence of good standing from all states in which the applicant is currently licensed; and

(g) Submit a completed application for reinstatement provided by the Board including certification of having completed continuing education credits as required by the Board during the period the license was expired. The Board may request evidence of satisfactory completion of continuing education courses.

(5) If a dentist or dental hygienist fails to renew or reinstate his or her license within four years from expiration, the dentist or dental hygienist must apply for licensure under the current statute and rules of the Board.

RECEIVED

APR 06 2026

Oregon Board

2104 $822.00
1290 $750.00
1706 $100.00
1707 $8.00

OREGON BOARD OF DENTISTRY
LICENSE AND PERMIT REINSTATEMENT APPLICATION

Return to: Oregon Board of Dentistry
Unit 23
PO Box 4395
Portland, OR 97208-4395

Name ASHLEY LEE
License # D11671

Licensure Fees:	$ 822.00
Penalty Fee:	$ 250.00
Reinstatement:	$ 500.00
PDMP fee	$ 100.00
OWHI Survey Fee:	$ 8.00
Total:	$ 1680.00

Please list the address to which you prefer your mail to be sent. At least one address must be a physical street address.

☒ Primary Business Address

☐ Home Address

Phone:

Email Address:

NOTE: ALSO COMPLETE AND SIGN ON THE REVERSE
INCOMPLETE FORMS WILL BE RETURNED

14. Request for Approval of a Nitrous Oxide Course – McKenzie Dental Practices of Oregon.

The Board has received a request for approval of a Nitrous Oxide Course. The course would be provided so licensees of the Board could apply for and obtain a permit to administer nitrous oxide in accordance with OAR 818-026-0040(1) and OAR 818-035-0040(2).

Relevant Rules:

OAR 818-026-0040 – Qualifications, Standards Applicable, and Continuing Education Requirements for Anesthesia Permits: Nitrous Oxide Permit

Nitrous Oxide Sedation.

(1) The Board shall issue a Nitrous Oxide Permit to an applicant who:
   (a) Is either a licensed dentist or licensed hygienist in the State of Oregon;
   (b) Maintains a current BLS for Healthcare Providers certificate or its equivalent; and
   (c) Has completed a training course of at least 14 hours of instruction in the use of nitrous oxide from a dental school or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association, or as a postgraduate.

OAR 818-035-0040 – Expanded Functions of Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.
(2) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist may administer nitrous oxide under the indirect supervision of a licensed dentist in accordance with the Board's rules regarding anesthesia.
(3) Upon completion of a course of instruction approved by the Oregon Health Authority, Public Health Division, a dental hygienist may purchase Epinephrine and administer Epinephrine in an emergency.

McKenzie Dental
Practices of Oregon

Oregon Board of Dentistry
Licensing/Examinations
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

May 8, 2026

Dear Oregon Board of Dentistry,

McKenzie Dental Practices of Oregon respectfully requests approval for a Nitrous Oxide Sedation course as a board-approved training course qualifying candidates to apply for a Nitrous Oxide Permit in Oregon.

The vision is for Dr. Lee, who is credentialed with HECC, to serve as the supervising dentist while we present a 14-hour course that meets Oregon standards for applying for a nitrous oxide permit. All instructors involved currently hold active nitrous oxide permits in Oregon. Instructors would be Tamara Maahs, RDH, BSDH, EP and Ashley Leavitt, RDH (curricula vita attached).
Highlights that support our request include:

- I have worked at Lane Community College (LCC) for over 30 years and taught in the local anesthesia course, including nitrous oxide training, for more than 25 years. During that time, I supervised students in the clinical setting as they administered nitrous oxide sedation to patients during their senior year winter and spring terms. In addition, during the second year of the dental hygiene program, I managed coursework that focused on the Oregon Dental Practice Act, the responsibilities of nitrous oxide permit holders, and the importance of submitting a complete and accurate nitrous oxide permit application as part of dental hygiene licensure. I also ensured that students reviewed medical emergencies and were able to clearly document our clinic's medical emergency protocols.
- Currently, I use nitrous oxide regularly in the dental practice where I work, treating both adult and pediatric patients. I routinely complete continuing education related to medical emergencies, nitrous oxide administration, and the management of anxious patients. This includes multiple nitrous oxide courses presented and sponsored by Porter Instrument/Parker for a professional study group.
- I am well-versed in the use of both centralized and portable nitrous oxide systems and have experience with Parker/Porter and Accutron flowmeter systems, utilizing both bag-tee systems and the Silhouette low-profile mask system without a reservoir bag.

- Ashley and I are well qualified to team-teach/deliver this course for McKenzie Dental Practices, similar to our current collaboration on the LAF Certification Course for Dental Assistants based on our education and clinical experience.
- Over the years, I have known many dental hygienists who have overlooked renewing their nitrous permits for various reasons and then have not pursued trying to get re-credentialed because of inconvenience due to travel or cost. We believe this course could provide an accessible pathway for reinstatement, while also offering foundational training for those seeking initial certification.

If additional documentation is required or any clarification is needed, please contact us.

Thank you for your time and consideration,

Tamara Maahs, RDH, BSDH, EP and Ashley Leavitt, RDH on behalf of McKenzie Dental Practices of Oregon and Dr. James Lee
CC: Marie Plouse, EFDA AnA-IV, Program Chair and Instructor

McKenzie Dental
Practices of Oregon

Course Title: Nitrous Oxide/Oxygen Sedation Course-14 Hours

Sponsor: McKenzie Dental Practices of Oregon
Contact: James Lee, DDS, Owner and Marie Plouse, EFDA, Program Director and Chair
Instructors: Tamara Maahs, RDH, BSDH, EP and Ashley Leavitt, RDH

Course Description:
This course is designed to prepare the dentist and dental hygienist licensed in Oregon to meet the requirements to properly administer nitrous oxide/oxygen sedation to patients and obtain a Nitrous Oxide Permit in Oregon. This 14-hour hybrid course provides 10 hours of online didactic instruction in patient assessment, understanding pharmacology of nitrous oxide, equipment to include safe equipment management, recognizing and understanding risks, and techniques for both adults and children to provide pain and anxiety management. This course will include management of emergencies in the dental office and legal requirements to include proper documentation for nitrous oxide sedation. The course will provide 4 hours of clinical instruction and practice administering nitrous oxide on a patient.

Prerequisites: Must have an Oregon dentist or dental hygienist license, BLS for Healthcare Providers certification or its equivalent, and professional liability insurance.

Course Outcomes:
- Review the history and characteristics of nitrous oxide/oxygen [N_2O/O_2] sedation
- Understand the pharmacokinetics and physical properties of nitrous oxide
- Describe the mechanism of action and effect of nitrous oxide/oxygen on body systems
- Learn how several healthcare disciplines are using nitrous oxide/oxygen sedation
- Review the delivery systems and current information on the latest equipment
- List the safeguards and proper storage associated with gas cylinders and machinery associated (e.g., manifold system, portable gas delivery system, flowmeter, breathing apparatus, etc.)
- Know the indications, contraindications, and complications of inhalation analgesia
- Conduct comprehensive patient assessments, including medical history, physical and psychological evaluation, and treatment complexity, to determine appropriate pain management and sedation approach
- Review administration, titration, and monitoring techniques
- Describe the signs and symptoms exhibited by the patient with sedation including those of over-sedation
- Discuss the advantages, disadvantages and complications associated with the use of nitrous oxide/oxygen conscious sedation
- Review the Oregon Board of Dentistry standards for the facility, duties of the nitrous oxide permit holder, and continuing education requirements for permit renewal

Course Certification Completion Requirements:

- Participate in all lectures and a clinical session for practical skill demonstration practicing as both the operator and patient
- Pass final written examination at 75% or higher
- Complete Oregon's Nitrous Oxide Permit Application https://www.oregon.gov/dentistry/Documents/Form_Nitrous_Oxide.pdf

Course Outline

Lesson One: Introduction (1 hour)

1. Review the history of nitrous oxide gas
2. Define the different types of sedation
3. Discuss the role of sedation in pain management
4. Discuss the benefits, limitations, and precautions with nitrous oxide/oxygen sedation
5. Describe the current use in dentistry and other healthcare disciplines

Lesson Two: Anatomy, Physiology and Pharmacology (1 hour)

1. Review the respiratory system and process
2. Discuss the clinical manifestations of analgesia and anesthesia on the cardiovascular system and central nervous system
3. Describe the effects of nitrous oxide/oxygen sedation on other body systems
4. Review the adverse reactions to nitrous oxide/oxygen sedation

Lesson Three: Patient Assessment (2 hours)

1. Understand why the medical questionnaire is important for identifying conditions, allergies or medications that could lead to adverse reactions, complications, or affect the effectiveness of nitrous oxide/oxygen sedation
2. Explain how the patient medical history is important for guiding treatment decisions and ensuring patient safety
3. Use the American Society of Anesthesiologists Physical Status Classification System to document physical status and help to determine which patients may be at medical risk for the administration of anesthetics/analgesics
4. Identify modifications to treatment to promote patient safety and comfort with the administration of nitrous oxide/oxygen sedation
5. Review stress reduction protocols for anxious patient management
6. List the contraindications for nitrous oxide/oxygen sedation
7. Review the use of nitrous oxide/oxygen sedation on both adult and pediatric patients

Lesson Four: Equipment and Delivery Systems (1 hour)

1. Differentiate between centralized system and portable system
2. Describe the gas cylinders and color coding for the gases
3. Describe the properties of the gases in relation to psi
4. Understand the purpose of a manifold with the central delivery system
5. Review the portable delivery systems with smaller gas tanks
6. Understand purpose and use of the flowmeter and scavenging systems
7. Be aware of combustion risk with gases
8. Review Bag Tee system vs. newer systems (i.e., Silhouette by Parker/Porter) that do not involve a reservoir bag

Lesson Five: Steps for Administering Nitrous Oxide/Oxygen Sedation (2 hours)

1. Demonstrate pre-operative unit preparation
2. Understand pre-operative patient preparation (pre-induction instructions) to include patient assessment and informed consent
3. Describe establishing tidal volume and process of titration
4. List the steps for administration
5. Describe the signs, symptoms, and stages of sedation with nitrous oxide/oxygen including signs of optimal sedation and over-sedation
6. Review how to calculate the percentage of the gases
7. List the post-operative procedures for the patient to include technique for initiating, monitoring and assessing adequate recovery
8. List the post-operative procedures for equipment
9. Review strategies to enhance the effect of nitrous oxide/oxygen sedation

Lesson Six: Complications, Adverse Reactions, and Occupational Risks (1 hour)

1. Understand employee safety and health guidelines
2. Understand the differences between the regulating agencies and their role in assuring the safety of the equipment and employees
3. Review the complications and how to prevent adverse reactions
4. Discuss the importance of and process for post-operative care
5. Discuss occupational risks associated with the use of nitrous oxide

Lesson Seven: Medical Emergency Protocols (1 hour)

1. Describe the medical emergency plan and protocols recommended for a dental team
2. Describe the contents and drugs required for a typical medical emergency kit in a dental office
3. Describe the airway equipment that should be available in a dental office

Lesson Eight: Legal and Ethical Issues (1 hour)

1. Understand the different regulatory agencies for nitrous oxide use (FDA, NIOSH, OSHA, NFPA)
2. Discuss the scope of practice for dental professionals in Oregon
3. Review the rules and regulations in the Oregon Practice Act
4. Review the documentation required for patient instruction and informed consent
5. Demonstrate proper documentation for the nitrous oxide/oxygen sedation record as required by the Oregon Board of Dentistry

Clinical Lab Session: 4 hours

This portion of the course will be scheduled following registration and upon completion of the lecture-based coursework. Participants will serve as both the patient and operator to demonstrate the proper administration of nitrous oxide/oxygen sedation and complete a skills check-off. The session will also provide a review of medical emergency equipment and protocols. The final written examination will be administered on-site following the clinical lab session and requires a minimum passing score of 75%. Documentation of successful course completion will be issued once both the lecture and clinical/laboratory requirements have been met.

CURRICULUM VITAE

Ashley Leavitt, RDH

EDUCATIONAL BACKGROUND

Lane Community College, Associate of Applied Science in Dental Hygiene, 2011
President of the Student ADHA 2009-2011

DENTAL HYGIENE LICENSURE/ OTHER CERTIFICATIONS

Oregon: H6096, August 2011-Active
California: 26291, August 2011-May 2025
Nevada: 101962, April 2014-June 2024
South Carolina: 10249. February 2015- December 2022
Ohio: 31.015630. February 2017-December 2021
Georgia: DH044219 Jan 2021-Active
Level I Laser Certification Associate Fellowship Certification from World Clinical Laser Institute: 2013

WORK EXPERIENCE

Impression Dental Care, Huntington Beach, CA (Aug 2011- April 2014)
Smile by Design, Irvine, CA (April 2013-April 2014)
Summerlin Dental, Las Vegas, NV (April 2014-Oct 2014)
Ivy Dental Care, Las Vegas, NV (Oct 2014-Feb 2015)
Keowee Smiles, Seneca, SC (March 2015-Feb 2017, Feb 2020-Dec 2020, July 2021)
Afinia Dental, Cincinnati, OH (Feb 2017-May 2017)
Dr. Tara Hardin, Mason, OH (May 2017-Aug 2017, Feb 2019-March 2019)
Willamette Dental, various offices OR (Aug 2018-Nov 2018)
Arrow Dental, Salem, OR (Aug 2018-Jan 2019)
Wallace Medical Concern, Portland, OR (Sept 2018)
Mill City Dental, Mill City, OR (Sept 2018)
Terwilliger Dental, Portland, OR (Sept 2018)
Aspen Dental, Eugene, OR (Sept 2018)
Mountain Stream Dental, Springfield, OR (Sept 2018)
Gentle Dental, Salem, OR (Oct 2018)
Somerset Dental, Las Vegas, NV (Oct 2018)
Moore Family Dentistry, Henderson, NV (Oct 2018)
McKenzie Dental Center, Springfield, OR (Nov 2018- Dec 2018)
Elm Street Dental, Albany, OR (Dec 2018)
Dr. Sproul, Eugene, OR (Dec 2018, Aug 2019-Jan 2020, Feb 2024)
Dr. Hunksman, Salem, OR (Jan 2019)
Gilmore Family Dentistry, Salem, OR (Jan 2019)
Dr. Trenton Young, Salem, OR (Jan 2019)
360 Dental, Eugene, OR (Feb 2019)
Eugene Periodontics & Implant Dentistry, Eugene, OR (March 2019-August 2019)

WORK EXPERIENCE (CONT)

Dr. Argawal, Beaverton, OR (Aug 2019-Sept 2019)
Dr. Stephenson, Eugene, OR (Sept 2019)
Newport Dental Care, Newport Beach, OR (Sept 2019-Oct 2019)
Dr. Furgason-Fife, Eugene, OR (Oct 2019, Jan 2020)
Dr. Holland, Springfield, OR (Oct 2019, Feb 2024)
Dr. Laster, Corvallis, OR (Oct 2019)
Dr. Winstead, Salem, OR (Oct 2019)
Gentle Dental, Beaverton, OR (Oct 2019)
Mt. Tabor Dental, Portland, OR (Oct 2019)
Dr. Bevans, Eugene, OR (Dec 2019)
Dr. Carly Peterschmidt, Eugene, OR (Jan 2020, Jan 2024)
Dr. Vivona-Dow, Eugene, OR (Jan 2020 and Jan 2024)
Downtown Dental, Greenville, SC (Jan 2021)
Grand Oaks Dental, Anderson SC (Jan 2021)
Benson Family Dentistry, Travers Rest, SC (Jan 2021)
Falls Park Dentistry, Greenville, SC (Jan 2021)
Conestee Family Dental, Greenville, SC (Jan 2021)
Mountain Lakes Family Dentistry, Clemson, SC (Jan 2021)
Dr. Keenan Smith, Greenville, SC (Jan 2019)
Dr. George Andrews, Atlanta, GA (Feb 2021)
Dr. Thornton, Marietta, GA (Feb 2021- Aug 2022)
V Cosmetic Dentistry, Suwanee, GA (Feb 2021)
Executive Park Dentistry, Atalanta, GA (Feb 2021)
Georgia Prosthodontics, Lawrenceville, GA (Feb 2021-Dec 2021)
Patrick Family Dental Care, Symrna, GA (Feb 2021-Jan 2022)
Dr. Veal, Dunwoody, GA (Feb 2022-Sept 2023)
Maple Drive Dentistry, Atlanta, GA (Jan 2022-March 2023)
Dentique, Atlanta, GA (June 2022-Aug 2022)
Peacetree Smile Center, Atlanta GA (July 2022)
Dr. Chartier, Decatur, GA (Aug 2022-Dec 2023)
Relief Dental, Tucker, GA (Sept 2022)
Georgia Dental Center, Decatur, GA (Oct 2022)
Atlanta Dental Center (Oct 2022-
Pumphrey Periodontics, Atlanta GA (Nov 2022-Dec 2023)
Art Cosmetic Dentistry of Buckhead, Atlanta, GA (Dec 2022)
Lavista Dentistry, Tucker, GA (Jan 2023-Nov 2023)
Smile 23, Atlanta, GA (Feb 2023)
DeMercy Dental, Roswell, GA (April 2023)
Dr. Resuta, Atlanta, GA (July 2023-Aug 2023)
Decatur Smiles, Decatur, GA (July 2023)
Gallery Dental, Atlanta, GA (Sept 2023-Oct 2023)

WORK EXPERIENCE (CONT)
Dr. David Lester, Eugene, OR (Jan 2024-Feb 2024)
Delta Oaks Dental Care, Eugene, OR (Jan 2024)
Alison Cadaret, Eugene, OR (Sept 2019-Dec 2019, Jan 2024-Feb 2024)
For Beautiful Smiles, Eugene, OR (Feb 2024-Present)
Oak Grove Dental Center, Milwaukie, OR (July 2025)

PROFESSIONAL ASSOCIATIONS
Board of Editorial Advisors- Inside Dental Hygiene Magazine (IDH) (Sept 2022- Present)

WRITING AND PUBLICATIONS
"The Front Line Defense Against Caries"- Article Publication in IDH Magazine, February 2021
"Shaping the Future"- Feature in IDH Magazine, October 2021
"Whitening, Aligners, and More: Trends in Dental Hygiene- Article Publication in IDH Magazine, October 2022
"What Works Best" feature in Inside Dental Hygiene Magazine, January 2024

COMMUNITY SERVICE
We Care to Share, Haiti- Volunteer Dental Mission. (2013, 2016, 2019)

EDUCATIONAL METHODOLOGY
Learning to Make Clinical Decisions- 2025
Clinical Teaching Strategies and Techniques- 2025
The Role of Adult Learning in Clinical Education- 2025
Dimensions of Clinical Teaching- 2025

CONTINUING EDUCATION
Local Anesthesia in Pediatric Dentistry- 2019
Sedation in the Dental Office: an overview- 2021
Managing Adult Emergencies in the Dental Office- 2023
Head and Neck Anatomy: Part I- Bony Structures- 2025
Head and Neck Anatomy: Part II- Musculature- 2025
Head and Neck Anatomy: Part III- Cranial Nerves- 2025

CPR/BLS Certification
American Heart Association Healthcare Provider Card, Expires Dec 2026

OREGON BOARD OF DENTISTRY

THIS PORTION FOR MAILING PURPOSES ONLY

ASHLEY D. LEAVITT
1458 N 66 ST
SPRINGFIELD OR 97478

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

H6096
License Number

OREGON BOARD OF DENTISTRY

2025/2027 Hygiene License

ASHLEY D. LEAVITT R.D.H.

Permits:
Nitrous Oxide
Endorsements:
Local Anesthesia

Restrictions:
None

Expires: 09/30/2027

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

TAMARA MAAHS, RDH, BSDH, EP
Health Professions: Dental Hygiene
Lane Community College

TITLE Dental Hygiene Faculty, Registered Dental Hygienist, Expanded Practice Dental Hygienist (Oregon)

APPOINTMENT September 1994 (initial appointment) to present, Part-time Faculty (up to .67 FTE)
Temporary Contracted Faculty for 2021-22
Temporary Contracted Faculty for 2018-19
Temporary Contracted Faculty for 2004-05
Temporary Contracted Faculty for 2001-02

DENTAL HYGIENE LICENSURE/OTHER CERTIFICATION

- Oregon Dental Hygiene License: 1993 active, license number H3105
- PERMITS: Nitrous Oxide, Expanded Practice with Collaborative Agreement
- Oregon Certificate of Instructor Approval for Radiologic Proficiency
- DANB Radiation Health and Safety Certificate

EDUCATION

Bachelor of Science in Dental Hygiene
Oregon Institute of Technology, Klamath Falls, OR,
March 2001

Associate of Applied Science in Dental Hygiene
Lane Community College, Eugene, OR
June 1993

Associate of Applied Science in Dental Assisting
Oregon Institute of Technology, Klamath Falls, OR
June 1982

EDUCATIONAL METHODOLOGY

Dental Hygiene National Review Course, San Jose, CA, 2015

Educator Program Oregon Dental Hygiene Association Conference "Educational Methodologies for Successful Communication", 2013

"Striving for Better: An Intentional Approach to Clinical Teaching", Dental Hygiene Educators Workshop, University of Texas Health Science Center of San Antonio, 2013

Inservice courses in clinical instruction, educational methodology, and online instructional design (specifically Quality Matters Training for recognition of online courses 2007: Certified Peer Reviewer 2007 and SoftChalk interactive software for online instruction)

"Balancing Clinical Teaching and Evaluation", Dental Hygiene Clinical Educators Workshop, San Antonio, TX, 2005

Oregon Institute of Technology, DHY 450 Instructional Methods, 1998
Oregon Institute of Technology, DHY 451 Instructional Experience, 1998

DENTAL HYGIENE WORK EXPERIENCE

Academic

1994 to Present	Part-time and Temporary Contracted Faculty, Dental Hygiene Lane Community College, Eugene OR

Faculty Internship

June-Sept 2018	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2016	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2014	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2013	Eugene Periodontics & Implant Dentistry, Andrew N. Dow, DMD, MSD

Clinical

1993 to Present	General Practice Dental Hygienist, part-time Coleman A. Dow, DMD and Douglas N. Dow, DMD, Springfield, OR
1994 to 1997	General Practice Dental Hygienist, part-time Patrick V. Hagerty, DMD, Albany, OR
	Dental Hygiene Substitute Andrew N. Dow, DMD, MSD, Eugene, OR (6/2013-9/2015) Steven Abbott, DMD, Veneta, OR (6/2001-8/2001) Fred C. Platt, DMD, Eugene, OR (8/1994-12/1994) Stephen Skipworth, DDS, Cottage Grove, OR (8/1994) Stephen J. Dose, DMD, Eugene, OR (8/1994) Donald Tillman, DDS, Eugene, OR (7/1994) Mel Bryson, DMD, Springfield, OR (6/1994-7/1994) Mark G. Thoreson, DDS, Eugene, OR (6/1994-9/1994) Richard Smith, DMD, Springfield, OR (1/1994) Dennis W. Clark, DDS, Lebanon, OR (8/1993-9/1993) Michael E. Lacey, DMD, Eugene, OR (7/1993)
1992 to 1994	General Practice Dental Hygienist and Dental Assistant, part-time Andrew Holub, DDS, Eugene, OR
1987 to 1991	General Practice Dental Assistant, full-time Nicholas L. Kenney, DDS, Springfield, OR
1987	Dental Assistant substitute and part-time Steven W. Thurn, DMD, Springfield OR John Baron, DDS, Springfield, OR
1982 to 1987	General Practice Dental Assistant, full-time Terry L. Dressell, DMD, Klamath Falls, OR

CURRENT AND PAST TEACHING CONTENT

Oral Biology
Special Needs Patient/Medical Emergencies
Periodontology 1 and 2
Clinical Dental Hygiene 4 and 5 (didactic)
Clinical Dental Hygiene: first and second year clinic (second year lead and shared lead)
Local Anesthesia (orientation and lab instructor)
Trends and Issues in Dental Hygiene

AREAS OF SPECIAL COMPETENCE

- Patterson EagleSoft Software/Direct Digital Radiography
- Dental Hygiene Treatment Planning
- Dental Hygiene Current Dental Terminology and Coding: presentations for local study groups
- Local Anesthesia
- Power Driven Scalers (Ultrasonic Instrumentation)
- Periodontal Scaling/Advanced Instrumentation

WRITING AND DEVELOPMENT: EDUCATIONAL MATERIALS AND PUBLICATIONS

Periodontal Abscess or Gingival Abscess: "The Perils of Popcorn": A Clinical Case Report, Dentistry IQ, September 2022

Ultrasonics Lecture: Guest Speaker for Lane County Dental Hygienists' Association April 28, 2011

Trends & Issues in Dental Hygiene, developed first dental hygiene online course at LCC using Web CT and Moodle, 2002-present. Recognized in 2007 by Quality Matters Peer Course Review.

Design and delivery of online courses for LCC Dental Hygiene to include Clinical Dental Hygiene (lecture and lab), Periodontology, Trends and Issues in Dental Hygiene: made possible by the NPDHS distance learning Dental Hygiene Program project.

Dental Hygiene **CDT** Codes Instructional Module, co-author, 1996 and author of subsequent current revisions.

Nonsurgical Periodontal Therapy (Scaling and Root Planing) Consent Form for Lane Community College Dental Clinic

Instructional modules and educational materials for the Dental Radiology Continuing Education Course, 1996-2006.

"A Different Spin on Polishing." RDH Magazine, November 2006: 46-50 &102.

"The Beauty of Managed Care." RDH Magazine, June 2000: 46-50 & 100.

RELEVANT EDUCATION AND CONTINUING EDUCATION

- Dental Anxiety and Management of Symptoms February 2025
- Western Society of Periodontology Referring to Periodontist and Implant Maintenance October 2024
- 2024 Annual ADEA Meeting New Orleans: Building Clinical Preparedness, Approach to Faculty Calibration, Opportunity to Create Change in Dental and Dental Hygiene Licensure, Ethical Dilemmas, Artificial Intelligence March 2024
- Educators Platform Conference for Clinic and Lab Instructors October 2023
- Periodontal Classification System, April 2023
- Educator's Role in Teaching Implant Assessment, Maintenance, Homecare (also Mastery course), 2023
- Recordkeeping Board Protocols from Oregon Board of Dentistry, May 2022
- Review of Periodontology, Sept 2022
- Special Care Dentistry Series, Oct 2022
- Oral Pathology Cases and Concepts, Nov 2020
- Incorporating 2018 AAP Classifications of Periodontal Disease and Peri-Implant Diseases and Conditions into Practice, June 2020
- 2018 Western Society of Periodontology 66th Annual Scientific Session, San Diego, CA
- 2018 Western Society of Periodontology Program: Prognosis for the Periodontally Compromised Tooth, Improve Your Quality of Hygiene Care, and Peri-Implantitis: Prevalence, Risk Factors, and Non-Surgical Treatment, Portland, OR

- 2014 Optimizing Hygiene, Regenerative, and Implant Dentistry, Corvallis, OR
- 2012 Soft Tissue Laser Certification Course, Los Angeles, CA
- 2008 Western Society of Periodontology Annual Session, Las Vegas, NV
- 2007 WREB Educators' Forum, Rio Salado College, Tempe, AZ
- 2006 RDH Under One Roof Conference, Las Vegas, NV
  ▪Courses on Writing/Publishing and Hypersensitivity/Desensitizing
- 2001 Dental Hygiene National Board Review Course, San Francisco, CA
- 1999 Oregon Institute of Technology BUS 316 Total Quality in Health Care
- 1999 Oregon Institute of Technology BUS 317 Health Care Management

CPR/BLS CERTIFICATION

American Heart Association Healthcare Provider Card, expires January 2027

14. Request for Approval of a Local Anesthesia Endorsement for Dental Hygienists or Oregon Local Anesthesia Functions Certificate (LAFC) for Dental Assistants – McKenzie Dental Practices of Oregon.

The Board has received a request for approval of a Local Anesthesia Course – for dental hygienists and dental assistants. The course would be provided to Expanded Practice Dental Assistants and Oregon dental hygiene licensees so the EFDAs could apply for and obtain a certificate from DANB and the hygiene licensee could apply for the local anesthesia endorsement to administer local anesthesia in accordance with OAR 818-035-0040(1) and OAR 818-035-0040(2).

Relevant Rules:

OAR 818-035-0040 – Expanded Functions of Dental Hygienists

(1) Upon completion of a course of instruction in a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board, a dental hygienist who completes a Board approved application shall be issued an endorsement to administer local anesthetic agents and local anesthetic reversal agents under the general supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds. The Board shall issue a Nitrous Oxide Permit to an applicant who:

OAR 818-042-0096 – Local Anesthesia Functions of Dental Assistants

(1) The Board shall issue a Local Anesthesia Functions Certificate (LAFC) to a dental assistant who holds an Oregon EFDA Certificate, and has successfully completed a Board approved curriculum from a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the Board.

(2) A dental assistant may administer local anesthetic agents and local anesthetic reversal agents under the indirect supervision of a licensed dentist. Local anesthetic reversal agents shall not be used on children less than 6 years of age or weighing less than 33 pounds.

McKenzie Dental
Practices of Oregon

Oregon Board of Dentistry
Licensing/Examinations
1500 SW 1st Avenue, Suite 770
Portland, OR 97201

May 5, 2026

Dear Oregon Board of Dentistry,

McKenzie Dental Practices of Oregon respectfully requests approval for our course, Local Anesthesia Functions for Dental Clinicians, as a board-approved training course qualifying candidates for the Local Anesthesia Endorsement for Dental Hygienists or Oregon Local Anesthesia Functions Certificate (LAFC) for Dental Assistants.

We currently deliver an approved Local Anesthesia Functions for Dental Assistants course and we are seeking approval to update and expand this course to include dental hygienists who may be seeking the Oregon endorsement or who require a refresher for local anesthesia skills.

Included with this request are the Syllabus/Course Description, Curricula Vitae for Ashley Leavitt, RDH and Tamara Maahs, RDH, BSDH, EP, both credentialed instructors currently teaching the Local Anesthesia Functions course for Dental Assistants at McKenzie Dental Practices of Oregon.

Other materials/artifacts have been previously approved. If the board would like to see more samples of the coursework this can be provided on request.

If additional documentation is required or any clarification is needed, please contact us.

Thank you for your time and consideration,

James Y. Lee
James Lee, DDS, Program Owner

Marie Plouse
Marie Plouse, EFDA AnA-IV, Program Chair and Instructor

McKenzie Dental
Practices of Oregon

Local Anesthesia Academy (LAA)

Local Anesthesia Functions Certification/Endorsement Course Oregon

Course Title: Local Anesthesia Functions for the Dental Clinician

Sponsor: McKenzie Dental Practices of Oregon
Contact: James Lee, DDS, Owner and Marie Plouse, EFDA, Director and Program Chair
Instructors: Ashley Leavitt, RDH and Tamara Maahs, RDH, BSDH, EP

Course Description:
This course provides dental auxiliary clinicians with essential knowledge and clinical skills for the safe and effective administration of local anesthesia. Topics include neuroanatomy, pharmacology, patient assessment, injection techniques, pain management, and emergency protocols. The curriculum integrates lectures, independent study, clinical training and hands-on practice to develop competency in preparation, administration, and management of local anesthesia.

Prerequisites: Must have an Oregon Expanded Function Dental Assistant (EFDA) Certification or Oregon Certified Anesthesia Dental Assistant certificate (DAANCE) with a minimum of 3 years current work experience as a dental assistant *or* a dental hygiene license in Oregon, BLS for Healthcare Providers certification or its equivalent, and professional liability insurance.

Course Outcomes:

- Understand neuroanatomy and neurophysiology of local anesthetics.
- Understand the pharmacology of local anesthetics.
- Identify anatomical landmarks and understand the physiology related to the delivery of local anesthetics.
- Conduct comprehensive patient assessments, including medical history, physical and psychological evaluation, and treatment complexity, to determine appropriate anesthetic use.
- Select appropriate anesthetic based on the patient's dental, medical, physical and psychological assessment, procedure(s) to be performed, the duration needed and the maximum safe dosage.
- Recognize indications, contraindications, and complications of local anesthetics, and select appropriate medications and injection techniques.
- Describe the basic technique steps for maxillary and mandibular injection techniques.

- Describe supplemental administration techniques used in general and specialty dentistry
- Safely and effectively administer local anesthesia under supervision practicing maxillary and mandibular injection techniques.
- Develop clinical precision and confidence by performing safe and effective local anesthesia injections.
- Maintain infection control and safety standards by following proper protocols and demonstrating correct needle handling.
- Prevent and manage complications by identifying and responding to potential adverse complications [systemic or local] such as hematoma, nerve injury, anesthesia failure, allergic reactions, etc.
- Consider legal aspects of delivering local anesthesia to include documentation and state requirements.

Course Certification Completion Requirements:

- Participate in all lecture, lab, and clinical sessions*
- Pass final written examination at 75% or higher
- Practical skill demonstrations
- Clinical performance/competency assessments
- Complete the Expanded Functions of Dental Hygienists – Local Anesthesia Endorsement Application (hygienists) https://www.oregon.gov/dentistry/Documents/Form_Dental_Hygiene_Local_Anesthesia.pdf
- Complete the DANB Application (assistants) https://danbsfprodassets.azureedge.net/assets/docs/default-source/state-application-packets/or_lafc.pdf?sfvrsn=2c9b2569_9
  *See https://www.danb.org/state-requirements/oregon-expanded-function-dental-assistant-with-local-anesthesia-functions-certificate

Teaching Methods:

50 hours with a hybrid study format: 30 hours lecture coursework online (approximately/average 5 hours/week over 6 weeks) and 20 hours in-person class/clinical sessions (Four total sessions: 8 hours first session then 4 hours/week over 4 weeks).
*Clinical sessions include hands on partner practice requiring the student to participate as a clinician as well as a patient.
In person on-site proctored final certification exam required week 6.

Required Textbook:

Local Anesthesia for Dental Professionals, 2nd Edition 2022 update, Bassett, DiMarco, & Naughton
Additional required resources will be provided

CURRICULUM VITAE

Ashley Leavitt, RDH

EDUCATIONAL BACKGROUND

Lane Community College, Associate of Applied Science in Dental Hygiene, 2011
President of the Student ADHA 2009-2011

DENTAL HYGIENE LICENSURE/ OTHER CERTIFICATIONS

Oregon: H6096, August 2011-Active
California: 26291, August 2011-May 2025
Nevada: 101962, April 2014-June 2024
South Carolina: 10249. February 2015- December 2022
Ohio: 31.015630. February 2017-December 2021
Georgia: DH044219 Jan 2021-Active
Level I Laser Certification Associate Fellowship Certification from World Clinical Laser Institute: 2013

WORK EXPERIENCE

Impression Dental Care, Huntington Beach, CA (Aug 2011- April 2014)
Smile by Design, Irvine, CA (April 2013-April 2014)
Summerlin Dental, Las Vegas, NV (April 2014-Oct 2014)
Ivy Dental Care, Las Vegas, NV (Oct 2014-Feb 2015)
Keowee Smiles, Seneca, SC (March 2015-Feb 2017, Feb 2020-Dec 2020, July 2021)
Afinia Dental, Cincinnati, OH (Feb 2017-May 2017)
Dr. Tara Hardin, Mason, OH (May 2017-Aug 2017, Feb 2019-March 2019)
Willamette Dental, various offices OR (Aug 2018-Nov 2018)
Arrow Dental, Salem, OR (Aug 2018-Jan 2019)
Wallace Medical Concern, Portland, OR (Sept 2018)
Mill City Dental, Mill City, OR (Sept 2018)
Terwilliger Dental, Portland, OR (Sept 2018)
Aspen Dental, Eugene, OR (Sept 2018)
Mountain Stream Dental, Springfield, OR (Sept 2018)
Gentle Dental, Salem, OR (Oct 2018)
Somerset Dental, Las Vegas, NV (Oct 2018)
Moore Family Dentistry, Henderson, NV (Oct 2018)
McKenzie Dental Center, Springfield, OR (Nov 2018- Dec 2018)
Elm Street Dental, Albany, OR (Dec 2018)
Dr. Sproul, Eugene, OR (Dec 2018, Aug 2019-Jan 2020, Feb 2024)
Dr. Hunksman, Salem, OR (Jan 2019)
Gilmore Family Dentistry, Salem, OR (Jan 2019)
Dr. Trenton Young, Salem, OR (Jan 2019)
360 Dental, Eugene, OR (Feb 2019)
Eugene Periodontics & Implant Dentistry, Eugene, OR (March 2019-August 2019)

WORK EXPERIENCE (CONT)

Dr. Argawal, Beaverton, OR (Aug 2019-Sept 2019)
Dr. Stephenson, Eugene, OR (Sept 2019)
Newport Dental Care, Newport Beach, OR (Sept 2019-Oct 2019)
Dr. Furgason-Fife, Eugene, OR (Oct 2019, Jan 2020)
Dr. Holland, Springfield, OR (Oct 2019, Feb 2024)
Dr. Laster, Corvallis, OR (Oct 2019)
Dr. Winstead, Salem, OR (Oct 2019)
Gentle Dental, Beaverton, OR (Oct 2019)
Mt. Tabor Dental, Portland, OR (Oct 2019)
Dr. Bevans, Eugene, OR (Dec 2019)
Dr. Carly Peterschmidt, Eugene, OR (Jan 2020, Jan 2024)
Dr. Vivona-Dow, Eugene, OR (Jan 2020 and Jan 2024)
Downtown Dental, Greenville, SC (Jan 2021)
Grand Oaks Dental, Anderson SC (Jan 2021)
Benson Family Dentistry, Travers Rest, SC (Jan 2021)
Falls Park Dentistry, Greenville, SC (Jan 2021)
Conestee Family Dental, Greenville, SC (Jan 2021)
Mountain Lakes Family Dentistry, Clemson, SC (Jan 2021)
Dr. Keenan Smith, Greenville, SC (Jan 2019)
Dr. George Andrews, Atlanta, GA (Feb 2021)
Dr. Thornton, Marietta, GA (Feb 2021- Aug 2022)
V Cosmetic Dentistry, Suwanee, GA (Feb 2021)
Executive Park Dentistry, Atalanta, GA (Feb 2021)
Georgia Prosthodontics, Lawrenceville, GA (Feb 2021-Dec 2021)
Patrick Family Dental Care, Symrna, GA (Feb 2021-Jan 2022)
Dr. Veal, Dunwoody, GA (Feb 2022-Sept 2023)
Maple Drive Dentistry, Atlanta, GA (Jan 2022-March 2023)
Dentique, Atlanta, GA (June 2022-Aug 2022)
Peacetree Smile Center, Atlanta GA (July 2022)
Dr. Chartier, Decatur, GA (Aug 2022-Dec 2023)
Relief Dental, Tucker, GA (Sept 2022)
Georgia Dental Center, Decatur, GA (Oct 2022)
Atlanta Dental Center (Oct 2022-
Pumphrey Periodontics, Atlanta GA (Nov 2022-Dec 2023)
Art Cosmetic Dentistry of Buckhead, Atlanta, GA (Dec 2022)
Lavista Dentistry, Tucker, GA (Jan 2023-Nov 2023)
Smile 23, Atlanta, GA (Feb 2023)
DeMercy Dental, Roswell, GA (April 2023)
Dr. Resuta, Atlanta, GA (July 2023-Aug 2023)
Decatur Smiles, Decatur, GA (July 2023)
Gallery Dental, Atlanta, GA (Sept 2023-Oct 2023)

WORK EXPERIENCE (CONT)
Dr. David Lester, Eugene, OR (Jan 2024-Feb 2024)
Delta Oaks Dental Care, Eugene, OR (Jan 2024)
Alison Cadaret, Eugene, OR (Sept 2019-Dec 2019, Jan 2024-Feb 2024)
For Beautiful Smiles, Eugene, OR (Feb 2024-Present)
Oak Grove Dental Center, Milwaukie, OR (July 2025)

PROFESSIONAL ASSOCIATIONS
Board of Editorial Advisors- Inside Dental Hygiene Magazine (IDH) (Sept 2022- Present)

WRITING AND PUBLICATIONS
"The Front Line Defense Against Caries"- Article Publication in IDH Magazine, February 2021
"Shaping the Future"- Feature in IDH Magazine, October 2021
"Whitening, Aligners, and More: Trends in Dental Hygiene- Article Publication in IDH Magazine, October 2022
"What Works Best" feature in Inside Dental Hygiene Magazine, January 2024

COMMUNITY SERVICE
We Care to Share, Haiti- Volunteer Dental Mission. (2013, 2016, 2019)

EDUCATIONAL METHODOLOGY
Learning to Make Clinical Decisions- 2025
Clinical Teaching Strategies and Techniques- 2025
The Role of Adult Learning in Clinical Education- 2025
Dimensions of Clinical Teaching- 2025

CONTINUING EDUCATION
Local Anesthesia in Pediatric Dentistry- 2019
Sedation in the Dental Office: an overview- 2021
Managing Adult Emergencies in the Dental Office- 2023
Head and Neck Anatomy: Part I- Bony Structures- 2025
Head and Neck Anatomy: Part II- Musculature- 2025
Head and Neck Anatomy: Part III- Cranial Nerves- 2025

CPR/BLS Certification
American Heart Association Healthcare Provider Card, Expires Dec 2026

OREGON BOARD OF DENTISTRY

THIS PORTION FOR MAILING PURPOSES ONLY

ASHLEY D. LEAVITT
1458 N 66 ST
SPRINGFIELD OR 97478

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

H6096
License Number

OREGON BOARD OF DENTISTRY

2025/2027 Hygiene License

ASHLEY D. LEAVITT R.D.H.

Permits:
Nitrous Oxide
Endorsements:
Local Anesthesia

Restrictions:
None

Expires: 09/30/2027

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE IN PLAIN SIGHT OF LICENSEE'S PATIENTS

TAMARA MAAHS, RDH, BSDH, EP
Health Professions: Dental Hygiene
Lane Community College

TITLE Dental Hygiene Faculty, Registered Dental Hygienist, Expanded Practice Dental Hygienist (Oregon)

APPOINTMENT September 1994 (initial appointment) to present, Part-time Faculty (up to .67 FTE)
Temporary Contracted Faculty for 2021-22
Temporary Contracted Faculty for 2018-19
Temporary Contracted Faculty for 2004-05
Temporary Contracted Faculty for 2001-02

DENTAL HYGIENE LICENSURE/OTHER CERTIFICATION

- Oregon Dental Hygiene License: 1993 active, license number H3105
- PERMITS: Nitrous Oxide, Expanded Practice with Collaborative Agreement
- Oregon Certificate of Instructor Approval for Radiologic Proficiency
- DANB Radiation Health and Safety Certificate

EDUCATION

Bachelor of Science in Dental Hygiene
Oregon Institute of Technology, Klamath Falls, OR,
March 2001

Associate of Applied Science in Dental Hygiene
Lane Community College, Eugene, OR
June 1993

Associate of Applied Science in Dental Assisting
Oregon Institute of Technology, Klamath Falls, OR
June 1982

EDUCATIONAL METHODOLOGY

Dental Hygiene National Review Course, San Jose, CA, 2015

Educator Program Oregon Dental Hygiene Association Conference "Educational Methodologies for Successful Communication", 2013

"Striving for Better: An Intentional Approach to Clinical Teaching", Dental Hygiene Educators Workshop, University of Texas Health Science Center of San Antonio, 2013

Inservice courses in clinical instruction, educational methodology, and online instructional design (specifically Quality Matters Training for recognition of online courses 2007: Certified Peer Reviewer 2007 and SoftChalk interactive software for online instruction)

"Balancing Clinical Teaching and Evaluation", Dental Hygiene Clinical Educators Workshop, San Antonio, TX, 2005

Oregon Institute of Technology, DHY 450 Instructional Methods, 1998
Oregon Institute of Technology, DHY 451 Instructional Experience, 1998

DENTAL HYGIENE WORK EXPERIENCE

Academic

1994 to Present	Part-time and Temporary Contracted Faculty, Dental Hygiene Lane Community College, Eugene OR

Faculty Internship

June-Sept 2018	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2016	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2014	Absolute Dental Hygiene, Tamra Johns, RDH, BSDH, EP, Owner
June-Sept 2013	Eugene Periodontics & Implant Dentistry, Andrew N. Dow, DMD, MSD

Clinical

1993 to Present	General Practice Dental Hygienist, part-time Coleman A. Dow, DMD and Douglas N. Dow, DMD, Springfield, OR
1994 to 1997	General Practice Dental Hygienist, part-time Patrick V. Hagerty, DMD, Albany, OR
	Dental Hygiene Substitute Andrew N. Dow, DMD, MSD, Eugene, OR (6/2013-9/2015) Steven Abbott, DMD, Veneta, OR (6/2001-8/2001) Fred C. Platt, DMD, Eugene, OR (8/1994-12/1994) Stephen Skipworth, DDS, Cottage Grove, OR (8/1994) Stephen J. Dose, DMD, Eugene, OR (8/1994) Donald Tillman, DDS, Eugene, OR (7/1994) Mel Bryson, DMD, Springfield, OR (6/1994-7/1994) Mark G. Thoreson, DDS, Eugene, OR (6/1994-9/1994) Richard Smith, DMD, Springfield, OR (1/1994) Dennis W. Clark, DDS, Lebanon, OR (8/1993-9/1993) Michael E. Lacey, DMD, Eugene, OR (7/1993)
1992 to 1994	General Practice Dental Hygienist and Dental Assistant, part-time Andrew Holub, DDS, Eugene, OR
1987 to 1991	General Practice Dental Assistant, full-time Nicholas L. Kenney, DDS, Springfield, OR
1987	Dental Assistant substitute and part-time Steven W. Thurn, DMD, Springfield OR John Baron, DDS, Springfield, OR
1982 to 1987	General Practice Dental Assistant, full-time Terry L. Dressell, DMD, Klamath Falls, OR

CURRENT AND PAST TEACHING CONTENT

Oral Biology
Special Needs Patient/Medical Emergencies
Periodontology 1 and 2
Clinical Dental Hygiene 4 and 5 (didactic)
Clinical Dental Hygiene: first and second year clinic (second year lead and shared lead)
Local Anesthesia (orientation and lab instructor)
Trends and Issues in Dental Hygiene

AREAS OF SPECIAL COMPETENCE

- Patterson EagleSoft Software/Direct Digital Radiography
- Dental Hygiene Treatment Planning
- Dental Hygiene Current Dental Terminology and Coding: presentations for local study groups
- Local Anesthesia
- Power Driven Scalers (Ultrasonic Instrumentation)
- Periodontal Scaling/Advanced Instrumentation

WRITING AND DEVELOPMENT: EDUCATIONAL MATERIALS AND PUBLICATIONS

Periodontal Abscess or Gingival Abscess: "The Perils of Popcorn": A Clinical Case Report, Dentistry IQ, September 2022

Ultrasonics Lecture: Guest Speaker for Lane County Dental Hygienists' Association April 28, 2011

Trends & Issues in Dental Hygiene, developed first dental hygiene online course at LCC using Web CT and Moodle, 2002-present. Recognized in 2007 by Quality Matters Peer Course Review.

Design and delivery of online courses for LCC Dental Hygiene to include Clinical Dental Hygiene (lecture and lab), Periodontology, Trends and Issues in Dental Hygiene: made possible by the NPDHS distance learning Dental Hygiene Program project.

Dental Hygiene **CDT** Codes Instructional Module, co-author, 1996 and author of subsequent current revisions.

Nonsurgical Periodontal Therapy (Scaling and Root Planing) Consent Form for Lane Community College Dental Clinic

Instructional modules and educational materials for the Dental Radiology Continuing Education Course, 1996-2006.

"A Different Spin on Polishing." RDH Magazine, November 2006: 46-50 &102.

"The Beauty of Managed Care." RDH Magazine, June 2000: 46-50 & 100.

RELEVANT EDUCATION AND CONTINUING EDUCATION

- Dental Anxiety and Management of Symptoms February 2025
- Western Society of Periodontology Referring to Periodontist and Implant Maintenance October 2024
- 2024 Annual ADEA Meeting New Orleans: Building Clinical Preparedness, Approach to Faculty Calibration, Opportunity to Create Change in Dental and Dental Hygiene Licensure, Ethical Dilemmas, Artificial Intelligence March 2024
- Educators Platform Conference for Clinic and Lab Instructors October 2023
- Periodontal Classification System, April 2023
- Educator's Role in Teaching Implant Assessment, Maintenance, Homecare (also Mastery course), 2023
- Recordkeeping Board Protocols from Oregon Board of Dentistry, May 2022
- Review of Periodontology, Sept 2022
- Special Care Dentistry Series, Oct 2022
- Oral Pathology Cases and Concepts, Nov 2020
- Incorporating 2018 AAP Classifications of Periodontal Disease and Peri-Implant Diseases and Conditions into Practice, June 2020
- 2018 Western Society of Periodontology 66th Annual Scientific Session, San Diego, CA
- 2018 Western Society of Periodontology Program: Prognosis for the Periodontally Compromised Tooth, Improve Your Quality of Hygiene Care, and Peri-Implantitis: Prevalence, Risk Factors, and Non-Surgical Treatment, Portland, OR

- 2014 Optimizing Hygiene, Regenerative, and Implant Dentistry, Corvallis, OR
- 2012 Soft Tissue Laser Certification Course, Los Angeles, CA
- 2008 Western Society of Periodontology Annual Session, Las Vegas, NV
- 2007 WREB Educators' Forum, Rio Salado College, Tempe, AZ
- 2006 RDH Under One Roof Conference, Las Vegas, NV
  ▪Courses on Writing/Publishing and Hypersensitivity/Desensitizing
- 2001 Dental Hygiene National Board Review Course, San Francisco, CA
- 1999 Oregon Institute of Technology BUS 316 Total Quality in Health Care
- 1999 Oregon Institute of Technology BUS 317 Health Care Management

CPR/BLS CERTIFICATION

American Heart Association Healthcare Provider Card, expires January 2027